Department of Health

Departmental Report 2006

Departmental Report

The Health and Personal Social Services Programmes

This document is part of a series of Departmental Reports (Cm 6811 to Cm 6838) which, along with the Main Estimates 2006-07, the document *Public Expenditure Statistical Analyses 2006* and the Supplementary Budgetary Information 2006-07, present the Government's expenditure plans for 2005 to 2008.

Departmental Report 2006

Department of Health

DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health

and the Chief Secretary to the Treasury

by Command of Her Majesty

May 2006

Cm 6814

Price £22.00

Contents

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

This report and those of 1998 to 2005 are available on the Internet at:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/fs/en#5717390

The Department of Health also has a Public Enquiry Office which deals with general queries, 0207 210 4850.

Foreword by the Secretary of State

This year's annual report stands as a testament to the hard-working staff of the National Health Service, to those in public service who support them, and their commitment to creating a world-class system of health and social care.

The NHS is a huge enterprise. It is the third largest employer in the world. If the NHS were a country, it would be the 33rd largest economy in the world. It serves a population which is growing, living longer, and becoming more demanding. New technology and innovative drug companies are producing new treatments almost daily that are turning fatal diseases into treatable conditions. The public wants the same level of customer service from the NHS that we receive on the high street or when we are shopping online.

We have asked the British people to make a record investment in the NHS through their taxes and contributions, and by 2008, we will have trebled investment since 1997. But investment alone cannot deliver the improvements we all want to see. For the extra money to work for patients, we must step up our reforms. As we enter the halfway point in our ten-year plan to improve the NHS, it is useful to take stock and remind ourselves how far we have come:

- the lowest waiting lists since records began – what patients told us was their top priority;
- 19 out of 20 people seen in A&E within four hours;
- more hospitals repaired and built than ever before;
- since 1997 more lives saved – 43,000 lives saved from cancer; 60,000 lives saved from coronary heart disease;
- over 200,000 more staff since 1997, and better paid staff than ever before;
- more choice for patients, including a choice from this year of at least four hospitals for operations; and,
- innovations like NHS Walk-in Centres, NHS Direct, NHS foundation trusts and independent sector treatment centres (ISTCs) – all working to get better, faster care for patients.

From the new NHS Walk-in Centres in major railway stations such as Manchester and Liverpool St, to the announcement of a £1 billion new hospital for the people of East London, to new health centres across Britain like those I opened recently in Wolverhampton, Leicester and Harlow, we are seeing an NHS which is delivering more services to more people, and saving more lives than ever before.

If you just read some of the newspapers you would think the NHS was in crisis. If you look around the NHS itself, you can see a service that is back in business. Just consider the winter we've just come through. Only a decade ago, winter meant packed A&E departments, patients queuing in corridors on trolleys, exhausted staff, and real risks to patients' lives caused by the pressures on the system. The media pencilled in winter every year for the annual 'crisis in the NHS' story. This year, despite the coldest winter for four decades, the NHS has managed superbly, vaccinating record numbers against flu, and cutting waiting times to a maximum of six months: a target that many believed could not be met.

Of course, reforms on the ambitious scale we are delivering cannot be achieved without tough decisions. Our new financial framework, fairer and more transparent, is helping us to turn about the minority of NHS organisations with financial overspends. We will have an NHS back in balance by next year.

We know that the short-term noise and turbulence will be followed by a step-change in the quality of NHS care. Patients will continue to see the difference. The NHS will be sustainable and self-improving. Crucially, it will ensure that healthcare is available for the next generation, free at the point of use, and based on need, not the ability to pay.

That will only be achieved by further and faster reform:

A new system where money follows the patient much more effectively through the NHS. This means greater transparency on budgets with trusts being paid based on the number of people that they treat. More power is being given to practitioners to decide in consultation with their patients how and where they should be treated. We are tackling the inequalities in funding which meant that poorer areas of the country received less money than wealthier parts.

Improving productivity in the NHS. Our most effective hospitals, PCTs and primary health services are already using the best medical practice and technology to give people more personal, more local, and better care. And this is one of the main reasons why pay has increased for all in the NHS – they need the incentives to deliver the improved services which the public demand. But the results are better for patients as well as better value for money. Reorganising the way we deliver care inevitably means changes in how we use staff – with fewer in some hospital roles, and more in the community.

Improving preventative care. We are living longer with a much greater understanding of how to avoid illness through diet, exercise and other preventative measures. A genuine health service means supporting people to do more to care for themselves rather than simply treating them when they become ill.

The values underpinning the NHS are as relevant today as sixty years ago. They are a monument to progressive, enlightened thought. But the way those values are applied to the modern world must, by necessity, change. Through investment and reform we are laying the foundations for an NHS which will meet the challenges of the future, deliver more care, be more efficient, and maintain popular support. That is surely a prize worth having.

Rt Hon Patricia Hewitt MP
Secretary of State for Health

Ministerial Responsibilities

Secretary of State:
The Right Honourable Patricia Hewitt MP

Overall responsibility for the work of the Department with particular responsibility for: NHS and social care delivery and system reform, finance and resources, and strategic communication.

Minister of State for Health Services, MS (HS):
Rosie Winterton MP

Responsibilities include: International and EU business; emergency preparedness; cancer services; cardiac services; diabetes services; renal services; mental health (incl. Mental Health Bill); prison healthcare; dentistry; patient and public involvement, counter fraud and equality and diversity issues.

Minister of State for Delivery and Quality, MS(DQ):
The Right Honourable Jane Kennedy MP

Responsibilities include: Delivery of targets (access, 18-week, winter); financial recovery; NHS efficiency and productivity; PFI and major service reconfigurations; safety and quality and research, pharmacy and healthcare products.

Ministerial Responsibilities

Minister of State for NHS Reform, MS(R): Lord Warner

Responsibilities include: NHS budget setting and allocations; system reform; *Our Health, Our Care, Our Say* White Paper (health lead); community hospitals; unscheduled and emergency care; NHS workforce issues; primary care and NHS LIFT; chronic disease and NHS IT and Connecting for Health.

Parliamentary Under-Secretary of State for Public Health, PS (PH): Caroline Flint MP

Responsibilities include: Public Health White Paper implementation (including Health Improvement and Protection Bill); health inequalities; drugs; tobacco; alcohol; physical activity; diet and nutrition; communicable disease; immunisation; sexual health; HFEA and FSA; fluoridation and sustainable development.

Parliamentary Under-Secretary of State for Care Services, PS (CS): Liam Byrne MP

Responsibilities include: Social care finance, performance and workforce issues; social care inspection (CSCI and SCIE); children's health; maternity services; CAMHS; older people's services; physical and learning disabilities; allied health professionals; voluntary sector; *Our Health, Our Care, Our Say* White Paper (social care lead) and departmental management and ALB review implementation.

NB Ministerial details were correct up to 5th May 2006.

Department Of Health Organisation Chart

DH Department of Health

Chief Executive: Sir Nigel Crisp

Health and Social Care Delivery Group

Director: John Bacon

- Access
- Finance and Investment
- Workforce
- Programme and Performance
- Commercial
- Development
- Group Business Team
- Commissioning a Patient Led NHS
- Connecting for Health
- IT Service Implementation

Health and Social Care Standards and Quality Group

Director and Chief Medical Officer: Sir Liam Donaldson

- Healthcare Quality
- Programmes
- Research and Development
- Care Services
- Health Improvement
- Health Protection, International Health and Scientific Development
- Regional Directors of Public Health
- Group Business Team

Strategy and Business Development Group

Director: Hugh Taylor

- Corporate Management and Development
- Equality and Human Rights
- Policy
- User Experience and Involvement/Professional Leadership
- Communications
- Strategy
- Arms Length Bodies Review
- Group Business Team

1. Introduction

INTRODUCTION

1.1 This is the Department of Health's sixteenth annual report. In it, you will find a wealth of information about our current spending and investment programmes, and, more importantly, about the service improvements we have achieved through our use of public funds, particularly as measured by public service agreements (PSAs). The report also sets out our plans for the future, which is particularly important in a year when we critically evaluate the full extent of achievements made since 1997 as an integral part of preparations for the 2007 comprehensive spending review. This review will set the financial context for further investment in health and social care in future years.

1.2 The Department is responsible for the stewardship of over £90 billion of public funds. It advises ministers on how best to use funding to achieve and inform their decisions and carry out their objectives. The report also plays a central part in the Department's accountability to Parliament and ensures that there is full and open reporting to the general public.

1.3 This report was developed in consultation with other departments, Parliament and others. It was produced and published under the reporting framework issued by HM Treasury.

DEPARTMENT OF HEALTH

1.4 The Department sets overall policy on all health and social care issues, including public health matters and the consequences of environmental and food issues.

1.5 The Department is responsible for the provision of health services through the National Health Service (NHS).

1.6 The NHS includes independent contractors such as general medical practitioners (GPs), dentists, pharmacists and opticians.

1.7 The Department is responsible for managing performance against its statutory responsibilities.

1.8 The Department also determines the overall policy for the delivery of adults' personal social services (PSS) and for certain elements of children's services (e.g. child and adolescent mental health services). It gives advice and guidance to local authorities, whose responsibility it is to manage social care funding according to local priorities and the principles of local accountability.

NATIONAL HEALTH SERVICE (NHS)

1.9 In the 2004 spending review, the Chancellor confirmed the five-year settlement for the NHS announced in his 2002 Budget.

1.10 NHS funding will increase by an average of 7.1 per cent a year over and above inflation for the three-year period of the 2004 spending review (2005-06 to 2007-08). This will take NHS expenditure from £69.3 billion in 2004-05 to £92 billion in 2007-08.

PERSONAL SOCIAL SERVICES (PSS)

1.11 In the 2004 spending review, the Government allowed for continued, substantial growth in personal social services (PSS) resources in England.

1.12 Over the three years 2005-06 to 2007-08, there will be an average real terms increase in funding of 2.7 per cent over and above inflation. This compares to 6 per cent average annual growth from 2003-04 to 2005-06.

1.13 Globally, Government funding for social care currently stands at around £12 billion each year, with the majority administered by the Office of the Deputy Prime Minister through the formula grant. The Department sets the overall policy for delivery of adults' social care, while also contributing £2 billion in direct local authority allocations for specific grant funding and through the central budgets programme.

DELIVERING THE NHS PLAN

– NHS Improvement Plan – Putting People at the Heart of Public Services

1.14 *The NHS Plan*[1.1] was announced by the Prime Minister and the Secretary of State for Health on 27 July 2000. This plan set out the investment and reform strategy for the NHS, alongside the public service agreement targets for the NHS and Social Services.

1.15 The five-year funding increase announced in the 2002 Budget and confirmed in the 2004 spending review have enabled the Government to implement the vision set out in *The NHS Plan*.

1.16 *Delivering the NHS Plan*[1.2] in April 2002 outlined the improvements in services that the public can expect to see as the plan is put into action. It set out how the NHS would operate to secure the best use of resources.

1.17 In June 2004, the Department published *The NHS Improvement Plan – Putting People at the Heart of Public Services*[1.3]. This document set out the priorities for the NHS up to 2008. It supports the ongoing commitment to the ten-year reform process first set out in *The NHS Plan*.

1.18 *The NHS Improvement Plan* sets out the key commitments that the NHS will deliver to transform the patients' experience of the health service by 2008 through dramatic reductions in waiting times, increased choice for patients, more focus on the treatment of patients with chronic illness and prevention of disease and the tackling of ill health through public health interventions.

1.19 *The NHS Improvement Plan* also sets out how these services will be delivered by the NHS. For example, through NHS foundation trusts; independent and NHS treatment centres; and new ways of meeting patient needs in primary care. There will also be increases in NHS staffing coupled with new ways of working to meet patients' needs and investment in state-of-the-art information systems to allow patients to choose more convenient and higher quality personal care. This will all be supported by a system of financial incentives and performance management that will drive the delivery of the new commitments whilst continuing to hand money, control and responsibility to local health services.

– Creating a Patient-led NHS – Delivering the NHS Improvement Plan

1.20 In support of the *NHS Improvement Plan* the Department published *Creating a Patient-led NHS – Delivering the NHS Improvement Plan*[1.4] on 17 March 2005. The ambition over the next few years is to deliver a profound change to the NHS – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a fundamental change in the relationship with patients and the public. The plan is to move from a service that does things to and for its patients to one that is patient-led, to deliver a service that works with patients to support them with their health needs. Every aspect of the new system is designed to be patient-led through:

- a greater range of choices and range of information to help make those choices;
- stronger standards and safeguards for patients; and,
- NHS organisations being better at understanding patients and their needs, who use new and different methods to do so and have better and more regular sources of information about preferences and satisfaction.

1.21 *Creating a Patient-led NHS* describes the major changes underway in the NHS and explains how some of the biggest changes will be taken forward. It is aimed primarily at NHS leaders to provide clarity on how they should carry forward the transformation of the NHS to be truly patient-led. This process will be supported by a programme of work for the national issues, delivered mainly through the 'National Leadership Network' for health and social care and steered by the Department.

1.22 More recently, the Department has published the document *Health Reform in England: Update and Next Steps* [1.5] on 13 December 2005. The document describes the elements of reforms to the healthcare system and how they are expected to interact, resulting in better patient services and value for taxpayers' money. It sets out a framework for reform and:

- explains how the reforms are intended to be mutually reinforcing;
- re-states the rationale for reform;
- summarises the initiatives already announced; and,
- lays out a programme of further policy development for 2006.

1.23 In 2005, the Department conducted two consultations, *Independence, Well-being and Choice* [1.6] and a listening exercise, *Your Health, Your Care, Your Say* [1.7]. *Independence, Well-being and Choice,* the adult social care Green Paper, asked for views

on how social care services could be improved. The listening exercise, *Your Health, Your Care, Your Say*, allowed the public to speak directly to ministers, health professionals, and each other on how improvements could be made to their local services.

1.24 In the consultations, people wanted to see change that put them more in control. They also called for a consistent quality of services around the country and more 'joined up' care to support them in their everyday lives, closer to their homes. The consultations have formed the basis of the new White Paper, *Our Health, Our Care, Our Say: A New Direction for Community Services* [1.8]. The new White Paper was published on 30 January 2006.

1.25 The White Paper proposes action to give people better access to services and greater control over their own health. It promises 'a radical and sustained shift' in the way resources are used and sets out to address future challenges with a new emphasis on preventative care to help people enjoy good health as they live longer.

1.26 During the course of 2006, the Department, working in close collaboration with people from across the NHS and health related organisations, will produce a series of policy framework documents on the next steps for health reform. These reforms offer a real opportunity to provide a better service to patients and the public, enabling the people in the NHS to make the most of their skills and commitment.

CONTENT SUMMARY

1.27 The following chapters in this report provide Parliament and the public with an account of how the Department of Health has spent the resources allocated to it, as well as its future spending plans. It also describes our policies and programmes and gives a breakdown of spending within these programmes. This section serves as a guide to the content and structure of this report.

• Chapter 2 – Delivering Better Public Services – progress

This section outlines the aims and objectives of the Department. We also list the progress against those targets and standards set following the 1998, 2000, 2002 and 2004 spending reviews. The 2000 review was also informed by 15 cross-departmental reviews of issues that may benefit from a joint approach involving two or more Government departments. Some of these reviews resulted in targets that appear in our Department's public service agreement (PSA). Progress is also shown against these as well as our 'Modernising Government' action plans.

• Chapter 3 – Expenditure

Chapter 3 provides information on the Government's expenditure plans up until 2007-08 and includes outturn figures for 2004-05. Supplementary tables to this chapter can be found in the Annexes A1 to A3.

• Chapter 4 – Investment

Investment continues to play a pivotal role in the modernisation of the NHS. The *NHS Plan* and the *Departmental Investment Strategy* [1.9] set out a planned programme of investment in the NHS. This chapter serves to highlight those priorities.

• Chapter 5 – Delivering the NHS Plan

The *NHS Plan* set the direction for modernisation and reform. It set out how an NHS fit for the 21st century will be delivered. The next steps for investment and reform were published in *Delivering the NHS Plan* in April 2002. A summary of the progress to date in achieving those aims is given.

In June 2004, the Department of Health published *The NHS Improvement Plan – Putting People at the Heart of Public Services*. This document set out the priorities for the NHS up to 2008. It supports the ongoing commitment to the ten-year reform process first set out in *The NHS Plan*. Following on from this in March 2005, *Creating A Patient-led NHS* was published. This set out our ambition to transform the relationship between the healthcare system and patients and the public.

• Chapter 6 – Breakdown of Spending Programme

This provides a breakdown of spending across our main programme areas (NHS, family health services (FHS) and personal social services (PSS) etc) as well as providing such breakdowns as spend per head of population and by age profile.

• Chapter 7 – Activity, Performance and Efficiency

Chapter 7 is broken down into four main areas: activity; performance; efficiency and PSS activity, performance and efficiency. It provides such activity data as hospital activity, in-patient and outpatient waiting trends as well as those services provided by general and personal medical services. It also demonstrates how we are making improvements in our performance and efficiency that will enable the effective delivery of services.

• Chapter 8 – Managing the Department of Health

This section outlines the running costs, staffing, recruitment policy and senior civil service salaries of the Department as well as describing how well the Department manages risk, handles correspondence from the public and the environment in which we operate.

• Annexes

The annexes provide a list of the non-departmental public bodies (NDPBs), NHS bodies and agencies that help the Department discharge its functions. There is also an account of the Department's spend on publicity, advertising and sponsorship. The annexes also contain tables that are supplementary to other sections in this report.

2. Delivering Better Public Services – Progress

INTRODUCTION

2.1 In setting out its spending plans for 1999-2002 in the 1998 comprehensive spending review (CSR), the Government set new priorities for public spending with significant extra resources in key services such as education and health.

2.2 The Government also made a commitment to link this extra investment to modernisation and reform, to raise standards and improve the quality of public services. The White Paper, *Public Services for the Future: Modernisation, Reform, Accountability*[2.1], December 1998 and its supplement[2.2] published in March 1999, delivered this commitment by publishing for the first time measurable targets (public service agreements – PSAs) for the full range of the Government's objectives.

2.3 The Department of Health's aims and objectives, followed by a detailed analysis of the PSA targets resulting from the comprehensive spending review (CSR) as well as the spending reviews from 2000, 2002 and 2004 are set out in the following paragraphs and tables. The tables focus primarily on 'live' or outstanding targets. Where targets have already been met or superseded these have been presented in a table at **Annex F** to this report.

2.4 The next comprehensive spending review (CSR 2007) will set the Government's priorities for the longer term. The CSR is an excellent and timely opportunity for the Department and wider Government to consider the outcomes achieved from the considerable investment in health and social care during the last ten years, and to determine whether the correct level of progress has been made against the rigorous targets we have set for improvement and performance. Completing this review will help provide a solid foundation for the future value for money investment of public funds. A central strand to our CSR 2007 preparations will involve us working to refine the relevant parts of the performance management framework.

THE DEPARTMENT OF HEALTH AIMS AND OBJECTIVES

Aims

2.5 The Department's overall aim is to improve the health and well-being of the people of England.

2.6 The distinctive roles of the Department include:

- developing strategy and direction for the health and social care system – including not for profit and private providers – while maintaining the integrity of the system and its values;
- providing the legislative framework;
- building capability and capacity;
- setting some standards and ensuring others are set;
- securing and allocating resources and ensuring that their usage provides value for money; and,
- ensuring accountability to the public and Parliament.

2.7 To carry out this role, the Department has been organised into three Business Groups, responsible for Standards and Quality, Delivery, and Strategy and Business Development. The Departmental Management Board, under Sir Nigel Crisp's chairmanship, coordinated the leadership and management of the department, in support of Ministers. In January 2006, following a review of the Department's top structure and capability, the Secretary of State and Sir Nigel announced some changes in the Department's structure and associated arrangements. These are designed in particular to support delivery primarily through commissioning rather than through performance management, to enhance the challenge role of finance and to raise the profile of social care in the Department. Work is in hand to implement the review's conclusions by July 2006.

Objectives

2.8 The Department has the following objectives, derived from its public service agreement with HM Treasury:

- improve and protect the health of the population – with special attention to the needs of the poorest, and those with long-term conditions;
- enhance the quality and safety of services for patients and users, giving them faster access to services and more choice and control;
- deliver a better experience for patients and users;
- improve the capacity, capability and efficiency of the health and social care systems, ensuring that system reform, service modernisation, IT investment, and new staff contracts deliver improved value for money and higher quality;
- improve the service we provide as a Department of State to – and on behalf of – Ministers and the public, nationally and internationally; and,
- become more capable and efficient as a Department, and cement our reputation as an organisation that is both a good place to do business with, and a good place to work.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS – MONITORING AND REPORTING

2.9 Targets are intended to be outcome-focused, delivering further improvements in key areas of public service delivery and capturing the outcomes that matter to people, and this inevitably means that measurement may be complex in some cases. We are committed to ensuring that the data used in monitoring and reporting on PSAs is robust and reliable. The data systems underpinning PSA targets are subject to validation by the National Audit Office (NAO). We accept that there are some areas where data collection needs to improve, and work is in place to ensure that this is happenning. The Department works closely with HMT, PMDU and analytical experts to ensure improvements to data relating to all target areas.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (CSR 1998) ANALYSIS

2.10 Targets 1, 2, 5, 13 and 20 have been subsumed into SR 2002 targets. Final reporting took place in the Autumn Performance Report 2003 and the Departmental Report 2004 with regards to the majority of the other targets. Information on those that remain live, targets 3, 4, 7, 29 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 per cent by 2010, from a baseline of 15.9 per 100,000 population for the three years 1995 to 1997.	Death rate from accidents.	**Slippage:** Data for 2002-04 (three-year average) show a rate of 15.9 deaths per 100,000 population – a rise of 1.0 per cent from the baseline (1995-97).
Target 4: Reduction in the rate of hospital admission for serious accidental injury by at least 10 per cent by 2010, from a revised 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 four or more days.	**Slippage:** These data are single financial year figures, available annually. Single year data for financial year 2002-03 show a rate of 327.8 admissions per 100,000 population – an increase of 3.8 per cent from the baseline estimate (1995-96).

Objective II: To treat people with illness, disease, or injury quickly, effectively, and on the basis of need alone.

PSA Target	Measure	Progress
Target 7: Ensure everyone with suspected cancer is able to see a specialist within two weeks of their GP deciding they need to be seen urgently and requesting an appointment for: all patients with suspected breast cancer from April 1999; and, for all other cases of suspected cancer by 2000.	Percentage of patients with suspected breast cancer and other cancers able to see a specialist within two weeks of urgent referral.	**Nearly met:** 99.8 per cent of all patients referred urgently with suspected cancer were seen by a specialist within two weeks during October to December 2005. The Department also measures a maximum one-month wait from diagnosis to first treatment for breast cancer. Between October to December 2005, 98.9 per cent of women with breast cancer received first treatment within one month of diagnosis. The Department also measures the number of women with breast cancer who receive treatment within two months of urgent referral by their GP. Between October to December 2005, 98.1 per cent of patients received treatment within two months. The NHS must also maintain targets of a maximum one month wait from diagnosis to first treatment and a maximum wait of two months from urgent referral to first treatment for all cancer patients. These were introduced from January 2006. The latest progress data, for the period October to December 2005, shows that 96.8 per cent of cancer patients received treatment within one month of diagnosis and 83.9 per cent of patients received treatment within two months of urgent referral.

Objective V: To assure performance and support to Ministers in accounting to Parliament and the public for the overall performance of the NHS, Personal Social Services (PSS) and the Department of Health.

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

PSA Target	Measure	Progress
Target 29: Payment of all undisputed invoices within 30 days or the agreed contractual terms if otherwise specified.	Percentage of payments made on time.	**Nearly met:** At the end of January 2006 (2005-06 year-to-date), the Department had a total of 96.2 per cent of its undisputed invoices paid within 30 days. This is a significant improvement on the 2004-05 full year figure of 92.5 per cent. This is due to improved business processes in the Department enabled by the introduction of a new finance system, Vista, and increased usage of the Government Procurement Card (GPC).

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 per cent by April 2000. Performance improvement 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 per cent. Over 99 per cent 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 per cent by the end of 2001-02; and, To reduce the number of incidences by 30 per cent by the end of 2003-04. In November 2003 and March 2004, the NHS, supported by the NHS Security Management Service, introduced two comprehensive legal frameworks of measures to tackle violence against NHS staff as well as general security management measures. In 2004-05, it is estimated that 85,000 front-line NHS staff received training on how to prevent and manage violence. By March 2006, it is expected that nearly 40 per cent of front-line staff in the NHS will have been trained in the Conflict Resolution Training syllabus. A specific syllabus for staff working in mental health and learning disability settings was introduced in November 2005. In 2004-05, 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. In December 2005, figures for the acute and ambulance services were published. For the acute sector this reveals that there was an estimated 11,482 physical assaults, and for the ambulance service the figure is 1,329. The exercise has been validated by an independent statistician and the estimate is accurate to +/- 1.5 per cent, with an overall confidence level of 95 per cent. From the DH survey in 2002-03 there were 37,776 assaults reported for the acute sector and 5,412 for the ambulance service. Figures on physical assaults in the primary care sector will be released early in 2006. The Healthcare Commission's staff survey in 2004 saw a one per cent reduction in NHS staff experiencing abuse and violence over that reported for 2003.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (SR 2000) ANALYSIS

2.11 The majority of SR 2000 targets were subsumed within SR 2002 targets. Information on the remaining live target – target 10 – is given here.

Objective V: Value for Money.

PSA Target	Measure	Progress
Target 10: The cost of care commissioned from trusts which 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 five years, with agreed milestones for 2003-04.	Reference Cost Index.	**On course** (subject to amendment): The NHS Trust National Reference Cost Indices for 1999-2000, 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 per cent in 1999-2000, to 21 per cent in 2000-01, to 17 per cent in 2001-02, to 15 per cent in 2002-03, to 12 per cent in 2003-04, and to 10 per cent in 2004-05.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (SR 2002) ANALYSIS

2.12 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 (PSAs). The targets from that review are laid out in the table below with updates on progress. Targets 5 and 6 have been subsumed within SR 2004 targets. Targets 2, 3, 4 and 7 have been adopted as DH standards at SR 2004.

Objective I: Improve Service Standards.

PSA Target	Measure	Progress
Target 1: Reduce the maximum wait for an outpatient appointment to three months and the maximum wait for in-patient treatment to six months by the end of 2005; and to achieve progressive further cuts with the aim of reducing the maximum in-patient and day case waiting time to three months by 2008.	Number of patients on NHS waiting lists.	**Outpatient waiting times – met:** Number of English residents waiting more than three months (13 weeks) – quarterly figures: December 2002 – 223,575 December 2003 – 121,908 December 2004 – 62,752 December 2005 – 171[1] [1] Of the 171 patients who have been waiting over 13 weeks, 18 were waiting for an appointment at English trusts and 153 were waiting for an appointment at Welsh hospitals. **In-patient waiting times – on course:** Number of English residents waiting more than six months – monthly figures: February 2001 – 251,474 February 2002 – 242,900 February 2003 – 207,271 February 2004 – 113,485 February 2005 – 60,493 December 2005 – 48[2] February 2006 – 116[3] [2] Of the 48 patients who have been waiting over six months, 12 were waiting for an admission at English trusts and 36 were waiting for an admission at Welsh hospitals. [3] Of the 116 patients who have been waiting over six months, 91 were waiting for an admission at English trusts and 25 were waiting for an admission at Welsh hospitals.

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 two per cent per annum, with annual improvements of one per cent 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 2004-05, this measure suggests that value for money through cost efficiency increased by 0.8 per cent. As outlined in chapter 7 (productivity section) the Department is working with ONS to develop new measures of NHS productivity. In terms of assessing the value for money derived from social care expenditure, we have used a measure which compares council's own record of estimated cashable efficiency savings (from the Annual Efficiency Statements submitted to ODPM) against total adult social care funding allocated by the Department of Health in the same year. Annual efficiency statements are not available for years prior to 2004-05. Based on the mid-year Efficiency Statements for 2005-06, the level of social care efficiency has increased to 1.54 per cent. This measure does not take account of changes in service quality. The Personal Social Services Research Unit (PSSRU) at the University of Kent and London School of Economics is working to develop an output measure that takes account of changing quality of care and client dependency.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (SR 2004) ANALYSIS

2.13 Further to the 1998, 2000 and 2002 spending reviews, the 2004 review again 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 Target	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 per cent in people under-75, with a 40 per cent reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole;	Death rate from heart disease, strokes 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 (three-year average latest available data) the rate had fallen to 96.7 deaths per 100,000 – a fall of 31.4 per cent. Three-year average rates have fallen for each period since the baseline. If the trend of the last ten years were to continue, the target would be met before the target period. **Inequality dimension – On Course** Three-year average rates have fallen in the spearhead group and England as a whole for each period since the baseline. During this period, the inequality gap has reduced from a baseline absolute gap of 36.7 deaths per 100,000 population in 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 per cent since the baseline, compared to the required target reduction of at least 40 per cent by 2009-11.
from cancer by at least 20 per cent in people under-75 with at least a reduction in the inequalities gap of at least 6 per cent between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole;	Death rate from cancer amongst people aged under-75.	**Cancer – overall mortality – On Course** The 1995-97 baseline figure for overall mortality for cancer in people aged under-75 in England was 141.2 deaths per 100,000 population. However, in 2002-04 (three-year average, latest available data) the rate had fallen to 121.6 deaths per 100,000 – a fall of 13.9 per cent. Three-year average rates have fallen for each period since the baseline. The milestone for 2004/05/06 has been passed and if the trend of the last 10 years were to continue the target would be met. **Inequality dimension – Provisionally Met** Three-year average rates have fallen in the spearhead group and England as a whole for each period since the baseline. Following a small increase in the inequality gap in the first monitoring period, the gap has reduced slightly from a baseline absolute gap of 20.7 deaths per 100,000 population in 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 per cent since the baseline, compared to the required target reduction of at least six per cent 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 per cent.	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 three-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 per cent 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.

PSA Target	Measure	Progress
Target 2: Reduce health inequalities by 10 per cent 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 (three-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 per cent higher than in the total population. This compares with 13 per cent higher in the baseline period of 1997-99, although there have been year-on-year fluctuations in intervening years.
	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, but there are early signs of progress on some key disease areas and in some geographical areas: Data for 2002-2004 (three-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 one per cent, for females by eight per cent. 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 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less.	Smoking: reduction in numbers of adult (26 per cent) and routine/manual (31 per cent) groups of smokers (2002-03 baselines). Prevalence from General Household survey.	**Adult Smoking Rates – on course** The percentage of adults smoking has fallen by two per cent since 2001. Whilst 27 per cent of the whole population smoked in 2001, this figure had fallen to 25 per cent in 2004. Of these, the routine and manual figures were 33 per cent and 31 per cent respectively. These figures are taken from ONS General Household Survey 2004.
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 for Culture, Media and Sport).	Obesity: Prevalence of obesity as defined by National BMI percentile classification for children aged between two and 10 years (inclusive) measured through the Health Survey for England. Baseline year is weighted average for three-year period 2002–2004.	**Obesity** Progress against the target will be measured through the Health Survey for England. The baseline established for the three-year period 2002-04 is 14.9 per cent.
Reducing the under-18 conception rate by 50 per cent by 2010, as part of a broader strategy to improve sexual health (joint target with the Department for 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 2004 show a 11.1 per cent reduction in the under-18 conception rate for England since 1998. Between 1998 and 2004, rates have declined in all regions and in around 75 per cent 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 per cent and 60 per cent by 2010. To accelerate progress work is underway to intensify delivery of the strategy to vulnerable groups and high rate neighbourhoods, and to broaden delivery to address the underlying factors which put young people at risk of teenage pregnancy. The fifth full year of implementation of local strategies ended in March 2006 and all 30 action points set out in the Teenage Pregnancy Strategy are being implemented.

Objective II: Long-Term Conditions.

PSA Target	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 five per cent 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 uses of care.	**Reduction in number of emergency bed days** Between 2003-04 and 2004-05, the number of emergency bed days decreased by 1.80 per cent, 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 (i.e. number of patients on NHS waiting lists) until the launch of the full GP referral to hospital treatment measure.	The 18-week delivery programme has developed an initial assessment that has identified four 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; and, ensuring the 18-week and system reform agendas are aligned. A delivery plan will be published in spring 2006.
Target 6: Increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.	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 Treatment Monitoring System (NDTMS), reveal that 160,450 people received specialist, structured drug treatment in England during 2004-05, an increase of 27 per cent on 2003-04 (125,545) and 89 per cent 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: Improving the 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 aspects 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 seven different NHS settings. Four 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. Full details and the results (including results for all participating NHS organisations and nationally aggregated data) for all surveys conducted to date are available on the Healthcare Commission website: **http://www.healthcarecommission.org.uk/NationalFindings/Surveys/PatientSurveys/fs/en?CONTENT_ID=4000117&chk=XPJRIh**

PSA Target	Measure	Progress
Target 7 (continued):		**Surveys** – on course (continued): 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 have 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 seven in ten (73 per cent) answered "yes completely", 24 per cent answered "yes to some extent", while four per cent answered "no".

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

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 one per cent 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, i.e. 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 are assessing 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 working with the Health and Social Care Information Centre to pilot a new collection to assess the VCS contribution to community based services.
increasing by 2008 the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care.	Those people receiving more than 10 contact hours of home care and six 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 increased to 32 per cent 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 per cent of the total by 2005-06) was met two years early when 2003-04 performance was 30.1 per cent. A small proportion of councils are performing below expectation and so we are working with the Care Service Improvement Partnership (CSIP) to consider specific interventions that we hope will improve those councils' ability to improve their performance.

DH SR 2004 STANDARDS

2.14 The following standards were adopted by the Department at SR 2004. Previously they were part of the PSA target agreed with HM Treasury at SR 2002.

Standard	Measure	Progress
Standard 1: Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge; and reduce the proportion waiting over one hour.	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 per cent of all attenders were admitted, transferred or discharged within four hours of arrival.
Standard 2: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.	PCT performance is measured through the Primary Care Access Survey (PCAS) and is reflected in the PCT performance ratings. PCAS 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 March 2006 survey showed that nationally: 99.94 per cent of patients were able to be offered a GP consultation within two working days; and, 99.94 per cent of patients were able to be offered a primary care professional consultation within one working day. The Department is now: Broadening the scope of the 24/48hr access target to include advance booking, the opportunity for patients to see their preferred GP, and responsive telephone access; and, Improving the reporting system. Strengthened checks will include tighter monitoring by PCTs through varying monthly survey dates, a sample check of PCT data and introducing a new patient survey at practice level.
Standard 3: 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.	The Department's monthly central data collection measures the percentage of patients given the opportunity to choose most convenient date from a range of dates.	**Booking – early stages of delivery:** Figures for January 2006 show that there has been a percentage point increase of 1.4 per cent in the number of day cases booked over the past year. January 2004 – 84.6 per cent January 2005 – 98.2 per cent January 2006 – 99.6 per cent The number of in-patients' appointments booked (day cases and ordinary admissions) has increased by a percentage point change of 5.4 per cent over the past year. January 2004 – 75.1 per cent January 2005 – 94.1 per cent January 2006 – 99.5 per cent Outpatient booking has increased over the past year by a percentage point change of 16.3 per cent. January 2004 – 52.7 per cent January 2005 – 82.5 per cent January 2006 – 98.8 per cent Electronic booking The Choose and Book system will enable patients to choose their hospital and book their appointments electronically either from the GP's surgery or later from home or work by contacting a call centre (Choose and Book Appointments Line CABAL). They will also be able to make or change appointments by e-mail and eventually via digital television. **Choice – on course** Since 1 January 2006, eligible patients needing planned hospital care are being offered a choice of at least four providers where this is clinically appropriate at the point of GP referral to consultant-led first outpatient appointments. The implementation of choice at referral follows the earlier introduction of choice in stages for patients needing elective care: Since August 2004, patients who would otherwise wait longer than six months for elective surgery have been offered the choice of having faster treatment at an alternative provider; Since April 2004, 76,327 patients have accepted such an offer of choice; Since January 2005, cataract patients have been offered the choice of two or more providers at the point of referral; and, From April 2005, patients needing cardiac surgery have been given the choice of two or more providers at the point of referral by the cardiologist.

Standard 4: Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and CAMHS (child and adolescent mental health services).	Annual mapping of CAMHS and quarterly local delivery plan returns. For crisis services there are two main forms of measurement: Number of patients who are subject to at least one consultant episode (acute home based) per annum is measured. Number of Crisis Resolution teams established.	**Access to CAMHS – continuing progress:** Progress is measured by the availability of access to three particular elements of CAMHS set out below. The figures show the percentage of PCT areas where the services are available as at Q3 2005-06: 24/7 emergency service: 82.5 per cent; CAMHS service for those with learning disability: 50.5 per cent; and, Service for 16/17s: 74.3 per cent. **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. The 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) – 28,500 2003-04 (Q4) – 45,800 2004-05 (Q2) – 69,800 2005-06 (Q2) – 48,800[1] [1] Due to definitional issues some data has been estimated.

TARGETS FROM CROSS-DEPARTMENTAL REVIEWS

2.15 Cross-departmental reviews play a key role in developing public service agreement (PSA) targets and encouraging effective working across Government on key issues like health inequalities. They can also inform spending reviews – SR 2002 involved seven cross-departmental reviews, including a review on health inequalities while SR 2004 strengthened public health PSA targets and underpinned *Choosing Health* [2.3].

Health Inequalities

2.16 The Health Inequalities Unit (HIU) leads the Department's work on health inequalities. It is responsible for driving delivery of the national health inequalities strategy, set out in the *Programme for Action* [2.4], and meeting the PSA health inequalities target for reducing the gap in life expectancy and infant mortality. Health inequalities have a higher profile because of SR 2004 which:

- retained the overall health inequalities target – by 2010 to reduce by 10 per cent health inequalities as measured by infant mortality and life expectancy;
- introduced new targets to reduce the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by at least 40 per cent for cardiovascular disease and by at least six per cent for cancer;
- added the target to reduce adult smoking prevalence in routine and manual groups to 26 per cent or less by 2010 to the PSA portfolio;
- added a new target to halt the year-on-year rise in obesity among children under 11 by 2010, jointly with the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS); and,
- retained the target to reduce the under-18 conception rate by 50 per cent by 2010, jointly with DfES.

2.17 The establishment of a spearhead group of 70 local authority areas with the worst health and deprivation indicators (covering 28 per cent of the population) has been a key development arising from the decision to add a health inequalities dimension to the cancer and heart disease targets. These targets focused on narrowing the gap between the population as a whole and the "fifth of areas with the worst health and deprivation indicators" and made a good fit with the life expectancy element of the health inequalities target which is also area based. A meeting of the spearhead group was held in March 2005 with over 200 representatives from the NHS, local authority and other interests. Prospects for the delivery of the target will be significantly enhanced by the Department's decision in January 2006 to make health inequalities one of the top six NHS priorities (this is set out in more detail in chapter 5).

2.18 A report on the national health inequalities strategy was published in August 2005, *A Status Report on the Programme for Action* [2.5]. This document reported developments against life expectancy and infant mortality data, the 12 cross-government headline indicators, and departmental commitments to the national strategy. It showed that while the health gap on life expectancy and infant mortality continues to widen in line with the trend, there are signs of a narrowing of the gap in some of the main determinants of health. These areas included deaths from heart disease and stroke, a major reduction in the number of children in poverty and a narrowing of the gap in terms of housing. Almost all commitments for 2004 made by Government departments in the *Programme for Action* were achieved.

Cross-Government Headline Indicators on Health Inequalities

1. **The big killers** – there have been significant improvements in death rates from cancer and heart disease since 1995-97 (including in disadvantaged areas); there have been some signs of a narrowing of the gap in cancer death rates, and a 22 per cent narrowing of the gap in heart disease death rates in absolute terms.
2. **Teenage pregnancy** – there has been a 9.8 per cent drop in the rate of under-18 conceptions between1998 and 2003, but no significant narrowing of the gap; findings from a national evaluation of the Teenage Pregnancy Strategy indicate that over a longer period, teenage conception rates in the most deprived top-tier local authorities fell faster than in other areas.
3. **Road accidents** – there has been a significant reduction in the rate of road accident casualties for children since 1998, but no significant narrowing of the gap in such casualties.
4. **Primary care services** – there has been an improvement in the number of GPs since 2002 (including in disadvantaged areas), but no significant narrowing of the gap in the number of GPs.
5. **Flu vaccinations** – there has been an improvement in the percentage of uptake of flu vaccinations since 2002, accompanied by a slight narrowing of the gap in the uptake of these vaccinations.
6. **Smoking** – there has been a reduction in smoking prevalence among all adults since 1998 (including a slight reduction in manual groups), but no significant narrowing of the gap in smoking prevalence between manual groups and other groups; there is a strong social gradient in smoking prevalence among pregnant women (smoking in pregnancy data are only available for the baseline year 2000).
7. **Educational attainment** – there has been a significant improvement in the proportion of those aged 16 who get 5 GCSEs grade A*-C since 2002 (including for the most disadvantaged groups), and some signs of a narrowing of the gap between pupils eligible for free school meals (FSM) and all pupils.
8. **Fruit and vegetable consumption** – since 2001 there has been no improvement in fruit and vegetable consumption for the most disadvantaged groups and no significant narrowing of the gap.
9. **Housing** – there has been a significant reduction in the proportion of households living in non-decent housing since 1996, with a significant narrowing of the gap between vulnerable households and all households overall in absolute terms.
10. **PE and school sport** – nearly two-thirds of pupils in school sport partnerships spend at least two hours a week on high quality PE and school sport but with lower participation rates in schools with a high proportion of FSM pupils (data are only available for the latest year).
11. **Poor children** – there has been a significant reduction in the proportion of children living in low income households since 1998-99 on all measures.
12. **Homeless families** – since March 2002 there has been a significant reduction in the number of homeless families in bed and breakfast accommodation; there has been a significant increase in the number of families living in temporary accommodation.

Action Against Illegal Drugs

2.19 This programme seeks to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs. As part of the Government's drugs strategy, a target has been set to:

- increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008 and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

2.20 The results from the National Drug Treatment Monitoring System (NDTMS) reveal that 160,450 people received specialist, structured drug treatment in England during 2004-05, an increase of 27 per cent on 2003-04 (125,545) and 89 per cent on the 1998-99 baseline of 85,000. This is well ahead of the schedule to double the numbers in treatment by 2008.

2.21 In March 2005, 75 per cent of all clients in treatment either successfully completed or retained in treatment, compared to 72 per cent in March 2004. This meets the PSA target of increasing the proportion of drug misusers either retained or successfully completing treatment.

2.22 Average waiting times for drug treatment have fallen from 9.1 weeks in December 2001 to 2.4 weeks in December 2005.

CROSS-GOVERNMENT INITIATIVES

Sure Start

2.23 Sure Start programmes, including a wide range of universal and targeted initiatives, aim to improve the health, well-being, and development of young children and families, particularly those in the most disadvantaged areas. They also help strengthen families and reduce child poverty, and contribute to building and sustaining strong local communities.

2.24 The Sure Start 'Extended Schools and Families' group of the Children, Young People and Families Directorate of DfES, reports jointly on Sure Start to DfES and DWP. It has governmental responsibility for disadvantaged area programmes for young children, including children's centres, early years education (three and four-year-olds) and childcare (0-14, and 0-16 for those with special needs), extended schools – which offer a range of services beyond the school day – and parental advice and support.

2.25 The Government has invested well over £17 billion on early years and childcare services since 1997 (including under-fives sub block funding to local authorities to support free early education for three and four-year-olds) as part of an unprecedented expansion of provision for young children and families.

2.26 The *Ten Year Childcare Strategy*[2.6], published in December 2004, set out ambitious plans to create a sustainable framework for high quality services for children and families. Key commitments were the delivery of universal affordable childcare for 3 to 14-year-olds and a Sure Start children's centre for every community, so early years and childcare services become a permanent, mainstream part of the welfare state.

2.27 *The Childcare Bill*[2.7] was published on 8 November 2005 to take forward, and give statutory force to, key commitments in the ten-year strategy. The Bill provides for:

- a new duty on local authorities to improve the outcomes of all children under five, and close the gaps between groups with the poorest outcomes and the rest, by ensuring early years services are integrated and accessible;
- a new duty on local authorities to secure sufficient childcare to ensure it meets the needs of their local communities, in particular those on low incomes and with disabled children;
- an extended duty on local authorities to ensure people have access to the full range of information they may need as a parent; and,
- a reformed and simplified regulatory framework for early years and childcare including the introduction of the early years foundation stage to support the delivery of quality integrated education and care for children from birth to age five – to reduce bureaucracy and raise quality.

2.28 All three and four-year-olds are now guaranteed a free, part-time (12½ hours per week), 33 weeks a year, early education place. From 2006, all three and four-year-olds will receive their free early education over 38 weeks of the year. From 2007, three and four-year-olds will begin to receive an enhanced entitlement of 15 hours per week, with all of them receiving it by 2010. Our longer-term goal is an extension of the entitlement to 20 hours a week. Parents will also have flexibility to use the free entitlement across a minimum of three days. In addition, we will pilot an extension of free, part-time early education to 12,000 two-year-olds in disadvantaged areas by 2008.

2.29 The expansion of childcare provision continues, and at September 2005, more than 1.2 million new childcare places had been created since 1997. Taking into account turnover, over 582,000 new Ofsted (Office for Standards in Education) registered childcare places have been created since 1997.

2.30 For some time we have been encouraging the delivery of childcare alongside early education and other health and family services, as research has shown that this approach delivers the best outcomes for children, especially those in the most disadvantaged areas. Sure Start children's centres are building on earlier initiatives, including Sure Start local programmes, to spread this approach to all communities.

2.31 Whilst there will be a further increase in the years ahead in good quality stand alone childcare, much of the expansion will be provided on school premises, or in other integrated centres, as we ensure childcare becomes part, increasingly, of a web of good quality, personalised, early years services for the individual child and their family.

2.32 524 Sure Start local programmes have been established, offering early learning, health and parenting support to 400,000 young children and families living in disadvantaged areas, including a third of under-fours living in poverty. Each local programme is specially designed to meet local needs, including enhanced health services. All local programmes are expected to become children's centres.

2.33 2,500 children's centres will be established by 2008, covering all the 20 per cent most disadvantaged wards in England, and many pockets of deprivation beyond these. The ten-year strategy confirmed there will be 3,500 centres by 2010, so every family has easy access to high quality integrated services in their community and the benefits of Sure Start can be felt nationwide.

2.34 470 centres had been designated by January 2006. We expect the number to exceed 800 by the end of March 2006, and reach 1,000 by December 2006.

2.35 Child and family health services are a key part of the core offer for children's centres, as they are rolled out across the whole country by 2010. Health will remain a priority for local authorities in all areas of the country when developing their children's centre services, whatever the levels of disadvantage or affluence there. All children's centres should offer ante- and post-natal care to mothers in their areas as a vital part of the core offer of health services.

2.36 Families with children from three up to 14, who need it, will have access to affordable, flexible and high quality childcare that meets their circumstances from 8am to 6pm and throughout the year. We want to build that offer around schools as part of a range of extended services that they will host to reflect and strengthen their central position in the local community. We want all schools to become extended schools by 2010, providing a core offer of activities, with at least half of primary schools and a third of secondary schools doing so by 2008.

2.37 More information can be found at:
http://www.surestart.gov.uk

Every Child Matters: Change for Children

2.38 *Every Child Matters: Change for Children*[2.8] sets out the Government's strategy for children and young people. The 2004 *Children Act*[2.9] gave statutory force to the five key outcomes included in the *Every Child Matters* Green Paper. These outcomes are:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and,
- achieve economic well-being.

2.39 Further details can be found in chapter 5.

National Service Framework (NSF) for Children, Young People and Maternity Services

2.40 Work has continued to promote the Children's NSF which was jointly published by the Department of Health and the Department for Education and Skills in September 2004, with a delivery plan, *Supporting Local Delivery*[2.10], published in December 2004. (See chapter 5 for details of progress to date.)

Social Exclusion and Neighbourhood Renewal

2.41 The Department continues to work closely with the Social Exclusion Unit on a range of issues including projects addressing the complex and multi-dimensional causes and consequences of exclusion.

2.42 The Department continues to meet its *NHS Plan*[2.11] commitment by supporting the Neighbourhood Renewal Unit to implement the Government's national strategy for neighbourhood renewal.

2.43 The neighbourhood renewal strategy aims to ensure that within 10-20 years no one is seriously disadvantaged by where they live. The focus of a wide range of the Department's activity is improving health services and tackling poor health and health inequalities in deprived neighbourhoods.

2.44 The Department and the Neighbourhood Renewal Unit published in March 2005 revised guidance on health and neighbourhood renewal *Creating Healthier Communities: A Resource Pack for Local Partnerships*[2.12], which is designed to support local activity. The Department is supporting the development of small area health and social care data to improve knowledge and understanding at the local level.

2.45 The Department is also working with other departments to develop local strategic partnerships. It helped to prepare the consultation paper *Local Strategic Partnerships: Shaping their Future*[2.13] published in December 2005. These partnerships are key to neighbourhood renewal, and to implementation of the *Choosing Health* White Paper and the development of Local Area Agreements (LAAs).

2.46 The Department is working centrally and regionally to support the development of LAAs across England from 2007. These provide an opportunity to bring the health of the public to the forefront of community planning and through the focus on healthier communities and older people, an opportunity to improve health and well-being. 21 pilot area LAAs were agreed for implementation from April 2005, and a further 66 are being prepared in phase two to be implemented from 2006.

Sustainable Development

2.47 The Department, in response to the UK Government's sustainable development strategy, has produced a *Sustainable Development (SD) Action Plan*[2.14] approved by the Department's Sustainable Development Minister and Permanent Secretary in March 2006 and which will be signed off by the Departmental Management Board and published in early 2006. The action plan commits the Department to consider the five key SD guiding principles in both its operational performance (as set out in chapter 8) as well as within policy development. In addition, DH recognises that a more cross-departmental integrated approach is needed in some areas, such as 'travel and transport', 'procurement', and 'social issues', and the action plan will help clarify the actions required and help monitor progress in these areas. DH is a member of the interdepartmental SD programme board that monitors implementation of the UK Government's SD strategy.

2.48 Health, wealth and the environment in which people live are inextricably linked – something acknowledged in the *Choosing Health* White Paper. This explicitly acknowledges the importance of links between environment and health and confirms commitment to the 'Cleaner, Safer, Greener' communities programme. It acknowledges the role of the NHS in corporate social responsibility and renews commitment through the sustainable development 'Healthy Futures' programme. It also recognises the links between health and the economy. All these actions are central to the core strands of action necessary to achieve sustainable development. The Sustainable Development Commission (commissioned by the Department) developed a self-assessment model for the NHS to assess their progress towards becoming a good corporate citizen. The web-based interactive model, launched in February 2006, enables NHS organisations to self-assess, receive a score and advice on their progress. The model looks at transport, procurement, facilities management, employment and skills, community engagement and new buildings.

2.49 In recognition that the environment in which people live and work has a key influence on health, the Department's Estate and Facilities Division provides advice and guidance to promote the sustainable development agenda across the NHS in England such that environmental considerations should be properly taken into account in the activities and services of the NHS. In 2002, work commenced with the issue of the environmental pack – the *New Environmental Strategy for the NHS in England*[2.15]; guidance document *Sustainable Development for the NHS in England*[2.16]; and a software tool, the 'NHS Environmental Assessment' tool (based on BREEAM). Since then the programme has continued with further more specific guidance on *Energy/Carbon Management*[2.17] and *Waste Management*[2.18] issued in 2004; and continues with the recent publication of a joint Departmental/Carbon Trust UK-wide document *Encode – Making Energy Work in Healthcare*[2.19]. This process is continuing with a *Transport and Car Park Management*[2.20] and a UK-wide joint agencies document *Safe Management of Healthcare Waste*[2.21]. In line with the Department's overarching sustainable development action plan, activity will continue with a clear focus on sustainable construction given the procurement opportunities available through such a significant build programme underway within the NHS at this time.

2.50 Sustainable procurement continues to be seen as a way to implement sustainable development. The Department is represented on the Sustainable Procurement Task Force, which has the goal of developing an action plan to make the UK amongst the EU leaders in sustainable procurement by 2009. The NHS Purchasing and Supply Agency (PASA), an executive agency of the DH, continues to work in this area. It was highlighted in the National Audit Office's 2005 study on sustainable procurement across government that NHS PASA is one of the forerunners in sustainable procurement. In 2005, NHS PASA published its second sustainability report, *Towards Sustainability – Facing the Future 2004-05*[2.22]. This year's report builds on the information provided last year, as well as the three environmental reports before this. *Facing the Future* contains information on NHS PASA's environmental, social and economic impacts and comments on many of the issues most important to their stakeholders, including innovation, healthcare associated infections, collaborative procurement hubs and sustainable procurement.

2.51 Caroline Flint MP is the Department's Sustainable Development Minister; a member of the Ministerial Committee on Energy and the Environment Sub-Committee on Sustainable Development [EE(SD)], and of the Government's Sustainable Development Task Force established to ensure an effective follow up of the UK's World Summit on Sustainable Development (WSSD) commitments.

2.52 The Department's sustainable development lead policy official is Dr Gina Radford.

MODERNISING GOVERNMENT ACTION PLANS

Business Improvement

2.53 Improving policy-making is a key part of the Department's commitment to continuous business improvement. The Departmental board made a commitment in 2005 to focus on six areas of business improvement, namely:

- a common policy initiation process;
- stronger leadership to the social care and health systems;
- a better service to Ministers and the public;
- being a good organisation to do business with;
- being a good place to work; and,
- managing performance to ensure improvement.

2.54 DH staff were consulted through a series of listening events in Autumn 2005 on what actions in each of these areas would best drive improvements in the way the Department works. An action plan to deliver improvements has been developed and we will shortly move into the implementation phase. The Department will measure the success of business improvement through stakeholder and staff surveys and service delivery targets.

2.55 The policy hub is responsible for better policy-making and better regulation.

Better Regulation and Regulatory Impact Assessments (RIAs)

2.56 There is a strong commitment throughout the Department (including its agencies) to regulation, which is:

- necessary;
- fair;
- simple to understand; and,
- commands public confidence.

2.57 The better regulation agenda is supported by a Department appointed board-level 'Better Regulation Champion' and three officials in the Department's Regulatory Impact Unit (RIU).

Legislation

2.58 The Department introduced two Bills (the *Health Bill*[2.23] and the *NHS Redress Bill*[2.24]) in 2005. Work is continuing on the reform of mental health legislation. We made 106 Regulations (including Orders that are not laid before Parliament) during the period April 2005 to March 2006. Only 20 imposed costs on business, charities or voluntary bodies and one resulted in cost savings. We also continued to make good progress with our consolidation of NHS legislation made since 1977. This work should be concluded in 2006.

Regulatory Impact Assessments (RIAs)

2.59 We published 33 RIAs on our Department of Health website (**www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/fs/en**) in addition, 20 full RIAs which accompanied regulations were placed in the libraries of both the Houses of Parliament. Our compliance with the RIA process was 100 per cent during this period. No legislation introduced by this Department included a sunset clause (sun-setting allows a law to be removed automatically after a fixed period unless action is taken to keep it in place).

The Regulation Reform Action Plan (RRAP)

2.60 The Department made good progress with 48 reform measures in the Government's regulatory reform action plan (RRAP). Of the 48 reform measures proposed to date, 27 have been completed, three are new, 11 are on track, and completion timetables have been delayed on seven. The RRAP can be accessed on the following website:
www.cabinetoffice.gov.uk/regulation/regulatory_reform/act/action_plan.asp

Better Regulation Task Force (BRTF)

2.61 The BRTF report *Regulation – Less is More*[2.25], published March 2005 set out two main recommendations:

- encourage the Government to take a systematic approach to reducing administrative burdens; and,
- reduce overall regulatory burdens by achieving a better balance between the introduction of new regulation and simplification of existing regulation.

Administrative Burdens Reduction Project

2.62 The Department is working with the Cabinet Office and Whitehall departments to measure the administrative cost to the private sector of compliance with regulation. The Department has identified over 90 regulations and codes of practice in force in May 2005 (the cut off date for the project), which impose an administrative burden on business, charities or the voluntary sector. The project has interviewed many hundreds of businesses for information on the time and resource needed to comply with particular regulations. Fieldwork finished on 7 February, and the results of the exercise will inform Government-wide targets for administrative burdens reduction, to be announced in the Budget statement. A monitoring group, largely made up of representatives from the private sector, including a number of trade associations, ensures the project focuses on the right things. It is chaired by the Department's 'Better Regulation' board level champion.

Simplification of Existing Regulation

2.63 We have identified a number of simplification measures, which will help reduce regulatory burdens on the public and private sector. Our simplification plan is now available on the Department's website:
www.dh.gov.uk/Consultations/LiveConsultations/fs/en
We have invited both the public and private sector to comment and submit further ideas for simplification. The DH plan includes, for example:

- the reconfiguration of DH's arm's length bodies;
- the wider review of health and social care regulations aiming to balance patient safety with reducing administrative burdens;
- work on consolidating our NHS law, which will amalgamate all Acts of Parliament regarding the NHS into a single Act, making NHS law more readily accessible for lawmakers, as well as the private and public sector;
- initiatives being introduced to streamline data gathering and dissemination and reduce bureaucracy on the NHS; and,
- the Better Regulation of OTC Medicines Initiative (BROMI) group which has been set up to determine what measures need to be in place to enable better operation and delivery of 'over the counter' (OTC) medicines regulation.

2.64 We have also set up an e-mail address **Simplification@dh.gsi.gov.uk** to receive simplification proposals from the private and public sector. We have made a commitment to respond to any ideas within 90 working days with an action plan for implementation or reasons why the simplification proposal is not being pursued.

Regulatory Reform Orders (RROs)

2.65 We are taking forward one of our regulatory changes – the removal of the cancer cures consent regime – as part of an umbrella order under the *Regulatory Reform Act 2001*[2.26]. This is being coordinated by the Office of the Deputy Prime Minister, addressing several local authority consent requirements. The order proposes to remove the requirement for a local authority to obtain the Attorney General's consent to initiate a prosecution under the *Cancer Act 1939*[2.27] for publishing certain advertisements concerning cancer treatment. The RRO is scheduled to come into effect later in 2006.

Public Consultations

2.66 The Department undertook 43 consultations since 1 April 2005, 35 (81 per cent) met the 12- week minimum period. This marked improvement has been the result of our efforts to promote active engagement in consultations, being inclusive, and adopting innovative methods for example the Department's:

- *Independence, Well-being and Choice: Our Vision for the Future of Adult Social Care in England*[2.28] consultation set out the Government's proposals for the future direction of social care for all adults of all ages in England. The four month consultation resulted in an estimated 100,000 individuals providing input including those people who are traditionally considered 'hard to reach'; and,
- *Your Health, Your Care, Your Say* was one of the largest deliberative consultations ever to take place in the country. People were asked to debate what we should do in the future to support their health and well-being. 33,166 people completed on-line and paper based questionnaires; 8,460 people took part in locally organised events; 254 people randomly selected from electoral registers took part in four regional events organised and facilitated by Opinion Leader Research. Nearly 1,000 people (randomly selected from electoral registers around the country) took part in a 'National Citizens' summit in Birmingham on 29 October 2005. In addition, written responses to the consultation were received from a wide range of stakeholders.

Avoiding Regulatory Creep

2.67 The Department began implementing a review of its arm's length bodies (ALBs) with a view to a 50 per cent reduction. During 2005, the Department continued to promote the requirement for ALBs to produce RIAs.

Welsh Language Scheme

2.68 The Department is currently drafting a 'Welsh Language Scheme', which sets out our commitment to adhering to the provisions of the *Welsh Language Act 1993*[2.29]. This includes a commitment to producing public documents in Welsh when appropriate. The *Welsh Language Act* applies across government, and aims, as far as possible, to ensure that in the provision of services to Wales, the English and Welsh languages are treated on a basis of equality.

2.69 Where they don't already have one, the Department's arm's length bodies will be made aware of the 'Welsh Language Scheme', and invited either to sign up to its commitments, or adhere to a scheme of their own.

2.70 All officials should consider if their policy area affects the population in Wales, and where appropriate, public documents should be produced in both English and Welsh language versions.

2.71 The use of Welsh language materials will be monitored to ensure it meets the commitments of the *Welsh Language Act*, and will be reported on in the DH annual report.

Rural Proofing

2.72 The Department is striving to become much more strategic, devolving real power and responsibility to the front line. Although the Department sets the national policy framework, it is for strategic health authorities to performance manage primary care trusts in dealing with rural issues across the work of the NHS.

2.73 Rural proofing of policies across much of the Department's business, especially at the level of development and evaluation of policies nationally, continued throughout 2005-06. The Department made advice available to all staff through the business planning guidance set out on the Department's Intranet. The Department also had regular meetings with the Department for the Environment Food and Rural Affairs (Defra), other relevant Departments and the Countryside Agency to develop the rural agenda and help ensure it is taken forward.

2.74 To further support this agenda, we funded the Institute of Rural Health for the production of a rural proofing toolkit. This was launched at the House of Commons in October 2005, and now acts as a resource for primary care organisations to help ensure that all healthcare delivery is accessible and appropriate for people living in rural areas.
www.ruralhealthgoodpractice.org.uk/index.php?page_name=toolkit_menu

2.75 Relevant rural proofing activities in 2005-06 included:

- the introduction of a series of reforms to the rules governing NHS pharmaceutical services, known as "control of entry". Included were measures developed by the Pharmaceutical Services Negotiating Committee, the General Practitioners' Committee of the British Medical Association and the Dispensing Doctors' Association to regularise the position on NHS dispensing in rural areas. The reforms, designed to open up the pharmacy market and encourage innovation and excellence in service provision, also ensured that services to patients in rural areas did not suffer. We shall be reviewing progress in 2006;
- policy on the reform of the welfare food scheme was developed in discussion with beneficiaries and suppliers to ensure that those in rural areas are not disadvantaged; and,
- the publication of our new White Paper *Our Health, Our Care, Our Say* [2.30] highlights policies aimed at providing care closer to the home. Proposals for social care and integration, initiatives to support carers (such as a dedicated telephone helpline), and a set of community hospitals will be particularly beneficial to rural populations.

2.76 The promotion of the use of Defra's urban/rural classification for all health statistics in the Department. The Office for National Statistic's Neighbourhood Statistics website data will have information on health at different geographic levels, for example on hospital admissions and discharges, smoking cessation, and episodes relating to people with mental health conditions.

Equality and Human Rights

2.77 To strengthen the Department's capability in achieving real change, both in the NHS and the Department itself, the first National Director of Equality and Human Rights, Surinder Sharma, was appointed in October 2004. The equality and human rights agenda is being taken forward by the Equality and Human Rights Group (EHRG) and the following illustrates some of its work programme.

Race Relations (Amendment) Act 2000 – Ensuring the Department Meets its Responsibilities.

Background

2.78 The *Race Relations (Amendment) Act 2000* (RR(A)A) [2.31] placed key public bodies, including all Government departments, under a statutory general duty to promote race equality. This duty means that listed public authorities must have due regard to the need to:

- eliminate unlawful discrimination;
- promote equality of opportunity; and,
- promote good relations between people of different racial groups.

2.79 The duty to promote race equality covers all aspects of an organisation's activities – policy and service delivery, as well as employment practices.

Race Equality Scheme

2.80 The Department's *Race Equality Scheme* (RES)[2.32], a requirement of the specific duties of the RR(A)A, was published in May 2005. This included an action plan and a commitment to include in the Departmental Report a summary report on progress on the scheme's implementation. Progress on the implementation of the Department's scheme is outlined below.

NHS Compliance Race Relations Legislation

2.81 The Department continues to support strategic health authorities (SHAs) and their local NHS organisations in promoting the equality and human rights agenda across the NHS. In 2005, the EHRG, with the help of three NHS secondees, provided assistance and advice to NHS colleagues on various equality issues. The Department also organised three productive national learning events where NHS colleagues had the chance to discuss and consult on equality issues. More events are scheduled to take place this year focusing on tackling the wider equalities agenda with the possibility of developing specific guidance for the NHS on producing single equality schemes.

2.82 In September 2005, SHAs were asked to use their role in driving the promotion of race equality across the NHS to provide a progress report on how they and their local NHS organisations were making demonstrable progress in reviewing their RES's. The responses received were very encouraging. An analysis will be made available on the EHRG web pages.

Raising Awareness of the Contribution of Black and Minority Ethnic (BME) and Other Minority Groups to the Health Sector

2.83 *The Leadership and Race Equality Action Plan*[2.33] (LREAP), launched by Sir Nigel Crisp in February 2004, challenges all NHS leaders to address race equality and the needs of minority ethnic communities in a systematic and professional way. LREAP 2006-2009 is currently being updated and, subject to Ministerial approval, will be published in spring 2006. Building on progress made by the NHS on the original LREAP, it aims to help chief executives and boards improve health outcomes for black and minority ethnic patients and communities, and to help ensure that the NHS recruits, develops and retains the best talent from all communities.

2.84 An Independent Panel (chaired by Trevor Phillips, Chair of the CRE) was set up to help keep the LREAP under review, provide advice and challenge progress on the plan. The Panel provides constructive and creative external scrutiny and supports NHS leaders in promoting race equality in all functions. The Independent Panel now has an advisory role in the new EHRG governance structure.

2.85 The Department celebrated Black History Month in October 2005 to recognise the contributions made by black and minority ethnic people, not only to the health sector, but to all fields of British life. The event linked to our offices in Skipton House and Quarry House and was attended by over 140 DH and NHS staff. There was a panel discussion which featured Sir Nigel Crisp and Surinder Sharma. Presentations were made by the National Blood Service and the Afro-Caribbean Leukaemia Trust to highlight the urgent need for blood and bone marrow donors from all communities.

2.86 The EHRG continues to work with lead officers in PCTs in the 'Race for Health' transformational programme. This is a PCT-led programme, sponsored through Central Manchester PCT and brings together thirteen PCTs across the country to pioneer and model inclusive ways of partnership working with black and minority ethnic communities that will enable race and minority ethnic issues to be embedded into the mainstream of health and social care action and delivery.

2.87 'Race for Health' provides active leadership that links directly to development of improved services, delivering a wider choice for service users, enhancing health outcomes and creating greater diversity within the NHS workforce. The project supports these PCTs to provide clear and visible leadership, within their own local health community, within the programme, and to share learning and experience more widely across all PCTs.

Improving Ethnic Origin Information

2.88 In July 2005, EHRG published a *Practical Guide to Ethnic Monitoring in the NHS and Social Care*[2.34]. This guide promotes the standard collection and use of ethnic group and related data on patients, service users and staff of the NHS and Social Services. Information on the ethnicity of NHS patients and staff is important in helping to plan and deliver services and ensuring that employment practices are fair.

Mosaic

2.89 The Mosaic project seeks to promote race equality through and in procurement. The project focuses on three main areas:

- working with NHS organisations and staff, especially on workforce development issues;
- working with NHS prime or first tier suppliers and getting them to understand the legal responsibility to the RRA and review their own work practices in relation to BME communities; and,
- promoting the use of small and medium-sized enterprises (SMEs), and BME suppliers in particular, as a means of promoting race equality.

Pacesetters Programme

2.90 EHRG is planning a 'Pacesetters' programme, which will involve working with up to five SHAs, and three trusts in each of their areas, to work on innovations across all strands of equality – age, disability, ethnicity, gender, religion or belief, sexual orientation and gender identity. The programme will focus on both public health/patient care and the NHS workforce. The aim of the programme is to test and evaluate a range of innovations with a view to identifying what works and in what setting/location. Good practice from the programme will be spread throughout the NHS during the course of the programme. Through committed leadership and community participation, the programme aims to make a fundamental, lasting and significant change to the way in which the NHS approaches equality and diversity. It is hoped to launch the programme, subject to funding being made available, early in 2006-07.

Legislation

2.91 The equalities legislative agenda has been driven forward over the past year with the introduction of the *Equality Bill*[2.35], the *Disability Discrimination Act 2005*[2.36] and extended protection against discrimination for various groups. The Department is using the opportunity these legislative developments provide, to progress the equalities agenda beyond race equality to ensure our policies and services meet the needs of all our service users. Over the next year, DH will be working closely with the NHS to support their approach to the forthcoming legislative developments and public sector equalities duties.

Equality Impact Assessment

2.92 DH has established a project to strengthen current arrangements to ensure DH policy-making processes address the

needs of all sectors of the community, and comply with existing and planned statutory requirements, specifically to:

- produce updated advice and guidance to policy teams on the conduct of equality impact assessment of emergent policies;
- further build equality impact assessment into policy-making processes;
- ensure appropriate training is available to policy-makers;
- ensure appropriate methodologies are available to policy-makers; and,
- feed into, and draw from, pan-Whitehall activity on equality impact assessment.

2.93 A panel, including external experts, has been established to provide guidance.

Sexual Orientation and Gender Identity

2.94 The Department's position in the *Stonewall Corporate Equality Index 2006*[2.37] significantly improved on the previous year. For the first time, the Department is one of the top 20 employers for lesbians and gay men. In June 2005, the Department sponsored its first float for the annual 'Pride London' parade for DH and NHS Lesbian, Gay, Bisexual and Transgender (LGBT) staff. The Department also celebrated the second LGBT history month with an event held on 23 February 2006 in London for DH, NHS and social care staff. Speakers included Surinder Sharma. This event provided an opportunity to celebrate LGBT healthcare champions and outlined work underway to improve access to health and social care services.

2.95 The Department has been working with external stakeholders on the development of a strategy to promote equality and eliminate discrimination for LGBT people in health and social care (as both service users and employees). A Sexual Orientation and Gender Identity Advisory Group is assisting with the development and delivery of a programme of work. At its first meeting in May 2005, the advisory group agreed the following four key work streams:

- better employment;
- inclusive services;
- transgender issues; and,
- reducing health inequalities.

2.96 Work on each of these is now underway.

Black and Minority Ethnic Mental Health

2.97 The Department's progress with the *Delivering Race Equality in Mental Health Action Plan*[2.38] is reported in the mental health section of this report (see chapter 5).

Disability

2.98 DH has agreed a comprehensive joint programme of work with the Disability Rights Commission that is – amongst other things – designed to help deliver compliance with the new statutory duty to promote disability equality, both within DH and across health and social care.

Employment and Ethnicity Data in DH

2.99 Following a significant change programme in 2004, the Department commissioned an independent consultant to undertake an equality impact assessment on its restructuring. The headlines from this piece of work are that overall, there was no adverse impact, but there were some specific areas where improvements could be made.

2.100 The recommendations from that report are being developed into an *HR Diversity Action Plan*, which is in the process of being implemented. The action plan includes work that needs to be taken forward on monitoring, training, recruitment and appointments. Outputs have been included in the Department's new *Race Equality Scheme*.

2.101 The Department delivered valuing diversity training to all staff during 2002 and 2003. This included awareness raising and information on the specific implications of the *Race Relations (Amendment) Act 2000*. The Department will be launching a new interactive diversity training tool to all staff in 2006. In addition, the Department has developed a delivery plan setting out its commitments to increase diversity in the senior civil service as part of the Cabinet Office's ten-point plan on diversity.

2.102 The Department's Workforce Planning and HR Information team is working with business groups to improve the quality and coverage of data held on the Department's personnel information system, including data needed for diversity monitoring. The system has been developed to allow staff to submit information on their ethnicity, nationality and disability status directly into it.

Equality Guide to NHS Boards

2.103 In July 2005, EHRG published a guide, *Promoting Equality and Human Rights in the NHS: A Guide for Non-Executive Directors of NHS Boards*[2.39]. The guide contains facts and figures about equality issues and about patients and NHS staff. It sets out the legal and business cases for equality and includes a set of prompts for boards to use to influence strategic development and cultural change.

RESEARCH AND DEVELOPMENT

2.104 Approximately £650 million was allocated over the last year through three main funding streams:

- commissioned research – through a portfolio of national research programmes (£150 million in 2005-06);
- support for our partners' research in the NHS 'Support for Science' (£400 million in 2005-06); and,
- funding trusts to research their own projects – 'Priorities and Needs' (£100 million in 2005-06).

What We Got For It

2.105 Evidence from primary care research and research synthesis was produced to support NICE, DH policy and service delivery. Evaluation of policy roll-out and services continue.

2.106 We invested in research networks to support clinical research. Adding to the existing cancer network, five additional topic specific networks – mental health, stroke, diabetes, medicines for children, dementia and neurodegenerative disorders – coordinating centres were commissioned and a national network coordinating centre based in Leeds, established. In addition, we provided substantial longstanding funding support to academic centres and networks in primary care.

2.107 The series of experimental medicine facilities across the country will continue. These include the Wellcome/NHS Millennium Centres in Manchester, Birmingham, Southampton and Cambridge. While the Wellcome Trust funded the capital costs, the NHS R&D budget funds support for the ongoing patient-related costs. Under the auspices of the UK Clinical Research Collaboration, calls for a new tranche were advertised in summer 2005.

2.108 We fund research units and centres in priority areas for health and social care such as the National Centre for Primary Care in Manchester (which provided evidence to support the White Paper *Our Health, Our Care, Our Say*). Through our capacity development programme, we spend £13.5 million supporting research training for individuals at a range of levels and across the range of disciplines required for patient focused research including public health and primary care. We support studentships and fellowships through direct training schemes as well as unknown numbers of all types of clinicians and career scientists through individual trusts.

2.109 Following the Walport report *Medically and Dentally Qualified Academic Staff: Recommendations for Training the Researchers and Educators of the Future*[2.40], we have been working in partnership, under the auspices of UK Clinical Research Collaboration, to establish career structures for medical, dental and non-medically qualified research staff. These include clear routes of entry and transparent career structures, flexibility in the balance of clinical and academic training and in geographical mobility, with properly structured and supported posts upon completion of training. Academic training paths will be supported by expanding training opportunities for medical and dental staff and the development of clinical lectureships.

2.110 With respect to research governance, the Department is working with partners in the UK Clinical Research Collaboration to harmonise, streamline and simplify procedures. The *Research Governance Framework*[2.41] was revised in 2005, both to take account of changes in the law, and to clarify processes and procedures so as to reduce unnecessary bureaucratic process.

Future Plans – Health Research Strategy

2.111 The new national health research strategy – *Best Research for Best Health: A New National Health Research Strategy*[2.42], published January 2006 – aims to:

- create a health research system in the NHS that supports outstanding individuals, working in world-class facilities, conducting leading-edge research, focused on the need of patients and the public; and,
- enable the NHS to play the key role it has in determining the future health and wealth of this country and – by harnessing NHS capacity – to make the UK the best place in the world for health research, development and innovation.

2.112 The key goals of the strategy are about:

- developing the infrastructure;
- creating an environment that supports researchers;
- expanding and developing programmes of research to improve health and social care; and,
- improving the systems of research management and governance to drive up efficiency.

2.113 We intend to ensure that funding allocated to the NHS for research is allocated in a transparent contestable manner.

3. Expenditure

INTRODUCTION

3.1 In 2006-07, the planned total expenditure of public funds by the Department is £96,581 million. This includes the NHS pension budget of £10,182 million.

3.2 **Figure 3.1** summarises the resource plans for the Department for the years 2000-01 to 2007-08. Further detailed information is provided in **Annexes A2 and A3**.

Figure 3.1: Department of Health Public Spending

£ million

	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 est'd outturn	2006-07 plan	2007-08 plan
Consumption of Resources								
NHS	45,020	52,070	55,501	61,965	66,942	74,081	79,997	87,062
Personal Social Services	482	730	1,591	1,618	2,128	2,140	1,846	1,886
NHS pensions[1] [2]	3,782	3,949	4,569	6,194	6,396	8,892	10,182	11,072
Credit Guarantee Finance (AME)[3]					3	-3	-4	
Total Department of Health Resource Budget	**49,284**	**56,750**	**61,661**	**69,777**	**75,469**	**85,110**	**92,021**	**100,021**
Of which:								
Department of Health Departmental Expenditure Limit (DEL)	45,501	52,800	57,092	63,581	69,070	76,221	81,843	88,949
Capital Spending								
NHS[4]	1,238	1,719	2,073	2,602	2,835	4,411	5,227	6,199
Personal Social Services	48	93	72	84	83	87	102	121
Credit Guarantee Finance (AME)[3]						377	84	
Total Department of Health Capital Budget	**1,286**	**1,812**	**2,144**	**2,686**	**2,919**	**4,875**	**5,412**	**6,320**
Of which:								
Department of Health Departmental Expenditure Limit (DEL)	1,286	1,812	2,144	2,686	2,689	3,998	5,328	6,320
Total Public Spending in Department of Health[5]	50,279	58,259	63,376	72,071	77,904	89,324	96,581	105,238
Of which:								
NHS[6][7]	45,967	53,486	57,152	64,183	69,306	77,847	84,387	92,173
Personal Social Services[8]	530	823	1,654	1,694	2,199	2,210	1,932	1,992
NHS Pensions	3,782	3,949	4,569	6,194	6,396	8,892	10,182	11,072
Credit Guarantee Finance (AME)[3]					3	374		
Spending by Local Authorities on functions relevant to the department								
Current	**10,703**	**11,457**	**12,931**	**14,751**	**16,121**			
Of which:								
Funded by grants from the Department of Health	913	1,133	1,881	1,816	2,148			
Capital	**93**	**90**	**125**	**186**	**209**			
Of which:								
Financed by grants from the Department of Health	48	50	72	132	140			

Footnotes:

(1) NHS Pensions is the resource budget of the pension scheme, and it is included in table 3.1 because it is part of the Department of Health resource budget. Figures from 1999-2000 onwards have been restated to reflect the requirement specified by Financial Reporting Standard 17 – Retirement Benefits.

(2) Employers' National Insurance Contributions increased from 7% to 14% from 1 April 2004 onwards.

(3) HM Treasury funding available for Private Finance Initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with Treasury.

(4) Includes funding available to NHS Foundation trusts for 2004-05 and 2005-06.

(5) Total public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £291/304/430/391/484/662/852/1103m.

(6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £291/304/421/383/472/646/837/1088m.

(7) For a more detailed breakdown of NHS expenditure in England see Figure 3.4.

(8) PSS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £0/0/9/8/12/16/15/16m.

(9) Figures may not sum due to rounding.

3.3 This chapter provides information on the Government's expenditure plans up until the financial year 2007-08. A breakdown of the spending programme can be found in chapter 6.

NHS EXPENDITURE PLANS

Spending Review 2004 Settlement

3.4 In the 2004 spending review (SR2004) the Chancellor confirmed the sustained levels of investment that were set in the five-year NHS settlement as announced in the 2002 Budget. The expenditure plans for the NHS up to 2007-08 represent an annual average increase of 7.1 per cent in real terms between 2005-06 and 2007-08, a total increase of 23 per cent in real terms over the period.

3.5 The expenditure plans announced by the Chancellor as part of the SR2004 are set out in **Figure 3.2.**

3.6 The spending plans have been adjusted to reflect the reduction in the discount rate applied to future liabilities from 3.5 per cent to 2.2 per cent. This adjustment has been treated as a classification change by HM Treasury. This means that the basis on which expenditure figures are reported within this chapter, and in **Annexes A2** and **A3**, have been adjusted for this change.

Figure 3.2: England Net NHS Expenditure Plans (Stage 2 Resource Budgeting) 2004-05 to 2007-08, as per the 2004 Spending Review

	£ billion			
	2004-05 plan	2005-06 plan	2006-07 plan	2007-08 plan
Net Revenue Expenditure (1)	**66.0**	**72.0**	**78.7**	**86.0**
Net Capital Expenditure (2)	**3.4**	**4.4**	**5.2**	**6.1**
Total Net NHS Expenditure	**69.4**	**76.4**	**83.8**	**92.1**

Footnotes:
(1) Net of planned depreciation of £545/648/712/787m.
(2) Excludes income from land sale receipts and capital investment generated through the Private Finance Initiative (PFI).

3.7 Whilst the change mentioned above affects the total level of NHS expenditure, it does not increase or decrease the spending power of the NHS. It is cost neutral and is merely a definitional change.

Personal Social Services (PSS)

3.8 As part of the 2004 spending review, the Chancellor confirmed the central government provision for adults' personal social services (PSS) to be funded by both the Department of Health and the Office of the Deputy Prime Minister during the period 2005-06 to 2007-08. These plans mean an average growth in resources for PSS of 2.7 per cent in real terms over the three years. These new spending plans are set out in **Figure 3.3**.

Figure 3.3: Funding announced for PSS by the Chancellor in the 2004 Spending Review

	£ billion			
	2004-05 plan	2005-06 plan	2006-07 plan	2007-08 plan
Total Expenditure	10.7	11.5	12.0	12.5
% real terms increase		5.6	1.2	1.4

HEALTH AND PERSONAL SOCIAL SERVICES PROGRAMMES

3.9 The health and social services programmes consist of spending by the National Health Service on the following programmes:

- NHS hospital and community health services, and discretionary family health services.

  This covers hospital and community health services, prescribing costs for drugs and appliances and general medical services (which include reimbursements of GMS GPs' practice staff, premises, out of hours and IM&T expenses). It also includes other centrally funded initiatives, services and special allocations managed centrally by the Department (such as service specific levies which fund activities in the areas of education and training and research and development);

  HCFHS includes all GMS funding. The introduction of the new GP contract in April 2004 means that there is no longer any GMS non-discretionary funding. All GMS funding is discretionary. In order to present a consistent run of expenditure in **Figure 3.4** GMS non-discretionary expenditure has been restated as HCFHS.

- NHS family health service (FHS) non-discretionary

  This covers demand-led family health services, such as the cost of general dental and ophthalmic services, dispensing remuneration and income from dental and prescription charges;

- central health and miscellaneous services (CHMS)

  Providing services which are administered centrally, for example, certain public health functions and support to the voluntary sector;

- administration of the Department of Health; and,

- expenditure on personal social services (PSS) by way of:
  - funding provided by the Department of Health; and,
  - funding provided by the Office of the Deputy Prime Minister.

National Health Service, England – by area of expenditure

3.10 **Figure 3.4** shows the main areas in which funds are spent for the years 2003-04 to 2007-08 on a stage 2 resource budgeting basis. Total NHS expenditure figures are consistent with those in **Figure 3.1**.

Figure 3.4: National Health Service, England – By Area of Expenditure (Stage 2 Resource Budgeting)

£ million

	2003-04 outturn	2004-05 outturn	2005-06 estimated outturn	2006-07 plan	2007-08 plan
Departmental Programmes In Departmental Expenditure Limits National Health Service Hospitals, Community Health, Family Health (discretionary) and related services and NHS trusts[1][2]					
Revenue expenditure[4][5][6]					
Gross	60,303	65,666	73,297	79,945	86,584
Charges and receipts	-2,146	-2,665	-3,184	-3,325	-3,345
Net	58,157	63,001	70,112	76,620	83,239
Capital expenditure					
Gross	2,854	3,157	4,774	5,385	6,297
Charges and receipts	-289	-353	-393	-205	-130
Net	2,566	2,804	4,381	5,180	6,167
Total					
Gross	63,158	68,823	78,071	85,330	92,881
Charges and receipts	-2,435	-3,018	-3,577	-3,530	-3,475
Net	60,723	65,804	74,493	81,800	89,406
National Health Service family health services (non-discretionary)[2][3]					
Revenue expenditure					
Gross	3,052	2,980	2,781	1,565	1,616
Charges and receipts	-912	-850	-769	-466	-454
Net	2,141	2,129	2,011	1,099	1,162
Central health and miscellaneous services[7][8]					
Revenue expenditure					
Gross	1,398	1,464	1,479	1,592	1,717
Charges and receipts	-115	-124	-167	-151	-143
Net	1,283	1,340	1,312	1,441	1,574
Capital expenditure					
Gross	36	32	30	47	32
Charges and receipts	0	0	0	0	0
Net	36	32	30	47	32
Total					
Gross	1,434	1,496	1,509	1,639	1,749
Charges and receipts	-115	-124	-167	-151	-143
Net	1,319	1,372	1,343	1,488	1,606
Total National Health Service Revenue expenditure					
Gross	64,758	70,110	77,556	83,102	89,917
Charges and receipts	-3,173	-3,639	-4,120	-3,942	-3,943
Net	61,581	66,471	73,436	79,160	85,975
Net percentage real terms change(%)		5.6	8.2	5.2	5.8
Capital expenditure					
Gross	2,890	3,418	4,804	5,432	6,329
Charges and receipts	-289	-582	-393	-205	-130
Net	2,602	2,835	4,411	5,227	6,199
Net percentage real terms change(%)		6.7	52.4	15.7	15.5
Total					
Gross	67,644	73,298	82,361	88,534	96,246
Charges and receipts	-3,461	-3,992	-4,513	-4,147	-4,073
Net	64,183	69,306	77,847	84,387	92,173
Net percentage real terms change(%)		5.7	10.0	5.8	6.4
GDP as at 23 December 2005	97.9	100.0	102.1	104.6	107.4

Footnotes:

(1) Includes Departmental Unallocated Provision (DUP) for 2005-06 to 2007-08.

(2) Funding for Primary Dental Services in 2006-07 and 2007-08 is included in the HCFHS provision. By April 2006 General Dental Services(GDS) will be replaced by PCT commissioned dental services funded from discretionary resources.

(3) Initial provision for non-discretionary General Dental Services (GDS) in 2005-06 is reduced by a provisional transfer of resources to the HCFHS programme to fund Personal Dental Service (PDS) schemes. The scale of transfer will be re-assessed in year as the rate of conversion to PDS and the development of dental services is confirmed.

(4) Includes (AME) funding available to Foundation Trusts for 2003-04 and 2004-05.

(5) Excluding HCHS depreciation of (£m): 354 443 614 802 1055

(6) With the introduction of PMEds allocation in 2004-05, there is no longer any GMS non discretionary funding. All GMS funding is now discretionary. Therefore, figures for HCFHS and FHS non-discretionary for 2002-03 to 2005-06 have been restated to present a consistent run in expenditure.

(7) Excluding CHMS and Dept Admin Depreciation of (£m): 29 29 32 35 36

(8) Includes expenditure on key public health functions such as environmental health, health promotion and support to the voluntary sector. Also includes expenditure on the administration of the Department of Health.

(9) The increase in DEL in 2006-07 reflects resource increases agreed in the 2004 spending review settlement, and adjustments to non-cash expenditure (including provisions, cost of capital, depreciation and impairments) within the SR2004 spending review period.

(10) Figures may not sum due to rounding.

Expenditure in 2005-06

3.11 **Figure 3.5** compares estimated outturn expenditure in 2005-06 with planned expenditure published in last year's report.

Figure 3.5: Comparison of Net NHS Expenditure for 2005-06 with those in last year's Departmental Report (Cm 6524)

£ million

	Departmental Report 2006 Cm 6814 Figure 3.4	Departmental Report 2005 Cm 6524 Figure 3.4	2005-06 difference
HCFHS current	70,112	69,117	995
HCFHS capital	4,381	4,206	175
FHS non discretionary	2,011	1,660	352
CHMS Revenue	1,026	1,091	-65
CHMS Capital	11	11	0
Dept Admin Revenue	286	283	3
Dept Admin Capital	19	20	0
NHS Total[(1)]	**77,847**	**76,387**	**1,460**

Footnotes:
(1) Totals may not sum due to rounding.

3.12 The main areas of change (£10 million or over) to the spending plans for the various parts of the programme are shown in **Figure 3.6.**

NHS Expenditure Plans in 2006-07

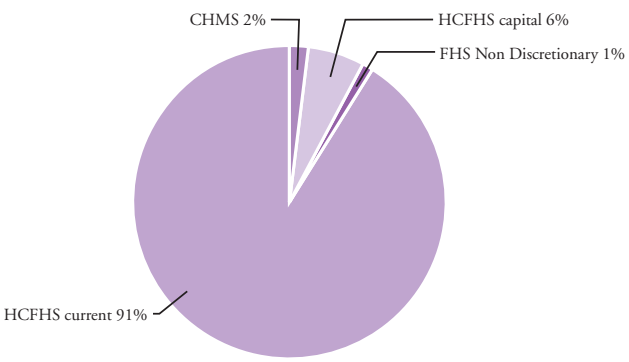
3.13 Of the £96.5 billion planned expenditure by the Department in 2006-07, NHS net expenditure is planned to be £84.4 billion.

3.14 The largest part of NHS spending is on hospital and community health services, discretionary family health services and related services.

3.15 For 2006-07, the planned HCFHS revenue expenditure is £76.6 billion. Net HCFHS capital expenditure is planned to be £5.2 billion. Within overall NHS net expenditure, the total for non-discretionary FHS is expected to account for £1.1 billion in 2006-07. The remainder will be spent on central health and miscellaneous services.

3.16 **Figure 3.7** contains the breakdown of NHS net expenditure for 2006-07 (plan).

Figure 3.7: NHS Net Expenditure, 2006-07 (Plan)



Total: £84,387 million

Figure 3.6: Main areas of change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm 6524)

2005-06	Difference[(1)]		
HCFHS current	995	including:	
		-200	Reduction in Provisions
		-352	Transfer to FHS Non Discretionary
		200	Transfer from HCFHS capital
		-192	Third Party Grants transferred to HCFHS capital
		1,538	Trust Depreciation move into DEL (technical adjustment)
		65	Revised recording of EEA medical cost provisions
		-68	Transfer to/from Other Government Departments
HCFHS capital	175	including:	
		192	Third Party Grants from HCFHS current
		196	Take up of EYF
		-200	Transfer to HCFHS current
		-12	Transfer to Other Government Departments
FHS non discretionary	352	including:	352 Transfer from HCFHS current
CHMS revenue	-65	including:	-65 Revised recording of EEA medical cost provisions
CHMS capital	0	including:	No change over £10m

Footnotes:
(1) Totals may not sum because only those changes over £10 million are included.

NHS Resources

3.17 **Figure 3.8** shows how NHS resources are allocated. It shows that 83 per cent of the total NHS budget will be controlled by primary care trusts (PCTs) in 2006-07.

3.18 They are therefore consistent with the NHS settlement received as part of SR 2004. They do not take account of any subsequent changes in the expenditure plans as a result of changes set out in paragraph 3.6, such as the effect of the change in the discount rate.

PROGRAMME BUDGETING

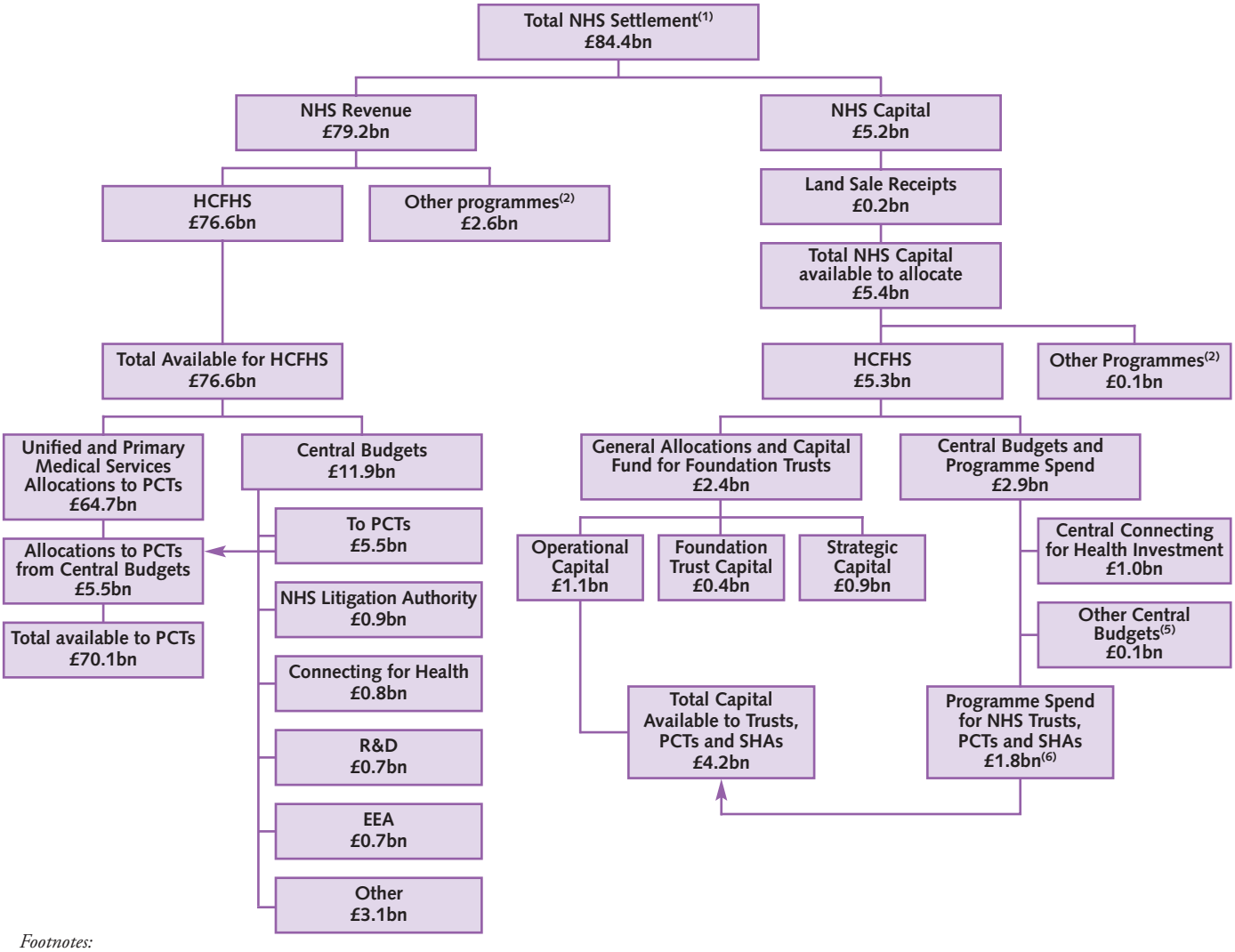
Background to programme budgeting

3.19 Programme budgeting is a retrospective appraisal of resource allocation, broken down into meaningful programmes, with a view to tracking future resource allocation in those same programmes.

3.20 Programme budgeting had its roots in the Rand Corporation in the USA in the 1950s. Its first major application was for the US Department of Defence in the 1960s, where it was used as part of a cost accounting tool that could display, over time, the deployment of resources towards specific military objectives. Such objectives were looked at in terms of wars overseas, the support of NATO or the defence of the homeland, instead of the conventional 'inputs based' budgetary headings of tanks, missiles or diesel fuel. Allocation of new resources, or shifts between budgets, could be judged on their relative contribution to these specific objectives.

3.21 This approach can equally be applied to healthcare. Instead of seeing investment at the level of a hospital or drug budget, the focus switches to specific health objectives or medical conditions. The aim is to maximise health gain through deploying available resources to best effect. Clearly, this aim complements the commissioning role of PCTs.

Figure 3.8: Disposition of NHS Resources, 2006-07



Footnotes:

(1) NHS Settlement as per the Spending Review 2004 settlement, and taking into account the change in the discount rate set out in paragraph 3.6 of this chapter.

(2) FHS non Discretionary, CHMS and DH Admin.

(3) Funding allocated to the Workforce Development Confederations for the education and training of doctors, nurses and other NHS workers. Also includes funding for other NHS workforce related budgets (e.g. injury allowances and NHS University).

(4) Funding allocated to NHS Trusts, the Modernisation Agency, Universities and other Statutory Bodies such as the Prescription Pricing Authority.

(5) Funding allocated for central spending mainly by NDPBs such as the National Blood Authority.

(6) Funding to deliver NHS Plan objectives such as cancer, coronary heart disease, mental health, and improving access and choice for patients.

(7) Figures may not sum due to rounding.

Department of Health – background

3.22 In 2002, the Department initiated the national programme budgeting project. The aim of the project is to develop a primary source of information, which can be used by all bodies, to give a greater understanding of 'where the money is going' and 'what we are getting for the money we invest' in the NHS.

3.23 The project aims to provide an answer to these two questions by mapping all primary care trust (and strategic health authority) expenditure, including that on primary care services, to programmes of care based on medical conditions. The focus on medical conditions clearly forges a closer and more obvious link between the object of expenditure and the patient care it delivers.

3.24 Analysis of expenditure in this way should help PCTs examine the health gain that can be obtained from investment, and will help inform understanding around equity and how patterns of expenditure map to the epidemiology of the local population.

3.25 Accordingly, the initiative will clarify the existing disposition of resources across programme areas. Equally important is the potential to accelerate modernisation. Comparative analysis, together with a process of challenge, offers the opportunity to identify best practice elsewhere for local application, in either its original or modified form.

Financial Year 2004-05

3.26 2004-05 is the second year in which comparable programme budgeting data have been collected. Stakeholders are therefore provided with a range of valuable comparative information, using a consistent framework, that:

- identifies where resources are currently invested, e.g. for the purpose of monitoring expenditure against national service frameworks;
- assists in evaluating the efficacy of the current pattern of resource deployment; and,
- strengthens the process for identifying the most effective way of investing in services for the future.

3.27 The programme budgeting figures for 2004-05 are included within Schedule 5 of the resource accounts 2004-05. This is shown at **Figure 3.9**.

3.28 It is recognised that the implementation of programme budgeting is a process that will require refinement over a long period. In particular, figures produced in the early years (2004-05 being the second) will be a best estimate rather than a precise measurement of expenditure.

3.29 Within this context, the Department will be looking for year-on-year improvements, in both the process and outcomes of programme budgeting, rather than early data being absolutely right.

Schedule 5

Background to Schedule 5

3.30 In addition to the analysis of net operating costs by programme budgeting category, Schedule 5 of the 2004-05 resource accounts also published details of expenditure by Departmental objectives of:

- improving service standards; and,
- improving health and social care outcomes for everyone.

3.31 This analysis is shown in **Figure 3.10**.

Figure 3.9: Resources by Programme Budgeting Categories

	Gross £'000	2004-05 Income £'000	Net £'000	2003-04 Net £'000
Mental Health Problems (Total)	7,905,131	317,004	7,588,127	7,161,618
of which				
Mental Health Sub Group: Substance Abuse	632,655	23,303	609,352	–
Mental Health Sub Group: Dementia	838,168	26,510	811,658	–
Mental Health Sub Group: Other	6,434,308	267,191	6,167,117	–
Circulation Problems (CHD)	6,187,935	234,066	5,953,869	5,521,041
Cancers and Tumours	3,773,203	103,070	3,670,133	3,308,732
Trauma and Injuries (includes burns)	3,590,581	93,914	3,496,667	3,124,029
Musculo Skeletal System Problems (excludes Trauma)	3,577,089	103,207	3,473,882	3,064,718
Gastro Intestinal System Problems	3,526,063	93,045	3,433,018	3,087,194
Genito Urinary System Disorders (except infertility)	3,097,564	85,852	3,011,712	2,749,885
Respiratory System Problems	3,072,258	93,463	2,978,795	2,676,744
Maternity and Reproductive Health	2,617,116	51,535	2,565,581	2,532,335
Dental Problems	2,424,788	448,831	1,975,957	1,869,084
Learning Disability Problems	2,355,887	98,861	2,257,026	2,194,393
Neurological System Problems	1,779,449	59,820	1,719,629	1,524,352
Infectious Diseases	1,615,451	95,175	1,520,276	943,528
Social Care Needs	1,612,406	94,785	1,517,621	1,433,118

	Gross £'000	2004-05 Income £'000	Net £'000	2003-04 Net £'000
Endocrine, Nutritional and Metabolic Problems (Total)	1,599,318	71,502	1,527,816	1,449,458
of which				
Endocrine Sub-group: Diabetes	687,402	31,803	655,599	–
Endocrine Sub-group: Other	911,916	39,699	872,217	–
Eye/Vision Problems	1,302,579	24,979	1,277,600	1,183,181
Skin Problems	1,213,925	36,888	1,177,037	1,038,362
Healthy Individuals	1,157,915	44,848	1,113,067	1,074,946
Blood Disorders	944,496	39,794	904,702	799,473
Neonate Conditions	776,483	32,539	743,944	637,024
Poisoning	598,916	12,763	586,153	475,829
Hearing Problems	318,899	10,104	308,795	292,690
Other Areas of Spend/Conditions:				
• General Medical Services/Personal Medical Services	6,377,342	157,936	6,219,406	4,881,246
• Strategic Health Authorities (inc WDCs)	4,044,893	507,713	3,537,180	3,605,694
• National Insurance Contribution	-	15,133,971	(15,133,971)	(12,777,958)
• Miscellaneous	6,452,492	98,655	6,353,837	8,479,067
Net Operating Cost	**71,922,179**	**18,144,320**	**53,777,859**	**52,329,783**

Source: Department of Health Resource Accounts 2004-05.

Footnotes:

(1) The analysis contained in Schedule 5 is a calculation which uses 2004-05 activity indicative provider costs (reference costs) and prescribing information as the basis for apportioning the totality of NHS/Department spend across various programme budget categories.

(2) The analysis was based on a "bottom up" approach. PCTs allocated/apportioned their spend at the local level and reported the results to the Department. Schedule 5 is an aggregate of these returns.

REGIONAL BREAKDOWN OF SPEND

3.32 The spending data shown in **Figures 3.11** to **3.13** is consistent with the country and regional analysis (CRA) published by HM Treasury in the Public Expenditure Statistical Analyses (PESA). PESA contains more tables analysed by country and region, and explains how the analysis was collected and the basis for allocating expenditure between countries and regions.

3.33 The tables include the spending of the Department and its NDPBs on payments to the private sector and subsidies to public corporations. They do not include capital finance to public corporations but do include public corporations capital expenditure. They do not include payments to local authorities or local authorities own expenditure.

3.34 The data are based on a subset of spending – identifiable expenditure on services – which is capable of being analysed as being for the benefit of individual countries and regions. Expenditure that is incurred for the benefit of the UK as a whole is included.

Figure 3.10: Resources by Departmental Aims and Objectives 2004-05

Resources by Departmental Aim and Objective for the year ended 31 March 2005

Aim: Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities. In persuance of this aim, the department has the following objectives (as set as part of the 2002 Spending Review process):

	£ million
Objective 1	
Improve Service Standards	30,228
Objective 2	
Improve Health and Social Outcomes for Everyone	32,633
Other	8,998
Total Expenditure	71,859
Total Income	-18,081
Net Operating Cost	53,778

Source: Department of Health Resource Accounts 2004-05

Footnotes:

(1) The Resource Accounting Manual required net operating costs to be analysed by objective (Schedule 5).

(2) In previous years the Department has been unable to make this disclosure and as a substitute has analysed net operating cost by programme budgeting category.

*(3) As the analysis by programme budgeting category provides useful information regarding NHS expenditure it has been retained as part of the Departmental Report (see **Figure 3.9**).*

Figure 3.11: Department of Health Identifiable Expenditure on Services, by country and region

£ million

	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 plan	2005-06 plan	2006-07 plan	2007-08 plan
North East	2,404.2	2,718.0	3,001.6	3,198.5	3,597.2	3,988.7	4,431.6	4,849.8
North West	6,535.1	7,024.7	7,922.2	8,769.4	9,570.1	10,416.6	11,365.2	12,535.7
Yorkshire and Humberside	4,581.5	4,765.3	5,352.1	5,948.1	6,678.1	7,413.3	7,957.2	8,700.5
East Midlands	3,323.1	3,835.1	3,939.2	4,438.4	4,981.4	5,482.9	6,041.4	6,714.8
West Midlands	4,465.9	5,175.1	5,509.5	6,010.0	6,730.2	7,292.7	8,140.1	8,954.7
Eastern	4,230.5	4,567.9	5,292.3	5,741.6	6,451.8	6,734.7	7,651.5	8,483.0
London	7,442.1	8,269.7	9,193.9	10,149.3	11,440.1	12,057.1	12,832.2	14,021.4
South East	6,516.7	7,242.1	7,977.4	8,666.2	9,659.3	10,139.6	11,524.1	12,662.3
South West	4,263.4	4,621.2	4,909.1	5,411.7	6,090.2	6,685.2	7,443.8	8,185.3
Total England	**43,762.5**	**48,219.1**	**53,097.5**	**58,333.2**	**65,198.5**	**70,210.8**	**77,387.2**	**85,107.6**
Scotland	5.4	-0.9	-0.2	-16.8	-18.3	-24.1	-25.4	-28.7
Wales	36.6	-8.8	-7.1	-148.4	-162.3	-213.1	-223.9	-253.7
Northern Ireland	1.9	1.9	0.6	-1.5	-1.9	-2.7	-3.4	-3.9
Total UK identifiable expenditure	**43,806.4**	**48,211.2**	**53,090.8**	**58,166.6**	**65,016.0**	**69,971.0**	**77,134.5**	**84,821.3**
Outside UK	221.9	219.9	262.9	247.2	356.1	-61.6	-106.3	-119.0
Total identifiable expenditure	**44,028.3**	**48,431.1**	**53,353.7**	**58,413.8**	**65,372.1**	**69,909.4**	**77,028.2**	**84,702.2**
Non-identifiable expenditure	0.0	0.0	0.0	0.0	0.0	300.0	700.0	700.0
Total expenditure on services	**44,028.3**	**48,431.1**	**53,353.7**	**58,413.8**	**65,372.1**	**70,209.4**	**77,728.2**	**85,402.2**

Source: HM Treasury Public Expenditure Database.

Footnotes

(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in DEL/AME. They do include salaries, procurement expenditure, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.

(2) The figures were taken from the HM Treasury Public Expenditure database in December 2005 and the regional distributions were completed in January/February 2006. Therefore, the tables may not show the latest position and are not consistent with other tables in the Departmental report.

(3) Across Government, most expenditure is not planned or allocated on a regional basis. The analysis shows the regional outcome of spending decisions that have on the whole not been made primarily on a regional basis.

Figure 3.12: Department of Health Identifiable Expenditure on Services, by country and region, per head

£ per head

	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 plan	2005-06 plan	2006-07 plan	2007-08 plan
North East	945.3	1,070.0	1,182.7	1,259.6	1,413.4	1,575.4	1,752.3	1,919.4
North West	964.7	1,037.2	1,167.9	1,288.8	1,401.8	1,527.3	1,664.0	1,832.5
Yorkshire and Humberside	924.0	957.5	1,071.9	1,187.4	1,325.3	1,472.1	1,575.7	1,718.0
East Midlands	797.3	915.4	932.8	1,043.8	1,164.0	1,275.8	1,398.4	1,546.1
West Midlands	847.5	980.0	1,038.7	1,129.7	1,261.8	1,365.2	1,520.4	1,668.5
Eastern	787.1	845.8	976.0	1,051.0	1,174.9	1,216.7	1,373.2	1,512.5
London	1,028.4	1,129.4	1,247.3	1,373.8	1,540.0	1,612.8	1,706.2	1,853.0
South East	815.5	902.6	991.7	1,072.5	1,191.0	1,241.7	1,403.6	1,533.8
South West	867.1	934.8	988.2	1,082.5	1,208.8	1,320.2	1,460.5	1,595.5
Total England	**888.9**	**975.1**	**1,069.5**	**1,170.0**	**1,301.5**	**1,396.7**	**1,532.9**	**1,678.5**
Scotland	1.1	-0.2	0.0	-3.3	-3.6	-4.8	-5.0	-5.7
Wales	12.6	-3.0	-2.4	-50.5	-55.0	-71.8	-75.1	-84.9
Northern Ireland	1.1	1.1	0.4	-0.9	-1.1	-1.6	-2.0	-2.2
Total UK identifiable expenditure	**743.9**	**815.6**	**895.0**	**976.7**	**1,086.6**	**1,165.7**	**1,280.1**	**1,402.4**

Source: HM Treasury Public Expenditure Database.

Footnotes

(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in DEL/AME. They do include salaries, procurement expenditure, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.

(2) The figures were taken from the HM Treasury Public Expenditure database in December 2005 and the regional distributions were completed in January/February 2006. Therefore, the tables may not show the latest position and are not consistent with other tables in the Departmental report.

(3) Across Government, most expenditure is not planned or allocated on a regional basis. The analysis shows the regional outcome of spending decisions that have on the whole not been made primarily on a regional basis.

Figure 3.13: Department of Health Identifiable Expenditure on Services by Function, by country and region, 2004-05

£ million

	Health:			Social protection:			
	Central and other health services	Medical services	Total health	Personal social services	Public sector occupational pensions	Total social protection	Grand total
North East	51.1	3,643.8	3,695.0	13.9	-111.6	-97.8	3,597.2
North West	135.5	9,702.2	9,837.7	36.7	-304.2	-267.5	9,570.1
Yorkshire and Humberside	94.5	6,767.1	6,861.5	25.6	-209.0	-183.5	6,678.1
East Midlands	69.9	5,053.6	5,123.4	18.9	-161.0	-142.1	4,981.4
West Midlands	93.9	6,811.4	6,905.3	25.4	-200.5	-175.1	6,730.2
Eastern	90.6	6,556.0	6,646.6	24.5	-219.4	-194.8	6,451.8
London	160.5	11,511.9	11,672.3	43.5	-275.7	-232.2	11,440.1
South East	135.9	9,844.5	9,980.5	36.8	-358.0	-321.2	9,659.3
South West	86.1	6,233.9	6,320.1	23.3	-253.1	-229.8	6,090.2
Total England	**918.0**	**66,124.4**	**67,042.4**	**248.7**	**-2,092.5**	**-1,843.9**	**65,198.5**
Scotland	0.0	0.0	0.0	0.0	-18.4	-18.4	-18.3
Wales	0.0	0.0	0.0	0.0	-162.3	-162.3	-162.3
Northern Ireland	0.0	0.5	0.5	0.0	-2.5	-2.5	-1.9
UK identifiable expenditure	**918.0**	**66,125.0**	**67,042.9**	**248.7**	**-2,275.6**	**-2,027.0**	**65,016.0**
Outside UK	**425.6**	**0.0**	**425.6**	**0.0**	**-69.5**	**-69.5**	**356.1**
Total identifiable expenditure	**1,343.6**	**66,125.0**	**67,468.5**	**248.7**	**-2,345.1**	**-2,096.4**	**65,372.1**
Not identifiable	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total	**1,343.6**	**66,125.0**	**67,468.5**	**248.7**	**-2,345.1**	**-2,096.4**	**65,372.1**

Source: HM Treasury Public Expenditure Database.

Footnotes

(1) The functional categories used are the standard United Nations Classifications of the Functions of Government (COFOG) categories. This is not the same as the strategic priorities used elsewhere in the report.

SOURCES OF FINANCE

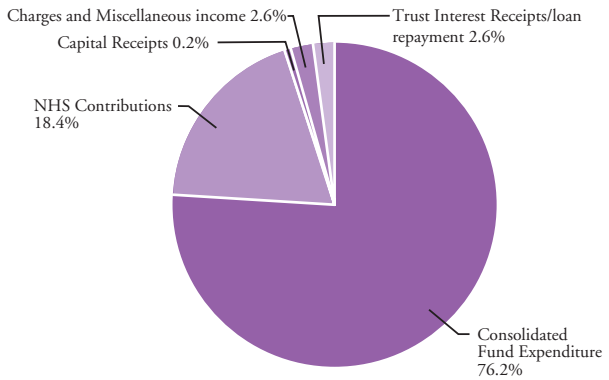
3.35 The NHS is financed mainly through general taxation with an element coming from national insurance contributions.

3.36 In 2006-07, it is estimated that 94.6 per cent of financing for the NHS in England will be met from these two sources, 76.2 per cent from the Consolidated Fund, that is, from general taxation and 18.4 per cent from the NHS element of national insurance contributions.

3.37 The remainder of the NHS financing comes from charges and receipts, including land sales and proceeds from income generation schemes.

3.38 **Figure 3.14** represents NHS sources of finance for 2006-07.

Figure 3.14: NHS Sources of Finance, 2006-07 (Total £84.383 million)



NHS BANK

3.39 The NHS Bank was set up in 2003-04 as a mutual organisation of the 28 strategic health authorities (SHAs) with the purpose of supporting NHS organisations in maximising the use of resources across the NHS over time.

3.40 Its main functions include:

- responsibility for managing brokerage across the public capital programme, working with SHAs to manage the profile of capital expenditure across the NHS and across years, to ensure that the NHS as a whole makes optimum use of total resources on an annual basis;
- co-ordinating cash brokerage across SHAs;
- assisting in the management of the impairments/accelerated depreciation central budget and any other central budgets it is requested to manage. For 2005-06, this includes advising on the distribution of the nGMS Quality and Outcomes Framework (QoF) achievement allocation and developing a framework for providing revenue support for capital developments under payment by results (PBR); and,
- providing advice to the Department on the financial impact of new policy developments.

COMPLEMENTARY SOURCES OF FUNDING

Big Lottery Fund

3.41 The Big Lottery Fund (BLF) was formed in June 2004 from the merger of the New Opportunities Fund (NOF) and the Community Fund, and is responsible for handing out over half of the funding for good causes. The new BLF will build on the experience and best practice of both organisations to simplify funding in those areas where the two bodies currently overlap, and to ensure lottery funding provides the best possible value for money. The projects below were originally funded by the NOF but are now managed by the BLF. More details on the BLF can be found at: **www.biglotteryfund.org.uk**

Healthy Living Centres

3.42 The first tranche was launched in January 1999 with the 'Healthy Living Centre' (HLC) initiative. The initiative has a budget of £232.5 million in England (£300 million UK).

3.43 The programme targets areas and groups that represent the most disadvantaged sectors of the population and is on course to meet its target of making HLCs accessible to 20 per cent of the population.

3.44 HLCs influence the wider determinants of health, such as social exclusion, poor access to services, and social and economic aspects of deprivation that can contribute to health inequalities. Projects cover a range of activities including, for example, smoking cessation, dietary advice, physical activity and training and skills schemes. Local communities and users are involved in all aspects of design and delivery of a project.

3.45 The fund announced in March 2003 the establishment of a support and development programme for HLCs across the UK. The programme will be responsive to the needs of HLCs both individually and collectively and deliver activities that will support HLCs and help them to network and become sustainable.

Living with Cancer

3.46 A second tranche of £116 million for England (£150 million UK) was made available from the New Opportunities Fund (NOF) in September 1999. In England, £23 million is to reduce inequalities in cancer services through provision of home care, support to carers and information about cancer and cancer services. £93 million is to fund the purchase of equipment for the diagnosis and treatment of cancer including linear accelerators, MRI scanners and mammography equipment. This programme aims to help hospitals to improve their services for cancer screening, detection, diagnosis and treatment.

Fighting Heart Disease

3.47 In 2003, the New Opportunities Fund (NOF) awarded £6 million to launch the national defibrillator programme in England. This funding has been used to provide 2,300 defibrillators in the community together with funding for a community defibrillation officer (CDO) within each ambulance trust to deliver the programme activities.

3.48 £65 million of Big Lottery funding has been used to purchase new angiography labs, which provide diagnostic facilities for heart disease. Ninety have now been ordered. The Department has made available an extra £60 million to contribute towards the instalment costs of this equipment, which will speed up diagnosis significantly for patients with suspected heart disease.

3.49 £52 million was deployed to fund nutritional projects to reduce heart disease and cancer. £10 million was allocated to support community initiatives to promote 5-a-Day. Initiatives took place in 66 PCTs in the areas with the highest levels of deprivation. An evaluation of the impact of these initiatives is available on the Big Lottery Fund website. £42 million was allocated to regional pilots of the school fruit and vegetable scheme. The last pilot in the North East ended in March 2005. From April 2006, the Department took over the funding and administration of the school fruit and vegetable scheme in all the English regions. Nearly two million children, aged 4-6, in over 16,000 schools, now receive a free piece of fruit or vegetable every school day. The Big Lottery Fund website also has an evaluation of the lottery funded pilot in the North East.

Palliative Care

3.50 £48 million is being used for palliative care for children to improve the quality of life for children with life threatening or life limiting conditions and their families. At March 2004, 135 grants had been made (25 for hospice provision, 70 for home based care and 40 for bereavement services).

3.51 £22 million is to improve community palliative care for adults suffering from life threatening or life limiting conditions. It has been targeted at areas of the country with the highest palliative care need. Awards have been made to multi disciplinary teams who will provide therapeutic, nursing and emotional support and in some cases complementary therapies to patients in their homes.

Invest to Save Budget

3.52 The 'Invest to Save' Budget (ISB) was introduced by the Government in 1999 to encourage partnership and cross-boundary working by Government departments; it was subsequently extended to local authorities and the NHS.

3.53 The aim of ISB is to provide more assistance towards the cost of innovative projects, which may need up-front funding not otherwise available. The ISB will seek to realise the gains, which should be in the form of efficiency savings and/or benefits to the public. 'Invest to Save' is a practical example of the Government's commitment to modernisation.

Supporting projects

3.54 Following the announcement of ISB Round 8, funding will be received to fund the following projects:

- London Street Rescue
  The pilot will test whether use of a telephone helpline by the emergency services and the public, to directly task voluntary sector homelessness providers to respond to vulnerable people on the streets, is a better value alternative to dialling 999.
- Provision of Enhanced Medical and Care Services in Custody Centres
  The improvement of medical and care services in Surrey Custody Centres (Static and Mobile) capable of providing fast and fully supported 24/7 responses and critical incident management capability consistent with measurable and accountable service standards through use of Surrey Ambulance Service Paramedics and Voluntary Sector Nursing Personnel.

RECOVERY OF NHS COSTS FOLLOWING ROAD TRAFFIC ACCIDENTS

3.55 For over 70 years, hospitals have been able to recover the costs of treating victims of road traffic accidents who have gone on to make a successful claim for personal injury compensation. The principle behind this is that those causing injury to others should pay the full cost of their actions, including any related health care costs.

3.56 *The Road Traffic (NHS Charges) Act 1999*[3.1] put in place a centralised recovery scheme administered on the Department's behalf by the Compensation Recovery Unit (CRU), which is part of the Department for Work and Pensions. In 2004-05, CRU recovered more than £117 million, money which was then given direct to the trusts that provided the treatment.

3.57 Work continues to expand the current scheme so that in the future NHS hospital treatment and NHS ambulance service costs can be recovered in all cases where personal injury compensation is paid. The legislative framework for this is contained in Part 3 of the *Health and Social Care (Community Health and Standards) Act 2003*[3.2].

PERSONAL SOCIAL SERVICES (PSS) EXPENDITURE

3.58 The Department provides a significant proportion of the financial resources needed to deliver the social care commitments of local authorities in England. Chapter 6 details the adults' social care provision for 2006-07 and 2007-08, made available by the Department.

3.59 **Figure 3.15** shows the latest available local authority current and capital expenditure on social care services. Between 1994-95 and 2004-05, the net current expenditure has almost doubled in real terms.

Figure 3.15: Expenditure by Local Authorities on Personal Social Services

£ million

	1994-95 outturn	1997-98 outturn	1998-99 outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn
Current expenditure									
gross [1]	7,503	9,984	10,847	12,048	12,848	13,598	15,199	16,839	18,219
charges [1]	886	1,530	1,788	1,998	2,152	2,229	2,305	2,077	2,001
net									
cash	6,617	8,454	9,059	10,050	10,696	11,369	12,894	14,763	16,218
real terms [2]	8,518	9,804	10,372	11,285	11,855	12,297	13,517	15,078	16,218
Capital expenditure [1]									
gross	185	150	140	134	156	158	199	260	285
income	69	43	53	51	63	70	75	74	75
net	116	107	87	83	93	88	124	185	210
Total local authority expenditure									
gross	7,688	10,134	10,987	12,182	13,004	13,756	15,398	17,099	18,504
charges/income	955	1,573	1,841	2,049	2,215	2,299	2,380	2,151	2,076
net	6,733	8,561	9,146	10,133	10,789	11,457	13,018	14,948	16,428

Source: PSS EX1, RO and RA LAs Returns.

Footnotes:

(1) Gross current expenditure, income from charges and capital figures are not available for 2005-06.

(2) At 2004-05 prices using the GDP deflator.

4. Investment

CHARACTERISTICS OF CAPITAL INVESTMENT

4.1 In contrast to revenue expenditure, which is expenditure on goods and services to be consumed in the current financial year, capital investment is expenditure now (typically on buildings and large pieces of equipment) which will continue to provide benefits into a number of future financial years. To count as NHS capital expenditure, the expenditure must generally be on assets that individually cost £5,000 or more and that are recorded on the balance sheet as fixed assets.

AVAILABLE CAPITAL RESOURCES

4.2 In this, the 2nd year of the 2004 spending review (SR 2004), the public capital resources available to the NHS will increase by a further £950 million (21 per cent real) to £4.9 billion, giving the health service further scope to improve the quality of the assets with which services are delivered. As in previous years, there will also be further investment through the private finance initiative (PFI) and through NHS LIFT (Local Improvement Finance Trust) the Public Private Partnership (PPP) vehicle for transforming primary care premises. Some capital assets will also result from the independent sector treatment centres programme.

4.3 The capital resources available to health are set out in **Figure 4.1**. The remainder of this chapter explains how NHS systems reforms will impact on the management of capital investment and how public capital resources will be distributed to the NHS. It also outlines the priorities for capital investment during 2006-07 and progress with the PPP arrangements for delivering improved NHS facilities.

Figure 4.1: NHS Capital Spending 2005-06 to 2007-08 (resources)

			£ million
	2005-06 Forecast Outturn	2006-07 Plan	2007-08 Plan
Government Spending	3,911	4,862	5,798
Percentage Real Terms Growth[(1)]		*21.3*	*16.2*
Foundation Trust Capital Expenditure	500	365	401
Percentage Real Terms Growth[(1)]		*n/a*	*n/a*
Receipts from Land Sales	393	205	130
Percentage Real Terms Growth[(1)]		*–49.1*	*–38.2*
PFI Investment	1,188	1,111	1,327
Percentage Real Terms Growth[(1)]		*–8.7*	*16.4*
Total	**5,992**	**6,543**	**7,656**
Percentage Real Terms Growth[(1)]		*6.6*	*14.0*

Footnote:
[(1)] *Real terms growth calculated using GDP deflators 102.091/104.585/107.364*

Figure 4.2: Disposition of 2006-07 Capital Resources

		£ million
Total capital resource for Investment in Health		**6,543**
Less: PFI Investment		–1,111
Gross Public Capital available for investment in DH and NHS		**5,432**
Less:		
Capital funding for Department of Health	18	
Capital grants to independent sector parties	66	
Costs from the management and disposal of the "retained estate":	10	
NHS Trust Receipts from asset sales (normally reinvested locally)	120	
CFH central capital spend	1,000	
Other central capital spend, including Capital Funding for ALBs and funds for innovations in capital procurement	144	
		–1,358
HCHS capital available for allocation to NHS Organisations:		**4,074**
To be allocated as follows:		
Direct allocations to Strategic Health Authorities, NHS Trusts and Primary Care Trusts		
SHA Strategic Capital	941	
Trust and PCT Operational Capital	1,100	
Total Direct Allocations for local prioritisation		**2,041**
Programme Capital Budgets		
PACS & other local implementation of CfH	124	
Community Hospitals	20	
Choose & Book Incentives	55	
Resource cover and enabling for IS procurement	114	
Coronary Heart Disease	40	
CAMHS Specialist Services and other Childrens investments	37	
Drugs Misuse	38	
DSPD	20	
Mental health place of safety and PICU development	65	
High Secure Facilities	23	
Audiology	26	
Dental School expansion	20	
Medical school places & radiology Academies	18	
Improving provisions of decontamination services	43	
Other investment in physical capacity	15	
Resources reserved to cover capital expenditure by FTs and uncommitted funds	1,374	
		2,033

NHS REFORMS

4.4 As set out in chapter 5, reforms to the NHS's organisational structure will continue during 2006-07 with changes to the configuration and functions of SHAs and PCTs. However, the reform likely to have the most profound impact on capital investment is the transition of further NHS trusts to NHS foundation trust (NHS FT) status.

4.5 NHS FTs are free to reinvest all cash generated from their operations, rather than relying on operational and strategic capital allocations for the maintenance and replacement of their assets, and they may borrow from a loan facility to fund further capital investment.

4.6 At the time of writing, there are 32 NHS FTs, with 24 further applications under consideration by Monitor. Capital funds for these organisations are not included in allocations but are "pooled" centrally to cover investment by NHS FTs.

CAPITAL FUNDING SYSTEM REFORMS

4.7 Over the past few years, capital resource has been allocated on a formulaic basis to NHS trusts and PCTs, as operational capital (based on depreciation and thus the current asset-bases), and to SHAs, as strategic capital (based on weighted capitation), or from central programme capital budgets, targeted at particular investment objectives.

4.8 Continuing with this system is likely to have two potential difficulties:

- capital resources could be allocated to organisations that under patient choice may attract less activity and thus less revenue income with which to service the capital charges resulting from its investment; and,
- NHS trusts may develop investment plans under the current system that may not be allowable within an eventual prudential borrowing limit (PBL), thereby creating an obstacle to their transition to foundation status.

4.9 For these reasons, it is planned to move from 2007-08 to a system for distributing capital investment funding to NHS trusts that is more similar to that applying to NHS FTs. Consequently, the capital allocations for 2006-07, that were announced on 15 January 2006, are expected to be the last.

CAPITAL INVESTMENT PLANS

4.10 The Department's planned disposition of capital resources is set out in **Figure 4.2**. The following paragraphs provide some explanation of these plans and what individual budgets are intended to deliver.

FOUNDATION TRUST CAPITAL INVESTMENT

4.11 In **Figure 4.2**, one of the largest single items is the capital resource set aside for investment by foundation trusts. NHS FTs are not dependent on capital allocations and may reinvest all cash generated through their operations (i.e. cash generated through depreciation, asset-sales and operating surpluses). If they plan to invest more than this, they may borrow to do so, provided their projections of future cash-flows show that they are able to afford the resultant payments of interest and principal when these would be due.

4.12 They are authorised to borrow from commercial banks but the Department has established a loan facility to make long-term loans available to foundation hospitals while they establish the credit histories that will enable them to borrow from commercial banks at reasonable rates. Loans drawn down from the Department's loan facility will be on commercial terms and several have been agreed to date.

4.13 Capital investment by NHS FTs is charged to the Department's capital resource total so funds must be set aside to cover this. Although they are independent and not subject to capital allocations, they are subject to the same service targets and standards as non-NHS FTs and can therefore be expected to make similar capital investments. Using this assumption, we have estimated a proportion of all capital resource budgets, whether local operational and strategic capital or capital resources planned for SR programme initiatives (see below), that must be set aside. This £365 million should be sufficient to cover capital investment by the 32 trusts currently operating as NHS FTs in 2006-07, but further amounts may need to be transferred to this reserve during the year as more organisations become NHS FTs.

INVESTMENTS CONTRACTED FOR BY THE DEPARTMENT AND ITS AGENCIES

4.14 Where it is commercially and operationally appropriate to do so, DH signs contracts for the provision of services that may include the provision of assets. In these circumstances, the expenditure is counted as expenditure by the Department, even where the main beneficiaries of the services are NHS trusts and PCTs.

4.15 The most significant example of this is Connecting for Health (CfH), the information technology programme that will transform information provision in the NHS. £1,000 million is available for investment through this programme in 2006-07, with a further £124 million likely to be allocated to help fund local implementation.

4.16 The key deliverables of this programme, their benefits to patients and clinicians, and their important role in achieving several PSA targets are set out in detail in chapter 5. In summary, the national programme will deliver:

- electronic appointment booking;
- a National Care Record Service; and,
- an electronic prescribing service, and an underpinning IT infrastructure with sufficient capacity to support the critical national applications and local systems.

4.17 £144 million is also being invested centrally for a range of other bodies that provide services to the NHS, including bodies such as the Healthcare Commission that provide regulatory services, and bodies such as the National Blood and Transplant that provide essential input for NHS services. This sum also includes some capital funding for initiatives to improve the efficiency of capital procurement.

DIRECT CAPITAL ALLOCATIONS TO SHAs, NHS TRUSTs AND PCTs

4.18 One of the highest investment priorities is to ensure that local NHS organisations are able to implement the capital investments that they consider necessary to maintain the facilities in which local health services are provided and the further small and medium sized investments, which they consider necessary to improve the quality of local services and access to them.

4.19 To fund these local investment priorities, direct allocations have been made using national needs-based formulae, and will total £2,041 million in 2006-07. Bearing in mind that NHS FT capital spend is no longer funded from these resources, this figure equates to an increase of around 19 per cent on 2005-06. This continues the trend of increases of the last few years, in line with DH policy that the NHS should enjoy greater freedom to invest capital. Of this, £1,100 million was allocated to NHS trusts and PCTs as operational capital and £941 million was allocated to SHAs as strategic capital.

4.20 Operational capital is allocated unconditionally to NHS trusts and PCTs and is predominantly spent on maintaining buildings and replacing equipment. The £1,100 million allocated for spend in 2006-07 (after allowing for £175 million that is expected to be accessed by NHS FTs under their own arrangements) amounts to a 25 per cent increase on 2005-06's figure of £1,021 million and is altogether 66 per cent higher than the £766 million allocated as operational capital in 2002-03.

4.21 The £941 million allocated as strategic capital is typically used by SHAs to fund larger investments that are prioritised within the health communities for which they are responsible. Roughly, after allowing for the £151 million likely to be accessed by NHS FTs under their own arrangements, this equates to a 13 per cent increase compared to last year's level of £966 million.

SPENDING REVIEW CAPITAL INVESTMENT COMMITMENTS

4.22 The Department's capital investment plans are based on the need to achieve key spending review commitments, including in particular the 18-week maximum waiting time for treatment, and other service targets such as those contained in national service frameworks.

4.23 In deciding how this SR programme capital should be managed, the Department has considered carefully whether it is essential to manage the funding centrally, for example where the distribution of need varies from region to region, or whether the funding is best managed locally because investment needs are best understood at that level. Whether included in direct allocations or centrally managed, capital funding has been planned for:

- improvements to access and waiting times, in particular with capital funding for increasing the availability of the most modern diagnostic equipment;
- local implementation of Picture Archiving and Communications Systems (PACS);
- cancer screening and finishing the programme of investment in CHD facilities;
- increasing the availability of drugs misuse treatment and rehabilitation places;
- children's health services, including improving hospital environments where children's services are delivered, in line with the national service framework and facilities to support the extension of child and adolescent mental health services to 16 to 18-year-olds;
- mental health facilities, including increasing secure capacity, improving in-patients psychiatric ward and intensive care environments and increasing the provision of 'dedicated places of safety' for psychiatric assessment as required by section 136 of the *Mental Health Act 1983*[4.1];
- further investment to support retinopathy screening as recommended by the NSF for diabetes and further increases to dialysis capacity to meet rising demand;
- improving the environments in sexual health clinics, which have often received insufficient capital investment in the past and are frequently in poor accommodation;
- workforce training and in particular expanding the number of training places for dentists;
- additional physical capacity, including funding to support the development of further one-stop primary care centres; and,
- further decontamination projects.

CENTRALLY MANAGED CAPITAL INVESTMENTS

4.24 **Figure 4.2** contains a list of the capital budgets that we expect to remain centrally coordinated and allocated in 2006-07. These will be retained, in the main, because allocation through the capitation-based strategic capital allocation formula would not achieve the uneven distribution of capital funding necessary to deliver the investment objectives. These centrally coordinated funds include the following:

Coronary Heart Disease

4.25 A further £79 million is available for capital investment in the modernisation and expansion programme for cardiac services. Of this, up to £50 million will be invested during the current year, with a significant proportion of that being spent in the foundation trust sector. This will complete a major capital programme that includes 19 cardiac centres at a cost of £600 million, which will expand cardiac services with around 27 additional cardiac theatres, critical care capacity, diagnostic services, outpatient facilities and 620 extra beds. To date, nine schemes have been completed and a further four are expected to be completed in 2006-07.

4.26 This investment has already helped to reduce waiting times for heart surgery patients in the areas served by the units receiving funding. Capital investment is also being targeted at expanding diagnostic angiography to reduce waiting times for tests and in-patient admissions and catheter laboratories to support increased access to angioplasty.

Mental Health

4.27 £108 million of capital is available centrally in 2006-07 for investment in mental health facilities. In addition to funding improvements to in-patient psychiatric wards and intensive care environments and increasing the provision of "dedicated places of safety" for psychiatric assessment, as required by section 136 of the *Mental Health Act 1983*, there will be continued investment in developing facilities for people with dangerous severe personality disorder (DSPD) and high secure facilities. There will also be investment in facilities to permit the transfer of some patients into more appropriate care settings and to develop specialist facilities for particular client groups, including medium secure facilities for deaf people and dedicated units for women.

Waiting Times and a New Direction for Community Services

4.28 The 18-week maximum waiting time for treatment and the White Paper, *Our Health, Our Care, Our Say*[4.2] will be important drivers of capital investment in 2006-07. In addition to significant capital funding in SHAs' strategic capital allocations for investment in diagnostic equipment in primary care and community settings, £189 million of capital will be held centrally in 2006-07 for these initiatives.

4.29 This includes £107 million of capital resource cover that has been reserved to cover the balance sheet implications of the independent sector treatment centres (ISTCs) because, even though the set-up investment is provided by the private sector, the nature of the contract means that auditors are likely to view them as NHS assets. The remainder will be used in the early stages of the programme to deliver a new generation of community hospitals, as set out in the White Paper and also to fund the capital incentives scheme to encourage early uptake of 'Choose & Book', the electronic appointment booking system.

Decontamination

4.30 A further £37 million of capital funding will be managed centrally in 2006-07 to continue improving NHS decontamination facilities and thereby lessen the risk of transmitting vCJD and other infectious diseases.

4.31 This will bring to nearly £300 million the amount that the Department has allocated for decontamination in hospitals since 2001-02 for the replacement of worn-out equipment, the upgrading of unsuitable premises and the purchasing of surgical instruments to facilitate centralised processing.

4.32 The initiative is now in its second phase, that of putting arrangements in place to ensure that the redeveloped decontamination facilities continue to meet the latest standards, and will require continued investment.

4.33 This will increasingly be through joint venture arrangements. At the time of writing, 18 projects involving 82 NHS trusts and NHS foundation trusts are looking to modernise their sterile services via a joint venture with a private sector sterile services provider. The first, involving the Bradford, Leeds and Calderdale Trusts, is expected to award the contract to its preferred bidder in the early part of 2006 and should be running in the spring of 2007. The other four projects in wave 1 – South Manchester, Birmingham, Thames Valley and Kent – should be operational later the same year.

Drugs Misuse

4.34 £38 million will be available in 2006-07 to fund the capital costs of increasing the number of in-patient places for drug treatment and drug rehabilitation. In-patient and residential facilities are under-provided for within drug treatment pathways and unlike other types of drug treatment have not grown in recent years. A shortage of these facilities reduces patient choice and the proportion of patients who become drug-free.

Capital Funds for Other Uses

4.35 A further £63 million is currently set aside in the 2006-07 disposition for a number of smaller investments including continuation of the investment in digital hearing aids and some funding for childrens' services, to cover amongst other things extending child and adolescent mental health services to 16 to 18-year-olds and the requirements of the *Laming*[4.3] report, regarding child protection.

UNALLOCATED CONTINGENCY

4.36 The capital disposition currently contains a substantial contingency, that is being held to cover possible additional capital pressures that are likely, but not yet formally detailed in 2006-07's investment plans. Examples include potential further investment in implementing the White Paper and a potential acceleration of capital spend by NHS foundation trusts.

DELIVERY OF PUBLIC CAPITAL FUNDED BUILDINGS AND WORKS – NHS PROCURE21

4.37 ProCure21 was launched in April 2000 as the NHS response to *Rethinking Construction*[4.4] and HM Treasury's *Achieving Excellence*[4.5]. It provides a standardised approach to the procurement of public-capital funded healthcare facilities in the NHS, based upon long-term relationships with pre-selected supply chains.

4.38 A competitive OJEU (Official Journal of the European Union) tendering process took place to select principal supply chain partners (PSCPs) to a national framework. NHS trusts can select a partner from this framework without the need to go through an additional OJEU process. The intention is that NHS facilities are completed on time, within budget and are well designed to provide first class facilities for NHS patients.

4.39 The ProCure21 programme was rolled out nationally in September 2003 and is becoming an established method for publicly funded construction and refurbishment in the NHS. It has started to deliver tangible benefits for patients. The progress of the initiative is summarised in **Figure 4.3**.

Figure 4.3: Summary of ProCure21 Schemes

Stage	Number of schemes	Value (£ million)
Pre-construction	95	1,400
On site	65	575
Completed	74	287
Total	**234**	**2,262**

4.40 Completed schemes include:

- Ormskirk Hospital - new maternity and paediatric unit;
- Phoenix Unit (mental health provision) at Springfield University Hospital;
- Milton Keynes General Hospital - treatment centre; and,
- Withington Hospital - diagnostic treatment centre.

4.41 The provision of these facilities is allowing patients to access these services more quickly since they have been provided without the need for the NHS trust to go through the OJEU selection process.

4.42 The ProCure21 programme is being further developed and improved to ensure that value for money in the use of public funds for NHS construction projects is effectively demonstrated.

RESTRICTIONS ON CAPITAL TO REVENUE TRANSFERS

4.43 In 2006-07, the Department expects to have no flexibility to vire capital funds to revenue, except for the flexibilities that exist around capital grants to the private sector and public corporations, which are accounted for as revenue resources but count as capital investment in the national accounts. This means that the funding must be used to invest in buildings and equipment assets and cannot be diverted to other uses, such as financing deficits.

PUBLIC PRIVATE PARTNERSHIPS AND INNOVATIVE INVESTMENTS

4.44 The NHS is continuing its major programme of investment through the use of public private partnerships:

- PFI, which continues to deliver most of the major hospital building schemes; and,
- NHS LIFT, an investment vehicle for modernising primary care premises.

4.45 The partnering principle is also incorporated in the Department's ProCure21 initiative.

4.46 Recent progress of these initiatives and their plans for 2006-07 are outlined below.

PFI - 100 Hospital Schemes

4.47 Over the past twelve months, PFI continued to help deliver the *NHS Plan*[4.6] target of ensuring that over 100 hospital schemes will be delivered by 2010.

4.48 During 2005, a further six PFI schemes with a combined capital value of nearly £650 million became operational. This means that in total, 57 hospital schemes are now operational against the *NHS Plan* target. Of these, 48 were delivered under the *Private Finance Initiative*[4.7].

4.49 In addition to those schemes that became operational in 2005, a further 6 reached financial close and began construction making a total of 31. The new schemes under construction continue to vary widely in terms of size, purpose and location; examples are:

- the new £24 million Northern Neuro Disability Service Centre in Newcastle will bring together a range of neurological specialities currently undertaken across the region;
- £129 million oncology rationalisation by Oxford Radcliffe Hospitals will provide facilities for a full range of modern diagnostic, medical and surgical cancer services;
- new Daventry Community Hospital costing £28 million will allow more local people to receive services closer to home in a high quality environment; and,
- the £326 million scheme being undertaken by Sherwood Forest Hospitals NHS Trust to redesign King's Mill Hospital and Mansfield Community Hospital. The scheme also includes the re-development of local primary care facilities, improvements to Newark Hospital and significant investment in information technology.

4.50 In *The NHS in England: The Operating Framework for 2006-07*[4.8], published in January 2006, the Government reaffirmed its commitment to the hospital building programme and confirmed that PFI would continue to be the delivery vehicle for the majority of capital developments in acute services.

4.51 In doing so, a number of measures were put in place to ensure the long-term viability of the programme:

- SHAs have been asked to work with PCTs and trusts to reconfirm their investment plans (including PFI schemes) in light of current reforms to the NHS. This specifically includes choice, movement of services into primary and community settings, and the current and new financial regime. The Department will issue guidance on assessing the impact of these reforms on their schemes and on all aspects of affordability. SHAs will need to have their conclusions ratified by the Department before proceeding;
- trusts with significant deficits will not be allowed to proceed to market with large capital investment schemes without agreed plans to deal with those deficits before financial close; and,
- in future, trusts will be required to obtain formal approval prior to appointing a preferred bidder on a PFI scheme.

4.52 Shortly afterward, the White Paper, *Our health, Our Care, Our Say*, emphasised this message by confirming that long-term planning of all capital schemes must be consistent with the move of services out of hospitals and that all the financial impacts are to be considered by the trust.

NHS LIFT

4.53 The NHS LIFT initiative is contributing to the redevelopment of primary care infrastructure. In doing so, it is addressing several of the main themes of the White Paper on out-of-hospital care. It aims to improve the infrastructure of primary and social care by providing buildings that are fully up-to-date and which are located where they are most needed. This helps improve patient access to primary and social care services and also helps to improve the quality of those services.

4.54 NHS LIFT also aims to improve quality in primary care through the delivery of primary care services in purpose-built buildings that are fit for use in the 21st century. This improves the morale of staff working there and, therefore, the quality of care they give, and it helps to attract more GPs into inner-city areas where, formerly, conditions were unlikely to attract GPs. Furthermore, LIFT is supporting patients to make informed decisions about their healthcare through the provision of proactive health interventions such as community cafes, community space and community resource teams.

4.55 As NHS LIFT enables GPs and other health professionals to work together in the same buildings, this helps to reduce the number of journeys that patients must make between different health professionals. It also helps the NHS to move more services from hospitals to the primary care sector and so gives patients easier access to services. In many cases, local authority staff also work in the same buildings, and in some cases the NHS and their local authority partners are, in effect, delivering an integrated health and social care service.

4.56 Local LIFTs are being set up as limited companies with primary care trusts (PCTs), the private sector and Partnerships for Health (PfH), as shareholders. Established in September 2001, PfH is the 50:50 joint venture company between the Department and Partnerships UK and provides procurement support to local NHS LIFT schemes as well as equity investment.

4.57 The priority for investment was initially those parts of the country, such as inner cities, where primary care premises are in most need of improvement. NHS LIFT now includes a mix of both rural and inner city LIFT schemes, including parts of the country designated as growth areas by the Office of the Deputy Prime Minister.

4.58 There are now 50 LIFT schemes of which, all 42 schemes from the initial three waves have reached financial close. From these schemes, nearly 70 primary care premises are open to patients with over 50 more expected to open in 2006. See **Figure 4.4** for a full list of NHS LIFT schemes. By the end of 2005-06, NHS LIFT will have attracted nearly £775 million of private capital investment and this level of investment will continue to grow in 2006-07 and beyond. This programme is supported by £210 million of public capital.

ASSET DISPOSAL

4.59 The *Sold on Health*[4.9] report recommendations regarding the disposal of surplus NHS estate continue to be implemented. These required a corporate approach to the disposal of surplus estate to achieve best value, and proceeds from this central disposal have made a valuable contribution to the Department's capital funding in recent years.

4.60 Following agreement with the Office of the Deputy Prime Minister, in April 2005 a ground breaking partnership was entered into between the Department and English Partnerships. The partnership involves nearly 100 surplus sites in the ownership of the Secretary of State for Health being transferred to English Partnerships to assist in the Government's sustainable communities programme. The majority of the sites will be redeveloped with housing and it is estimated that they will provide around 15,000 housing units many of which will be affordable, including for NHS key workers.

4.61 The properties are being transferred in phases during 2005-06 and 2006-07 with an initial payment of £280 million received in 2005-06 and a further £40 million in 2006-07. Further payments will be received in future years linked to the onward sale of the sites by English Partnerships. In addition, during 2005-06 £45 million is expected from the disposal of other surplus property owned by the Secretary of State for Health.

4.62 Further sales of surplus property that is owned by NHS trusts and PCTs are expected, yielding in the region of a further £100 million for reinvestment in local services.

INVESTMENT IN PERSONAL SOCIAL SERVICES

4.63 In social care, new investment has been primarily through revenue funding, which allows local authorities to commission, develop or purchase services, to launch joint funded partnerships and to develop innovation in social care through the private finance initiative.

4.64 Nevertheless, in 2006-07, there have been increases in the capital funding available to deliver personal social services comparable to those for the NHS. Not included in the above capital disposition is £101 million earmarked to support investment in personal social services, as well as £115 million of "PFI Credits" to support the development of typically larger social care investments.

4.65 Asset-based services can also be supported via the mechanisms set out in the 1999 *Health Act Partnership Arrangements*[4.10], which enable:

- pooled funds;
- lead commissioning;
- integrated provision; and,
- money transfer powers.

4.66 All these have been taken up as new forms of investment in joint services, incorporating a mix of health and social services, and also housing and education.

Figure 4.4: NHS LIFT Schemes

Strategic Health Authority	Scheme
LIFT Schemes reached Financial Close with buildings open to patients	
Avon, Gloucestershire and Wiltshire	Bristol
Birmingham and Black Country	Sandwell
Birmingham and Black Country	Birmingham and Solihull
Birmingham and Black Country	Wolverhampton
Cheshire and Merseyside	Liverpool and Sefton
Cheshire and Merseyside	St Helens, Knowsley and Warrington
Cumbria and Lancashire	East Lancashire
Greater Manchester	Ashton Leigh and Wigan
Greater Manchester	Manchester, Salford and Trafford
Greater Manchester	Oldham
Hampshire and the Isle of Wight	East Hants, Fareham and Gosport
Leicestershire, Northants and Rutland	Leicester
Norfolk, Suffolk and Cambridgeshire	Norfolk
North & East Yorks and North Lincolnshire	Hull
North Central London	Camden and Islington
North Central London	Barnet, Enfield and Haringey
North East London	East London
North East London	Barking and Havering
North East London	Redbridge and Waltham Forest
North West London	Ealing, Hammersmith and Hounslow
Northumberland Tyne and Wear	Newcastle
South West Peninsula	Cornwall and the Isles of Scilly
South West Peninsula	Plymouth
South Yorkshire	Barnsley
Thames Valley	Oxford
Trent	Southern Derbyshire
Trent	Greater Notts (Gedling)
West Yorkshire	Leeds
West Yorkshire	Bradford
LIFT schemes reached Financial Close with buildings under construction	
Birmingham and Black Country	Dudley South
County Durham and Tees Valley	Tees Valley
Essex	Colchester and Tendring
Kent and Medway	Medway
North West London	Brent, Harrow and Hillingdon
North West London	Lambeth, Southwark and Lewisham
Shropshire and Stafford	North Staffordshire
South East London	Bromley, Bexley and Greenwich
South West London	South West London
South Yorkshire	Doncaster
South Yorkshire	Sheffield
Trent	North Notts (Ashfield)
West Midlands South	Coventry
LIFT schemes in early stages of procurement	
Avon, Gloucestershire and Wiltshire	Wiltshire
Bedfordshire and Hertfordshire	South East Midlands
Essex	Southend, Castle Point and Rochford
Greater Manchester	Rochdale, Bolton, Heywood and Middleton
Greater Manchester	Bury, Tameside and Glossop
Hampshire and the Isle of Wight	SW Hampshire
Kent and Medway	Sustainable Communities in Kent
Leicestershire, Northants and Rutland	South Midlands

5: The NHS Plan – a plan for investment: a plan for reform

THE MODERNISATION AND REFORM PROGRAMME:

5.1 OVERALL STRATEGY

5.43 PROGRESS WITH INVESTMENT AND REFORM

WHAT IS BEING DELIVERED FOR PATIENTS:

5.186 CANCER –
improve care of patients with cancer and reduce mortality and morbidity from cancer

5.227 CORONARY HEART DISEASE AND STROKE –
improve the care of patients with CHD and stroke, and reduce mortality and morbidity of CHD and stroke

5.243 OLDER PEOPLE'S SERVICES –
improve the care provided to older people

5.262 MENTAL HEALTH SERVICES –
improve the care of patients with mental illness and reduce mortality and morbidity from mental illness

5.280 CHILDREN –
improve children's health and social care services

5.298 SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS (chronic disease management)

5.335 IMPROVING THE PATIENT EXPERIENCE

5.399 NHS DIRECT

5.408 MODERNISING PATHOLOGY SERVICES

5.414 NHS DENTISTRY – REFORM PROGRAMME

5.420 A VISION FOR PHARMACY

5.442 AUDIOLOGY MODERNISATION PROJECT

5.444 GENETICS WHITE PAPER

5.448 INDEPENDENT RECONFIGURATION PANEL (IRP)

5.451 NATIONAL SPECIALIST COMMISSIONING ADVISORY GROUP (NSCAG)

IMPLEMENTING CHOOSING HEALTH:

5.459 HEALTH INEQUALITIES –
improve public health services and reduce inequalities in health status

THE MODERNISATION AND REFORM PROGRAMME

OVERALL STRATEGY

5.1 In March 2000, the NHS was set the challenge to modernise and reform its practices alongside an historic four-year increase in funding. The *NHS Plan*[5.1] set out measures to modernise the NHS to make it a health service fit for the 21st century and putting patients' needs at its centre.

5.2 The plan involved the largest consultation exercise ever undertaken within the health service.

5.3 The first five years of the plan have been about building capacity and capability. The coming years will be about improving quality, making sure that we get best value for money and use the new capacity and capability to build a truly patient-led service.

The NHS Plan – Step by Step Reform

5.4 The *NHS Plan* sets out a programme of change, underpinned by ten core principles, which aim to tackle the systemic problems which have undermined the effectiveness of the NHS. The *NHS Plan* sets out practical step by step reforms, which will improve care, treatment and service right across the board.

5.5 The *NHS Plan* reforms and investment are transforming the NHS. Improvements are being delivered in key areas such as reduced mortality rates in cancer and coronary heart disease. Expanded capacity and improved ways of working are delivering improved access and quality across a range of NHS services.

5.6 The investment and reform initiated by the *NHS Plan* in 2000 has delivered results for patients. *The NHS Improvement Plan – Putting People at the Heart of Public Services*[5.2], published in June 2004, and Creating a Patient-Led NHS[5.3], published in March 2005, both build on the commitment to a ten-year reform process first set out in the *NHS Plan*.

5.7 Strengthening of the commissioner role has begun to ensure that patient choice is made truly real. *Commissioning a Patient-Led NHS*[5.4], published in July 2005, started this phase of reform.

The NHS Improvement Plan – Putting People at the Heart of Public Services

5.8 The five-year settlement for the NHS announced in the 2002 Budget means that expenditure on the NHS will have risen from £54 billion in 2002-03 to £92 billion by 2007-08.

5.9 The *NHS Improvement Plan* sets out how this massive investment will be used in transforming the patients' experience of the NHS providing faster access to services, choice of services, more effective treatment of long-term conditions in the community and action on public health.

5.10 The *NHS Improvement Plan* sets out how the ongoing reform coupled to investment will deliver transformed services. The key objectives are:

- waiting for treatment will reduce to the point where it is no longer the major issue for patients and the public with maximum waits of 18 weeks for hospital treatment and patients offered real choice;
- people with long-term conditions will receive higher-quality care through the expert patient programme, the introduction of community matrons and the GP contract;
- the NHS will become more of a health service and not just a sickness service with a greater focus on health inequalities and disease prevention;
- NHS foundation trusts, treatment centres, independent sector providers of NHS services and a wider range of primary care services will enable patients to have a greater degree of choice;
- more staff and more flexible working will contribute to better quality and more choice;
- better use of information and information technology will drive improvements in patient care, for example electronic booking and prescribing;
- incentives will be aligned with patients and professionals through payment by results and the performance management regime; and,
- local communities will take greater control of budgets and services with the balance of power shifting even further to PCTs and the NHS. There will be fewer national targets and fewer arm's length bodies.

Restructuring and Reorganisation

5.11 *Commissioning a Patient-Led NHS* was published on 28 July 2005. Its aim was to ensure that the NHS secured the best possible health and healthcare, for all patients, in every local area.

5.12 At its heart was a commitment to deliver stronger PCTs with a more focused role, especially in relation to the following:

- to commission better services for patients;
- to work more closely with local government; and,
- to ensure that we get the best value for money from the system.

Progress to Date

5.13 The first stage of the reorganisation is now underway. Consultations on proposals for PCT configurations began on 14 December 2005 and concluded on 22 March 2006. It is anticipated that PCT reorganisation will be completed in October 2006. The SHA reorganisation announced on 12 April 2006 set out the creation of 10 new strategic health authorities:

- North East;
- North West;
- Yorkshire and The Humber;
- East Midlands;
- West Midlands;

- East of England;
- London;
- South East Coast;
- South Central; and,
- South West

5.14 The purpose of these changes is to see improvements in health and services. Reconfiguration is not an end in itself. This process is about ensuring organisations are properly configured and fully prepared for their new role.

5.15 This is also being followed by the development of a 'fitness for purpose' tool, in conjunction with PCTs, which incorporates an assessment tool to look at financial viability, strategic planning, governance arrangement and external relationships. It also contains a diagnostic tool which will allow PCTs to compare best practice commissioning across all services (including those commissioned jointly with social care), identify gaps and produce a high level development plan.

Health Reform in England

5.16 Much has been achieved during the last five years of investment and reform, but we need to go further. The aim is to achieve an NHS that is 'self-improving': to provide the highest possible quality of care, delivered in the most efficient way, led by the needs and wishes of patients and supported by staff. Such an in-built dynamic for continuous improvement is essential to enable the NHS to keep pace with fast changing technology, to tackle inequalities and to raise standards of care.

5.17 The reforms will give doctors, nurses, managers and other NHS professionals incentives to drive improvements in health and healthcare, and to increase responsiveness to patients.

5.18 The reforms are a means to improvement rather than a blueprint for how services should be delivered. They will support the development of high-quality services by embedding the right balance of incentives, transparency, plurality of providers and patient choice into the system. Better commissioning of healthcare services will be critical.

5.19 These reforms are rooted in the core values of the NHS: providing equal access to care that is available at the point of need regardless of ability to pay, personal to the individual patient and achieved within a taxpayer-funded system that must demonstrate value for money.

Independence, Well-Being and Choice – Our Vision for the Future of Adult Social Care

5.20 This Green Paper, published in March 2005, set out our vision for the future direction of social care for adults of all ages in England, and informed a significant part of the thinking behind the *Our Health, Our Care, Our Say* White Paper[5.5]. In fact, the White Paper confirms the Green Paper's vision of high-quality support that meets people's aspirations for independence and greater control over their lives, making services flexible and more responsive to individual needs.

5.21 The vision expressed in *Independence, Well-being and Choice*[5.6], encompasses both older people and younger adults who need care and support, people with a disability or mental health problems, and people who care for or support other adults, including care service providers.

5.22 We believe that services should be person-centred, seamless and proactive. They should support independence (and not encourage dependence) and allow all sections of society to enjoy a good quality of life, including the opportunity to contribute fully to community life. Services should treat people with dignity and respect, helping them to overcome barriers to inclusion.

5.23 Within the next 10 to 15 years, we propose to work with people who use social care services to help them transform their lives by:

- ensuring they have more control over the care they receive;
- giving them greater choice, and helping them decide how their needs can best be met;
- giving them the chance to do the things that other people take for granted, especially within the wider community; and,
- giving the best quality of support and protection to those with the highest levels of need.

5.24 We aim to achieve this by:

- changing the ways in which social care services are designed. For example, we will give people more control over services through self-assessment, and through planning and management of their own services, always with appropriate levels of advice and support;
- developing new and innovative ways of supporting individuals;
- building and harnessing the capacity of the whole community to ensure that everyone has access to the full range of services; and,
- improving the skills and status of the social care workforce.

A New White Paper: Our Health, Our Care, Our Say – A New Direction for Community Services

Why Do We Need This White Paper?

5.25 *Our Health, Our Care, Our Say* sets a new direction for the whole health and social care system. It confirms and builds on the vision put forward the Green Paper *Independence, Well-being and Choice*, and proposes a radical and sustained shift in service delivery – not least by ensuring that services are more personalised. People will have a stronger voice to drive service improvement.

5.26 People are living longer – therefore services have to respond to ensure that this longer life is matched by years of health and well-being. Those aged over 65 with a long-term condition will double each decade. Consequently, healthy living needs to start early. Not being in work affects people's health and well-being, as

do feelings of isolation or not being supported. Health inequalities are still too stark and need to be addressed.

5.27 Medical science, assistive technology and advances in the pharmaceutical industry will also rapidly change the way in which people's lives can be improved by health and social care services. The organisation of care, whether in hospital or in the community must fully reflect such technological advances. For example, procedures that could once only take place in hospital can now be done in a community setting. Assistive technology will mean that more people can be supported safely in their own homes.

Four Main Goals

Better Prevention Services with Earlier Intervention

5.28 Primary care trusts (PCTs) and GP practices will work more closely with local government services to ensure that there is early support for prevention. For example, we will introduce a new NHS 'Life-Check' for people to assess their lifestyle risks and to take the right steps towards making healthier choices. This check is in two stages:

- on-line or locally available self assessment; and,
- specific health and social care advice and support for those who need it.

5.29 NHS 'Life-Check' will be piloted in spearhead PCTs in 2007-08.

5.30 We will introduce more support to maintain mental health and emotional well-being. For example, during 2006, there will be an announcement on national demonstration sites for psychological therapies for mental health.

Giving People More Choice and a Louder Voice

5.31 We propose to give patients a guarantee of registration onto a GP practice in their locality and simplify the system for doing this, including the provision of better information. To ensure real choice, we will introduce incentives for GP practices to offer opening times and convenient appointments which respond to the needs of their patients.

5.32 In social care, we will increase the take up of direct payments by introducing new legislation to extend their availability to currently excluded groups and, from 2006-07, will pilot the introduction of individual budgets, bringing together several income streams from social care, community equipment, Access to Work, Independent Living Funds, Disability Facilities Grants and Supporting People.

Tackling Inequalities and Improving Access to Community Services

5.33 We will ensure that local health and social care commissioners work together to understand and address local inequalities. There will be a clear focus on those with ongoing needs. We will increase the quantity and quality of primary care in under-served and deprived areas, and we will ensure that people with particular needs (e.g. young people, mothers, ethnic minorities, people with disabilities, people at the end of their lives and offenders) get the services they require.

More Support for People with Long-term Needs

5.34 People with long-term conditions will be supported to manage their condition themselves with the right help from health and social care services. If people have a clear understanding of their condition and what they can do, they are more likely to take control for themselves. To enable this, we will treble our investment in the Expert Patient Programme, developing an 'information prescription' for people with long-term health and social care needs and their carers, and continuing to develop assistive technologies to support people to stay in their own homes.

5.35 Many people who have to manage a long-term condition have both social care and health needs. Therefore, to support a more integrated approach, by 2008 we will put in place personal health and social care plans and integrated health and social care records. We will provide more support for carers.

How Will We Achieve These Improvements?

Practice Based Commissioning

5.36 Linked to our commitments in respect of commissioning a patient-led NHS, practice based commissioning will give GPs more responsibility for local health budgets, while individual budget pilots will test how users can take more control of their social care needs. These will act as a driver for more responsive and innovative models of joined-up support within communities, delivering better health and well-being outcomes, including an emphasis on prevention.

Shifting Resources into Prevention

5.37 Given future demographic challenges, we must re-orientate our health and social care services to focus together on prevention and health promotion.

More Care Undertaken Outside Hospitals and In the Home

5.38 We aim to provide more care in more local settings which are convenient to service-users. This will include the provision of more care in the home. Over the next year we will work with the Royal Colleges to define clinically safe pathways within primary care for dermatology, ear, nose and throat medicine, general surgery, orthopaedics, urology and gynaecology. We will achieve this partly through the introduction of a new generation of community hospitals and facilities with strong links to social care.

Better Joining Up of Services at the Local Level

5.39 Work will be done to encourage more integrated commissioning at the primary care and social care interface. We will develop a procurement model and best practice guidance to underpin a joint commissioning framework for health and well-being.

5.40 To assist this, we will align the budget and planning cycles of PCTs and those councils with social services responsibilities

based on a shared, outcome-based performance framework. There will also be aligned performance assessment and inspection regimes. Local Area Agreements will be a key mechanism for joint planning and delivery. There will be a new role of Director of Adult Social Services, a strengthened role for Directors of Public Health, and more joint health and social care appointments.

Encouraging Innovation

5.41 Innovation will be encouraged by greater patient and user choice. The more that people can ensure that services are provided to suit their lives, the more there will be innovative approaches to service development. For example, in primary care, we will assist this process by introducing new 'local triggers' on public satisfaction and service quality to which PCTs will be expected to respond publicly. In social care, direct payments and individual budgets will ensure that services have to develop in a more responsive way.

Allowing Different Providers to Compete for Services

5.42 In some deprived areas of the country there are fewer doctors per head of population than in others. We will increase the quantity and quality of primary care in these areas through nationally supported procurement of new capacity with contracts awarded by local PCTs.

PROGRESS WITH INVESTMENT AND REFORM

Increasing Devolution – Driving Extra Provision Locally

Planning Framework

5.43 In July 2004, the Department published the new planning framework, *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005-06 – 2007-08*[5.7]. This planning framework sets out the national targets for the NHS and social care which are closely based on the PSA targets attached to the 2004 spending review. 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.

5.44 The planning system is based on a three-year local delivery plan (LDP), which covers NHS and joint NHS/social care priorities. For 2005-06 to 2007-08, this focuses only on the few key priorities set out in the planning framework.

Operating Framework

5.45 In January 2006, the Department published the operating framework *The NHS In England: The Operating Framework for 2006-07*[5.8]. This document sets out the service priorities for the year.

5.46 As priorities for 2006-07, the NHS is, and will remain, committed to delivering the plans set out in *National Standards, Local Action* covering the three years 2005-06 to 2007-08. Nationally, we shall be putting a particular focus in 2006-07 on:

- achieving robust financial health;
- pushing forward the implementation of reform; and,
- achieving six specific service priorities derived from the planning and priorities framework.

NHS Workforce

5.47 This section sets out the progress in increasing the size of the NHS workforce since 1997 and 1999 and the new pay arrangements that have been put in place for NHS staff.

Nurses, Scientific, Therapeutic and Technical Staff

5.48 Figures for September 2005 show that since September 1999 there has been an increase of 74,520 nurses and since 1997, there has been an increase of 85,300. Within this increase, the number of nurses working in primary and community care settings, delivering more treatment, advice and support to patients either in their homes or as close to them as possible, has increased by 23,170 since 1999 and by 28,500 since 1997. These extra community and general practice nurses are helping to put patient needs at the centre of the NHS.

5.49 Figures for September 2005 show that since September 1999 there has been an increase of 32,140 qualified scientific, therapeutic and technical staff, and 38,240 since 1997.

GPs and Consultants

5.50 Figures for September 2005 show that since September 1999, the number of consultants has increased by 8,670, GPs (excluding retainers, registrars and locums) by 4,270 and GP Registrars by 1,040. Since September 1997, the number of consultants has increased by 10,520, GPs (excluding retainers, registrars and locums) by 4,690 and GP Registrars by 1,220. Figures for September 2005 show that the number of Registrar Group doctors has increased by 5,320 since 1999 and 6,100 since 1997.

Social Workers

5.51 Figures for September 2005 show that since September 2000 there has been an increase of 12 per cent in the number of full time equivalent social workers for local councils and since September 1997 there has been an increase of 18 per cent in the number of full time equivalent social workers for local councils.

Affordable Housing for Healthcare Staff

5.52 Using housing initiatives to support recruitment and retention in front-line public services is one of the Government's key domestic priorities. The intention in helping key workers to buy or rent a home is to help keep them in the jobs they have trained for, thereby retaining essential skills. Regarding health, this is an integral part of the effort to deliver improved health services.

5.53 Some 3,900 healthcare workers had completed purchasing their own homes under the Government's Starter Home Initiative by the end of October 2004. A new Key Worker Living Programme started in April 2004 and 2,648 health staff had completed on purchasing a home, or exchanged, under the open market purchase part of this scheme by the end of January 2006. Over 450 health staff had, in addition, accessed the new build product.

5.54 From 1 April 2006, a new set of funding for 'Key Worker Living' will be made available for the 2006 - 2008 period which will be marketed by zone agents appointed by ODPM/the Housing Corporation. Subject to other eligibility criteria, all clinical staff, excluding doctors and dentists, together with social workers and qualified nursery nurses employed by the NHS in London, the South East and East of England, will be eligible for help.

5.55 Beyond these areas, zone agents will operate throughout England offering a one-stop shop for low cost home-ownership products.

Pay Modernisation in the NHS

5.56 Through Agenda for Change and the new consultant contract (2003) we have demonstrated our commitment to improving the terms and conditions for all NHS staff. With an investment of over £1 billion, we have seen an increase in the average earnings of NHS staff at just under five per cent in the last two years. This compares favourably with the national average of around four per cent. As we move forward, we will continue to balance the need for appropriate pay awards with issues of affordability within the service.

Agenda for Change

Progress on implementation

5.57 As reported last year, national roll-out of Agenda for Change began on 1 December 2004, with an effective date of 1 October 2004 for most terms and conditions. The NHS put in great effort and by September 2005 had achieved 88 per cent assimilation. The Department has been working with NHS Employers and SHAs to achieve full assimilation as soon as possible. The position at the end of January 2006 was 95 per cent assimilation.

Unsocial hours

5.58 The Department has agreed to a request from the joint unions and NHS Employers for a delay in producing proposals for the harmonisation of unsocial hours to allow for rigorous testing and completion of the negotiation and ballot process with trade unions.

Benefits Realisation and Productivity

5.59 Achievement of the agreed 'Partnership Success' criteria published within Annex E of the *Final Agreement*[5.9] can be measured through a mixture of quantitative and qualitative data. The Department has, therefore, been working with NHS Employers and SHAs to produce a benefits realisation framework and all NHS organisations were required to produce a benefits realisation plan. Furthermore, the benefits realisation network, led by NHS Employers, has produced a proforma for NHS organisations to use in developing case studies and will work to produce a compendium of these. Benefits from Agenda for Change will be included within ISIP planning.

Funding

5.60 In line with requirements of the agreement, financial monitoring during national roll-out was undertaken. This work identified the requirement for some adjustment to tariff in 2006-07.

Two-tier Workforce

5.61 In October 2005, agreement was reached on the best way forward on Agenda for Change for contracted out staff working in soft facilities management. With effect from 1 October 2006, all private sector staff who benefit from the new approach will be entitled to terms and conditions of employment no less favourable than the Agenda for Change equivalent. They will commit to introducing systems for job evaluation and staff development, and to working with the NHS on issues such a cleaners progressing to train as health care assistants.

5.62 In the period between 1 October 2005 and full implementation on 1 October 2006, staff will benefit from the following interim arrangements:

- from 1 October 2005 staff covered by the agreement will receive a minimum of £5.65 an hour basic pay; supervisors will receive a minimum of £5.93 an hour; in addition, all staff will benefit from an additional two days annual leave; then,
- from 1 April 2006, the minimum hourly rate of basic pay will rise to £5.88 (matching the current minimum under Agenda for Change); supervisors will move to a minimum of £6.17 per hour; those working in the London area will receive a one-off payment of £500 in inner London, £375 in outer London and £125 in London fringe areas.

5.63 The costs of funding the new arrangements are to be shared in the interim period between NHS organisations and contractors. From 1 October 2006, the costs of the full arrangements will be met by the Department and this has been provided for in 2006-07 allocations.

Consultant Contract (from 31 October 2003)

5.64 The consultant contract was agreed with the British Medical Association (BMA) in October 2003. From 31 October 2003, existing consultants have had the option of taking up the new contract or remaining on their current terms and conditions. All consultants appointed on or after 31 October 2003 automatically take up the new contract.

5.65 A DH survey published in February 2005 showed that, as at 29 October 2004, 76.9 per cent of consultants had signed up to the new contract, and we now believe this to be around 86 per cent.

5.66 The contract provides a framework for planning and timetabling consultant time and for aligning individual objectives with local service priorities and patient needs. It includes new rules governing the relationship between NHS work and private practice. Detailed guidance and a toolkit to assist trusts and consultants with job planning was published by the Consultant Contract Implementation Team (CCIT) in January 2005. The Consultant Contract Benefits Realisation Team (CCBRT) has worked with SHAs and NHS trusts to ensure that an effective, prospective approach to job planning activities continues to be applied.

Benefits Realisation – Consultant Contract

5.67 The key to benefits realisation lies in clear and agreed annual job plans. New services and service reconfigurations can be planned and consultant work commitments agreed to meet the needs of the patient. This should allow services to be responsive to patient and commissioner needs, and help prevent services being maintained or indeed developed just because a consultant has an interest (or skill) in one area of medicine.

Career Grade Doctors

5.68 In December 2004, Ministers asked the NHS Employers organisation to enter into negotiations with the BMA on a new contract for staff grade and associate specialist doctors. Negotiations have been progressing and a proposal will be put to the Department in due course.

General Medical Services

5.69 The new contracts were backed by a guaranteed 36 per cent increase in resources in England, rising from £5 billion in 2002-03 to £6.8 billion in 2005-06. Such increases for primary care are unprecedented and a measure of the Government's commitment to improved care for all.

5.70 Evidence from PCT expenditure forecasts show that PCTs have made available additional resources to secure the range of services and improvements in care to meet national and local priorities. The overall increase in resources is now forecast to be more than 40 per cent for the three-year period (equating to spend on primary medical care services of around £7.6 billion in 2005-06).

5.71 The increased investment is directly benefitting the vast majority of patients who are experiencing improvements not only in the range of services available locally but also improvements in the quality of clinical services they receive.

5.72 We currently forecast that PCTs are having to manage a financial pressure of £150 million in 2004-05 and 2005-06 in the context of up to a £7 billion allocation as a consequence of resourcing the contracts.

5.73 This is a consequence of overspend on allocation primarily from:

- high achievement in the Quality and Outcomes Framework;
- increased spend on out-of-hours; but,
- offset by further efficiency savings in PMS contracts.

5.74 High levels of achievement in the Quality and Outcomes Framework are to be congratulated. It shows we have a system in place that motivates general practice to provide high quality evidence based clinical care. This benefits the vast majority of patients and improves health prevention in ten of the most common long-term illnesses as well as impacting on the wider NHS, for example, fewer avoidable hospital admissions due to better chronic disease management.

5.75 Increased spending on out-of-hours shows that PCTs are maximising use of their unified budgets in order to establish integrated networks of unscheduled care provision so that when patients contact out-of-hours services they can be assured that their clinical needs will be consistently met through fast and convenient access to care, delivered by the most appropriate professional in the most appropriate place.

5.76 Revisions to the GMS contract negotiated by NHS Employers ensure the contract will continue to:

- deliver better services for patients – through investment in new services including incentives for improved access and choice;
- be fair to the profession – in view of the substantial investments made over the last three years, practices can maintain their profit levels where they deliver our priorities; and,
- represent good value for money to taxpayers – zero increase for inflation and new service investments funded in the main from recycled efficiency savings.

5.77 The agreement also includes an ongoing commitment that the GP contract will continue to deliver efficiencies and productivities in the future.

Connecting for Health – IT and e-Health in the NHS

5.78 The national programme for IT (NPfIT) in England is being delivered by the Department's NHS Connecting for Health agency. Its work continues to gather momentum and the impact is beginning to be felt more and more across the NHS and the wider community. The programme already has 212,034 registered NHS users across England, has delivered new systems in thousands of locations and is benefiting millions of patients. By 4 April 2006 :

- over 260,000 hospital appointments had been booked electronically at a current rate of over 20,000 per week and rising;
- over 790,000 prescriptions had been issued using the Electronic Prescription Service, at a current rate of over 13,000 per day and rising;
- over 21,000,000 digital images had been stored in Picture Archiving & Communications System (PACS);
- over 14,000 connections to the National Network (N3) have been installed; and,
- the NHS email service was supporting a registered population of nearly 170,000 users. In March 2006 alone, the service handled over 20 million emails at a rate of nearly 700,000 per day.

5.79 Along the way, some local service provider system deployment activity has been rescheduled because suppliers and their subcontractors have taken longer than anticipated to deliver software solutions that interface with national applications. However, in the context of a ten-year programme, the impact of the rescheduling has not been significant and the programme remains within budget, ahead of schedule in some areas and broadly on track in others.

5.80 The *Care Record Guarantee*[5.10], published in May 2005, now sets out the rules that will govern information held in the NHS Care Records Service (NHS CRS), the national programme's core element, when it goes live in some places later this year. The guarantee deals with people's access to their own records, the control of access by others, how access will be monitored and policed, options people will have to further limit access, access in an emergency, and what happens when someone cannot make decisions for themselves.

5.81 September 2005 saw the beginning of a major information campaign about how the NHS CRS will change the way care is delivered. All NHS staff are receiving an overview of what to expect when the NHS CRS is introduced. Front-line staff will then receive more detailed guidance, based on the *NHS Care Record Guarantee*, and tailored to their role and level of involvement with the NHS CRS. This will pave the way for an exercise later in 2006 to inform patients and the public about the arrival of the NHS CRS, and ensure they have the information they need to gain maximum benefit and make choices about storing, sharing and accessing their health data.

5.82 The focus of NHS management on delivering the national programme as a mainstream activity has been reinforced through commitments made within the performance management regime. In addition, the appointment of a service implementation director is helping to provide national influence and guidance for education, training and development and for benefit realisation planning through the Integrated Service Implementation Plan (ISIP).

5.83 There are increasing indications of the effectiveness of this approach, with NHS staff increasingly believing the Care Records Service to be an important priority, and supportive of what it and the wider national programme will achieve. The future focus will be on further linking the deployment of systems and services with the necessary improvements in clinical processes that will help clinicians, managers and administrators to improve patient care, delivering better information for better health.

Across Government

5.84 The European Health Insurance Card (EHIC) project has been the largest single card-issuing operation in the UK this year, and is the most successful Government project to date in encouraging on-line applications. The project, to replace the old E111 form as evidence that UK residents travelling in most European countries are entitled to receive treatment locally, has delivered 15 million cards to people in the UK, to time and budget, using modern e-auction procurement techniques. It has received a significant amount of positive feedback from members of the public who have used the system, and has also brought incidental benefits, including a significant increase in the number of people registering as organ donors.

5.85 NHS Connecting for Health is also supporting the Office of the Deputy Prime Minister's 'UK Digital Challenge' – to use technology to transform the face of services, including local and central government services, to better meet the needs of local communities – by helping the NHS to work locally with the public and other agencies to find high quality, sustainable solutions for local services to 'bridge the digital divide'.

Abroad

5.86 The UK is in the vanguard in implementing e-Health in Europe and beyond. The national programme and related ICT initiatives are central to meeting the UK's commitment to the European e-Health action plan to develop a national roadmap for e-Health, focusing on the deployment of e-Health systems and the use of electronic health records. The Department actively collaborates with the Commission and other European health administrations on sharing expertise and best practice. On an even broader canvas, NHS Connecting for Health and SNOMED International (a Division of The College of American Pathologists) have announced a proposal to establish an international standards development organisation to diversify the development, ownership and maintenance of Systemised Nomenclature of Medicines

Clinical Terms (SNOMED CT). The aim is to encourage international interest in establishing SNOMED CT as a worldwide clinical terminology. SNOMED CT is considered to be the most comprehensive standardised, multilingual clinical healthcare terminology available in the world.

Clinical Quality and Patient Safety

5.87 The Department's broad strategies for promoting clinical quality and patient safety in the NHS were first set out in *A First Class Service*[5.11] in 1998 and in *An Organisation With A Memory*[5.12] in 2001. Later this year the Department will publish a further strategic document which will review progress since 1998 and give further guidance on how healthcare and social care organisations can continue to seek continuous improvement in the quality of their services in the context of the Department's reform programmes (see *Health Reform in England: Update and Next Steps*[5.13]).

5.88 Broadly speaking, the quality strategy has three key components:

- setting clear national standards;
- local delivery; and,
- assessment and feedback.

NHS Healthcare Standards

5.89 The first set of national standards for the NHS, *Standards for Better Health*[5.14], were published in July 2004. They sit at the heart of the relationship between the Department and NHS and cover the full range of services for NHS patients, including services provided by NHS foundation trusts, NHS treatment centres and the independent sector.

5.90 The standards are required to be taken into account by all NHS bodies when discharging the duty of quality in healthcare. This duty requires the NHS to put and keep in place arrangements for monitoring and improving the quality of health care provided by, or, for them.

5.91 *Standards for Better Health* contains 24 core standards and 13 developmental standards, covering seven broad domains:

- safety;
- clinical and cost effectiveness;
- governance;
- patient focus;
- accessible and responsive care;
- care environment and amenities; and,
- public health.

5.92 National service frameworks (NSFs) and guidance from NICE are integral to the standards system. They have a key role in supporting local improvements in service quality. Organisations' performance is assessed not just on how they do on national targets but increasingly on whether they are delivering high quality standards across all domains, and across the broad range of NSFs and NICE guidance.

5.93 The core standards set out in one place the key requirements on providers and the standards which patients can expect from the NHS. The developmental standards are designed to promote continuous improvement over time and to help the public to see the progress which is being made year-on-year. The standards are used by the Healthcare Commission as part of the annual 'health check' assessment process for rating organisations.

5.94 The Health Care Standards Unit at Keele University continue their work to improve the use of *Standards for Better Health* throughout the NHS. They have published a range of resources supporting the standards including:

- information banks containing policy documents, regulations and legislation which underpin the standards; and,
- tools to help understand the standards.

These are available at their site at: **http://www.hcsu.org.uk/**

5.95 It is the intention in the coming year to better align *Standards for Better Health* and the standards applied to the private and voluntary care sectors. This will complement the Healthcare Commission's work to harmonise and align its inspection and review methodologies for the two sectors.

Clinical Governance

5.96 The concept of clinical governance was first introduced in the White Paper *The New NHS – Modern, Reliable*[5.15] in 1997. It describes both a culture and a set of specific processes through which healthcare organisations can ensure the quality and safety of their clinical care and seek continuous improvement in standards. Clinical governance processes are now well established in all NHS organisations, but more work is still needed to embed cultural change and to ensure that all staff at all levels are fully involved. The national clinical governance support team (CGST) are carrying out a series of visits to hospital trusts and PCTs to enable them to take stock of their current clinical governance arrangements and to plan further improvements.

Quality and Health Reform

5.97 The health reform agenda will support the drive for quality in three main ways. Firstly, commissioners will have a key role in ensuring that the organisations from which they commission services are giving high priority to quality and patient safety and have appropriate clinical governance systems and culture. Secondly, patient choice – with funding following the patient under Payment by Results – will reward those providers that are providing innovative, high-quality services in appropriate environments, and will provide an incentive to others to raise their game. Thirdly, the Healthcare Commission will continue to assess both existing and new providers to ensure that all organisations providing treatment to NHS patients meet the core national standards. We will be publishing more detailed guidance on the new arrangements for system regulation in the summer.

Clinical Audit

5.98 Clinical audit– the process of reflection on patient outcomes in order to improve the quality of care – is a key aspect of clinical governance. The Healthcare Commission has continued the development of a programme of national clinical audits. Full details can be found at: **www.healthcarecommission.co.uk**

Patient Safety

5.99 The vast majority of NHS patients receive safe and effective care, but we have to recognise that in our modern, increasingly complex health service, mistakes can and will inevitably happen. Often it is systems that have failed, rather than any individual being at fault.

5.100 Patient safety is an international problem which no country in the world can claim to have solved. Our own NHS patient safety programme is amongst the first in the world to give priority to tackling patient safety at a national level, and we are seen as one of the world leaders in the international drive to improve the safety of health care.

5.101 Whilst the NHS is clearly responding well to these systematic measures to improve safety – and the transformations in culture, staff, attitudes, leadership and working practices necessary to drive that improvement – we must recognise that we are only still at the beginning of this process.

5.102 We have continued to provide a clear and coherent message about our patient safety programme through key policy reforms and initiatives.

5.103 The first set of standards in the Department's *Standards for Better Health* requires NHS health care organisations to ensure that patient safety notices, alerts and other communications concerning patient safety are acted upon within required timescales.

5.104 The 'Modernising Medical Careers' initiative has allowed the Department to promote the importance of developing junior doctors' skills in relation to patient safety.

5.105 The Safety Alert Broadcast System (SABS), set up in 2004, continues to be an important tool for issuing nationally endorsed safety guidance to the NHS and collate the NHS' assessment of how far each piece of guidance has been implemented. To date, 170 alerts and safety notices have been issued via this route.

5.106 The National Patient Safety Agency (NPSA) was established in 2001 to help take forward the recommendations set out in the Chief Medical Officer's seminal report *An Organisation With A Memory*. Its role is to promote a culture of reporting and learning from adverse events.

5.107 All trusts have reported to the NPSA's National Reporting and Learning System (NRLS) and the NPSA published its first report on patient safety information derived from the NRLS and its Patient Safety Observatory (PSO) in July 2005. Reporting levels continue to increase significantly and the NPSA is receiving approximately 60,000 reports per month.

5.108 Learning from patient safety problems has been translated into practical solutions for safer care. Since 2002, the NPSA has developed solutions in 15 key areas related to patient safety that warranted a national response. Specific NPSA interventions should achieve results either in terms of lives saved or value for money. For example, 321 safety incidents relating to infusion devices were identified in a six-month pilot. Since the NPSA's safer practice notice was issued, opportunities for high risk incidents identified with infusion pumps have been reduced by half and savings of between £21 – £122 million have been achieved (based on a 63 per cent implementation rate).

5.109 In addition, the NPSA has released a number of very well received guidance materials, training packages and other practical tools to help ensure the NHS can provide safer care. This includes a casebook 'Medical Error' to promote reporting amongst junior doctors that complements the 'Modernising Medical Careers' initiative which has allowed the Department to promote the importance of developing junior doctors' skills in relation to patient safety.

5.110 The arm's length body (ALB) review was an opportunity to refocus efforts on promoting patient safety in the NHS. As of April 2005, the NPSA work encompasses safety aspects of hospital design, cleanliness and food (transferred from NHS Estates). It ensures research is carried out safely, through its responsibility for the Central Office for Research Ethics Committees (COREC). It is supporting local organisations in addressing their concerns about the performance of individual doctors and dentists through its responsibility for the National Clinical Assessment Service (NCAS), formerly known as the National Clinical Assessment Authority. It also manages the contracts with the three national confidential enquiries.

5.111 Patient safety was a priority theme for the UK's Presidency of the European Union in 2005. Work highlighting European and world action to improve the safety of patient care culminated in a highly successful 'Patient Safety' summit held in London on 28-30 November 2005, which brought together international and European politicians, experts, patients, clinicians and many other stakeholders from 56 countries.

5.112 The National Audit Office's November 2005 review *A Safer Place for Patients: Learning to Improve Patient Safety*[5.16] highlighted the progress we have already made in implementing this agenda. The NAO found that the safety culture within NHS trusts is now more open and fair. Most trusts have established a clear and strong focus on patient safety, driven largely through implementing the clinical governance initiative and the development of more effective risk management systems. The increase in reported incidents to the NPSA's national reporting and learning system – all NHS trusts in England and Wales are now reporting to the national system – demonstrates that trusts are making progress in creating a culture in which staff are prepared to report. The NAO report's recommendations provide a useful

focus for further work to embed patient safety as part of our wider quality and NHS reform programmes.

Provider Side Reforms – Patients Need a Range of Different Services to Exercise Choice

NHS Foundation Trusts

5.113 NHS foundation trusts were set up under the powers in the *Health and Social Care (Community Health and Standards) Act 2003*[5.17]. There are now 32 NHS foundation trusts in operation and a further 24 NHS trusts are currently progressing their application to Monitor (Independent Regulator of NHS Foundation Trusts) with a view to being authorised between April and July 2006. Further waves will follow. The Government is committed to providing all NHS trusts with the opportunity to apply for foundation status at the earliest available opportunity. For most acute and mental health trusts we expect this will be within the next three years. The decision on when to apply remains one to be taken locally.

5.114 Modelled on cooperative and mutual traditions, NHS foundation trusts are independent, not for profit public benefit corporations – with accountability to local communities rather than central Government control. NHS foundation trusts exist to provide and develop healthcare services for NHS patients in a way that is consistent with NHS values and standards. Monitor has statutory duties to authorise trusts as NHS foundation trusts, oversee compliance by NHS foundation trusts with their terms of authorisation ('licence' to operate) using a risk-based compliance regime and intervene in the event of significant non-compliance with the authorisation and other statutory obligations.

5.115 NHS foundation trusts can use their management and capital freedoms to respond much more quickly to the needs of patients. They can retain any operating surpluses and access a wider range of options for capital funding to invest in the delivery of new services. Examples include:

- Basildon and Thurrock – £60 million cardiothoracic centre is under construction at Basildon University Hospital. The centre was the Trust's first major business case after becoming an NHS foundation trust. As a result, from 2007 patients in Essex will no longer have to travel out of the county for life saving heart and lung surgery; and,
- Moorfields – capital spend has more than doubled by use of a loan facility. This has allowed the hospital to build a new Children's Eye Hospital at least two years in advance, as well as providing capital funding to enhance the patient environment on its main City Road site and at some of its outreach centres.

5.116 NHS foundation trusts are helping the NHS sustain the progress that is being made to improve services by giving more power to the elbow of front-line staff and their local communities over the delivery of local healthcare. Their governance arrangements increase patient and public involvement beyond the current arrangements for other NHS bodies and give greater opportunity for more local involvement in decision making. NHS foundation trusts have members drawn from patients, the public and staff and are governed by an independent board of governors comprising of people elected from and by the membership base. Local stakeholders such as PCTs are also represented. Membership in NHS foundation trusts is now heading towards the half a million mark. Members and governors are providing a new way for local citizens to become involved in and help shape their local health services. Examples include:

- Chesterfield Royal Hospital – all 10,000 staff and community members had their say on plans to adopt controlled visiting hours to achieve balance between infection control and visitor access. They have also contributed to the organisation's plans to become a smoke-free site. Public governors are helping to decide how more than £9 million of capital budget should be spent – by getting involved in capital schemes from the planning stage onwards;
- Gateshead – working with the board of directors, governors contributed to work to develop the trust's top 10 priorities, included in the trust's annual plan; and,
- Royal Devon and Exeter – engaged with staff and public members to determine a number of core service strategies, including improved access to services, building better partnerships and improved use of the skills of staff.

5.117 The Healthcare Commission's independent review into NHS foundation trusts, which was commissioned by the Secretary of State and published last year, confirmed that NHS foundation trusts are making good progress in improving local accountability to their local populations, as well as developing new services and providing better quality services to NHS patients. The review also found that original concerns about NHS foundation trusts have not materialised. Other independent reports by the Foundation Trust Network have also highlighted the significant benefits and opportunities presented by foundation status.

5.118 The recent announcement allowing 2 star acute, specialist and mental health trusts to apply for foundation status, in addition to 3 star organisations, supports our commitment to rolling out NHS foundation trust implementation as soon as possible. The requirements of Monitor for authorisation as an NHS foundation trust will remain as rigorous as before. The Department will revisit entry requirements for foundation status in line with the Healthcare Commission's annual 'healthcheck' performance rating system from next year.

5.119 A national analytical or diagnostic programme (Whole Health Community Diagnostic Project) is now being rolled out to all acute trusts to improve financial management in the NHS by assessing the financial robustness and viability of all acute trusts that have not yet applied to become NHS foundation trusts. The programme is allowing NHS trusts to develop action plans with SHAs that set out what needs to be done in order to become a viable NHS foundation trust, and give an indication of when they might be ready to apply. The project will provide an assessment of what needs to be done to get NHS trusts in England ready to apply for foundation status.

Treatment Centres

5.120 Treatment centres provide safe, fast, pre-booked surgery and diagnostic tests for patients, by separating scheduled treatment from emergency pressures, in some of the specialties with the highest waiting times (in orthopaedics and ophthalmology, for example). They are at the heart of the drive to modernise the NHS.

5.121 The core objectives of the treatment centre programme are to:

- improve access to acute elective; and,
- spearhead diversity in NHS clinical services by allowing companies from the independent sector to run some treatment centres. Independent sector run treatment centres provide the NHS with extra capacity quickly and utilise the talents of some of the world's leading independent healthcare companies to deliver high quality care for NHS patients.

5.122 44 NHS treatment centres are currently open, with a further two in development, expected to be open during 2006. Over 275,000 patients have been treated in NHS treatment centres since the programme was launched in April 2003, over 128,000 of whom have been treated in this financial year, from April to January 2006.

Independent Sector Procurement

5.123 By the end of 2005, the Independent Sector Treatment Centre (ISTC) Programme had delivered almost 200,000 procedures and diagnostic tests to NHS patients. The programme has increased access to a range of elective and diagnostic facilities and is helping to offer alternative choices for NHS patients. The activity has also contributed to the reported reduction in waiting times for cataract and orthopaedic procedures.

5.124 In the first wave of ISTC procurements, 16 out of 17 wave 1 contracts have reached financial close with the remaining contract expected to close in March 2006. There are currently two mobile ophthalmology units and 12 mobile MRI units operating nationally. In addition to this, there are 17 further static ISTC sites offering services for a range of procedures including a minor injuries walk-in service, diagnostics, general surgery, orthopaedics and ENT.

5.125 The next wave of procurements are well advanced and comprise two main areas – elective procedures and diagnostic procedures:

- wave 2 electives may deliver up to 250,000 procedures per year and create an extended choice network (ECN) of independent sector providers who will deliver up to an additional 150,000 procedures per year, on an ad hoc basis. Overall, this could represent an investment of up to £3 billion over five years. The additional capacity will be provided through a variety of facilities, such as existing ISTCs, new build centres, refurbishments and existing NHS facilities, and will collectively contribute towards the provision of patient choice; and,
- wave 2 diagnostics is expected to deliver approximately two million additional diagnostic procedures per year for NHS patients, and could represent an investment of up to £1 billion over five years. The additional capacity will help cut 'hidden waits' brought about by patients waiting for diagnostic tests ahead of any further treatment required. It will also help the NHS to meet the Government's target that by 2008 all NHS patients should be treated within 18 weeks of their GP referral.

5.126 In addition, two NHS Walk-in Centres with a commuter focus also began service delivery in 2005. The NHS Walk-in Centres are set up and run by the independent sector close to busy commuter stations, in order to increase access to services outside of hospitals for commuters and people who live in busy commuter cities where the primary care resources are stretched by transient patients. The Manchester Piccadilly NHS Walk-in Centre opened on the 17 November 2005 and was the first NHS Walk-in Centre to be set up and run by the independent sector. The London Liverpool Street NHS Walk-in Centre began delivering services on 19 December 2005. Both centres will be open from 7am to 7pm, Monday to Friday.

5.127 A pharmacy based chlamydia screening pathfinder project also began in November 2005. The free service targets 18 to 24-year-olds who can pick up a chlamydia testing kit from over 200 Boots stores in London. The kit is then returned to the store and sent away for analysis. Results are then issued via the chlamydia screening officer through the chosen patient method, which can be a text message. If the results are positive, the treatment can be obtained from Boots though a number of options are discussed.

5.128 The aim of the project is to evaluate the pharmacy setting as an access point for chlamydia screening. If the project is successful throughout its two-year pilot period, it could be rolled out nationally.

Overseas Treatment

5.129 The Department ceased the central coordination in relation to overseas treatment initiatives and the use of overseas treatment teams as of 31 March 2005. Local NHS commissioners are responsible for decisions about patient mobility and the use of treatment teams.

Commissioning Reforms

5.130 The objective of the structural reforms (see **paragraph 5.11**) is to build stronger PCTs and increase their focus on commissioning the best services for patients, to work better with local government and to achieve value for money from the system.

Practice Based Commissioning

5.131 Practice based commissioning gives practices and professionals greater freedom to make commissioning decisions, and develop innovative, high quality services for patients.

5.132 As indicated in the *NHS Improvement Plan*, since April 2005 GPs have been able to receive an indicative budget. This enables practices to review how their patients use health services, and to redesign services to provide high quality local alternatives.

5.133 Practice based commissioning gives front-line professionals and managers the information, levers and incentives to improve services in response to the needs of their patients and local populations. It will facilitate clinical engagement, improve access and extend choice for patients.

5.134 Our intention is to maximise clinical innovation and quality within a support and accountability framework, which ensures proper and efficient use of public money on behalf of the taxpayer and helps to provide the tools to make change happen.

5.135 The Department has committed all PCTs to establishing arrangements to ensure the right environment for practices to engage in practice based commissioning by December 2006.

5.136 These arrangements were outlined in *Practice Based Commissioning: Achieving Universal Coverage*[5.18], published in January 2006. PCTs are accountable to, and will be performance managed by, SHAs over their provisions for universal coverage.

5.137 By the end of 2006, all GP practices will be significantly engaged in practice based commissioning. To help with the take up of this policy, the Department has published *Practice Based Commissioning: Early Wins and Top Tips*[5.19], a clinically focused document which has been sent to all GPs in England.

Redesigning NHS services around the needs of the patients

5.138 Giving patients more choice and control over their healthcare and services is one of the key elements of the Government's programme of reform for the NHS. 76 per cent of patients who took part in our national choice consultation in autumn 2003 said that they wanted to be more involved in decisions made about their healthcare and treatment.

5.139 Enabling patients to choose services that best meet their needs and preferences not only improves their patient experience, but will also encourage providers to develop more responsive, patient-centred services.

5.140 *Creating a Patient-led NHS*, published in March 2005, sets out how choice is to be introduced for patients across the whole system to deliver more personalised care. Wherever possible in the NHS, patients will have an informed choice of treatment options, treatment providers, location for receiving care, type of ongoing care and choice at the end of life. It also emphasises the importance of providing patients with easy access to information to help them make informed choices about their healthcare.

5.141 Over the past year, patients have had increasing choice of how, where and when they receive their treatment in primary care. NHS Direct has in excess of 2 million patient contacts per month. NHS Walk-in Centres, which allow quick and easy access to a range of NHS services, are increasingly popular with the public. Seventy-three Walk-in Centres are now open and over six million people have attended since the first one opened in 2000. Two independent sector Walk-in Centres aimed specifically at commuters have recently opened at Manchester's Piccadilly station and London's Liverpool Street.

5.142 Patients also have increasing choice in how they access medicines. A new contractual framework for NHS community pharmacy services came into operation on 1 April 2005. It provides PCTs and pharmacies with opportunities to work effectively together to meet the needs of the local population and will help to shift the focus of the health service towards health improvement, self-care and disease prevention.

Choice of Hospital

5.143 *Creating a Patient-Led NHS* also set out how we are increasing choice in elective care to give patients the opportunity to choose from a wide range of hospitals and services.

5.144 This choice is being introduced in stages. Where patients have already had the opportunity to choose their hospital evidence shows that this is proving popular. From April 2004, approximately 80,000 patients, who would otherwise wait more than six months for treatment, have taken up the opportunity to choose an alternative provider for faster treatment. Research conducted by Dr Foster and the University of Nottingham in March 2004 has also demonstrated that patients value being able to exercise choice over where they are treated. They become more involved in decision making when this is offered and want to use this opportunity to access better quality care.

5.145 Since 1 January 2006, eligible patients are being offered a choice of at least four providers, where clinically appropriate, and a booked appointment when they need a referral for elective care. PCTs are responsible for commissioning the choice options for their local communities and may include NHS trusts, NHS foundation trusts, NHS or Independent Sector Treatment Centres and other independent sector providers.

5.146 The new electronic booking system, Choose and Book, will enable patients to choose their hospital and book their appointments electronically either from the GPs surgery or later from home or work by contacting a call centre (Choose and Book Appointments Line). They will also be able to make or change appointments via the Internet and eventually via digital television. Where Choose and Book has not yet been implemented, we have introduced manual solutions to ensure that all patients are being given choice.

5.147 Patients need easy access to high quality information to help them make an informed choice. Early research and consultation has shown that patients want information on waiting times, access and location, clinical quality and patient experience. To support the introduction of choice at referral, we have produced a patient information booklet, tailored to each PCT, which gives patients and GPs comparative information about the hospitals available to them. It also includes a set of indicators taken

from the published Healthcare Commission's performance ratings. This information is also available on the nhs.uk website which has been enhanced to support choice. PCTs are providing further information and support tailored to meet the needs of their local communities, for example using voluntary and community services, patient advice and liaison services (PALS) and libraries.

5.148 As we increase choice in elective care, we anticipate that patients will want more detailed information on both clinical quality and patient experience to help them make their choices. We are already piloting a website in South Yorkshire called 'Patient Opinion', which provides an innovative way for patients to share their experiences of hospitals and services. We will be developing further information to support free choice, in particular on clinical quality, and to respond to patients' and GPs' expectations.

5.149 During 2006, we will be extending choice further, in addition to the four or more locally commissioned providers, patients will also have the opportunity to choose from appropriate NHS foundation trusts, all centrally procured Independent Sector Treatment Centres and other subsequently centrally procured independent sector providers. By 2008, patients will be able to choose to be treated by any healthcare provider that meets NHS standards and can provide care within the price the NHS is prepared to pay.

Choice for CHD Patients

5.150 The initial CHD choice pilot began in July 2002 when any patient waiting over six months for a heart bypass, angioplasty or heart valve operation was offered the choice of treatment at an alternative hospital to that at which they had been waiting. Most of the patients that took up the choice of treatment elsewhere did so for heart bypass surgery. About 50 per cent of those patients offered a choice went for treatment at an alternative hospital.

5.151 From April 2005, patients referred for heart bypass, heart valve and coronary angioplasty operations were offered a choice of two hospitals for that treatment, at the time that they are referred for treatment. Since 1 January 2006, this was extended to a choice of at least four hospitals in line with the wider choice policy.

Cataracts and Chronic Eye Conditions

5.152 The introduction of choice at referral for cataract patients has built on the major success of the NHS in reducing maximum waiting times for cataract treatment:

- the maximum waiting time for cataract operations was reduced from six months in March 2004 to three months in January 2005. This target was achieved four years ahead of the timescale set out in the *NHS Plan*;
- the use of a new streamlined care pathway for cataract services is allowing optometrists to refer patients directly to hospital. This means fewer appointments, better patient experience and more effective use of skills in primary and secondary care;
- since January 2005, patients who need a referral for cataract surgery have been offered a choice of at least two providers. In January 2006, this increased to a choice of at least four providers; and,
- Since February 2004, 20,323 NHS patients have been treated in mobile cataract units run by the independent sector, which help promote fast access to high-quality care.

5.153 The Department is funding eight pilots testing new care pathways for glaucoma, age related macular degeneration and low vision. In 2005, the Department launched seven associate sites to undertake further work on low vision services. Evaluation of the pilots will be completed in 2006-07.

Better Information, Better Choices, Better Health

5.154 Access to good quality information at an appropriate time is fundamental to making informed choices about personal health and care. The need to improve the information available to people continues to be amongst the loudest messages from recent national consultations, including *Your Health, Your Care, Your Say* in 2005 [5.20], *Choosing Health?* [5.21] in 2004 and the national choice consultation in 2003. We are now one year into our three-year strategy, *Better Information, Better Choices, Better Health* [5.22], which was developed to address these issues. This programme of action, at both national and local level, is designed to put information at the centre of health so people have the information that they need and want to exercise choices about their personal health and care.

5.155 The strategy places an emphasis on enhancing the relationship between care professionals and service users through opening up dialogues within consultations and supporting the move towards shared decision-making. It also sets out to build further national resources and make access to information easier and more equitable. We have already made progress in a number of areas, including testing the NHS Patient Information Bank, providing support to NHS organisations to target information to specific audiences, and incorporating communications training as part of the post graduation foundation programmes for all medical graduates. Work has also started on development of an information accreditation scheme, power questions for patients to ask their care professional, and information prescriptions.

Access to GPs Out-of-Hours

5.156 When general practice (GP) surgeries are closed in evenings, weekends and bank-holidays, patients who contact out-of-hours services can be assured that their clinical needs will be consistently met through nationally set quality requirements which will ensure fast and convenient access to care, delivered by the most appropriate professional in the most appropriate place.

5.157 All out-of-hours services must be delivered to the national quality requirements, ensuring patients have access to consistently high quality and responsive care, regardless of where they live. Providers must deliver services that meet the quality

requirements, as a contractual obligation. The requirements stipulate that:

- patients will be guaranteed a GP consultation – including a home visit if there is a clinical need;
- patients are treated by the clinician best equipped to meet their needs in the most appropriate location; and,
- services will be regularly audited to ensure that patients are receiving quality care.

5.158 PCTs have the responsibility of ensuring that they provide, or secure provision of a high quality, sustainable out-of-hours service for their local population.

Expanding Prescribing by Nurses, Pharmacists and Other Health Professionals

5.159 The Non-Medical Prescribing Programme aims to expand prescribing by nurses, pharmacists and other health professionals, to provide patients with improved and quicker access to medicines.

5.160 From May 2006, qualified nurse independent prescribers (formerly known as extended formulary nurse prescribers) and pharmacist independent prescribers will be able to prescribe any licensed medicine for any medical condition within their competence. Pharmacists will not be able to prescribe controlled drugs, but nurses will be able to prescribe some. These extended prescribing powers will improve choice for patients and enable more flexible team working within the NHS.

5.161 The *Nurse Prescribers Extended Formulary* (NPEF)[5.23] currently comprises a wide range of medicines to treat a variety of medical conditions. Around 6,600 nurses are qualified and registered to prescribe independently from the NPEF. Over 29,000 Community Practitioner Nurse Prescribers are also able to prescribe from a more limited formulary (consisting mainly of dressings, appliances and some medicines) for patients in community settings.

5.162 We have expanded the range of health professionals that can act as supplementary prescribers (in partnership with a doctor) to include radiographers, physiotherapists, podiatrists/chiropodists and optometrists. In addition to these professions, over 6,000 nurses and over 500 pharmacists (England) are now qualified and registered as supplementary prescribers. Supplementary prescribing is primarily used for the management of long-term medical conditions and health needs.

Transactional Reforms

Payment by Results

5.163 The implementation of payment by results (PbR) is continuing. In 2005-06, approximately £9 billion worth of NHS services were covered by PbR with all NHS hospitals being funded at national tariff rates for elective activity. NHS foundation trusts were also funded at tariff for non-elective activity, outpatients and accident and emergency services.

5.164 From 1 April 2006, approximately £22 billion worth of services will be covered with the tariff applying to all admitted patient care, outpatient and accident and emergency services falling within the scope of PbR and directly commissioned by primary care trusts and commissioning consortia from NHS trusts, NHS foundation trusts or primary care trusts.

5.165 Initial information on the scope and structure of the tariff to be used in 2006-07 was published on 31 January 2006 together with a *Code of Conduct for Payment by Results*[5.24]. This code establishes core principles, with some ground rules for organisational behaviour, and expectations as to how the system should operate. During the course of 2006-07 we will also implement an assurance framework which will focus on improving the quality of patient-level data that underpins the effective operation of PbR.

5.166 In the autumn, we will also publish a framework for the future operation of PbR in 2007-08 and beyond. This document will address wider policy issues and how PbR could and will be used as a tool to achieve overall policy objectives. The document will also include a policy update on the extension of PbR to cover critical care, mental health, ambulance services and long-term conditions.

System Management and Regulation

The Healthcare Commission

5.167 The Healthcare Commission was set up under the *Health and Social Care (Community Health and Standards) Act 2003*[5.25] and started work in April 2004. Its responsibilities in England include:

- awarding annual performance ratings to NHS organisations in England;
- carrying out reviews and investigations of healthcare and public health;
- co-ordinating reviews and assessments carried out by other bodies;
- registering and inspecting providers of independent healthcare;
- reviewing second stage complaints about the NHS; and,
- reporting annually to Parliament on the state of healthcare in England and Wales.

5.168 The Healthcare Commission have devised a set of criteria for assessing the provision of NHS services against the national *Standards for Better Health*. This will contribute to the annual rating given to each NHS body in the Commission's annual 'healthcheck' assessment process. The new process, which replaces the previous 'star ratings' process following a consultation in November 2004, was first applied to performance in 2005-06 and the resulting ratings will be published later in 2006.

5.169 In 2005-06, the Healthcare Commission received a grant in aid of £69.7 million. The Commission also derives income from the registration and inspection fees it charges private and

voluntary healthcare providers. By April 2005, 1,400 establishments were registered with the Healthcare Commission; it estimates that fee income for 2005-06 will be £7.5 million. From 2006-07 the Commission will be responsible for setting its own fee levels. In December 2005, the Commission launched a three-month consultation period on its proposed fee structure.

Complaints

5.170 Since the end of July 2004, the Commission has been responsible for the independent review of complaints against the NHS not resolved at local level. The Commission received over 8,000 referrals in the first year of the new system, under the previous NHS system some 3,600 complaints were referred for review.

NHS Performance 'star ratings' 2004-05

5.171 The performance ratings system awarded three stars to the highest performing trusts, down to zero stars for the worst performing. The rating awarded is based on the trust's performance against a number of key targets and a wider set of balanced scorecard performance indicators, selected to reflect the Government's priorities and assess a wide range of performance issues.

5.172 The ratings are produced by the Healthcare Commission, and were published in July 2005. A total of 590 star ratings were awarded to trusts for their performance in 2004-05. Trusts that provided services to more than one sector were given more than one rating. For example, a primary care trust (PCT), which also provided mental health services, was awarded a star rating for its PCT services and another for its mental health services.

5.173 The overall results were as follows:

165 ★★★
262 ★★
139 ★
24 0

5.174 For NHS acute and specialist trusts, the results were as follows:

73 ★★★
53 ★★
38 ★
9 0

5.175 For primary care trusts, the results were as follows:

58 ★★★
158 ★★
80 ★
7 0

5.176 For ambulance trusts, the results were as follows:

13 ★★★
6 ★★
9 ★
3 0

5.177 For mental health trusts, the results were as follows:

21 ★★★
45 ★★
12 ★
5 0

5.178 The results show a rise in the overall number of trusts with the maximum three stars, from 146 to 165. There was also a fall in the number of trusts with zero stars, 35 to 24. Further details of the ratings published in July 2005 can be viewed on the Healthcare Commission's website:
www.healthcarecommission.org.uk

The Commission for Social Care Inspection (CSCI)

5.179 The Commission for Social Care Inspection (CSCI) became operational on 1 April 2004, when it replaced the National Care Standards Commission. Its aim is to improve the quality and consistency of care provided to people who use social care services. It aims to ensure that service providers deliver services of an appropriate standard whether in the statutory or the independent sector. It promotes continuous improvement and high performance in social care organisations, providing an authoritative source of information on what service users should be able to expect.

5.180 The Commission:

- assesses the performance and quality of local councils in ensuring the delivery of social services by drawing together relevant quantitative and qualitative information, ensuring the evidence used is timely and accurate;
- assesses how far local councils achieve effective outcomes for the people who use social care services, including how effectively they deploy their resources to achieve best value;
- publishes performance ratings of local councils and other information on performance for the public, including judgements on prospects for improved performance;
- inspect and assess commissioners and providers of service taking account of national minimum standards and policy guidance set by central Government, including assessment of the appropriateness, responsiveness, equity, efficiency and effectiveness of provision and the outcomes achieved for users;
- regulates and inspects social care providers, making information available to the public about these services, and encourages improvements in the quality of registered services, offering guidance and advice to providers; and,

- takes appropriate enforcement action where service providers do not meet minimum standards.

5.181 The Commission publishes an annual report to the Department of Health and Parliament on the way in which it discharges its functions and on its findings on the provision of social care. It works closely with the Healthcare Commission and other bodies involved in quality.

5.182 Health Ministers announced a review of the national minimum standards in autumn 2004. This is aimed at achieving a regulatory system that works in the best interests of service users, and which assesses the effectiveness of services and their outcomes for users. The aim is also that inspection of services is proportionate to risk, avoiding unnecessary burdens on service providers who provide good quality services, targeting inspection where improvement is needed, while giving the necessary assurance to service users and their relatives that services are of appropriate quality and safety.

5.183 CSCI is in the process of modernising its regulatory activity (its Inspecting for Better Lives Programme, which complements the DH review of national minimum standards and regulations).

5.184 In 2005, the Government announced plans for CSCI to be merged with the Healthcare Commission by 2008, and the transfer of children's services from CSCI to Ofsted, due to take place in 2007. Final decisions on the merger will be taken in the light of a wider review of regulation in health and social care, which is expected to report in early 2006.

Feedback from Patients

5.185 A vital element of the process through which healthcare and social care organisations assess and improve their performance is feedback from patients and users. This can take various forms; for instance, results from the national patient survey are an integral part of the Healthcare Commission's annual 'healthcheck'. Complaints are also a key form of feedback to help NHS hospitals learn constructively when things go wrong.

WHAT IS BEING DELIVERED FOR PATIENTS

CANCER

– improve care of patients with cancer and reduce mortality and morbidity from cancer

5.186 The *NHS Cancer Plan* [5.26] was published in 2000. It is a ten-year national strategy to prevent, diagnose and treat cancer; to reform the way cancer services are delivered; to standardise care and improve patient experience; to coordinate research and to invest in equipment and the cancer workforce.

5.187 The Department published *The NHS Cancer Plan and the New NHS* [5.27] in October 2004. This sets out progress made since the *Cancer Plan* was published, as well as showing how cancer fits within a changing NHS.

5.188 Significant progress continues to be made in cancer care and this includes:

- almost a 14 per cent reduction in cancer mortality in the under-75s in the last seven years;
- over 99.8 per cent of patients urgently referred by their GP with suspected cancer, are now seen by a specialist within two weeks, compared to 63 per cent of patients in 1997;
- almost 99 per cent of women with breast cancer received their first treatment within one month of the decision to treat them being made, and over 98 per cent received their first treatment within two months of being urgently referred by their GP;
- figures published in August 2005 showed that in the first three years of the *Cancer Plan* additional investment in cancer services reached £639 million;
- since 1997 there has been a 44 per cent increase in the number of cancer specialists;
- over 1,200 items of the most modern equipment has been delivered to diagnose and treat cancer since 2000; and,
- on the latest evidence available, the number of cancer patients entering clinical trials has doubled in the last three years. The percentage of people entering trials in England is twice as high as in the United States.

Prevention

5.189 Smoking is still the leading single cause of avoidable ill health and death and is responsible for a third of cancers. Increasing fruit and vegetable consumption is the second most effective strategy for reducing the risk of cancer, and has major preventative benefits for heart disease. The incidence of some cancers is also linked to physical inactivity (**see paragraph 5.517**).

Breast Screening

5.190 As of March 2006, all of the 85 local breast screening units in England were inviting women aged 65 to 70 for breast screening as part of the expansion of the NHS breast screening programme. Since the age extension began in April 2001, over 600,000 more women have been invited for breast screening. In addition, all units are now taking two views of each breast at every screen (two-view mammography), which has led to a 40 per cent increase in the number of breast cancers diagnosed in the programme since roll-out began in 2001.

Cervical Screening

5.191 The national roll out of liquid based cytology (LBC), part of the modernisation of the NHS cervical screening programme begun in October 2003, will not only speed up result times, but also provide a more reliable test than previously available. When fully implemented, LBC will mean 300,000 women a year will not have to undergo repeat tests. The retraining of staff and installation of new equipment is a major undertaking, and we do not expect full implementation until the end of 2008.

Half of cervical screening programmes will have converted to LBC by summer 2006.

5.192 The Government is committed to speeding up the results of cervical screening (Labour Party Manifesto, May 2005 General Election). Work has begun on considering how this commitment might best be implemented.

NHS Bowel Cancer Screening Programme

5.193 The Secretary of State for Health announced in October 2004 that the NHS bowel cancer screening programme would begin in April 2006. Men and women aged 60 to 69 will be invited for screening using a testing kit they can complete in their own homes before sending it off to the laboratory for analysis. Around two per cent of those who are screened will be positive, and they will be invited for a full colonoscopy (examination of the interior of the bowel).

5.194 Five programme hubs across England will provide call/recall services, send out the testing kits, interpret the completed kits, and send results out. 90 to 100 local screening centres will provide endoscopy services for the two per cent of men and women who have a positive test result. Roll-out will expand over subsequent years and we expect full national coverage in England by 2009.

NHS Prostate Cancer Programme

5.195 Since the Department published the report *Making Progress on Prostate Cancer* [5.28] in November 2004, further progress has been made in tackling the disease that is the most commonly diagnosed cancer in men.

5.196 In 2004, Rosie Winterton, Minister for Health Services, announced a new public awareness pilot programme for prostate cancer. The pilot, which will begin in 2006, is intended to raise the awareness of the prostate and its function. It will take place in an NHS primary care trust area and its results will be evaluated. If successful, the initiative could be replicated across the country. The pilot will be jointly funded by the Department and signatories to the *Prostate Cancer Charter for Action* [5.29] (voluntary organisations, patient groups and professional groups).

5.197 In summer 2005, the Department issued for consultation a draft framework of advice for SHAs, cancer networks, PCTs and NHS trusts in England considering the introduction or continuation of low dose brachytherapy for the treatment of localised prostate cancer. This is a form of radiotherapy in which radiation is targeted directly by the implantation of small radioactive pellets. The responses to this consultation are being considered and a revised framework will be issued later in the year.

5.198 UK Prostate Link was launched on 4 November 2005, another joint venture between the Department and the *Prostate Cancer Charter for Action*. This is the first comprehensive independent online source of information of its kind, and will help prostate cancer patients, their families and health professionals to access the information they need about the disease. UK Prostate Link can be viewed at: **http://prostate-link.org.uk/**

5.199 The prostate cancer risk management programme, which is designed to help men make an informed choice about being tested for prostate cancer, is being evaluated by the Cancer Research UK Primary Care Education Research Unit at the University of Oxford, and papers will appear in the academic press in 2006. The primary care information packs sent to all practices in the country will be revised, based on the results of the evaluation, and the packs will be re-launched in summer 2006.

5.200 Decisions about treatment for prostate cancer can often be difficult and complicated. The first phase of the 'Action On Urology: Implementation of Decision Aids' programme ended in 2005. The pilot was designed to help make sure that the NHS is able to use decision aids for men with prostate cancer as part of its routine practice. The programme found that patients and professionals found the decision aids helpful in the decision-making process. The second phase of the programme has now begun, aiming to enhance effectiveness before any national roll-out takes place.

Cancer Waiting Times

5.201 Waiting for specialist assessment, for diagnostic tests and for treatment can be a major anxiety for patients who suspect they may have cancer, and for their families. Building on a previous commitment in the *NHS Cancer Plan* that all patients referred urgently by a GP with suspected cancer should be seen within two weeks, two key targets covering diagnosis and treatment are due to be implemented from the end of 2005. These are that:

- all patients with cancer should commence treatment within one month of decision to treat; and,
- all patients with cancer who are referred urgently by a GP should commence treatment within two months of referral.

5.202 NHS performance towards the *NHS Cancer plan* targets for the maximum time cancer patients should wait for assessment and treatment has been very impressive. In 2005:

- over 99 per cent of patients referred urgently by their GP for suspected cancer were seen within two weeks;
- 98.9 per cent of women with breast cancer were treated within one month of a decision to treat;
- 98.1 per cent of women with breast cancer were treated within two months of being referred urgently by their GP; and,
- the 2005 cancer waiting times targets became live at the end of December 2005. The NHS has been working hard to redesign services and introduce new, creative and more efficient ways of working, so that cancer patients treated from 1 January 2006 onwards can expect to be treated within target times.

5.203 Achievement of 2005 waiting times targets will be measured on performance in the quarter from January to March 2006 and data for this period will be published in early June 2006. The National Cancer Waits Project will continue to support the NHS in achieving and maintaining these standards in 2006.

In addition, the last manifesto included further commitments to ensure that we will go further to improve on the current cancer waiting times target.

Cancer Treatment

5.204 *Improving Outcomes*[5.30] guidance is now available from the National Institute for Clinical Excellence on eleven tumour groups (breast, colorectal, lung, gynaecological, upper gastrointestinal, urological, haematological and head and neck cancers, skin cancers, sarcomas and cancers in children and young people) as well as adult supportive and palliative care. Guidance of this nature makes recommendations to the NHS about how health services should be organised to improve outcomes for patients. Guidance on one further group of cancers (brain cancers) will be published during 2006.

5.205 Implementation of recommendations in the *Improving Outcomes* series of guidance is currently being assessed by the national cancer peer review programme. By the end of May 2006, 27 Networks will have been visited and the programme is on schedule to have completed the main visits to all the cancer networks in England by November 2006. A national report summarising the outcome of the peer review programme is expected to be published around spring 2007.

5.206 Sixteen cancer drugs have been appraised by NICE and a further nineteen drug appraisals are in progress or planned. The new appraisals will address treatments for breast cancer, lung cancer, colorectal cancer, head and neck cancers, mesothelioma, prostate cancer, brain cancer and cancer treatment-induced anaemia.

5.207 The *National Cancer Director's report*[5.31] published in June 2004 showed unacceptable variations across the country in the uptake of cancer drugs approved by NICE. In response, the Department set out a broad programme of action to support the NHS in implementing NICE guidance. This included the development of local action plans to address areas of concern. These action plans were encouraging, confirming that the profile of implementing NICE appraisals had increased and that where problems had been identified they had been, or were in the process of being, addressed. A repeat analysis is being conducted to confirm if variations have been reduced as a result of these actions. This should be available in the summer.

5.208 NICE also produces clinical guidelines on the appropriate treatment and care of people with specific diseases and conditions within the NHS. NICE published referral guidelines for suspected cancer in June 2005 to help primary care staff identify those patients who are most likely to have cancer and therefore require urgent assessment by a specialist. They also issued guidelines on the diagnosis and treatment of lung cancer in February 2005. Clinical guidelines are also in development for the diagnosis and treatment of breast and prostate cancers.

Supportive and Palliative Care

5.209 In recent years, the Government has announced a range of activities to improve the provision of high-quality supportive and palliative care, and to provide people with greater choice at the end of life.

5.210 The £12 million End of Life Care Programme (2004-2007) is tackling inequalities in the provision of palliative care services, and supporting people at the end of life to make choices about the treatment they receive and where they die. Central to the programme is the provision of palliative care training for general staff, so that all patients, regardless of their diagnosis, have access to high quality end of life care. This is being achieved through the dissemination of three key tools: the Liverpool Care Pathway, the Gold Standards Framework and the Preferred Place of Care. Now entering its second year, the programme has made significant progress. The latest figures show that 28 per cent of all GP practices in England have now implemented one or more of these tools, and that 60 per cent of acute trusts have implemented the Liverpool Care Pathway on one or more wards. Additionally, 47 per cent of hospices have implemented one of the tools.

5.211 The *Cancer Plan* made a commitment to invest an additional £50 million per annum for specialist palliative care. This commitment has been delivered. It has increased overall levels of funding for specialist palliative care by about 15 per cent, and NHS funding by about 40 per cent, over 2000 levels. So far, this extra money has funded 44 additional consultants in palliative medicine, 172 new clinical nurse specialists and 46 new specialist palliative care beds.

5.212 Action plans have been developed by the cancer networks to ensure that the NHS implements the recommendations in the National Institute for Clinical Excellence's guidance on *Supportive and Palliative Care*[5.32]. Whilst the guidance was developed for the care of those with cancer, the recommendations are applicable to other conditions. The action plans are being monitored by the SHAs.

5.213 Funding of £6 million has been provided for an Integrated Cancer Care Programme, which is now in its second, and final, year. The programme will explore models of delivery to help patients get the best quality of care possible, and to find out the most effective ways to use resources. It will also support patient choice by engaging patients more actively in decisions about their care.

5.214 The Government has made a commitment to double the investment in palliative care services for all people, regardless of their age or condition, so that more people have the choice to be treated and die at home. This will be delivered through the White Paper *Our Health, Our Care, Our Say*, which sets out a programme for action for end of life care. We will be working with key stakeholders in taking this forward.

5.215 A Public Accounts Committee report on improving the patient experience for those with cancer, *Tackling Cancer:*

Improving the Patient Journey [5.33], was published in January 2006. Although recognising that there is still work to be done, the report acknowledges that the cancer patient experience has improved markedly between 2000 and 2004. These recommendations will be taken into account in the Department's continuing work.

Cancer Workforce and Training

5.216 The cancer care group executive is overseeing a programme to ensure that we have enough people, with the right skills, available in the right locations, at the right times, to provide the care that cancer patients need. The programme includes projects within endoscopy, histopathology, radiology and improved treatment and these are already well underway.

5.217 A national training programme for colorectal cancer has been designed as part of the NHS bowel cancer programme. This training is for the whole colorectal cancer multi-disciplinary team. It brings together members of the team to learn about total mesorectal excision (TME), which has consistently resulted in lower rates of local recurrence of bowel cancer, reduced the need for expensive and unpleasant procedures, and improved survival rates. By March 2006, 140 colorectal teams will have participated in TME training courses.

5.218 Also, to prepare for the NHS bowel cancer programme, more than £9 million over three years was committed in 2003 to expand endoscopy training capacity further. Three national and seven regional training centres have been established and are training medical staff, general practitioners, nurses and allied health professionals in endoscopic procedures. The new training centres are increasing the pool of staff able to undertake these diagnostic procedures and, therefore, reducing waiting times and making services more convenient, which will facilitate the introduction of a national bowel cancer screening programme.

5.219 A national training programme has been developed in sentinel node biopsy, which is a new surgical technique for breast cancer patients, which offers substantial gains, both for breast cancer patients and health services. This technique reduces the amount of invasive surgery a patient needs to undergo and not only lessens the risk of pain and swelling, but also reduces the amount of time they need to spend in hospital. The programme is being rolled-out through workforce development directorates co-ordinated by the North East London SHA.

5.220 A national training programme is also being developed and piloted for prostate cancer teams with the aim of enhancing team working and improving the quality of surgical techniques (focusing initially on open prostatectomy).

5.221 Competency frameworks have been developed, by Skills for Health for staff working in endoscopy; chemotherapy; supportive and palliative care; MDT co-ordinators; and cystoscopy. National workforce competences will ensure skills are recognised and are transferable across the UK, and can be used to underpin a range of national qualifications and training programmes. For 2006, the care group have commissioned Skills for Health to develop new competency frameworks in breast assessment, cervical cytology sample taking, new roles relating to flexible sigmoidoscopy and to scope the competencies relating to urological assessment.

Cancer Equipment

5.222 The Department has continued to invest in facilities to ensure that patients have better access to diagnostic scanning and radiotherapy services by increasing machine capacity and replacing ageing equipment. £128 million capital investment was made during 2005-06.

5.223 **Figure 5.1** shows the total number of the larger items of diagnostic and radiotherapy equipment that were available in the NHS in 1997, January 2000 and now in March 2006. It also shows the percentage increase that the equipment programmes have contributed to.

Figure 5.1: Diagnostic and Radiotherapy Equipment

Equipment type	1997	Installed base January 2000	March 2006	% increase since 1997
CT scanner	200	285	366	83.5
Linear Accelerator	140	152	215	54.0
MRI scanner	110	182	273	148.0

Source: Intentional Medical & Environmenal Exposure (IMEeX) Department – National Radiological Protection Board – March 2006

5.224 Deliveries of a further 56 items of new and replacement diagnostic imaging equipment and 56 linear accelerators via the central programmes are anticipated in 2006-07.

5.225 Savings made by organising the equipment procurements centrally have been used to extend the programmes. Because of these central programmes, the NHS in England will have a stock of CT and MRI scanners as modern as any country in Europe. This equipment provides higher quality images and faster scanning times for patients. The new linear accelerators have enabled the latest radiotherapy treatment techniques to be provided.

Positron Emission Tomography

5.226 In October 2005, *A National Framework for the Development of Positron Emission Tomography Services in England* [5.34] was published on the Departmental website. This framework provides advice to commissioners and providers on the development of PET CT services.

CORONARY HEART DISEASE AND STROKE

– improve the care of patients with CHD and stroke, and reduce mortality and morbidity of CHD and stroke

Prevention

5.227 The section on key risk factors for delivering the health inequalities target at paragraph (**see paragraph 5.472**) gives details of how the Department's work will contribute to reducing the incidence of CHD.

In Primary Care

5.228 Primary care has a key role to play in preventing, diagnosing and managing coronary heart disease. Heart failure in particular is a long-term condition with a poor prognosis, but effective management in primary care, with good links to secondary and to palliative care, can improve patients' and carers' quality of life and avoid unnecessary hospitalisation.

5.229 The new GMS contract includes a range of quality indicators for CHD and heart failure, reflecting the high incidence and prevalence of these conditions. 2004-05 was the first year of the contract and practices achieved an average of 95 per cent of the points available in these areas. Spearhead PCTs achieved an average of 93 per cent of these points, suggesting both the additional challenge they face and their determination to meet the quality requirements. This is consistent with the continuing rise in prescriptions for key drugs for secondary prevention of CHD.

5.230 In particular, statin prescribing to control cholesterol continues to rise at 30 per cent a year. See **Figure 5.2**. The National Institute for Health and Clinical Excellence has published a technology appraisal on the use of statins, recommending that they be prescribed to patients at a 20 per cent 10-year risk of developing cardiovascular disease (including stroke) as well as to those with diagnosed disease. Previous guidance, set out in the NSF, recommended a prescribing threshold of a 30 per cent 10-year risk of coronary heart disease. We can, therefore, expect statin prescribing to continue to rise sharply, though reductions in the price of the most commonly-used statins (see **Figure 5.3**) means that costs will not rise at the same rate.

Figure 5.2: Total Number of Statins Prescription Items Prescribed and Dispensed in the Community, in England, since January 1991

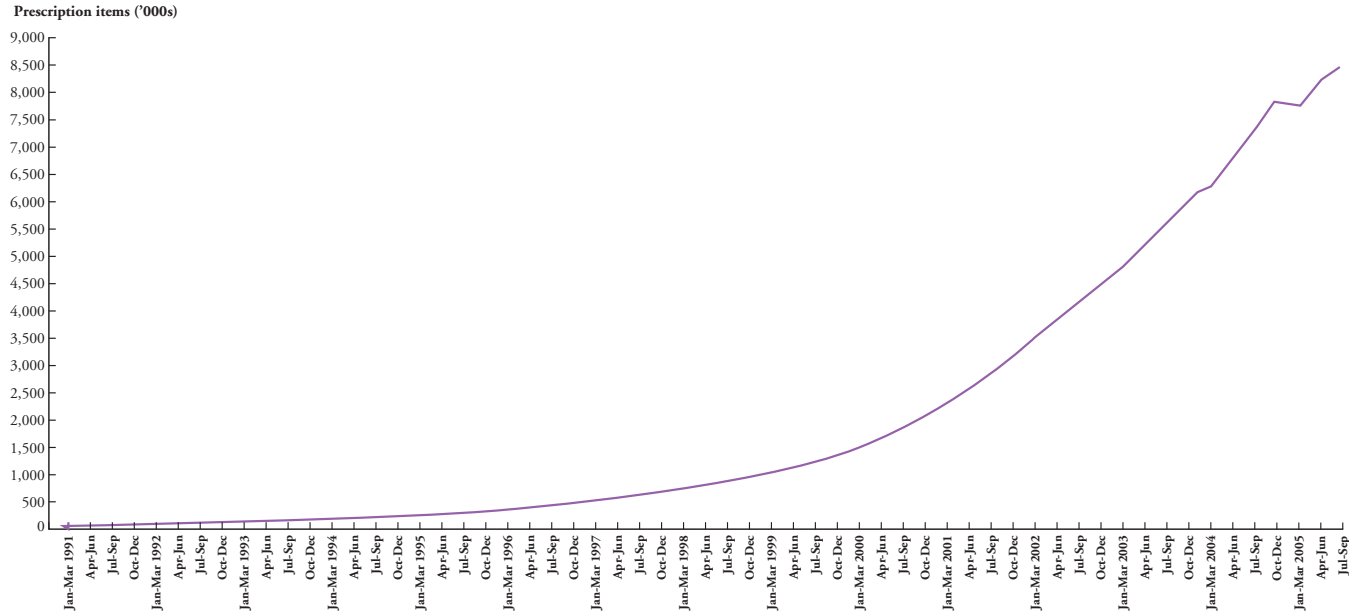
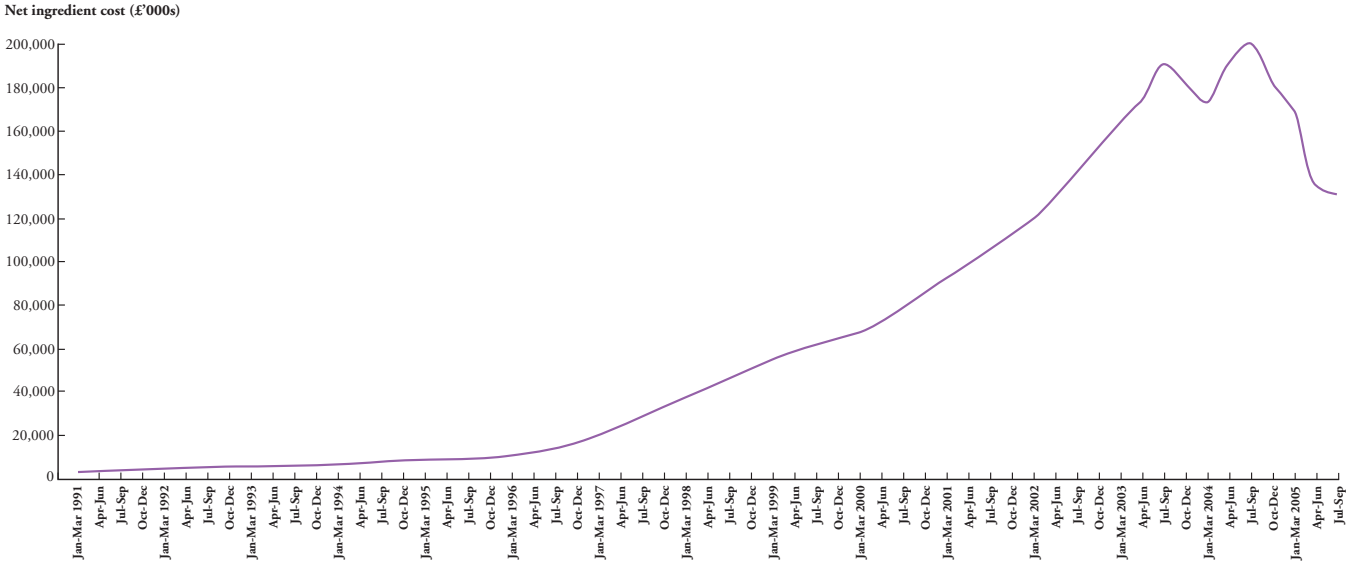


Figure 5.3: Net Ingredient Cost of Statin Prescription Items Prescribed and Dispensed in the Community, in England, since January 1991



5.231 The Quality and Outcomes Framework has been revised for 2006 and will include a section on atrial fibrillation as well as updating some of the other quality indicators. Atrial defibrillation is a key risk factor for stroke and these additional points should therefore have a significant impact on early diagnosis and treatment of atrial defibrillation.

In Emergency Care

5.232 There have been improvements in the treatment of heart attacks. 681 automatic external defibrillators (AEDs) were placed in 110 public places around the country in the first phase of the programme, which started in February 2000. Sites include railway stations, airports and one shopping centre. Management of these AEDs has been devolved to the NHS as of 1 February 2005. Ambulance trusts will be responsible for the training (and retraining) of volunteers and for maintaining the equipment in the sites where the AEDs have been installed. Up to January 2006, evidence suggests that 71 lives have been saved through the work of this programme.

5.233 A further 2,300 AEDs were procured in September 2004 with funding awarded to the British Heart Foundation by the Big Lottery Fund. Funding has also been approved for community defibrillation officers in 31 ambulance trusts. The Department is responsible for delivering the programme in the light of experience gained to date.

Clot-busting drugs

5.234 The national service framework goal is that eligible heart attack patients should receive clot-busting drug treatment (thrombolysis) within 60 minutes of calling for professional help. The proportion treated within 60 minutes continues to increase but further improvement is proving very challenging in some of the more rural areas. Early progress was largely in treatment after arrival in hospital. 88 per cent of people are now treated within 30 minutes of arrival. Good progress is being made in some more rural areas on reducing time treatment with the roll out of pre-hospital treatment by paramedics giving thrombolysis. To date, almost 4,000 patients have received paramedic thrombolysis and 29 out of 31 ambulance trusts have paramedics trained to do this. The proportion of patients receiving treatment within 60 minutes of calling for professional help is now 58 per cent, compared to 24 per cent in 2000 when the NSF was published. There is new evidence that thrombylosis can be beneficial for a proportion of stroke patients, but thrombylosis is clinically more complex than for CHD. Growing numbers of stroke services are actively involved in delivering thrombylosis, but developing systems of care and ensuring adequate training take time.

Primary Angioplasty

5.235 Primary angioplasty is use of angioplasty as the main or first treatment for patients suffering from a heart attack. Some mainly urban cardiac centres have been developing primary angioplasty services over the last few years and in 2005 they have started to expand them beyond their immediate catchment.

5.236 The Department is investing £1 million in a study to test the feasibility of rolling out primary angioplasty services across the whole country. There are seven pilots. Different service models and geographical challenges are being studied and there will be a detailed economic evaluation and patient experience evaluation. The project reports early in 2008. The project steering group has produced guidelines for any trust considering setting up this service in the meantime.

Rapid Access Chest Pain Clinics

5.237 Rapid access chest pain clinics (RACPCs) are designed to ensure that people who develop new symptoms of chest pain can be assessed by a specialist within two weeks of referral from their GP. The roll out of RACPCs started in 2000 and national coverage was achieved in 2003. Monitoring of performance began in March 2001, when 75 per cent of patients were seen within 14 days of referral. The most recent data, covering the quarter to September 2005, showed that 97.7 per cent of patients were seen within 14 days of referral.

Angiograms

5.238 In 2004-05, nearly 145,000 angiograms were carried out in the NHS compared to only 74,000 in 1995-96. No-one should be waiting more than six months for an angiogram by the end of 2005.

Heart Operations

5.239 In 2004-05, the NHS performed nearly 70,000 coronary revascularisations (a collective term for coronary bypass operations and angioplasty procedures), nearly 29,000 more heart operations than in 1999-2000. There have been radical reductions in the length of time patients wait for treatment. Only a few years ago it was not uncommon for patients to wait over two years for surgery. Now, no-one waits over three months and heart patients are being offered a choice of hospital for their treatment at the time of diagnosis. See **Figure 5.4** and **Figure 5.5**.

Figure 5.4: Trend in Number of Heart Procedures

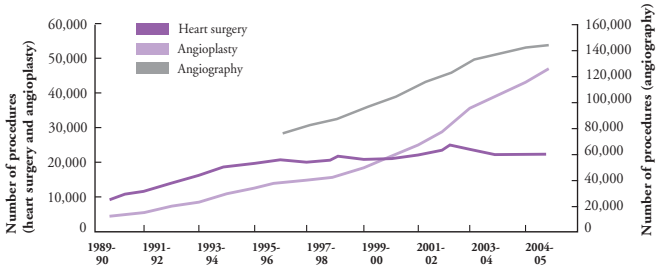
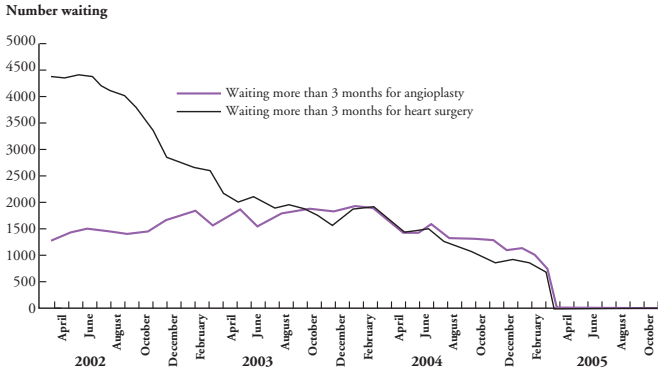


Figure 5.5: Trend in Number of People Waiting More Than 3 Months for Heart Treatment



Recruitment and Retention of Staff

5.240 The Department is working with professional bodies and the NHS to improve recruitment, retention, training and development of staff in key areas, including cardiac physiologists, perfusionists, critical care nurses and primary care. A competency framework for CHD has continued to develop. The first part of the competency framework covering prevention, heart failure and rehabilitation was launched in November 2003. The second part covering acute care was launched in March 2005. The third part covering abnormal heart rhythms is currently under development.

Long-term Investment

5.241 There has been continued long-term investment in the capital infrastructure needed to support further expansion of cardiology and cardiac surgery. In addition to the major capital developments announced in March 2001 and November 2001 (at Papworth, South Tees, Wolverhampton, Bristol, Liverpool, Blackpool, South Manchester, Central Manchester, Leeds, Sheffield, Southampton and Plymouth), a further three schemes at Nottingham, Leicester and Essex were announced in October 2003. A scheme at Hull was announced in January 2004, financial support for the network of Kent laboratories was announced in February 2004, and schemes at Dorset, Somerset and Newcastle were announced in March 2004. The total cost of these developments is £600 million.

5.242 £65 million from the Big Lottery Fund is being used to provide new angiography labs, which provide diagnostic facilities for heart disease. The Department has made available an extra £60 million to enable 90 labs to be installed, which will speed up diagnosis significantly for patients with suspected heart disease.

OLDER PEOPLE'S SERVICES

– improve the care provided to older people

5.243 There are around eight million people over 65 years living in England today. We are committed to ensure that we work to improve the quality of life and independence of older people so that they can live at home wherever possible by:

- increasing the proportion of older people being supported to live in their own home from 2006, by one per cent annually in 2007 and 2008; and,
- increasing by 2008, the proportion of those supported intensively to live at home to 34 per cent of the total being supported to live at home or in residential care.

5.244 We are making good progress to meet this target. In 2005, 32 per cent of older people being supporting to live at home or in residential care were supported intensively to live at home.

Encouraging Local Innovation:

Partnerships for Older People Projects (POPPs)

5.245 To further ensure we apply local innovation to help older people to live independently we are also investing £60 million ring-fenced funding over 2006-07 and 2007-08. Partnerships for Older People Projects (POPPs) will test and evaluate innovative ways of enabling health and social care communities to create a sustainable shift in their 'whole system' towards prevention for older people.

5.246 In November 2005, we announced the first wave of successful partnerships in Bradford, Brent, Camden, Dorset, East Sussex, Knowsley, Leeds, Luton, Manchester, Norfolk, North Lincolnshire, Northumberland, North Yorkshire, Poole, Sheffield, Somerset, Southwark, Wigan and Worcestershire covering about 150,000 older people. In March 2006, we invited bids to the second phase of the POPP programme for projects running from 2007.

5.247 The learning and experience of each of the partnerships will directly inform our forthcoming integrated comprehensive spending review bid for health and social care.

Telecare

5.248 In our last spending review we announced £80 million (2006-07 and 2007-08) for a 'Preventative Technology' grant to support 160,000 older people stay in their own homes. The purpose of the grant is to initiate a change in the design and delivery of health, social care and housing services and prevention strategies to enhance and maintain the well-being and independence of individuals.

5.249 The grant will be allocated to all local authorities in England with social services responsibilities using the Formula Spending Share for Older People formula. £30 million will be made available in 2006-07 and £50 million in 2007-08.

Transforming Choice – Individual Budgets

5.250 The recently published White Paper *Our Health, Our Care, Our Say*, stresses our commitment to pilot individual budgets. These will help vulnerable older and disabled people take control of their lives and choose the services that suit them best.

5.251 Individual budget pilots are being led by the Department of Health working with the Department for Work and Pensions (DWP) and the Office of the Deputy Prime Minister (ODPM).

The central idea behind the individual budget concept is to place the person who is supported, or given services, at the centre of the process and to give them the power to decide the nature of their own support. The concept builds on the successful features of direct payments and on other initiatives to develop self-directed support.

5.252 *Opportunity Age*[5.35] committed the Department to begin the pilot process (for older people) before the end of 2005. The first pilot site – West Sussex County Council – is focusing on older people and came on stream in December 2005. The remaining twelve pilot sites will come on stream throughout the first half of 2006. Pilot projects will continue for 18 months to two years.

5.253 The thirteen pilot sites are West Sussex, Barnsley, Oldham, Manchester, Norfolk, Essex, Lincolnshire, London Borough of Barking and Dagenham, Kensington and Chelsea, Leicester, Coventry, Bath and North East Somerset and Gateshead.

5.254 Each of the pilot sites will implement individual budgets in a different way, and with different groups of social care service users, but they will all test the basic core components of the individual budget approach.

The National Service Framework for Older People

5.255 The *National Service Framework for Older People* is now mid-way through its ten-year delivery programme.

5.256 The Healthcare Commission, Commission for Social Care Inspection (CSCI) and Audit Commission have published *Living Well in Later life: A Review of Progress Against the National Service*[5.36]. This is a joint report on the NSF's implementation in ten inspected communities across England.

5.257 That report will then inform our National Director for Older People's *Next Steps* report, due in May 2006, on key remaining priorities for the NSF's further delivery.

5.258 The NSF has enabled significant improvements in older people's lives and major progress has been made in promoting older people's health.

Delayed Discharge

5.259 Enabling smooth transfers of care between the NHS and social care is critical to the delivery of people centred services. Since the implementation of the *Community Care (Delayed Discharges) Act 2003*[5.37] the number of delayed discharges have continued to fall. Between October 2001 and October 2005 the number of delayed discharges fell from over 7,000 to below 2,500. In 2005, over 4,800 fewer people were experiencing a delayed discharge on any one day compared with 2001.

Life Chances for Disabled People

5.260 In January 2005, the Prime Minister's Strategy Unit published a joint report with the Department of Work and Pensions (DWP), Department of Health, Department for Education and Skills (DfES) and Office of the Deputy Prime Minister (ODPM) on *Improving the Life Chances of Disabled People*[5.38]. The report sets out a twenty-year cross-government strategy with the aim that by 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society.

5.261 The Department is committed to working with the new Office for Disability Issues and other government departments to drive forward this strategy.

MENTAL HEALTH SERVICES

– improve the care of patients with mental illness and reduce mortality and morbidity from mental illness

5.262 The PSA agreement states that we will:

improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and child and adolescent mental health services (CAMHS), and reduce the mortality rate from suicide and undetermined injury by at least 20 per cent by 2010.

Suicide Rate

5.263 The suicide rate for 2004, the most recent data available, is amongst the lowest recorded. The target requires a reduction from the 1995-1997 baseline of 9.2 deaths per 100,000 population to 7.3 deaths per 100,000 in 2009/2010/2011 (this target was revised from 7.4 following a change in the methodology used by the Office for National Statistics to record the cause of death). The latest suicide monitoring data for the three-year period 2002-2004 shows a reduction of 6.6 per cent from the baseline to 8.6 deaths per 100,000. We are continuing to take action at local and national levels to help reduce the number of suicides in our communities. Significant progress has also been made in reducing the rates of suicide by people in touch with mental health services and by young men, both of which groups have higher risks of suicide.

5.264 Implementation of the *National Service Framework for Mental Health*[5.39] (MHNSF) contributes to the suicide target. Mental health services in the community are being strengthened. Mental health services continue to take great strides to improve access to effective treatment and care, reduce unfair variation, raise standards and provide quicker and more convenient services. As at the end of March 2005, there were around 343 crisis resolution, 262 assertive outreach and 109 early intervention teams established in England. In the first three quarters of the financial year 2005-06, crisis resolution teams provided 61,130 home treatment episodes. At 31 December 2005, around 16,950 people had received care from assertive outreach teams, an increase of 14 per cent over the previous year.

5.265 In addition, progress has been made in establishing other new workers: around 1,500 community gateway workers are being employed to coordinate and ensure prompt access to mental health care; and around 650 graduate primary care mental health

workers, trained in brief therapy techniques, are being appointed to provide first line treatments within primary care teams and support clinical governance in primary care.

5.266 In July 2005, we announced an extra £130 million of capital funding to be available from 2006-07, to ensure the continued development of safe and therapeutic environments in mental health care, and also to ensure that each mental health trust has access to an appropriate place of safety for making assessments under the *Mental Health Act 1983* [5.40].

Delivering Race Equality – One Year On

5.267 *The Count Me In: Mental Health and Ethnicity Census* [5.41], published on 7 December 2005, was commissioned as part of the five-year action plan for tackling inequalities and discrimination in mental health, *Delivering Race Equality in Mental Health* [5.42] (DRE).

5.268 Other progress during the year includes:

- 17 focused implementation sites for DRE – "hothouses of reform", helping to develop and spread good practice with up to £50,000 each to fund innovation;
- community engagement pilot projects, supported by £2 million funding – 40 by the end of this financial year, with another 40 to come next year;
- £16 million a year to help PCTs recruit 500 community development workers; and,
- the development of twelve new training modules in race equality and cultural capability, to be piloted in 2006.

Strengthening the Workforce

5.269 There have been significant increases in the numbers of consultant psychiatrists (51 per cent), mental health nurses (21 per cent), clinical psychologists (75 per cent), non-medical psychotherapists (125 per cent), and art/music/drama therapists (23 per cent) working in the NHS since 1997. Guidance to help improve the recruitment and retention of the mental health workforce was published in 2005. The final report on the *New Ways of Working* [5.43] programme for consultant psychiatrists was published in October 2005 and an implementation programme is now under way. The review of mental health nursing, to ensure that we maximise the skills of mental health nurses, has been gathering pace and the report is scheduled to be launched in April 2006.

Future Developments

5.270 As part of the 'From Here to Equality' strategy, a five-year national programme, SHIFT, has been put in place to reduce stigma and discrimination amongst people with mental health problems. The SHIFT report on media coverage of mental health issues, published in January 2005, will seek closer working between the media, the mental health sector and the Government when covering mental health issues. SHIFT also plans to provide material to raise awareness about stigma and discrimination in all schools around England.

5.271 The National Institute for Mental Health in England, part of the Care Services Improvement Partnership, is co-ordinating action on the Social Exclusion Unit's 2004 report on mental health, through the National Social Inclusion Programme (NSIP). NSIP published its first annual report in November 2005 and recently issued guidance on direct payments, day services and vocational services for people with severe mental health problems. The NSIP annual report outlines key successes in its first year, such as the changes to the Incapacity Benefit 'Linking' rules so that the return to work and claiming of benefits is more flexible and supportive for people with mental health problems and the launch of the Social Inclusion website which publicises progress made in this field to all stakeholders – **www.socialinclusion.org.uk**. NSIP is also working with the Department for Work and Pensions to develop an agenda on vocational advisors in primary care.

5.272 Work developing mental health services within the context of choice and other key national initiatives is continuing. We will make more information available about mental health and illness to help people with mental illness manage their own care. Work is also continuing on the commitments in the public health White Paper, *Choosing Health*, which promotes the physical health of those with severe mental illness through guidance to the service on models of delivery.

5.273 The Improving Access to Psychological Therapies (IAPT) Programme will be launched shortly as a prelude to making the case for a national rollout of stepped increases in access to psychological therapies for people with common mental health problems. IAPT will run for 18 months, and is a key component of the Government's 'Health, Work and Well-being – Caring for Our Future' strategy. It sees the Department, the DWP and the Health and Safety Commission join forces to improve the health and well-being of the working age population. IAPT will help to ensure that where work-related mental illness occurs, that there is improved access to evidence-based psychological therapy services as an adjunct or alternative to medication, to create well-being at work.

5.274 We are continuing work to reform mental health legislation, ensuring that the framework for treating the small number of people with a severe mental illness who require compulsory treatment will be fit for the 21st century and fully compatible with our obligations under human rights legislation. On 23 March 2006, we announced plans to introduce a Bill to amend the *Mental Health Act 1983* which would focus on key policy changes.

Child and Adolescent Mental Health Services (CAMHS)

5.275 The Department is investing about £300 million in the period 2003-04 to 2005-06 to improve and expand CAMHS in line with the standard in the public service agreement to provide

a comprehensive service in all areas by 2006. This aim is not only supported by the extra investment, but also by the guidance given in the CAMHS section of the *National Service Framework for Children, Young People and Maternity Services*, published in September 2004.

5.276 CAMHS regional development workers are actively helping both commissioners and providers to expand and improve services in line with guidance set out in the national service framework. The main measure of progress is the annual CAMHS mapping exercise. The results of the 2004 CAMHS mapping exercise were published in July 2005. It indicated an increase caseload of 21 per cent and the total number of staff employed in CAMHS teams growing by almost 15 per cent.

Prison Mental Health

5.277 Suicide rates in prison remain higher than in the general population although there was a welcome decline in actual numbers, from 95 apparent self-inflicted deaths in 2004 to 78 in 2005. Suicide prevention measures have continued across the prison estate following collaboration between Prison Health (the Department of Health), the National Institute for Mental Health in England (NIMHE), the safer custody group (part of the Health and Offender Partnerships directorate of the National Offender Management Service) and the Prison Service. Forty-one prisons have implemented a new care–planning system, 'Assessment, Care in Custody and Teamwork' (ACCT) for at risk prisoners. ACCT will be extended to all prisons across the estate by mid 2007.

5.278 360 prison in-reach workers now provide mental health services for people with severe mental illness in 102 prisons. A project that aims to reduce waiting times and provide seamless transfers to hospital for those prisoners in the acute phase of a severe mental illness started in April 2005. *Procedures for the Transfer of Prisoners to and from Hospital Under Sections 47 and 48 of the Mental Health Act 1983* [5.44] has been provided following a national consultation. It explains each stage of the transfer process. It is available as a Prison Service Instruction and can also be viewed on the Department's website. The number of people transferred to hospital under sections 47 and 48 of the *Mental Health Act 1983* rose from 721 people in 2003 to 831 people in 2004.

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

CHILDREN

– improve children's health and social care services

Children's National Service Framework for Children, Young People and Maternity Services

5.280 The NSF for *Children, Young People and Maternity Services* was published jointly by the Department of Health and the Department for Education and Skills in September 2004, setting standards across health, social care, and some education services. It is consistent with and forms an integral part of the Government's strategy for children and young people, *Every Child Matters: Change for Children* [5.45]. The priorities for the Department's work to support local implementation was published in December 2004.

5.281 The NSF has been hailed internationally for the quality of its thinking. It set out, for the first time, five standards which apply to all children:

- promoting health and well-being;
- supporting parenting;
- child-centred care;
- rowing up into adulthood; and,
- safeguarding and promoting the welfare of children and young people.

5.282 It also set standards to cover children who are ill, disabled children and those with complex health needs, the mental health, the mental health and psychological well-being of children, medicines and maternity services. The NSF was supported by information and delivery strategies.

5.283 The NSF is a 10-year strategy, and progress is well underway. For example:

- progress is being made to meet the manifesto commitment that by 2009, all women will have choice over where and how they have their baby and what pain relief to use. An advisory group of key stakeholders meets quarterly to identify the blocks and the levers to change in maternity services and we have engaged SHA maternity leads on implementation issues; focus group and omnibus survey work on user experience of maternity services has been undertaken and research into the midwifery-led birth centre method of care and outcomes for mothers and babies has been commissioned; and,
- a series of emerging practice workshops around the country to disseminate examples of good local practice covering issues such as access for vulnerable groups, including teenage pregnancy, and delivering maternity services through children's centres.

5.284 The NSF set out details of the Child Health Promotion Programme – a comprehensive system of care that encompasses:

- childhood screening;
- immunisations;
- health promotion;
- the needs assessment; and,
- early intervention to address identified needs.

5.285 It will be delivered in a range of settings such as primary care practices, children's centres and extended schools by

midwives, health visitors, school nurses, GP and other healthcare professionals. Over the coming year we will be working with Departmental colleagues and healthcare professionals to develop a best practice guide to support implementation of the programme.

5.286 To help with local implementation of the NSF for *Children, Young People and Maternity Services*, the Department of Health and the Department for Education and Skills published exemplars during 2005 on complex disability and acquired brain injury. Exemplars illustrate good practice and aim to help people working locally to improve local commissioning and delivery of children's services.

5.287 The NSF for *Children, Young People and Maternity Services* promotes the role that managed children's clinical networks (standard 6) and managed maternity and neonatal care networks (standard 11) can play in helping to achieve the delivery of safe, comprehensive and integrated local services. We published in 2005, *A Guide To Promote A Shared Understanding Of The Benefits Of Managed Clinical Networks* [5.46] to support this. Recognising that children with life-limiting and life-threatening conditions are living increasingly longer, we published in November 2005, *Commissioning Children's and Young People's Palliative Care Services: A Practical Guide for Primary Care Trusts and Practice-based Commissioners* [5.47]. This sets out a model for commissioning and providing children's palliative care services that moves seamlessly across health, social care and education which will help them implement the high standards required by the Children's NSF as they plan and deliver children's palliative care.

Screening

5.288 Significant progress has been made in developing screening programmes in England and improving coverage to disadvantaged groups and areas. For example, the Down's syndrome screening programme aims to ensure equitable access around the country and screening is now offered in around 95 per cent of maternity units to women of all ages. The Newborn Hearing Screening Programme is now screening 99 per cent of newborns in England and nearly 1,100 babies have been confirmed with a hearing loss before six months. Early identification improves communication skills, leading to better educational achievement and quality of life.

5.289 A linked newborn and antenatal screening programme for sickle cell and thalassaemia disorder is being implemented across England. The aim of the newborn programme is to achieve the lowest possible childhood mortality rates and to minimise morbidity from sickle cell disease in childhood. By July 2005, newborn screening for sickle cell covered 90 per cent of newborns with completion of implementation due by April 2006. In the first seven months of the programme, 103,000 were screened and 125 babies identified. The rollout of antenatal screening for sickle cell and thalassaemia is almost completed in high prevalence areas. Low prevalence areas are due to have implemented antenatal screening using a family origin questionnaire by the end of 2006.

Every Child Matters: Change for Children

5.290 *Every Child Matters* sets out the Government's aim for every child, whatever their background or their circumstances, to have the support they need to:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic well-being.

5.291 These outcomes are interdependent and health is a key contributor.

Children Act 2004

5.292 The *Children Act 2004* [5.48] provided the legislative spine for the above programme. It set out a duty for local bodies, including PCTs, to cooperate with each other to improve outcomes. It also included a number of key reforms which have been progressed:

- AL Aynsley-Green was appointed to the office of Children's Commissioner to champion the views and interests of children and young people;
- *Working Together* guidance [5.49] is to be published in 2006;
- regulations to support Local Safeguarding Children Boards have been published; and,
- the first round of joint area reviews have taken place.

Chief Nursing Officer's Review

5.293 The CNO published in 2004, a review of the nursing, midwifery and health visiting contribution to the health and well-being of vulnerable children and young people. Progress has been made against the recommendations of the review, most notably in the development of a practice nurse checklist, on child protection competencies and on school nursing.

Development of Children's Trusts

5.294 The *Children Act 2004* set out the intention for children's trusts to bring together all services for children and young people in an area to focus on improving outcomes. Thirty-five 'pathfinder' children's trusts have been integrating services – testing the ideas behind children's trusts and helping to design policy. The learning and best practice emerging from the experience of the pathfinders will be used as children's trust arrangements are extended across all 150 local authority areas.

Regional Change Advisors

5.295 Regional change advisers were appointed by Department of Health and Department for Education and Skills and have been based in the regional government offices to engage directly with local authorities, strategic health authorities, primary care trusts and other local partners, to support the

development of integrated provision and improved outcomes for children and young people. Work is ongoing to ensure that new regional support roles are aligned to maximise the potential of integrated services.

Care Services Improvement Partnership (CSIP)

5.296 CSIP was launched in April 2005 following a formal consultation process to provide local, regional and national support to the delivery of a range of services, including better services for children and families.

Joint Inspection Arrangements

5.297 The Healthcare Commission has joined up with other inspectorates, including Ofsted and CSCI, to develop both a joint framework for the inspection of children's services, and arrangements for conducting joint area reviews which will look at an area in terms both of the five *Every Child Matters: Change for Children* outcomes and the contribution that different services make to those contributions. The first joint area reviews were published in December 2005, providing a high level picture of the outcomes for children and young people in five local areas.

SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS

(chronic disease management)

Improving Care for People with Long-term Conditions

5.298 Some 15 million people in this country report that they have a long-term condition (such as diabetes, asthma or arthritis). This includes children, adults and older people. For some people, particularly the most vulnerable, these conditions go unmonitored and unmanaged until a hospital visit becomes necessary, resulting in heavy and often inappropriate use of secondary care services. Care can often be unplanned and reactive. Services are on hand for patients in moments of crisis, but are frequently not there to stop crises from happening in the first place.

5.299 The *NHS Improvement Plan* set out the Government's priority to improve care for people with long-term conditions by moving from reactive care towards a systematic, patient centred approach. To help take this forward, a national public service agreement (PSA) target has been set and a long-term conditions model developed.

PSA Target

5.300 Centrally, the Government has taken the lead in setting a PSA target 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 five per cent by 2008, through improved care in primary and community settings. Progress has already been made in achieving a two per cent reduction in emergency bed days for 2005-06, which in the main has been driven by reductions in long lengths of stay. The delivery of the target is being driven by the implementation of a model for supporting people with long-term conditions.

An NHS and Social Care Model to Support Local Innovation and Integration

5.301 The model, *An NHS and Social Care Model to Support Local Innovation and Integration* [5.50] published in January 2005, provides a structured approach to help health and social care communities embed locally more effective systematic approaches for the care and management of their chronically ill populations. It highlights the infrastructure needed to support better care as well as a delivery system which categorises patients according to their degree of need, namely:

- level 1: supported self-care – applies to the 80 per cent of patients with a long-term condition who, given the knowledge, skills and confidence, can care for themselves and their condition effectively. *Supporting People with Long-term Conditions to Self-Care – A Guide to Developing Local Strategies and Best Practice* [5.51] was published in February 2006. It is the most recent publication in the long-term conditions 'family' of documents.

  The document sets out the context for why NHS and social care organisations need to embrace the philosophy of self-care and advocate it, in order to support patients with long-term conditions to adopt self-care behaviours. The document identifies four key areas in which patients need support (skills and training, information, tools and devices, and support networks) and gives examples of good practice together with the role of patients, professionals and PCTs/trusts in supporting these areas. The aim of the document is to help NHS organisations develop local self-care strategies;

- level 2: disease-specific care management – is for patients who have complex single need or multiple conditions, which require responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways. The national service frameworks and the Quality and Outcomes Framework will be key drivers for improving care and services; and,

- level 3: case management – is for the most vulnerable people, who have highly complex, single or multiple long-term conditions and who will benefit from a case manager or community matron, specifically allocated to help anticipate and coordinate their health and social care needs. A competency framework for case managers has been developed by Skills for Health, which outlines good practice guidance for developing community matron and case manager workforce competencies.

Patients at Risk of Re-hospitalisation (PARR) Case Finding Tool

5.302 The Department launched a software tool in September 2005 designed to predict patients at risk of repeated hospital admissions. The tool, which was developed by the King's Fund in partnership with Health Dialog Analytical Services and New York University, offers a more systematic and accurate approach to

patient identification using data extracted from hospital based systems. It is free to use by the NHS and a number of PCTs are already using it. The tool will help PCTs determine which patients will benefit most from a case management approach. Enhancements were made to the tool in January 2006, which has been rolled into a package of algorithms called PARR plus.

5.303 Further work is being undertaken by the King's Fund to develop a risk prediction model that will combine hospital and community based data, which in the main will be from GP practices and other community services, but could also include social services data. It is anticipated that this will have a higher power of prediction and this model should be available by summer 2006.

National Service Framework for Long-term Conditions

5.304 Strong general practice, social services, community nursing and hospital outreach services are at the heart of high quality services for people with long-term conditions. The national service frameworks (NSFs) are already demonstrating that new systems and approaches in primary care can have a radical improvement on outcomes for people. The NHS and social care are paving the way towards better care, improved quality of life and increased independence for people with long-term conditions. However, more needs to be done to establish a robust, systematic approach.

5.305 There is common ground between the NSF for long-term conditions[5.52] (and other disease management related NSFs) and the long-term conditions strategy, for example around person centred care planning, information and support, self care and improving the management of specific conditions.

5.306 The long-term conditions strategy sets out the key principals for a fundamental shift in the way services are delivered to people with long-term conditions. The *NSF for Long-term Conditions*, published in March 2005, provides a neurological focus for the strategy by aiming to improve services for people with neurological conditions whilst also drawing out some lessons that could be applied to other long-term conditions. It is important that the NSF maintains this focus during implementation and its own discrete identity under the broader agenda.

5.307 Over the last year, we have established a strategic advisory panel of experts from health, social care and the voluntary sector to identify and address issues affecting successful implementation of the NSF. We have also engaged with a wider group of stakeholders from the NHS, social care and the voluntary and independent sectors to raise awareness of the NSF and to promote and support local and national implementation. We have put in place a research initiative for long-term neurological conditions to underpin implementation, which will provide the 'baseline' data needed to assess the subsequent impact of the NSF.

5.308 We are working closely with the Healthcare Commission and Commission for Social Care Inspection to identify different ways in which the *NSF for Long-term Conditions* can feature in and inform the Commissions' service improvement, monitoring and inspection programmes. We have developed a set of clinical indicators, which the Healthcare Commission may use to assess progress towards achievement of the developmental standards in the *Standards for Better Health*[5.53], which include the implementation of NSFs. We are aiming to develop a minimum dataset for long-term neurological conditions using data extrapolated from the electronic patient record.

5.309 Over the next year we will build on this activity by working with SHA and PCT leads to make sure that implementation of the *NSF for Long-term Conditions* is taken forward across the country.

Your Health, Your Care, Your Say: Improving Community Health and Care Services (White Paper Consultation)

5.310 The White Paper, published at the end of January 2006, supports the long-term condition approach and considers it to be a key challenge coming out of the consultation process. We will ensure that implementation of the *NSF for Long-term Conditions* is consistent with this and other mainstream health and social care policy such as the NHS End of Life Care Programme, Carers Strategy and the 18-week patient pathway from GP referral to the start of treatment by 2008, as well as system reform issues such as practice based commissioning, payment by results and specialised commissioning, so that the needs of people with long-term neurological conditions are addressed across all of these areas.

Renal Services NSF

5.311 We published part two of *The National Service Framework for Renal Services*[5.54] in January 2005, and in September 2005 we published *Delivering the National Service Framework for Renal Services*[5.55], setting out progress to date towards implementation of the standards and early actions in the NSF, together with a review of the modernisation programme supporting delivery of the NSF as a whole.

5.312 In 2005-06, £14 million in capital funding was allocated to health trusts to expand renal dialysis facilities. There has been significant expansion of capacity at existing renal units, and a number of new satellite units have opened, helping reduce the burden of travel on kidney patients and families. Since the renal NSF was published, at least twelve new units have opened, at least three existing units have expanded, and building work has commenced on a further seven units. The NHS has also been working closely with the private sector to build up capacity and improve access, with several new private satellite dialysis units opening since the publication of the NSF and the construction of a number of new independent sector satellite units in the pipeline.

5.313 The Department funded six action learning sets in different parts of England, which brought practitioners from a range of disciplines and patient representatives together to develop new ideas for improving transport to renal units,

palliative care and the treatment of kidney disease in primary care. In keeping with the new style working set out in the *NHS Improvement Plan*, the NHS Modernisation Agency was commissioned to run two projects designed to develop robust local workforce development models to be used as a model by strategic health authorities. Four renal workforce group commissioned pilots helped develop a competency framework for staff in renal dialysis units, while a further seven, including one each in Scotland and Wales, are working to produce a parallel framework for staff in the area of renal transplantation.

Diabetes NSF

5.314 Diabetes is the exemplar of long-term conditions and is at the leading edge of developing approaches to some of the big Departmental challenges such as inequalities, public health in terms of obesity (and smoking) but also those underpinning system reform. Examples from diabetes are helping to highlight and suggest solutions in these areas. One such example is 'A Year of Care' for diabetes.

Year of Care

5.315 The commitment to test the 'A Year of Care' approach to commissioning diabetes services was introduced in *Choosing Health: Making Healthy Choices Easier* [5.56] and reinforced in the new White Paper on community services.

5.316 'A Year of Care' describes the on-going care a person with a long-term condition should expect to receive in a year, including support for self-management, which can be costed and commissioned. The approach involves shared decision making between patients and healthcare professionals in the design of a package that meets the patient's individual needs. The approach will result in more effective use of the care planning process to open up choice for patients with long-term conditions.

5.317 The 'A Year of Care' project has the potential to contribute to a number of Departmental programmes, including developing new commissioning approaches, supporting choice for people with long-term conditions and contributing to the development of payment by results. The project will aim to test the application and impact of system reform policies in an important group of patients with long-term conditions through a number of pilot sites. The project will also assess the extent to which these policies and the related improvements in the fit of services to personal preferences for care translate into better health outcomes and value for money for taxpayers.

5.318 A full-time project manager has been appointed to lead development of the project. A project board has been set up and should meet for the first time in April 2006.

Diabetic Retinopathy Screening

Background

5.319 *The Priorities and Planning Framework 2003 – 2006* (PPF) [5.57] and *Diabetes NSF Delivery Strategy* [5.58] both include a target that:

- by 2006, a minimum of 80 per cent of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100 per cent coverage of those at risk of retinopathy by end of 2007.

5.320 Data from local delivery plan returns indicate that the 80 per cent target for 2006 specified in the *Priorities and Planning Framework 2003 – 2006* (PPF) will be met at national level.

Action to Deliver the Target

5.321 The Department has a range of work in hand to support the NHS in delivering this target:

- Recovery and Support Unit (RSU) are actively performance managing all SHAs to ensure that they have arrangements in place to ensure delivery;
- PCTs are monitored on their progress towards achieving the target. The target is included within the local delivery agreements between SHA and PCTs (which are reviewed quarterly through a data return to DH);
- the Healthcare Commission recognised the importance of this condition and included retinal screening as an indicator in the balanced scorecard for PCT performance ratings for 2004-05 in summer 2005; and,
- the GMS contract includes an indicator on screening for diabetic retinopathy, which reinforces delivery of the national PPF target.

5.322 Funds have been made available to support the purchase of digital cameras and related equipment for diabetic retinopathy screening (£5 million in 2003-04, £9.6 million in 2004-05 and £12.4 million in 2005-06).

5.323 A UK National Screening Committee (NSC) Programme, carried out with professional organisations and Diabetes UK, is supporting local delivery. A programme of work is in hand to:

- reduce variability;
- help the development of a systematic approach where none exists; and,
- improve performance and quality.

Case Example

5.324 The Exeter programme is a good example of how an effective retinopathy service can work in practice. This started in 1986 with 2,000 patients, but by 1993 that figure had risen to 4,000 and now stands at about 12,500, showing that in 14 years the numbers of people with diabetes within their remit has grown more than six fold. They have successfully treated about 350 people who would otherwise have suffered loss of sight.

Structured Education

5.325 The *Diabetes NSF* highlights the importance of supporting self-care through structured patient education. The aim

of patient education is for people with diabetes to improve their knowledge, skills and confidence, enabling them to manage their condition more effectively.

NICE Recommendation

5.326 NICE *Health Technology Appraisal #60 – Guidance on the Use of Patient-education Models for Diabetes* [5.59] recommends that: "structured patient education is made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal, regular assessment of need".

5.327 The usual three-month funding direction that accompanies NICE technology appraisals was waived when the guidance on patient-education models was published in April 2003. However, Ministers have agreed to its reinstatement from January 2006, at which point the NHS will need to make funds available for patients to be treated in line with this guidance.

5.328 The Department has worked hard to promote structured education programmes. Examples of national patient education programmes available to PCTs, which meet the criteria covering type 1 and type 2 diabetes, are:

- the DAFNE (Dose Adjustment For Normal Eating) patient education programme for type 1 was already available in 2003 and was specifically recommended in the NICE guidance. There are currently 17 DAFNE centres in England; by February 2006, this will have increased to 32 centres; and,
- the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) patient education programme is a new programme for type 2 diabetes. This is now available to PCTs following a pilot in 2004.

Review of Children's Services

5.329 The *Diabetes NSF* has set standards on diabetes services for children and young people and the *Children's NSF* highlights the importance of holistic care for those with long-term conditions. In the light of this, the National Clinical Director for Diabetes and National Clinical Director for Children have set up a time limited working group with a remit to:

- "Establish what needs to be done to enable the NHS and local care services to meet the needs of children and young adults with diabetes as framed in national guidance including the *Diabetes* and *Children, Young People and Maternity Services NSF's* and NICE guidelines and appraisals."

5.330 The group first met on 14 October 2005 and is likely to meet approximately four times before reporting in the autumn of 2006. The group is considering type 1 and type 2 diabetes looking at children and young people up to age 25.

Outcomes

5.331 The group will publish a report which will act as an implementation support tool and use any resources available to enable people to commission and deliver the services necessary to meet the commitments as framed in national guidance including the *Diabetes* and *Children, Young People and Maternity Services* [5.60] national service framework's NFs's and NICE guidelines and appraisals.

5.332 The final report will include a number of service models detailing how services for children and young people with diabetes should be structured in different clinical settings and the standards of care that should be provided.

Diabetes NSF the Way Forward – 2006 and Beyond

5.333 The Diabetes Strategic Programme Board, chaired by the National Clinical Director for Diabetes agreed to examine the next steps in diabetes diabetes NSF delivery for the following reasons:

- March 2006 – three years into the *Diabetes NSF* implementation and also at the end of two national targets in the PPF (retinopathy and registers); and,
- new initiatives – such as *Creating a Patient-Led NHS, Your Health, Your Care, Your Say* made this a good time to re-evaluate the diabetes programme direction.

Future Work

5.334 The focus of work in diabetes for next year in supporting implementation on the *Diabetes NSF* and the common Department of Health agenda will include the continuation of current work programmes and new work streams involving inequalities and black, minority and ethnic groups and prevention and public health initiatives.

IMPROVING THE PATIENT EXPERIENCE

Patient Prospectus

5.335 The concept of local NHS organisations producing *Your Guide to Local Health Services* [5.61] (originally called *Patient Prospectus*) was first outlined in the *NHS Plan*, as part of the Government's drive to strengthen local accountability, provide better information for local people about their local NHS and to place patient views at the centre of service improvement.

5.336 Annually, every primary care trust (PCT) continues to publish *Your Guide to Local Health Services* to demonstrate that the local NHS is acting on information gained from service users and reporting back to the public about the performance of the healthcare providers in their area.

5.337 It contains information about health services across individual PCTs, ranging from how to access primary care to a hospital's performance in the annual health check. Improving the quality of information to patients helps them make the right decisions and choices about their own care.

Complaints

5.338 Complaints reform is an essential and integral element of the Department's programme for improving patients' overall experience of health care.

5.339 The complaints reforms will build on the existing procedures, and wider initiatives, to introduce improvements that place the focus on what patients want from the complaints procedures, rather than on process and timescales. In doing this, we will have regard to the recommendations of the 'Shipman', 'Ayling', 'Neale' and 'Kerr & Haslam' inquiries.

5.340 The White Paper *Our Health, Our Care, Our Say*, has recently announced our commitment to developing a comprehensive single complaints system across health and social care by 2009. NHS and social care complaints colleagues are working closely together, with the involvement of key stakeholders, to take forward the integrated approach to complaints handling, ensuring greater consistency between health and social care and a focus on resolving complaints locally. We are working closely with the Healthcare Commission and the Ombudsman, to introduce new standards for complaints handling at local level.

5.341 The merger of the Healthcare Commission and the Commission for Social Care Inspection provides us with the opportunity to review where best to place the independent review stage of a joined up complaints procedure.

5.342 In the short term, we are working with SHA complaints leads to build their capacity and develop the necessary skills to deliver a more patient focused NHS complaints system. We have been working with the Institute of Healthcare Management to consider how best to support complaints managers locally. This work included setting out options for the development of a professional qualification in complaints handling to improve both the status of the profession and the jobholder. We are also liaising with complaints staff in local NHS organisations to discuss what the Department can do at national level to support their role, as well as what should be delivered at local level.

Patient and Public Involvement in Health

5.343 Patients' Forums (also known as Patient and Public Involvement Forums) have been in place since 1 December 2003. There is one for each NHS trust, PCT and NHS foundation trust – there are around 4,500 forum members altogether. Since forums have been in operation, they have been working with local communities, the NHS and other key stakeholders to seek the views of the public about the NHS and through their reports and recommendations aim to improve patients' experiences of the NHS.

5.344 The Commission for Patient and Public Involvement in Health (CPPIH) was established in January 2003 and is responsible for providing support and advice to forums as well as performance managing them. The CPPIH will be abolished as part of the review of the Department's arm's length bodies.

5.345 The forthcoming changes to the configuration of PCTs, their changing role to be one of commissioner rather than provider of services, the move towards greater choice of service delivery are just some examples of how significantly the healthcare system is changing. In light of these changes, we used 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.

5.346 The White Paper *Our Health, Our Care, Our Say* sets out the principles for the way forward to ensure our commitment to giving people a stronger voice is maintained at every stage of how health and social care services are planned, designed and delivered locally. The key elements of the principles include:

- a strong emphasis on all commissioners to engage with their populations to ensure they develop a thorough understanding of their population's needs, experiences and preferences;
- much greater compliance with section 11 of the *Health and Social Care Act 2001* [5.62] – the duty to involve and consult patients and the public – with rigorous assessment of fulfilment by the regulators and support provided by a new Patient and Public Involvement Resource Centre;
- an examination of the strengthening of the existing health overview and scrutiny arrangements, performing a focused role to empower local people to hold commissioners to account for the decisions they are taking and the ways in which their money is spent;
- a new requirement for the health and social care regulators to put in place systematic and robust arrangements to involve patients and users in their work to inspect and assess the quality of services; and,
- a single complaints procedure, which spans health and social care services.

5.347 We will look at how these principles will be delivered as part of the ongoing review process and consider options for introducing, for example, strengthened overview and scrutiny arrangements. We have committed to completing this review by April 2006.

Overview and Scrutiny Committees

5.348 Since January 2003, every local authority with social services responsibilities (150 in all) have had the power to scrutinise local health services.

5.349 In October 2003, the Centre for Public Scrutiny (CfPS) was awarded £2.25 million to support and facilitate health scrutiny – this programme of work will run from April 2004 to March 2007. This support includes an implementation advisory team offering up to five days advisory support for each OSC and a series of publications tackling the key aspects of scrutiny.

Independent Complaint Advocacy Service (ICAS)

5.350 The Independent Complaints Advocacy Service (ICAS) was established to support patients and the public wishing to make a complaint about their NHS care or treatment. This statutory service was launched on 1 September 2003 and provides for the first time a national service delivered to agreed quality standards.

5.351 ICAS is a patient centred service, delivering support ranging from provision of self-help information, through to the assignment of a dedicated advocate to assist individuals with letter writing, form filling and attendance at meetings. ICAS aims to ensure complainants have access to the support they need to articulate their concerns and navigate the complaints system, maximising the chances of their complaint being resolved quickly and effectively.

5.352 Statistics from ICAS are shared with complaints leads, Patient Forum members and other stakeholders involved in improving the patient's experience. This provides another layer of information which can help alert the NHS to potential problem areas and ensure lessons from users' experiences of the NHS are fed back into the service to affect positive change.

5.353 Over the second year of ICAS delivery (1 September 2004 – 31 August 2005) advocates dealt with approximately 29,000 calls and went on to provide full advocacy support to just under 13,000 complainants.

New and Improved ICAS – the Future

5.354 The current contracts with ICAS providers run until March 2006. We have recently completed a rigorous procurement process, against a new and improved ICAS specification, as a result of which we have awarded new contracts that will be launched on 1 April 2006:

Region	New provider
North East	Carers Federation
North West	Carers Federation
Yorkshire and Humberside	Carers Federation
East Midlands	Carers Federation
West Midlands	POhWER
East of England	POhWER
London	POhWER
South East	SEAP
South West	SEAP

Director for Patients and the Public

5.355 Harry Cayton, the National Director for Patients and the Public, has made a significant contribution to ensuring a patient-centred vision for the Department and the NHS. Harry ensures that the views and experiences of service users are integral to policy development and service delivery. During 2005, a web-based best practice guide on patient and staff consent to filming in NHS premises was published. *Reward and Recognition* [5.63] – best practice guide on the payment and reimbursement for user involvement – was also published in January 2006.

5.356 Harry has continued his work as Chair of the Strategic Management Board of the Expert Patients Programme (EPP) and during the first six months of 2006 will be overviewing the transition of the EPP to a community interest company. Harry's appointment as Chair of the care record development board has also expanded to cover ethical and policy issues for Connecting for Health.

5.357 Future work includes:

- strategic leadership of self-care policy and the establishment of a Departmental self-care policy network;
- a review of arts in health which will report to the chief executive in 2006;
- a guide on ethics and patient and public involvement; and,
- continued liaison with patient organisations in the voluntary and community sector.

Voluntary and Community Sector

5.358 The Voluntary and Community Sector (VCS) already plays an important and valuable role in supporting service users and carers, having a long tradition of working with the NHS and social care to deliver quality services for a wide range of people with diverse needs. We remain fully committed to the recommendations in the 2002 Treasury crosscutting review of the VCS in public service delivery. We are working with the Home Office to implement its recommendations and to make the review's conclusions a reality in the specific health and social care context.

5.359 The majority of the recommendations from the 2003 review of the Section 64 grant scheme review have been implemented. A two stage application process used for the first time in the 2005-06 funding round, with a 50 per cent increase in the number of VCO's applying for S64 funding. The Department will also be making improvements to the operation of its 'Opportunities for Volunteering' scheme (OFV) in 2006 to strengthen its support for volunteering in health and social care. Both S64 and OFV are part of a wider strategy to build a progressive, dynamic and innovative partnership with the VCS.

5.360 Launched in September 2004, *Making Partnerships Work for Patients, Carers and Service Users – Strategic Agreement* [5.64] is the first exclusive agreement between the Department, the NHS and the VCS. It reflects and complements the 'Compact' and its codes of good practice at all levels of partnership working. A national strategic partnership forum (NSPF) has been established to build on the strategic agreement and enable the VCS to contribute at a national level to the health and social care reform agenda. The forum has published its statement of purpose and high level objectives, and agreed its work plan. Specifically the forum has established working groups to:

- define and demonstrate the distinctive added value of the VCS;
- review the strategic agreement;
- build a common understanding between the public sectors in health and social care; and,
- in partnership with the Third Sector Commissioning Task Force (see below) influence and streamline regulation and accreditation of VCS providers.

5.361 A Third Sector Commissioning Task Force has been established to complement the NSPF. The task force will develop solutions to the barriers that stop third sector organisations, including the voluntary sector and not for profit social enterprises, having a much greater involvement in delivering innovative person-centred health and social care services. The task force has established working groups to:

- inform development of greater expertise amongst commissioners across health and social care;
- streamline accreditation and regulation of third sector organisations; and,
- recommend consistent procurement processes and procedures as well as standard frameworks for contracting with the third sector across health and social care.

Supporting Self Care

5.362 Self care is one of the five named building blocks in the NHS Plan vision for a health service designed around the patient. There is growing evidence to show that self care support improves health. For example, emerging findings from the Expert Patients Programme indicate that self care skills training can be cost-effective and leads to beneficial health outcomes for people. Developmental standard D10 in the *National Standards* states that service users are to be provided opportunities and resources to develop competence in self care. In the White Paper *Our Health, Our Care, Our Say*, the Department has made a commitment to develop networks through which people can support one another to self care. There is also commitment to treble investment on the Expert Patients Programme. In addition, it commits to taking action to change profoundly how health professionals are educated so as to encourage support for individuals' empowerment and self care, involving, for example, work with professional bodies to embed self care in core curricula. At the end of February, the Department also published a guide for the services to help them develop local self care support strategies and good practice.

5.363 Self care support has become a major policy in the NHS and social care. The NHS Direct family of services, the Expert Patients Programme, the policy for the care of people with long-term conditions and the national service frameworks (NSFs) all focus on supporting self care. This is also in keeping with public expectations – a deliberative consultation on the White Paper found that patients and the public want more support for self care. Our plan is to build further on our existing priorities. We will continue to make collaborative efforts within all our policies, and develop partnerships with community, voluntary and private sectors and other Government departments to encourage innovation and best practice in supporting self care. As stated in the White Paper, the Department will seek to ensure that GP practices are engaged in supporting self care and will ask NHS employers to consider this as one of the highest priorities for future changes to contractual arrangements.

5.364 The main driver for this work is patient-centred care, increased choice and more appropriate use of services through the development of a culture in which self care is accepted as part of the integrated care solution. In 2005, we published a guidance, *Self Care – A Real Choice: Self Care Support – A Practical Option* [5.65], which describes why and how NHS and social care practitioners, professionals and managers can provide self care support in their routine business. In 2006, we produced an evidence base of research which details the impact of self care support, as well as a compendium of local good practice examples of successful self care support initiatives. We have also been helping the 'Working in Partnership' programme (established in the GMS contract) to develop and implement three innovative projects for setting up an integrated self care support resource in several PCT economies. These pilot projects and their evaluation are progressing at full speed and the results will be known by the end of 2006.

A Safe, Clean, Comfortable, Friendly Place to be

5.365 The patient experience is now firmly established at the very heart of everything that we do in the NHS. Greater attention is being given to getting the basics of care right – cleaner hospitals, better food, and a more pleasing hospital environment where services are provided by staff who are attentive to patients' needs and proactive about improving standards.

Clean Hospitals

5.366 The 2005 PEAT results show that out of the 1,284 hospitals assessed over 95 per cent were assessed as being rated "acceptable" or better.

5.367 Each year the PEAT programme is adapted to reflect changing expectations and to support the drive for higher standards. In 2005, infection control was added to the assessment and, following a major review, the structure of PEAT assessments have been closely aligned with the core national standards in *Standards for Better Health*. The 2006 assessments will also take a more stringent look at issues of cleanliness.

The Matron's Charter

5.368 The *Matron's Charter: An Action Plan for Cleaner Hospitals* [5.66] was launched in October 2004 to support improved cleanliness and lower rates of healthcare associated infection. The charter is one of a series of measures to tackle cleanliness in hospitals, announced in *Towards Cleaner Hospitals and Lower Rates of Infection* [5.67], published in July 2004.

5.369 The clear, non-technical document reaffirms principles of personal responsibility, teamwork and the importance of involving nurses, in particular matrons and infection control nurses, when setting up cleaning contracts.

5.370 An evaluation of the impact of this programme on staff across the NHS is to be undertaken and the information gained from this will be used to inform further work.

ON THE GROUND

As part of their implementation of the Matron's Charter principles, a multi-disciplinary team at Hull and East Yorkshire NHS Trust developed a 'Bedside Checklist' to raise standards of cleanliness in the wards and to give patients the power to tell staff if high standards were not maintained. The Team also used the Patient's Association's "Top Ten Tips" to show patients how they could support staff in improving cleanliness and tackling hospital acquired infections.

The team of modern matrons, a patient representative and staff from facilities, operational support, housekeeping and infection control teams used the Essence of Care approach to develop a new benchmark for cleanliness. To monitor scores and record actions, the team also developed an electronic database which has now become the model for monitoring all Essence of Care benchmarks, trust-wide.

Use of the checklist has led to a marked improvement in standards of cleanliness, patient satisfaction and staff teamworking.

Hospital Food

5.371 2005 food scores for hospitals show that 84 per cent of hospitals are providing an excellent or good service, delivering higher quality and better choice of food. Initiatives introduced through the better hospital food programme, such as protected mealtimes and 24-hour catering, have ensured that staff in the NHS play a key role in ensuring that patients receive and eat nutritionaly balanced meals.

Patient Environment Networks

5.372 Previously known as 'Basic Care Services' networks, the 'Patient Environment' networks have expanded to include all non clinical issues effecting patient areas. Nursing staff and support and facilities staff come together to discuss common issues, share good practice and devise local solutions, the networks have evolved in ways that suit them and their sites best.

A Healing Environment

5.373 The Department continues to support the nationally recognised King's Fund 'Enhancing the Healing Environment' initiative. By the end of 2006, over 120 NHS trusts and primary care trusts will have taken part in this innovative programme, launched and supported by HRH the Prince of Wales.

5.374 An independent evaluation of the national programme was published in January 2006, adding to the growing stock of evidence that good healthcare environments have a positive impact on patients, staff and visitors.

5.375 Our vision is to create a future where healthcare architecture and design positively contributes to healing and promotes well-being for patients, staff, and visitors through positively influencing design quality within the environment of care. Continuing work with the King's Fund and the construction industry is being driven forward to ensure that the investment being made in NHS buildings produces well-designed, therapeutic buildings of which we can all be proud.

Design and Costing

5.376 The design of the physical environment in the provision of fit for purpose, value for money, patient centred facilities underpins the delivery of modern healthcare. The Design and Costing section within the Department promotes quality standards and ensures the accountability of the NHS in the renewal or refurbishment of its buildings.

5.377 The Department's design programme 'Better Health Buildings' demonstrates its commitment to the Prime Minister's cross-government initiative 'Better Public Buildings'. During 2005, the section continued to carry out the appraisal of the estates' aspects of strategic, outline and full business cases submitted to the Department in line with the major capital investment approvals process. This included the NHS Design Review of 20 major capital schemes and 13 NHS Design Review workshops were held at the earliest stages of setting design objectives.

5.378 Working with The Prince's Foundation a pilot process of three enquiry-by-design projects were held to assess the benefits of an inclusive, patient and public involvement consultation and contribute to the NHS sustainable communities agenda. The support to the design of primary care facilities was undertaken through work programmes with stakeholders such as the Commission for Architecture and the Built Environment (CABE).

5.379 The implementation of framework guidance for the NHS to improve PFI design through better briefing and exemplar public sector comparator design and the development of design evaluation tools for the NHS to better measure the design quality of the patient and staff environment, were completed. Cost intelligence was maintained to advise the NHS of capital cost benchmarks and inflationary pressures.

5.380 In 2006, the section will continue to implement the design programme encompassing quality, safety and value for money in the physical environment. The section will continue the estates' appraisal of business cases and the undertaking of NHS Design Reviews.

5.381 The section will maintain its partnership with CABE and The Prince's Foundation, to support PCTs in the commissioning of well designed and sustainable local health facilities. It will also maintain and develop support for the 'Design Champion' programme, with HRH the Prince of Wales as the NHS Design Champion. Learning from its international partnerships, the section will develop an evidence based design approach to improve the physical environment.

5.382 A prime objective will be to contribute to the continuous improvement of the efficiency and effectiveness of investment initiatives through the standardisation of construction requirements and the updating of standard facilities management requirements. The development of a life cycle approach to capital cost intelligence and benchmarking will be undertaken to promote the appropriate modelling to demonstrate value for money of NHS capital works.

Engineering, Technology, Environment and Technical FM

5.383 Providing evidence-based strategic advice and guidance on all aspects of healthcare engineering is essential to ensuring the performance and continued safety and quality of the physical environment. New technologies and increasingly complex buildings require hospitals with high-quality engineering services. By incorporating the latest scientific technologies and best practice, we can ensure that we get the most out of our healthcare estate, and provide safe and efficient healthcare buildings for patients, staff and visitors.

5.384 There is a clear understanding that policies and strategies to promote safer, better quality environments have the capacity to deliver long-term social and economic benefits. Work continues to establish strong working relationships with a wide range of other Government departments, leading sustainable healthcare and engineering organisations and professional bodies to bring together expert knowledge to inform Departmental policy and strategy. Collaboration with a wide range of organisations promotes a move towards a national approach on a number of engineering and environmental issues.

5.385 During 2005, the Engineering and Science Advisory Committee on the Decontamination of Surgical Instruments including Prion Removal (ESAC-PR) was established. The work of this group, chaired by the Department's Chief Engineer, focuses on ensuring that decontamination is underpinned by appropriate knowledge and takes into account relevant new research and developments. ESAC-PR will continue to encourage research and the translation of new technologies into the hospital setting to ensure the continued high standard of decontamination of surgical instruments.

5.386 The built environment plays a critical role in the control of infection. In addition to developing new specialist engineering ventilation models, work continues on the broader concepts of designing and engineering out infection. This includes the development of best practice guidance as well as establishing working groups to develop features that will reduce reservoirs of infection and support the work to improve standards in clinical practice.

5.387 The work being undertaken within the Government's Capabilities (Essential Services (Health)) Programme emphasises the need for robust utility resilience within the critical national infrastructure. The Department's engineering group continues to provide technical and strategic advice and guidance across government to consider the impact of potential future scenarios. This includes major emergency planning in respect of hospital services infrastructures including electrical resilience and fuel supplies.

5.388 Work on developing national occupational standards relating to engineering disciplines as part of the workforce development strategy has been expanded to include health specific competencies for critical engineering services. In addition, analysis work undertaken has identified an ongoing and increasing reduction in the availability of experienced and qualified staff in estates and facilities management. A future objective for the group will be to provide consistent and integrated support to the NHS and link to the Department's national framework policy to support local workforce strategy development.

5.389 2005 has been a watershed for sustainability in the NHS. The NHS in England is using the 'NHS Environmental Assessment Tool' (NEAT) for use with its existing sites and to form part of the business case approvals process for capital development schemes. This software toolkit is proving invaluable as a sustainable healthcare estate gains importance and the NHS becomes more aware of its responsibilities to protect the environment.

5.390 In partnership with the Carbon Trust, work is continuing to assist the NHS to comply with its obligations through the Climate Change Programme and meet the NHS mandatory energy/carbon efficiency targets. This has resulted in a new 'one-stop shop' of energy guidance to assist healthcare providers throughout the UK. As part of this continuing approach to providing the NHS with advice and guidance on sustainable development, further guidance documents have been produced on waste management, carbon/energy management and transport.

5.391 Social aspects and community involvement will be enhanced through the Department's work with the Sustainable Development Commission in producing practical assistance through the 'Good Corporate Citizenship' assessment model, which was launched in February 2006.

5.392 These activities mean that the NHS is well placed to meet the Government's sustainable development requirements encapsulated in new and forthcoming legislation.

Patient Advice and Liaison Services (PALS)

5.393 PALS services are available in all trusts, providing information, advice and support to patients, families and their carers. Operating to national service standards PALS provide a focal point for patient feedback, acting as a catalyst for service change to improve the patient experience of using the NHS.

5.394 In 2005-06, funding has been used to further develop the service nationally in the following ways:

- development of PALS Online – a web based tool to enhance service access and best practice information exchange for PALS and members of the public;
- development of SHA PALS networks; and,
- strengthen partnerships with other key agencies to enhance mainstreaming and development of PALS.

5.395 In addition, a two-year national evaluation of PALS began in March 2005, to assess the extent to which PALS are contributing to a change in NHS culture that places patients and other service users at the heart of service planning, delivery and improvement.

Single-sex Accommodation

5.396 The Department has given a strong public commitment to protecting patients' privacy and dignity. We set the provision of single-sex accommodation as the first step in our programme of action because we know that many hospital patients feel more comfortable if they are in an area with others of their own gender.

5.397 Figures released in May 2005 showed that:

- 99 per cent of NHS trusts provided single-sex sleeping accommodation for planned admissions and have robust operational policies in place to protect patients' privacy and dignity;
- 99 per cent of NHS trusts met the additional criteria to ensure the safety, privacy and dignity of people who are mentally ill; and,
- 97 per cent of NHS trusts provided properly segregated bathroom and toilet facilities for men and women.

Ending Nightingale Wards

5.398 The elimination of Nightingale wards for older people is one of the key aims of the NSF. To date, over 338 Nightingale wards for older people, plus another 500 Nightingale wards for other patient groups, have been replaced or converted into more modern multi-bedded bays, which give patients more peace and greater privacy.

NHS DIRECT

5.399 NHS Direct is a nurse-led telephone helpline providing health information and advice 24 hours a day. The NHS Direct principle is to provide people at home with easier and faster advice and information about health and the NHS. NHS Direct nurses are highly experienced, qualified nurses who provide patients with the same high quality, consistent, safe level of service across the country. The benefits apply not only to patients who get fast and appropriate advice on the best way of tackling health problems, but also to the NHS because it provides an efficient way of using NHS resources. It allows other services, such as GPs co-operatives and accident and emergency departments, to concentrate their efforts where they are most needed.

5.400 The *NHS Plan* committed NHS Direct to a number of key access targets: NHS Direct, in collaboration with the British Dental Association, health authorities and the NHS Information Authority, has been able to direct patients to NHS dentistry since September 2001. The clinical algorithms were developed by dental professionals and implemented in NHS Direct. These algorithms introduced an element of clinical consistency and safety for dental calls that had not previously been available through the NHS.

5.401 A single call to NHS Direct will provide access to local providers of out-of-hours services. A patient will ring NHS Direct, and their details will be transferred to the provider, without them having to make a separate phone call. NHS Direct has been able to refer directly patients to pharmacists where appropriate, for advice about medication or minor ailments or injuries, since April 2002. This has helped many patients receive a quicker and more appropriate response to their problems. It also makes better use of the skills of pharmacists and helps relieve some pressure on GPs.

5.402 NHS Direct has also been involved in contributing to a responsible and coherent response to public health. NHS Direct has worked with the Department to provide a public helpline in the event of health alerts. These have ranged from local incidents, for example, chemical spills, to handling calls during a multi-regional hepatitis C look-back exercise, as well as the Alder Hey independent inquiry. NHS Direct has dealt with 1,235 health scares to date.

5.403 NHS Direct continues to provide a higher level of evidence based health information. This accounts for up to 30 per cent of telephone calls to the service and in excess of 75 per cent of visits to the website. NHS Direct continues to expand and integrate the range of access channels to the service. The on-line channel now receives in excess of 1million visits per month.

5.404 In addition to expanding the range of services offered by NHS Direct Online, NHS Direct will further extend choice through the new NHS digital interactive service.

5.405 The NHS Direct Interactive service was launched on digital satellite in December 2004 and will be extended to other platforms including Freeview during 2006. NHS Direct Interactive will provide the following information:

- an A-Z of health-related issues, including hundreds of topics covering illnesses and conditions such as flu, diabetes, coronary heart disease;
- advice on looking after yourself, on diet and nutrition, on exercise, on quitting smoking and on sexual health;
- video clips on a range of health topics; and,
- tips on how to use the NHS – such as how to register with a GP – and information in 16 different languages, directing users to the NHS Direct telephone interpretation service.

5.406 NHS Direct Interactive will open up a major new gateway that will further improve the speed and convenience of public and patient access to the NHS and health information from the NHS.

5.407 The expanded role for NHS Direct Online and the launch of the NHS Direct digital TV service will not only greatly increase access but is symbolic of a changing role for patients as co-partners in care. NHS Direct is continuing to develop new services to support local health economies and empower patients to better care for themselves, these will include supporting patients with long-term conditions and providing advice to patients with dental problems, particularly in the out-of-hours period to support PCTs.

MODERNISING PATHOLOGY SERVICES

5.408 In September 2005, the Department published *Modernising Pathology Services: Building a Service Responsive to Patients*[5.68]. This detailed progress made since the launch in 2004

of *Modernising Pathology Services* and focused on the challenges to come in 2005-06 and beyond. It also announced an independent review of pathology services to determine the feasibility of and benefits from wide-scale service reconfiguration and modernisation. The review panel, chaired by Lord Carter of Coles, is expected to make recommendations to Ministers in spring 2006.

5.409 In the last year, the Department has taken forward a number of initiatives to improve and modernise pathology services. These have included:

- a national pathology action learning programme to test ideas and new ways of working, with a strong focus on delivering quicker, more effective and timelier services to the patient;
- a national pathology service improvement programme to implement the tools and techniques of service improvement, linking process, workforce and technology;
- the funding and launch of a national network of histopathology training schools to bring more pathologists into the NHS. This has enabled an increase in the number of schools from three to 12 and raised the annual intake of senior house officers (SHO)s from 18 in 2002 to 108 by 2005-06; and,
- the development of good practice advice for staff working in NHS mortuaries.

5.410 The learning from the six action learning sets and the six service improvement pilots is being shared and disseminated nationally.

5.411 A key area on which the National Pathology Oversight Group (NPOG) has focused is how the NHS can be supported to deliver the quality agenda in pathology in line with *Commissioning a Patient-led NHS*.

5.412 The framework for the next stage of the Modernising Pathology Programme will be set by the forthcoming recommendations of the Review of Pathology Services and the White Paper on healthcare outside hospitals.

5.413 Over the period 2003-04 to 2005-06, specific funding of £9 million revenue and over £53 million capital has also been made available to support modernising pathology services.

NHS DENTISTRY – REFORM PROGRAMME

5.414 In July 2005, the Department confirmed that from April 2006 responsibility for commissioning primary dental care services was to be devolved to primary care trusts, in conjunction with the implementation of new contractual arrangements for dentists and a simpler system of patient charges.

5.415 These wide-ranging reforms are designed to provide a range of benefits for NHS patients:

- primary care trusts will be able to commission dental services in ways that are sensitive to local needs. For the first time, PCTs will have local control of resources for dentistry, enabling them to commission replacement capacity if a local dentist ceases to provide services;
- the new contractual arrangements will promote a more preventative style of dentistry, with more time for dentists to provide oral health advice;
- the new ways of working will also reflect the new clinical guidelines on patient recall intervals produced by the National Institute for Health and Clinical Excellence (NICE). Many of those patients who currently receive routine six-monthly check-ups are likely to be able to attend at less frequent intervals that better reflect their oral health needs; and,
- the new system of patient charges will be simpler, fairer and more transparent. Instead of over 400 separate charges for individual items of treatment, there will be just three bands of charges for overall courses of treatment. The maximum NHS charge will be halved.

5.416 The reforms are also designed to significantly improve the quality of dentists' working lives:

- dentists will have the security of a guaranteed annual NHS income, worth at least the value of their previous NHS earnings (in the reference period October 2004 to September 2005); and,
- there will be a 5 per cent reduction in the courses of treatment that dentists are expected to carry out that will enable dentists to carry out simpler courses of treatment. Evidence from personal dental services (PDS) pilots, which have been popular with both dentists and patients, has shown that this frees up significant time that can be spent with patients, focus on preventative activity, and better manage workload.

5.417 In December 2005, the Department notified PCTs of their devolved 2006-07 funding allocations for commissioning dental services. These allocations included a further £65 million investment (net of contributions from patient charges), building on the existing £250 million investment between 2003-04 and 2005-06.

5.418 In October 2005, the Department announced that the NHS had met and exceeded the target of recruiting the equivalent of an extra 1,000 whole time dentists. Since April 2004, the equivalent of an extra 1,459 dentists have joined or returned to the NHS, targeted at areas of the country that have faced particular access difficulties.

5.419 In October 2005, an additional 189 home dental students were admitted to dental schools in England, a 28 per cent increase over October 2003. The Government is funding an extra 170 training places per year between 2005 and 2009, with capital investment of up to £80 million over four years and new revenue funding reaching £29 million per year by 2010-11. As part of this programme of training expansion, the Department for Education and Skills and the Department of Health announced in January 2006 that the Higher Education Funding Council for England had approved a bid from the Universities of Exeter and Plymouth for a new 'Peninsula Dental School'.

A VISION FOR PHARMACY

5.420 *A Vision for Pharmacy in the New NHS*[5.69], published in July 2003, has built on the excellent progress achieved following *Pharmacy in the Future*[5.70], with pharmacy becoming an integral part of the NHS, contributing to the delivery of high quality NHS services to all patients, wherever they live and wherever they are treated.

New Contractual Framework for Community Pharmacy

5.421 The new contractual framework for community pharmacy, which contractors voted overwhelmingly to accept, went live on 1 April 2005, completing a long-held ambition to modernise and shape NHS community pharmacy for the future, extending services available to patients and making better use of pharmacists' skills and expertise. Following the transition, all community pharmacies are expected to provide essential services from 1 October 2005. By the end of November 2005, 33,269 'medicines use reviews' had been undertaken by pharmacists, as part of advanced services.

The OFT Report on Pharmacies

5.422 1 April 2005 also saw the introduction of a balanced package of reforms to the control of entry system for NHS community pharmacies through changes to the *NHS (Pharmaceutical Services) Regulations*[5.71].

5.423 This package designed to raise standards for patients, to support the needs of small businesses, and to do so without jeopardising the vital role played by community pharmacies, particularly in poorer and rural areas, comprises three main strands:

- introduction of new criteria of competition and choice to the current regulatory test;
- exemption of four types of applications from that test; and,
- reform and modernisation of the current procedures.

5.424 Two remaining elements of the package – introducing charges for applications and enabling the NHS to take account of improved access to over the counter medicines and advice when considering competing applications – are included in the *Health Bill* currently before Parliament.

Repeat Dispensing

5.425 Further progress has been made on the repeat dispensing of prescriptions, an important element of improving access to medicines highlighted in *Building on the Best*[5.72]. Repeat dispensing is now an essential service in the new contractual framework for community pharmacy. By 1 October 2005, all community pharmacies were expected to be able to undertake repeat dispensing. As a result, patients will be able to get their medicines supplied in instalments from their pharmacy, without having to go back to their GP each time they need a new prescription.

Better Advice, Better Knowledge

5.426 Building on the medicines' management collaborative, involving nearly half of PCTs helping people make the most of their medicines, a specific collaborative to realise the benefits from the new community pharmacy contractual framework was launched in July 2005. 28 PCTs are participating and will spread their learning to other PCTs in their SHA.

5.427 Following two previous successful events, the third 'Ask about Medicines' week was held in November 2005, to improve communication and shared decision making between people and their health professionals, to support effective medicine taking by enabling patients to ask questions about their medicines.

5.428 Following the pilot phase of Local Pharmaceutical Services (LPS) pilot schemes, which have been successful in providing opportunities for existing pharmacy contractors and others to get involved in innovative local PCT pharmacy contracts, the Department is taking steps to mainstream these arrangements for 1 April 2006.

Pharmacists as Prescribers

5.429 There are now over 730 pharmacist supplementary prescribers across Great Britain. Of those, over 500 are in England.

5.430 Supplementary prescribing involves a voluntary partnership between an independent prescriber (who must be a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific clinical management plan with the patient's agreement.

5.431 Following public consultation and recommendations to Ministers from the Committee on Safety of Medicines, qualified Pharmacist Independent Prescribers will be able to prescribe any licensed medicine for any medical condition, with the exception of controlled drugs.

Pharmacy Public Health

5.432 Honouring the commitment made in *Choosing Health – Making Healthy Choices Easier*, the Department published *Choosing Health Through Pharmacy: A Programme for Pharmaceutical Public Health*[5.73] on 1 April 2005. The strategy aims to maximise the contribution of pharmacists working in all sectors of the profession to improve health and reduce health inequalities.

5.433 A multi-professional implementation advisory group has been established to bring together key stakeholders nationally:

- to provide leadership and support for the implementation of the strategy; and,
- to work with relevant stakeholders to develop an education and training framework for pharmaceutical public health.

Modernising Hospital Pharmacy Services

5.434 By the end of March 2006, we invested £46 million capital in support of the on-going modernisation of manufacturing

of medicines in hospitals. In addition, £12 million over the last three years was committed to helping reduce antimicrobial resistance primarily by building on the important role of hospital pharmacists in improving the prescribing of antimicrobial medicines.

5.435 Promoting the involvement of multi-disciplinary teams in improving medicines management in hospitals continues to be high on the agenda. The Department's funding for the hospital medicines management collaborative totals £1.5 million since 2004. Adding to the 20 trusts, which have participated in the collaborative, a third wave of 24 trusts, including 9 mental health trusts, joined in 2005 and will complete the programme by June 2006.

Better Use of Pharmacists' Skills and Those of Other Staff Working in Pharmacies

5.436 The Department continues to strive to make better use of the skills of pharmacists and their staff, through improved skill mix and use of information technology. In March 2005, consultation ended on proposals that, in certain circumstances, pharmacists should not have to supervise personally the dispensing and sale of medicines, though they would retain overall responsibility for the conduct of business within the pharmacy. The *Health Bill*, introduced in Parliament in October 2005, reflects the outcome of that consultation. Amongst other things, the bill seeks to clarify statutory requirements on the pharmacist in charge of the pharmacy and pharmacist supervision of the sale and dispensing of medicines. These changes will allow pharmacists greater flexibility in how they use their own skills and those of pharmacy staff.

5.437 Since guidance on the development of consultant pharmacist posts was issued in April 2005, SHAs have been developing and putting in place the processes needed to approve the new consultant pharmacist posts. The first appointments are now coming on stream.

5.438 Pharmacists with a special interest can be expected to support developments in primary care and community settings, including the provision of more care for patients outside hospitals. Guidance on establishing these new posts is being produced.

Pharmacy and IT

5.439 The electronic prescription service (EPS) (formerly known as the electronic transmission of prescriptions (ETP)) is being developed by NHS Connecting for Health. In October 2005, the implementation strategy of the service was published highlighting that EPS will be rolled out in phases, with two releases of EPS compliant software. Release 1 requires paper prescriptions to be maintained alongside the electronic messages. However, release 2 enables the use of paper prescriptions to be vastly diminished. It also enables patients to nominate a pharmacy they wish to dispense their medicines and the electronic prescription can be sent to the Prescription Pricing Authority for reimbursement. Learning from the initial implementer sites (paired GP practices and pharmacies), wider deployment is gathering momentum, as the major GP system suppliers rollout the release 1 software.

5.440 As part of the wider NHS IT programme, the Department, and NHS Connecting for Health, are continuing to support the development of community pharmacy IT to ensure it will support pharmacists' expanding role and, in particular, services that they may undertake as part of the new community pharmacy contractual framework. These developments include e-mail, access to on-line information and appropriate community pharmacist access to patient records. Access to patient information is sensitive and we need to ensure such access is only given when needed to support safe effective treatment for patients, there is patient consent and there are safeguards in place to ensure confidentiality is maintained. To this end, the Department is looking to issue a consultation document on pharmacist access to patient records and patient confidentiality.

Modernising the Home Oxygen Service

5.441 1 February 2006 saw the introduction of a modern NHS home oxygen service. This replaced the fragmented service, which made use of a limited range of equipment. In each oxygen service region, a single supplier provides all home oxygen needs, offering a wide range of up to date equipment that can help patients better manage their symptoms and improve their quality of life. The new service provides advice and support to NHS clinical staff and patients on a 24/7 basis, via a free phone arrangement.

AUDIOLOGY MODERNISATION PROJECT

5.442 Between September 2000 and March 2005, the Department invested £125 million in the Modernisation of Hearing Aids Services (MHAS) project. It was run by the Royal National Institute for the Deaf (RNID) on behalf of the Department. Modernisation includes offering digital hearing aids to all patients that will benefit from them, and improving service facilities and audiologists' training. The MHAS project has been very successful and achieved the target that all 164 NHS audiology services in England should be routinely fitting digital hearing aids by April 2005. RNID estimated that, by November 2005, the NHS had now fitted more than half a million people with digital hearing aids.

5.443 The Institute of Hearing Research's evaluation of the MHAS project has shown significant increases in hearing aid use and patient satisfaction owing to the fitting of digital hearing aids as part of a modernised service.

GENETICS WHITE PAPER

5.444 The Department has continued to implement the commitments set out in the genetics White Paper *Our Inheritance, Our Future – Realising the Potential of Genetics in the NHS* [5.740], published in June 2003.

5.445 The new laboratory equipment funded through £18 million of investment announced in the White Paper has been commissioned over the last year and the service is on track to meet

the faster genetic test turnaround times as set out in the White Paper. We have continued to invest in training places for counsellors and laboratory scientists, and to work with the NHS through the UK genetic testing network to evaluate and improve equity of access to genetic tests within the context of NHS system reform.

5.446 Developing the skills and knowledge of non-genetic healthcare professionals continues to be a high priority. The NHS Genetics Education and Development Centre is working with key stakeholders to identify the educational needs of various groups and support the development of appropriate competences and curricula to meet these. We are also funding development projects in a range of clinical areas spanning primary, secondary and tertiary care.

5.447 The Department has also progressed the remaining White Paper commitments to support genetics research in key areas. We have awarded £1.5 million for seven projects in genetics health service research looking at topics such as how to communicate risk and the use of family history in primary care. Building on the £4 million-worth of projects in pharmacogenetics we have now invited bids for funding of £3 million over 5 years for a university chair in pharmacogenetics. In addition to the £6.5 million already invested in gene therapy research for single gene disorders, we have now provided financial support for vectors for two gene therapy cancer trials.

INDEPENDENT RECONFIGURATION PANEL (IRP)

5.448 The Independent Reconfiguration Panel is the independent expert on changes to clinical services. The Panel advises Ministers on proposals for NHS service change in England that have been contested locally and referred to the Secretary of State for Health. It also offers support and generic advice to NHS, local authorities and other interested bodies involved in NHS service reconfiguration.

5.449 While locations may vary, issues of concern are often very similar. Taking advantage of the experience and expertise of panel members early on in the development of proposals can help to maximise the benefit to patients. The Panel has worked with a variety of NHS bodies and local authority overview and scrutiny committees, sharing experience and disseminating good practice. In the last year, the Panel has also offered comments on six proposals referred to the Secretary of State for Health as well as participating in a nationwide series of events to support the development of the health scrutiny function.

5.450 The Panel consists of a chair, Dr Peter Barrett, and nine members providing an equal balance of clinical, managerial, and patient and citizen representation. Further information about the IRP can be found on the Panel's website at **www.irpanel.org.uk**

NATIONAL SPECIALIST COMMISSIONING ADVISORY GROUP (NSCAG)

5.451 NSCAG advises Ministers on which NHS services are best commissioned nationally, rather than locally, for reasons of clinical effectiveness, economic viability and equity of access.

5.452 NSCAG's objectives are to:

- help patients by improving access to some very specialised services;
- sustain high levels of expertise by preventing proliferation of too many centres; and,
- help providers by offering a focus for discussion about service development standards.

5.453 NSCAG commissioned 34 services in 2005-06 with a budget of £279 million, and will commission 39 services in 2006-07. A key element of the commissioning process is to develop service standards. In 2005-06, NSCAG published standards for lysosomal storage disorders, pancreas transplants, primary malignant bone tumours, liver transplants and therapeutic communities.

5.454 More information about NSCAG, including the 2004-05 annual report, can be found at **www.advisorybodies.doh.gov.uk/nscag**

IMPLEMENTING CHOOSING HEALTH

5.455 The Government's White Paper Choosing Health: *Making Healthy Choices Easier* was published in November 2004. It set out how the Government will make it easier for people to make healthier choices by offering them practical help to adopt healthier lifestyles. Choosing Health laid out a challenging programme of practical action aimed at saving thousands of lives in years to come. Choosing Health highlights action over six key priorities for delivery based upon more people making healthy choices:

- tackling health inequalities;
- reducing the numbers of people who smoke;
- tackling obesity;
- improving sexual health;
- improving mental health and well-being; and,
- reducing harm and encouraging sensible drinking.

5.456 In addition, action will be taken across government on:

- helping children and young people to lead healthy lives; and,
- promoting healthy and active life amongst older people.

5.457 Delivering these priorities will depend on four supporting strategies:

- promoting personal health;
- developing the workforce;

- building in research and development; and,
- using information and intelligence.

5.458 A key commitment of Choosing Health was to develop a comprehensive Social Marketing Strategy for Health in England. The goal is to create a cross-departmental integrated behavioural change programme aimed at tackling a whole series of lifestyle issues. The first phase of the programme – an independent review of our current health promotion activity and an evaluation of the benefits of embedding social marketing within the Department is nearing completion (undertaken by National Consumer Council – launch, May 2006.) The key findings of the independent report will be used to formulate the next phase – strategy development and implementation.

HEALTH INEQUALITIES
– improve public health services and reduce inequalities in health status

5.459 Health inequalities continue to mark the health of the population. Despite overall improvements in health, men, women and children living in disadvantaged groups and areas live shorter lives and suffer more illness and accidents.

5.460 The national health inequalities strategy, *Programme for Action*[5.75], seeks to achieve a long-term, sustainable reduction in health inequalities and meet the 2010 PSA target by improving the health of disadvantaged groups. The target is to reduce inequalities in health by outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

5.461 Health inequalities are one of six top NHS priorities announced in *The NHS in England: The Operating Framework for 2006-07*[5.76]. This development will significantly assist efforts to meet the target in the timescale by reinforcing performance and encouraging more effective working with local government and other partners.

5.462 *Tackling Health Inequalities: A Status Report on the Programme for Action*[5.77], published in August 2005, showed the gap in life expectancy and infant mortality is continuing to widen, albeit in line with the long-term trend. It also identified areas of improvement among the 12 cross government headline indicators that are most likely to contribute to a long-term, sustainable reduction in health inequalities. These areas included a major reduction in the gap in the death rates from heart disease, a reduction in the number of children living in poverty and improvements in housing quality. It also reported that almost all the cross government commitments for 2004 contained in the *Programme for Action* had been delivered.

5.463 Health inequalities were a priority in *Delivering Choosing Health*[5.78]. Translating the recommendations of the White Paper, it stressed the importance of cross government action, particularly in the spearhead group of areas – the 70 local authority areas with the worst health and deprivation indicators. These areas will receive early rollout of key public health initiatives, including health trainers, improvements in school nurses and the Healthy Schools Programme.

5.464 Greater emphasis was also placed on action in disadvantaged communities by the *Our health, Our Care, Our Say* White Paper published in January 2006. Local health and social care commissioners need to work together to understand and address health inequalities in their areas. The quantity and quality of primary care services in under-served deprived areas also needs to be addressed.

5.465 The NHS has a crucial part to play in meeting the target by improving service and preventing avoidable illness and premature death by focusing on some of the big killers. This is set out in the section below.

Tackling Health Inequalities: Primary Care

5.466 The *Programme for Action* highlighted the importance of improving access to, and the quality of, primary care services for disadvantaged areas and groups. This approach is reinforced by the NHS reform agenda and, specifically, the *Our Health, Our Care, Our Say* White Paper. Action on primary care includes:

- enabling 99 per cent of patients to be offered an appointment to see a primary care professional within 24 hours, and an appointment to see a GP within 48 hours, utilising outreach and community-based services, such as NHS Walk-in Centres, to improve access for specific groups with particular health needs, including young people, homeless people, students, refugees and asylum seekers;
- increasing the size of the primary care workforce, and encouraging staff to take up posts in more deprived areas, through the development of teaching PCTs, establishing more 'one stop' primary care centres, developing primary care-based outpatient services, and creating new GP Registrar (doctors training to be GPs) posts in these areas; and,
- improving the quality, and configuration, of primary care facilities through the NHS LIFT programme, which covers approximately three-quarters of those living in local authority areas with the poorest life expectancy. LIFT projects are targeted at deprived communities. For further information, please see chapter 4.

Contracting Routes

5.467 There are four PCT contracting routes to commission or provide primary medical services. They are general medical services (nGMS); personal medical services (PMS); which includes, specialist PMS, trust-led medical services (PCTMS) and alternative provider medical services (APMS).

5.468 Together, these routes give considerable flexibility to develop PCT services that offer greater patient choice, improved capacity, improved access, and greater responsiveness to the specific needs of the community.

5.469 Around 60 per cent of primary medical services are provided by contracts between PCTs and nGMS practices, and

most of the remainder through PCT contracts with PMS practices. PCTMS enables PCTs to provide services themselves. Under APMS, PCTs are able to contract for primary medical services with a wide range of potential providers, including from the commercial, voluntary, mutual, and public sectors.

5.470 Through the Innovation in Primary Care Contracting Programme, the Department has provided procurement support to six PCTs in deprived areas to help them procure primary care services on the open market. To varying degrees all six sites have problems, including access to local primary care services and difficulties recruiting and retaining GPs. They are hoping to attract new providers through the programme to provide the services that are needed.

Key Aspects for Delivering the Health Inequalities Targets:

Cardiovascular Disease

5.471 There are marked health inequalities in the incidence of cardiovascular disease and cancer, and in the survival rates for those who develop these conditions. To address these inequalities and deliver the PSA target, prevention and treatment services must better reflect need.

5.472 The *National Service Framework (NSF) for Coronary Heart Disease*[5.79], published in 2000, was designed to raise the standard of care along the entire pathway for CHD, from prevention through to rehabilitation and terminal care. Its twelve standards and service models were intended to ensure that care across the country would meet the same high standard. An additional chapter, published in March 2005, on *Arrhythmias and Sudden Cardiac Death*[5.80], has been written in the current style, in keeping with shifting the balance of power, but its quality requirements perform the same function as the old standards. Implemented in full, these will have the effect of tackling the inequalities in incidence and mortality in CHD.

5.473 Other policy initiatives, such as *Choosing Health*, the establishment of the spearhead group and the nGMS contract for primary care, are working together with the NSF to drive down health inequalities. The national target for reducing premature mortality from heart disease and stroke and related diseases includes a requirement to reduce the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 40 per cent by 2010. The most recent data show that the absolute gap has reduced by 24.7 per cent from the baseline, which is on track to meet the target.

5.474 Significant progress has been made in stroke services, with all hospitals that treat stroke patients now having specialist services in place as set out in the *Older People's NSF*[5.81]. The Department is currently developing a new national stroke strategy to speed up access to diagnosis, improve the quality of care, and to ensure that more patients benefit from the newest treatments once their safety is proven. This is an 18 month collaborative project with patients, clinicians, and the voluntary sector.

5.475 In primary care, the new GMS contract and its specific quality indicators emphasise and encourage key elements of secondary prevention, such as the control of cholesterol and blood pressure. National standards – such as patients suffering from heart attack should be given thrombolysis (clot busting drugs) within 60 minutes of calling for help – mean that quality of care has risen across the country. The proportion of people now treated within 60 minutes of calling for help is 58 per cent compared to about 24 per cent before the NSF.

5.476 In areas which are some distance from hospitals with emergency departments, more pre-hospital thrombolysis is now being given by paramedics. 29 out of 31 ambulance trusts have paramedics trained to give thrombolysis. Paramedic thrombolysis accounts for about nine per cent of thrombolytic treatments.

5.477 The increase in the number of coronary revascularisation procedures being carried out is properly targeted to its audience. Evidence suggests that the reallocation of revenue within a community can improve equity of access to revascularisation.

Reducing the Numbers of People Who Smoke

5.478 Smoking contributes significantly to inequalities in life expectancy between areas and population groups. Reducing smoking in manual groups will have a major impact on cancer, CHD and respiratory disease, and will narrow the health gap.

5.479 The 2004 PSA target on smoking is to:

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

5.480 The Department's comprehensive tobacco control strategy has six strands, each of which has a measurable impact on reducing smoking prevalence:

- highly successful media/education campaigns, which have proved to be the single most important factor triggering smokers' decisions to quit;
- restrictions on advertising, promotion and sponsorship: a comprehensive advertising ban has been in place since February 2003;
- supply reduction: our tobacco products are highly taxed – our cigarettes are the most expensive in the EU – and much is being done to stop the supply of cheap smuggled tobacco (this strand is owned by HM Revenue and Customs and HM Treasury);
- an extensive network of NHS stop smoking services and a national quitline, through which skilled advisers can help people of all ages to stop smoking;
- measures to make smokefree environments the norm at work and leisure; and,
- regulation of tobacco products, including pack health warnings.

5.481 The biggest story of the year for tobacco control has been the *Health Bill*[5.82], which contains provisions for virtually all enclosed public and workplaces to go completely smoke free from

summer 2007. This includes pubs, bars and private membership clubs. This will provide unprecedented protection from the harmful effects of second hand smoke and will also, judging by international evidence, contribute to decreased smoking levels.

5.482 The *Health Bill* also includes powers to raise the minimum age limit for tobacco sales, a full consultation will run in spring 2006 on using these powers to increase the age limit from 16 to 18.

5.483 NHS stop smoking services have also continued to go from strength to strength. During the period April 2005 to September 2005, around 264,508 people set a quit date through the services and around 137,894 (52 per cent) were successful at the four-week follow-up. For the same period in 2004, 208,389 smokers set a quit date and 112,250 were successful at four weeks – we have, therefore, seen annual increases of 27 per cent and 23 per cent respectively.

5.484 An evaluation of the NHS stop smoking services was published in April 2005 in a special supplement of the journal *Addiction* [5.83] and showed that:

- the services can contribute to a (modest) reduction in health inequalities;
- they show examples of innovation in reaching hard to reach groups; and,
- long-term quit rates for the services show about 15 per cent of people setting a quit date remain quit at 52 weeks, which is comparable with earlier clinical trials.

5.485 The Department's education campaigns have continued throughout 2005 with significant presence across the media. Amongst a number of initiatives in the last year, we have seen a new campaign targeting young smokers for the first time, concentrating on issues that motivate this population group: smoking and impotence for males and smoking and the skin/teeth for females. In addition, we have supported the British Heart Foundation on new, hard-hitting adverts. Media/education campaigns were the main reason why smokers said they tried to quit in 2005.

5.486 The *European Tobacco Advertising Directive* [5.84] came into force in July 2005, meaning a ban on all cross-border advertising across Europe. The UK's *Tobacco Advertising and Promotion Act 2002* [5.85] goes further than the directive, prohibiting newspaper, billboard and magazine advertising, in-pack promotions, direct marketing and tobacco sponsorship. In July 2005, UK regulations prohibiting tobacco brand sharing (the promotion of tobacco brands through non-tobacco products) came into force, as well as further prohibitions on sponsorship. Regulations prohibiting tobacco advertising on the internet will follow in spring 2006.

5.487 The European Commission published their image bank of hard-hitting 'picture health warnings' in 2005. In spring 2006, the Department will consult on introducing these picture warnings on tobacco packs in the UK.

5.488 In February 2005, the WHO Framework Convention on Tobacco Control (FCTC), the first ever global health treaty, came into force (the UK ratified in December 2004). The treaty provides the basic tools for countries to enact comprehensive tobacco control legislation. In February 2006, 121 parties to the treaty met in Geneva and agreed to take forward protocols to the treaty on the illicit trade of tobacco products and cross-border advertising.

5.489 The latest figures for adult smoking rates, show continuing progress towards the PSA target with adult smoking at 25 per cent in 2004 and routine and manual smoking at 31 per cent.

5.490 An important intervention to narrow the gap in infant mortality is to reduce smoking in pregnancy. For the year April 2004 to March 2005, 15,054 pregnant women set a quit date through the NHS stop smoking services and 7,702 (51 per cent) had successfully quit based on self-report at the four week follow-up stage. This is an increase from 5,756 in April 2003 to March 2004 (an increase of 34 per cent).

Tackling Obesity

5.491 There is a strong social gradient in terms of obesity, particularly among women. The rate of obesity among women from the most disadvantaged groups is almost twice that of women in professional groups (29 per cent to 16 per cent). A similar, though less marked trend, exists for men, 23 per cent to 16 per cent. This has implications for life expectancy and the burden of chronic disease.

5.492 Reducing obesity is one of the six over-arching priorities of the *Choosing Health* White Paper published in November 2004. The White Paper sets out a comprehensive plan of action on physical activity, diet, personalised support, information and curbs on marketing, which gives a strong foundation for tackling obesity.

5.493 We have set a national PSA target to halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of the broader strategy to tackle obesity in the population as a whole. The target is jointly owned by: the Department of Health, Department for Culture, Media and Sport and the Department for Education and Skills, which illustrates the importance of cross-Government work in tackling obesity.

Obesity Care Pathway and Weight Loss Guide

5.494 A comprehensive *Obesity Care Pathway and Weight Loss Guide* [5.86] will be disseminated to PCTs in spring 2006. The guide will be in the form of a leaflet to be distributed in primary care to be given to patients who intend to lose weight.

5.495 These will provide a model for prevention and treatment for use in primary care. Limited consultation was completed in January 2006.

5.496 The guide will cover:

- what is a healthy weight;

- assessing your personal weight gain;
- how to lose weight and prevent weight gain;
- pointers on diet and physical activity; and,
- simple, behaviourally focused, self-help weight management advice.

Obesity Social Marketing Campaign

5.497 The Department will lead on action to promote health by influencing people's attitudes to the choices they make through a strategy that extends across all aspects of health and involves a broad range of different government departments and agencies such as those covering interests in the NHS, food, sport, the environment and transport.

5.498 Following on from commitments in *Choosing Health* and more recently the *Our Health, Our Care, Our Say* White Paper, our intention is to launch a ten year programme in late 2006, encompassing the period pre and post the 2012 Olympics. The majority of stakeholders will become fully involved from January 2007 onwards The first phase of the programme will run for three years, 2007-2010, focusing on children aged two to ten through their primary influencers – parents and carers.

5.499 The scoping phase, identifying key behavioural and attitudinal influences, is nearing completion. Commitment has been gained from leading stakeholders to input their proprietary consumer insights into the process.

Measurement of Obesity in Children

5.500 The public service agreement (PSA) target on obesity focuses upon preventing and managing obesity in children. In November 2004, *Choosing Health* charged DH and DfES with developing appropriate systems for recording lifestyle measures, one of which was obesity through weight and height measures among school age children. They have agreed that height and weight data should be collected in all maintained primary schools in England.

5.501 Local data on childhood obesity is needed to:

- inform local planning and targeting of local resources and interventions; and,
- enable tracking of local progress against the PSA target on obesity and local performance management.

5.502 Good practice guidance on measuring child obesity was issued to the NHS and school authorities in January 2006, covering issues such as definitions, age groups, data collection options, stigma and confidentiality. The guidance specifies the minimum data requirements for monitoring the deferred NHS local delivery plan line on childhood obesity.

5.503 PCTs will be responsible for resourcing and implementing measurement of height and weight in primary school age children, within their existing resource allocations for obesity.

5.504 Schools will be approached by PCTs and arrangements made for PCT staff to visit schools and measure children in reception year and year 6 in the summer term (2006).

5.505 Data for performance management will be provided to DH by September 2006.

5.506 Further guidance is planned in the spring on data handling and transfer. In the meantime DH IT experts are developing data handling options and recommendations. Discussions are continuing with DfES on sharing data on pupils with DH which would facilitate the development of a wider obesity database to help us analyse the obesity epidemic in more detail.

Nutrition

Choosing a Better Diet: A Food and Health Action Plan

5.507 *Choosing a Better Diet: A Food and Health Action Plan* [5.87] was published in March 2005 following the White Paper *Choosing Health* and set out how we would deliver the White Paper commitments on nutrition.

5.508 The Department oversees the delivery of this action plan together with a working group including other Government departments, industry and consumer representatives. As well as the particular projects on which the Department is in the lead, we work closely with DfES on the 'Food in Schools' and with the Food Standards Agency on front-of-pack food labelling and reformulation of foods.

Healthy Start and Infant Feeding

5.509 Breastfeeding is the best form of nutrition for infants. It provides all the nutrients a baby needs for the first six months of life and protects against common childhood infections and diseases. A gap exists in the initiation and duration of breastfeeding by new mothers between social groups, with just under six out of ten new mothers initiating breastfeeding in the most disadvantaged groups, compared to more than nine out of ten among mothers in the highest social groups.

5.510 The Department supports the promotion of breastfeeding and this year we are undertaking the 'Infant Feeding' survey 2005 to better understand breastfeeding rates. We continue to press for amendments to the EU Directive on infant formula and follow-on formula.

5.511 The new 'Healthy Start' scheme will replace the 'Welfare Food' scheme. The first phase has been rolled-out in Devon and Cornwall. A national roll-out across Great Britain following evaluation of phase 1 will take place later in 2006.

5.512 'Healthy Start' allows beneficiaries of qualifying benefits (e.g. mothers on income support) to exchange vouchers for fresh fruit and vegetables as well as fresh milk and infant formula. It means that pregnant women, mothers and young children under four-years-old who are on a low income have access to a good balanced diet at this important stage in their life, and it provides a formal link with the NHS. The scheme also equalises benefits for

breastfeeding and non-breastfeeding women. A communications and training programme for beneficiaries and health professionals is being introduced in parallel to the scheme.

5 A Day including School Fruit and Vegetable Scheme

5.513 The message about the importance of eating five portions of fruit and vegetables a day is more widely recognised among the public. The proportion of people claiming to have eaten five portions the previous day has risen from 28 per cent in October 2003 to 51 per cent in October 2004. The 5 A Day logo continues to promote the message and it is now licensed with over 550 organisations. We are also continuing to explore ways to simplify the '5 A Day' messages for children and adults, for example, 'using a handful'.

5.514 Under the school fruit and vegetable scheme nearly two million 4 to 6-year-olds in over 16,100 schools are now receiving a free piece of fruit or vegetable every day. The scheme is popular with schools and with parents – over 97 per cent of parents and teachers rate it as good or very good. An evaluation by the Big Lottery Fund found that children in the scheme ate more fruit and had an increased awareness of '5 A Day' than those not in the scheme.

Food Promotion to Children

5.515 *Choosing Health* set out our commitment to having in place a comprehensive approach to change the nature and balance of food promotion to children across a wide range of media. The Office of Communications (Ofcom) are due to publish their consultation on proposals to restrict the promotion and advertising of high fat, sugar and salt food to children on TV and radio very shortly. We have established a new 'Food and Drink Advertising Promotion' forum to review, supplement, strengthen and bring together existing provisions on promotion of food to children in non-broadcast media.

5.516 The Government is developing plans to monitor the success of these measures, and assess their impact in relation to the balance of food and drink advertising and promotion to children. If, by 2007, they have failed to produce change in the nature and balance of food promotion, we will take action through existing powers or new legislation to implement a clearly defined framework for regulating the promotion of food to children.

Choosing Activity: A Physical Activity Action Plan

5.517 *At Least Five A Week*[5.88], the 2004 Chief Medical Officer's report, set out evidence on the impact of physical activity and its relationship to health. The evidence confirmed that there are many potential benefits from being active, including a lower risk of coronary heart disease, stroke, type 2 diabetes and certain types of cancer. Regular physical activity can have a beneficial effect on up to 20 chronic diseases or disorders and will have an important impact on tackling obesity (see above section on reducing obesity). The *Choosing Health* White Paper in November 2004 and the *Choosing Activity: A Physical Activity Action Plan*[5.89] published in March 2005 set out a series of projects aimed at increasing levels of physical activity.

5.518 Key achievements in the past year include:

- 75 per cent of all maintained schools are now in a schools sports partnership, with a target that all schools will be in a partnership by 2006. 69 per cent of pupils in partnership schools are now participating in at least two hours of high quality PE and sport in a typical week;
- 24 per cent of schools in England have active travel plans and these are helping more children to walk or cycle safely to school;
- development of new 'National Healthy School' criteria, which includes a physical activity theme and a toolkit to help physical activity providers in schools, meet these criteria;
- dissemination of interim guidance from 'Local Exercise Action' pilots to PCTs to help guide development of local initiatives around physical activity;
- a health impact assessment of the 'Sustainable Travel Towns' pilots to explore the health benefits of a community-wide sustainable transport policy and optimise the health impacts of the programme, with an emphasis upon health inequalities;
- the publication of a best practice guide on providing free swimming, in conjunction with Sport England and the Amateur Swimming Association;
- the launch of the school pedometer pilot, 'Schools on the Move' which uses pedometers as a motivational tool to increase physical activity among pupils;
- implementation of the 'National Step-o-Meter' programme, which loans pedometers to patients as a motivational tool and trains front-line health professionals in motivational behaviour change;
- launch of the first of a series of nine regional 'Sport and Health' seminars, to promote links between health and sport and the publication of a guide for the local NHS and clubs to encourage and foster links with football clubs on improving the health of their local communities;
- development of a social marketing campaign to be launched in summer 2006 that will take a broad approach in promoting healthy lifestyles through physical activity and diet;
- the launch of nine 'Well @ Work' pilots to trial "healthy interventions" aimed at improving the health of employees in workplaces in the private, public and voluntary sector; and,
- plans to deliver a health legacy based around the London 2012 Olympics.

Improving Sexual Health:

Sexual Health and HIV

5.519 The Government recognises that the consequences of poor sexual health can be serious and have a long-lasting impact. Sexually Transmitted Infections (STIs) and high-risk sexual

behaviours have increased since the mid 1990s, placing enormous pressure on services. The Government is committed to taking action to address these issues and improve the nation's sexual health. The public health White Paper, *Choosing Health*, led to a step change in action and established a new £300 million programme over three years, to modernise and transform sexual health services and work is progressing to implement a number of specific commitments.

5.520 A key driver for delivering this improvement is the inclusion of sexual health and access to Genito-Urinary Medicine (GUM) clinics, as one of six priorities for NHS delivery in 2006-07 as highlighted in *The NHS in England: The Operating Framework for 2006-07*. This priority will accelerate the drive for better sexual health. The White Paper also introduced better performance management for sexual health. PCTs now have LDP targets to improve GUM waiting times, chlamydia screening, waiting times for gonorrhoea treatment and teenage pregnancy. There is, additionally, a Healthcare Commission indicator to improve access to early abortion.

5.521 Faster access to GUM services will involve a renewed focus on modernisation and re-engineering of all sexual health services including those in reproductive health, in particular contraception. It signals the need to continue to do more in the community and develop a range of settings for sexual health services. This has been further reinforced with the our recent White paper *Our Health, Our Care, Our Say*, which signals the development of better community based and more patient-centred services across the board, and indeed the White Paper makes specific reference to sexual health as an important area for these developments. This will go hand in hand with the work we are doing on training and workforce development with the Faculty of Family Planning and Reproductive Healthcare (FFPRHC).

5.522 To date, we have made some solid progress. Already 49 per cent of patients are accessing GUM services within 48 hours nationally. Gonorrhoea rates, which are acknowledged as the best indicators of overall STI rates measured in GUM services, are decreasing. This is a welcome indication of progress being made.

5.523 It is through the implementation of *Choosing Health and Our Health, Our Care, Our Say* that continued progress on delivery of the key objectives in the 'Sexual Health and HIV' strategy will be monitored. In order to help drive delivery, a national support team for sexual health is being created, which will target its support at those areas which face the greatest challenges in meeting the GUM access target. The team will have an early focus on sexual health and it is currently assessing its approach and methodology at two pilot sites. To strengthen the drive from the centre, a Sexual Health Programme Board has been established within the Department which will help to monitor progress and manage risks to delivery.

5.524 The first two phases of the National Chlamydia Screening Programme have been rolled-out across the country. The programme now covers a quarter (84) of PCTs in England . A full programme will be rolled out by March 2007, with additional investment of £80 million (in addition to the £13.5 million invested to date). A pilot project of chlamydia screening in pharmacies (over two years) is also currently taking place across London.

5.525 A contraceptive services group has been established to develop an action plan for improvements to services. £40 million was announced through the White Paper to plug gaps in services which will be identified through a national survey, which is currently taking place.

Reducing Teenage Pregnancy/Supporting Teenage Parents

5.526 Variations in teenage pregnancy rates largely mirror the pattern of deprivation across England, with high teenage pregnancy rates overwhelmingly concentrated in areas of high deprivation. Throughout England, teenage pregnancy rates are highly concentrated geographically. Ward level data for 2001-2003 show 50 per cent of all conceptions occurred in the 20 per cent of wards with the highest under-18 conception rates, and provide a compelling picture of teenage pregnancy 'hotspots' across the country. All local authorities have at least one 'hotspot' ward.

5.527 The socio-economic and demographic make-up of 'hotspot' wards reflects many of the known risk factors for teenage pregnancy. Typically, high rate wards are among the most deprived 20 per cent areas in England and have poor educational outcomes. Low educational attainment, even after accounting for the effects of deprivation, is associated with higher teenage conception rates. On average, deprived wards, where fewer than 40 per cent of girls achieved five GCSE passes, had an average under-18 conception rate of 75.1 per 1,000, compared with an average rate of 48.7 per 1,000 in deprived wards, where more than 60 per cent of girls achieved five GCSE passes.

5.528 Progress is being made to the joint DH/Department for Education and Skills (DfES) PSA target to reduce under-18 conceptions rates by 50 per cent by 2010, within a broader strategy to improve sexual health. Data for 2004 show a reduction in the under-18 conception rate of 11.1 per cent and a reduction of 15.2 per cent in the under-16 conception rate since the 1998 baseline year.

5.529 Across England, the under-18 conception rate has fallen between 6 per cent and 16 per cent across the nine regions. This conceals wide variation between local authorities, ranging from a 42 per cent decline to a 42 per cent increase. Research has shown that high performing areas with the sharpest decline in under-18 conceptions were characterised by the following factors:

- a local champion for teenage pregnancy;
- well known, young people friendly contraceptive/sexual health services, including outreach work;
- strong delivery of sex and relationship education by schools;
- targeted work with at risk groups of young people;
- training for SRE for professionals working with young people at risk; and,

- a well resourced youth service with a focus on addressing young people's personal, social and health issues.

5.530 All local authorities and their partners have been asked to review their local strategies against these factors with a particular focus on reaching 'hotspot' wards and vulnerable groups. To support this work, local data analysis has been sent to local authorities and PCTs, including the names of hotspot wards, school attainment and attendance data and the characteristics of teenage mothers in their area. The local teenage pregnancy strategy should be included in the *Children and Young People Plan* [5.90], developed jointly with PCTs.

5.531 The Teenage Pregnancy Unit has also worked closely with DH on the publication of *You're Welcome* [5.91], a set of quality criteria for making health services young people friendly and increase teenagers' early uptake of health advice. The criteria, a commitment of *Choosing Health*, reflect the standards set out in the children's NSF. An accompanying resource, including case studies, provides a tool for PCTs, in liaison with local authorities, to implement the NSF and contribute to meeting the 'Be Healthy' outcome of *Every Child Matters* [5.92].

5.532 Teenage mothers are more likely to have low birth weight babies and the infant mortality rate for babies of teenage mothers is 60 per cent higher than for babies of older mothers. Teenage mothers are three times more likely to suffer post-natal depression and to suffer poor mental health for up to three years after the birth. They are the group least likely to breastfeed and most likely to smoke during pregnancy. Nearly 40 per cent of teenage mothers have no educational qualification.

5.533 The evaluation of the Sure Start 'Plus' pilot programme, which provides intensive support for teenage parents (including fathers) in 35 local authorities, was published in June 2005. The programme showed positive impact on the reintegration of school age mothers, family mediation, domestic violence and emotional support. Effective practice from Sure Start 'Plus' has been integrated into the new *Sure Start Children's Centres Practice Guidance* [5.93], published in November 2005. The guidance also highlights the importance of reducing repeat pregnancies – 20 per cent of births conceived to under-18s are estimated to be second pregnancies.

Improving Mental Health and Well-being:

Encouraging Sensible Drinking

5.534 The Government's *Alcohol Harm Reduction Strategy for England* [5.94] was published in March 2004, and was subsequently reinforced in the public health White Paper, *Choosing Health* (November 2004). Working across Government, the Department of Health and the Home Office are jointly responsible for implementing the strategy and working in partnership with other stakeholders from within and outside Government. The strategy aims to deliver a programme of work at preventing any further increase in alcohol-related harms.

5.535 Although there is no specific PSA target related to the Department's alcohol harm reduction programme, work on tackling alcohol misuse contributes to the Department's PSAs on reducing mortality rates from major killer diseases where alcohol is a contributing factor (e.g. cancer, cardiovascular and liver disease, suicide and health inequalities).

5.536 We will measure progress regularly in meeting the objectives of the *Alcohol Harm Reduction Strategy* and *Choosing Health* against clearly defined indicators, such as monitoring the effectiveness of interventions on alcohol misuse prevention for children and young people.

5.537 The Government continues to work with the drinks and retail industries to develop a voluntary social responsibility scheme, as recommended in the *Alcohol Harm Reduction Strategy for England*. This work has included:

- the development and publication of a national 'Principles and Standards' document for producers and retailers which covers things like clear protocols around seeking proof of age, etc. and includes, also, a commitment for the industry to work with the Department to develop sensible drinking messages for inclusion on containers and in advertisements; and,
- developing a 'National Producers Fund' – we are currently working with both industry and non-industry stakeholders to develop the existing Drinkaware Trust (the charitable arm of The Portman Group) as the mechanism for delivering the fund.

5.538 The Department published in November 2005 the results of the first ever English needs assessment for alcohol misuse (Alcohol Needs Assessment Research Project (ANARP)). The ANARP identifies services for those requiring treatment for alcohol use disorders and relates this to need at both regional and national level. Caroline Flint (Parliamentary Secretary for Public Health) announced the launch of *Alcohol Misuse Interventions: Guidance on Developing a Local Programme of Improvement* [5.95], as part of her keynote speech at Alcohol Concern's annual conference on 1 November 2005. The guidance is aimed at senior decision-makers and commissioners within local health organisations, local authorities and other stakeholders seeking to work with the NHS to tackle alcohol misuse, and provides practical guidance to improve screening and brief interventions for hazardous and harmful drinkers and treatment for dependent drinkers. A series of regional conferences has commenced to plan the development and implementation of local responses to the programme of improvement.

5.539 In addition, we have published *Models of Care for Alcohol Misusers* (MoCAM) [5.96] commissioned by the Department from The National Treatment Agency. MoCAM sets out a framework for commissioning and providing interventions and treatment for adults affected by alcohol misuse. MoCAM will represent a significant milestone towards achieving the second aim of the alcohol harm reduction strategy for England "to better identify and treat alcohol misuse".

Reducing Substance Misuse

5.540 In response to an estimated annual cost to society of £18 billion the Government launched its 10 year drugs strategy in 1998.

5.541 In order to assess progress against the strategy a number of public service agreement (PSA) targets were set, of which the Department has responsibility for the delivery of the drug treatment PSA target.

5.542 The evidence for focusing on treatment as having a crucial role in the delivery of the drugs strategy is backed up by research, which suggests that for every £1 spend on drug treatment there are an associated £9.50 savings to society as a whole. There is a strong link between the use of illegal drugs and crime and this is why we work closely with the Home Office on the delivery of this target.

5.543 To help deliver the improvements in the availability and effectiveness of drug treatment the Government set up the National Treatment Agency (NTA) as a special health authority in 2001. To support a programme of improvements the Department established the pooled drug treatment budget, which has risen from £129 million in 2001-02 to £300 million in 2005-06.

5.544 Latest figures 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 per cent on 2003-04 (125,545) and 89 per cent on the 1998-99 baseline of 85,000. This means we are well ahead of our schedule to double the numbers in treatment by 2008.

5.545 The other element of the target that was introduced in 2002, regarding a higher proportion of drug users being retained in treatment year-on-year is also currently on target. In March 2005, 75 per cent of all clients in treatment either successfully completed or were retained in treatment, compared to 72 per cent in March 2004.

5.546 As well as the Department's PSA target, treatment is crucial to the delivery of PSA's owned by other Government departments, in particular the Home Office target of 1,000 offenders a week entering treatment by March 2008. Treatment services are currently meeting this demand. However, further expansion will be required in the drug treatment sector if the Home Office are to meet their target.

5.547 Given that the target for numbers in treatment has almost been reached, the focus has now moved to offering more effective treatment, with an objective of driving up the numbers being retained in or successfully completing treatment.

5.548 A number of initiatives have been undertaken to support the improvements in the effectiveness of treatment. The two key initiatives are:

- Models of Care – to address variations in quality of drug treatment, the NTA published *Models of Care*[5.97], which sets out in detail the optimum framework of services that should be commissioned in each Drug Action Team (DAT) to ensure the needs of the local drug misusing population are met. *Models of Care* are currently being updated by the NTA, and a revised version will be published in 2006.
- Treatment Effectiveness Strategy – in June 2005 the Department and the NTA launched the Treatment Effectiveness Strategy, which is based on a review of international evidence and treatment data as well as consultations with leading experts and users and carer groups. The work programme consists of a number of key strands. These include:
  - the regular and rigorous performance management of DATs and PCTs against plans and targets by the NTA, SHA and other stakeholders;
  - parallel external verification and inspection by the Healthcare Commission and the NTA around nationally agreed standards;
  - the targeting of poor performers to provide action plans for improvement; and,
  - regular dissemination by the NTA of performance data, recent research, audit and examples of good practice.

5.549 Associated with the drive to improve the performance of drug treatment services, is the recognition of the importance that access to wider systems has to play in ensuring that drug users are able to successfully reintegrate into their community. Housing, education and training are those issues as identified as being key to successful treatment outcomes.

5.550 Relevant Government departments are working closely together to ensure that this type of partnership working is mirrored at a local level.

Helping Children and Young People to Lead Healthy Lives:

Helping 13-15-year olds To Address Risk

5.551 The Young People's Development Programme aims to address risk-taking behaviour, especially in relation to teenage pregnancy, substance misuse and educational attainment through a holistic, structured, developmental programme for 13-15-year olds. The programme has developed 27 sites in deprived areas using a similar approach to projects in the United States. The projects work with up to 30 young people at a time, with each young person in the programme for at least a year.

5.552 The programme is being evaluated by the Institute of Education at the University of London. The first outcome based report published in March 2005 showed that the programme is well developed and successful in recruiting young people who fit the target group. Further reports will be available in 2006. Subject to positive evaluation, the Department will want to encourage children's trusts to apply the approach of the programme more widely.

Healthy Schools

5.553 The Healthy Schools Programme is a key delivery vehicle supporting the *Every Child Matters: Change for Children* programme – particularly the being healthy, being safe, enjoying and achieving and making a positive contribution outcomes. It is also a critical driver for the health inequalities, childhood obesity, drugs and teenage pregnancy and broader sexual health PSAs.

5.554 The *Choosing Health* White Paper sets out the following targets for the Healthy Schools Programme:

- half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009;
- encourage local Healthy Schools Programmes to target deprived schools including Pupil Referral Units, and look to extend healthy schools to include nursery education; and,
- from 1 April 2005, a healthy school will provide an enabling and healthy environment where the 'whole school approach' is applied. Schools will need to demonstrate that they have met criteria in the following four core themes areas:
  - personal, social and health education;
  - healthy eating;
  - physical activity; and,
  - emotional health and well-being.

Improving Access and Sustainability of Health Services for Young People

5.555 *Choosing Health* identified the health needs of teenagers as a priority area. It recognised that tackling inequalities in childhood and among young people is the most cost-effective intervention for reducing health inequalities in childhood and later life.

5.556 As part of delivering this agenda, sustainable young people's health demonstration sites are being developed to explore and evaluate how services can become more effective in meeting the health needs of young people (11-19). The new and enhanced services will include primary, secondary and specialist health care services in locations aimed at attracting young people such as youth or sports centres and places with Internet facilities in both urban and rural locations. Key features of the model include:

- co-location of a team including health professionals, such as extended nurse prescribers, alongside youth advice workers and counsellors providing health information, advice, treatment and care;
- activities to minimise the problems caused by the transition from paediatric to adult services for young people with chronic or complex conditions such as diabetes, sickle cell, or epilepsy; and,
- engagement of young people to inform the development, management and evaluation of each service model.

Promoting Health and Active Life Amongst Older People:

Health, Work and Well-being

5.557 Reducing sickness absence and significantly increasing overall fitness for work in the adult population would have major benefits for the NHS, for the UK economy and for the economic well-being of local communities. The *Health, Work and Well-being* (HWWB) strategy [5.98] builds on commitments in the *Choosing Health* White Paper and the drive to improving working lives for NHS staff made in the *NHS Plan*. The strategy was published jointly by the Department of Health, the Department for Work and Pensions and the Health and Safety Executive in October 2005, a good example of Government departments working closely together.

5.558 The burdens resulting from ill health in the working age population have long been recognised. They include the loss of 35 million working days to occupational ill health and injury to the UK economy each year, at a cost to the public sector of £4 billion per year, and the total cost to the economy is £12 billion per year. Stress-related conditions, musculoskeletal disorders and cardio-respiratory problems (such as angina) are now the commonest reported causes of work-related sickness absence, but in many cases can be managed effectively with the right advice and support from the health community without leading to prolonged absence from work. Without active management, the longer someone is signed off, the less likely they are to return to work. For example, those off sick with chronic back pain for six months have only a 50 per cent chance of returning to work; after a year that chance reduces to 25 per cent. There is good evidence of the benefits to individuals, their organisations and the economy gained from engaging in healthy work practices.

5.559 The Department has a number of work programmes that support the delivery of the *Choosing Health* commitments to healthy employment and will contribute to the joint strategy. For example, we are working closely with Investors in People to develop a healthy business assessment for incorporation when their standards are reviewed in 2007-08, with good progress being made towards piloting the new standards. In conjunction with Sport England, British Heart Foundation and the Big Lottery Fund we are funding an innovative series of projects across the nine Government regions to develop the evidence base for effective interventions in the workplace that improve the health and well-being of employees. NHS Plus encompasses a programme of improvements to NHS occupational health services, including a website that gives easy access to evidence-based guidelines and good practice standards. The 'Improving Working Lives' initiative is a feature of everyday management in the NHS with successful implementation of modern employment practices. All NHS trusts have achieved the standard at practice level and are now working towards the practice plus level which requires demonstrable evidence through partnership working that the working lives of staff in all staff groups are continuing to improve. 'Pathways to Work' is a flagship programme, funded by the Department for Work and Pensions, that supports people on long-term incapacity benefit in rehabilitation for work. The Department is working

closely with DWP and, with partner PCTs, to deliver the innovative Condition Management Programme, one of the 'choices packages' in welfare reform which is being successfully delivered by the NHS.

5.560 Under the HWWB strategy, a new National Director for Occupational Health is being appointed to provide leadership and engagement across different sectors. The new director will be supported by a National Stakeholder Council and a cross ministerial group – both will have their inaugural meetings in March 2006. A stakeholder summit is being convened in May 2006 to achieve broad sign up to the spirit of the strategy and its new charter. There are high expectations on the Department to make a major contribution to the goals set out in the joint DH/HSE/DWP HWWB strategy. The goals are:

- the health and well-being of people of working age is given the attention it deserves;
- work is recognised by all as important and beneficial, and institutional barriers to starting, returning to, or remaining in work are removed;
- healthcare services in the NHS and the independent sector meet the needs of people of working age so they can remain in, or ease their return to, work;
- health is not adversely affected by work, and good quality advice and support is available to, and accessible by, all;
- work offers opportunities to promote individual health and well-being, and access to and retention of work promotes and improves the overall health of the population;
- people with health conditions and disabilities are able to optimise work opportunities; and,
- people make the right lifestyle choices from an early age and throughout their working lives.

Developing the Health Improvement Workforce

5.561 *Choosing Health* highlighted that its objectives would only be achieved if 'the right people with the right skills are in place to deliver them, and if barriers to change and old professional boundaries are broken down'. With this in mind, strategies to develop the health improvement workforce have focused on strengthening the capacity and capability of all those who can positively influence the health of individuals and communities, ranging from local authority and NHS staff to voluntary sector organisations.

5.562 Developing such a vast and diverse workforce cannot be achieved all at once, but cornerstones are being put in place which will support strong future multidisciplinary public health. These cornerstones include:

- the publication of shared career frameworks which will mainstream health improvement skills and responsibilities across the workforce;
- strengthening public health teaching by establishing teaching public health networks to embed public health learning into a wide range of pre- and post-qualification training and life long learning offered by higher education and further education;
- increased access to accreditation and registration for public health specialists from multidisciplinary backgrounds with a view to increasing consultant capacity; and,
- leadership development to equip the public health and wider workforce to be visionary and inspirational in enabling their organisations to achieve health improvement in the communities they serve.

Using Information and Intelligence

5.563 The development of the Public Health Information and Intelligence Strategy takes forward several key *Choosing Health* commitments aimed at providing evidence on the health of the population and the impact of interventions to improve health. A Public Health & Health Intelligence Task Force was established which made recommendations on the use of such information which are the subject of public consultation during spring 2006. Guidance on measuring childhood obesity has already been published and National and Community Health Profiles are nearing completion. The Strategy proposes four key approaches to the development and use of information and intelligence by health service providers, commissioners and the public. These cover:

- improved data and information provision;
- stronger information and intelligence organisations,
- workforce training and support; and,
- the development of a comprehensive national Health Information and Intelligence System.

5.564 Key outputs in the next two years will include obtaining and collating primary care data on lifestyles, the creation of an accessible population health web portal for the public and professionals, and population health 'safe havens' for secure and confidential linkage of personal health data.

Other Aspects of Health Inequalities:

Accidents

5.565 Accidents are characterised by a strong social gradient – with people living in disadvantaged groups and areas suffering higher accident rates than other groups. Child road accident casualties are one of the 12 national headline indicators in the *Programme for Action*.

5.566 The *Choosing Health* commitments include supporting projects aimed at providing advice and support for young people while promoting accident prevention.

5.567 The Department has supported the charity SmartRisk to assess the effectiveness of their 'Heroes' programme on the risks of accidental injury, in changing the behaviour of young people, and what lessons might be applied elsewhere. Leeds Metropolitan University School of Public Health undertook an independent evaluation of the programme. This concluded that the Programme

was effective in reaching large numbers of young people and achieved significant short-term effects in knowledge, attitudes and behavioural intention. There was also evidence for some sustained change.

5.568 The Department has also invited the Royal Society for the Prevention of Accidents to establish an accreditation scheme for safety centres across England to sustain best practice and new ways of delivering accident prevention messages. The project is underway with the appointment of a project coordinator and the establishment of a project steering group.

Screening

5.569 Significant progress has been made in developing screening programmes in England and improving coverage to disadvantaged groups and areas. For example, the Down's Syndrome Screening Programme aims to ensure equitable access around the country and screening is now offered in around 95 per cent of maternity units to women of all ages. The Newborn Hearing Screening Programme is now screening 99 per cent of newborns in England and nearly 1,100 babies have been confirmed with a hearing loss before six months. Early identification improves communication skills, leading to better educational achievement and quality of life.

5.570 A linked newborn and antenatal screening programme for sickle cell and thalassaemia disorder is being implemented across England. The aim of the newborn programme is to achieve the lowest possible childhood mortality rates and to minimise morbidity from sickle cell disease in childhood. By July 2005, newborn screening for sickle cell covered 90 per cent of newborns with completion of implementation due by April 2006. In the first seven months of the programme, 103,000 were screened and 125 babies identified. The rollout of antenatal screening for sickle cell and thalassaemia is almost completed in high prevalence areas. Low prevalence areas are due to have implemented antenatal screening using a family origin questionnaire by the end of 2006.

Oral Health

5.571 In November 2005, the Department published a new oral health strategy, *Choosing Better Oral Health – An Oral Health Plan for England* [5.99]. This provides evidence-based guidance for PCTs and dental practices on improving oral health and reducing inequalities, complementing the new local commissioning arrangements for primary dental care. The plan will be followed shortly by a distance-learning programme to support dental practices in developing a preventive focus and implementing the NICE guidelines on patient recall intervals. We are also taking forward work on the contribution the dental team can make to smoking cessation programmes.

5.572 *The Water Act 2003* [5.100] gives the NHS the power to commission water fluoridation schemes to improve oral health where the local population is in favour. In March 2005, regulations were made on the procedures that the NHS has to follow in conducting local consultations. In September 2005, the Department published guidance on fluoridation.

5.573 The Department has commissioned Cancer Research UK to undertake a three-year programme aimed at raising awareness of the causes and symptoms of mouth cancer. This programme included the production of materials to support doctors, dentists and pharmacists in diagnosing oral cancer. Caroline Flint MP, the Public Health Minister, launched the programme in November 2005 during Mouth Cancer Awareness week.

Prisoners

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

5.575 Budgetary and commissioning responsibilities for health services in almost all publicly run prison establishments in England and Wales were transferred to the NHS on 1 April 2005, in England to PCTs. The objective is that prison health services should be broadly equivalent to the wider NHS and, similarly, the *Choosing Health* agenda applies to prisons.

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

- *smoking* – prisons have been working in partnership with the NHS on smoking cessation projects, with NHS support available for all prisons;
- *nutrition* – nutritional standards for food in prisons are being revised by the Prison Service in line with FSA and Departmental advice. The service is also looking at reducing the levels of fat, salt and sugar in the food products it purchases and has piloted "5 A Day" fruit and vegetable schemes in prisons in the North West;
- *drug misuse* – two thirds of injecting drug users have been in prison but only half have started injecting before they go to prison. A rap CD, 'Music 4 Messages', produced by the Department in November 2005, provides information on primary protection about Hepatitis C to young offenders. It is being evaluated by the London School of Hygiene and Tropical Medicine;
- *hepatitis B* – 1,200 prisoners receive hepatitis B vaccinations each month – 40 per cent of those intravenous drug users in the wider community who report receiving one or more hepatitis B vaccinations received them in prison; and,
- *physical exercise* – the 'Walking The Way To Prison Health' scheme has been successfully piloted in 10 prisons. This was identified as a health promotion activity from the wider community that could successfully be transferred to prisons.

6. Breakdown of Spending Programme

HOSPITAL AND COMMUNITY HEALTH SERVICES

HCHS Resources by Sector

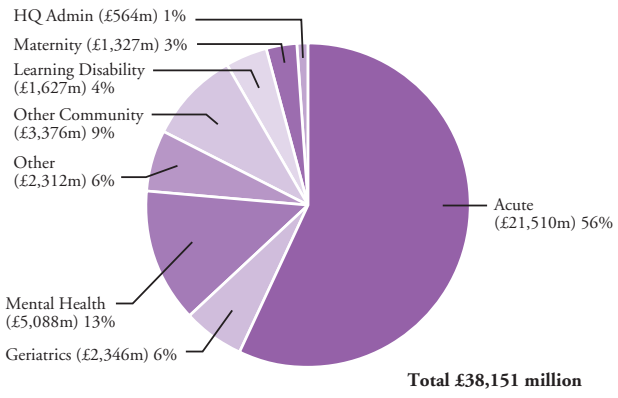
6.1 **Figure 6.1** shows the breakdown by service sector of gross current expenditure on the hospital and community health services (HCHS) in 2003-04, the latest year for which disaggregated data are available. (The figure includes capital charges, but does not include spending on general medical services (GMS) discretionary, family health service (FHS) prescribing and other related services.) For this reason the total differs from the figure shown in **Figure 3.4**.

6.2 The proportion of HCHS expenditure by programme of care is as follows:

- acute services 56 per cent;
- mental health 13 per cent;
- other community 9 per cent;
- geriatrics 6 per cent;
- learning disabilities 4 per cent;
- maternity 3 per cent;
- HQ administration 1 per cent; and,
- other 6 per cent.

6.3 The predominance of spending in the acute hospital sector reflects the demand for emergency treatment, and the continuing emphasis on reducing waiting lists and waiting times.

Figure 6.1: Hospital and Community Health Services Gross Current Expenditure by Sector, 2003-04



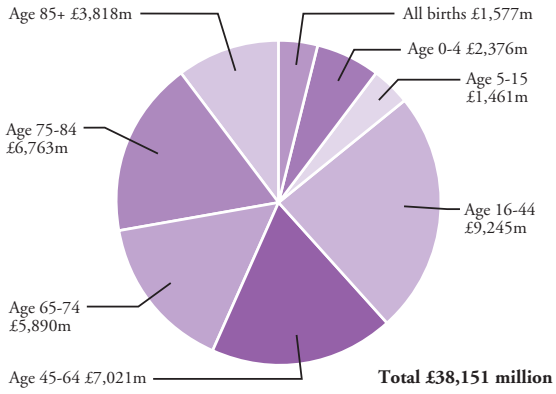
Footnote:
Figures may not sum due to rounding.

6.4 Of the total HCHS spend, i.e. £38.2 billion, £0.6 billion (1.5 per cent) is spent on HQ administration, leaving £37.6 billion (98.5 per cent) for patient services. From this, hospital expenditure accounts for £30.2 billion (80.4 per cent), community services £6.2 billion (16.5 per cent) and £1.2 billion (3.1 per cent) for ambulance services.

HCHS Current Resources by Age Group

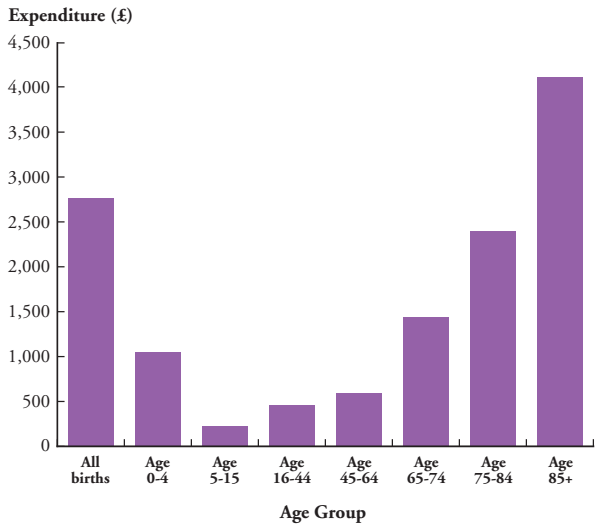
6.5 **Figure 6.2** shows that in 2003-04 people aged 65 and over accounted for approximately 43 per cent of total expenditure, a group, however, that comprises around 16 per cent of the population. This is primarily because approximately 49 per cent of acute expenditure and significant proportions of expenditure on services for mentally ill people (35 per cent) and other community services (20 per cent) are for people aged 65 and over.

Figure 6.2: Hospital and Community Health Services Gross Current Expenditure by Age, 2003-04



6.6 **Figure 6.3** shows the expenditure in 2003-04 on HCHS for each age group, expressed as a cost per head of the population. High costs are associated with early birth, but costs per head then fall steeply, remaining relatively low through young and middle age groups, before rising sharply from age 65. This reflects the greater use of health services by elderly people. The average spend per head of population for 2003-04 was £765.24, in comparison in 2002-03 the average spend was £707.98.

Figure 6.3: Hospital and Community Health Services Gross Current Expenditure Per Head of Population, 2003-04

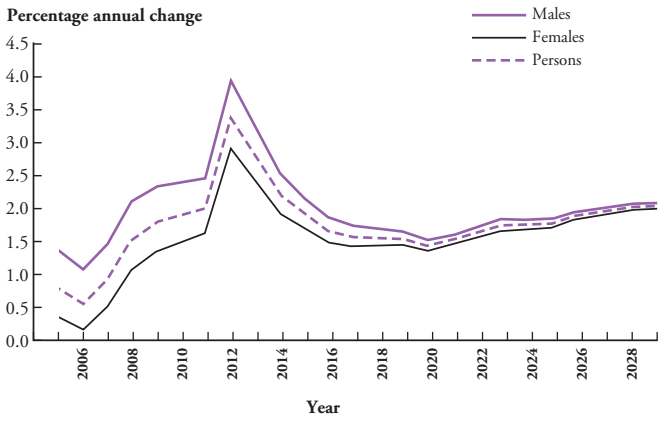


6.7 The changing demographic make up of the population affects the demand for NHS care. The elderly, in particular, have a significant impact. **Figure 6.4** shows that over the next 10 years the increase in the population, aged 65 and over, is expected to average 1.7 per cent per year.

6.8 Over the next 20 years, the growth rate is also at a similar magnitude of 1.7 per cent per year. To date the NHS has been able to manage the increase in the use of its services caused by an ageing population. But the pattern of service delivery may need to change in the future.

6.9 The current trend is for a reduction in the growth rate of people aged 65 and over; however, this will end in one year's time. Starting from 2006, the post-war baby boom will boost the year-on-year growth rates in the elderly populations, with growth rates peaking in the year 2012.

Figure 6.4: Estimated Growth in People Aged 65 and Over: Year-On-Year Percentage Increases



RESOURCE ALLOCATION

Revenue Allocations to Primary Care Trusts for 2006-07 to 2007-08

6.10 Revenue allocations to primary care trusts (PCTs) for 2006-07 and 2007-08 were announced in February 2005. The distribution of resources for the 2006-07 to 2007-08 revenue allocations is shown in **Figure 6.5**. Further information on the 2006-07 and 2007-08 revenue allocations can be found at: **www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/Allocations/fs/en**

6.11 The 2006-07 and 2007-08 revenue allocations represent £135 billion investment in the NHS, just over £64 billion to PCTs in 2006-07, and just over £70 billion in 2007-08. The average PCT growth is 9.2 per cent in 2006-07, and 9.4 per cent in 2007-08.

Figure 6.5: Distribution of Resources for 2006-2008

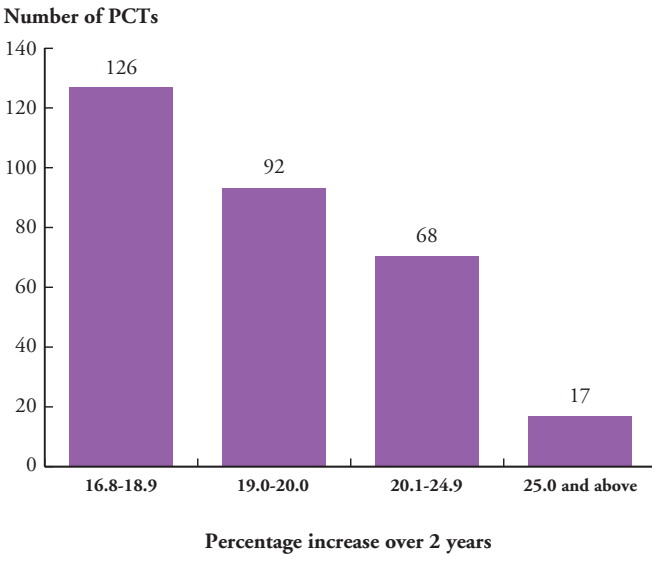
	2006-07 £m	2006-07 % increase	2007-08 £m	2007-08 % increase
HCHS[1]	74,119		80,960	
Capital charges and other funding adjustments				
Total available	75,754		82,744	
CFIS[2]	11,444		12,389	
Total for PCT recurrent revenue allocations	64,310	9.2	70,355	9.4

Footnote:
(1) Hospital and Community Health Services.
(2) Centrally funded initiatives and services.

6.12 For 2006-07 revenue allocations, the range of PCT increases is between 16.8 per cent and 32.3 per cent over the two years, with an average of 19.5 per cent.

6.13 **Figure 6.6** shows the distribution of increases over the period 2006-07 and 2007-08 by PCT.

Figure 6.6: Revenue Allocations 2006-07 and 2007-08: Distribution of Increases



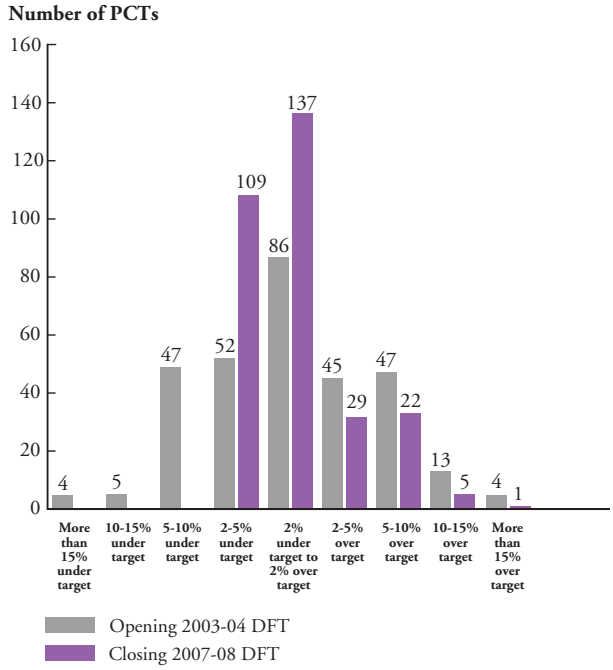
Revenue Allocations – Pace of Change Policy

6.14 In 2003-04, a revised needs formula was introduced. As a result, some PCTs were still receiving 22 per cent less than their fair share of available resources. By 2007-08, no PCT will be 3.5 per cent below their fair share of resources.

6.15 **Figure 6.7** shows PCT's:

- opening 2003-04 distances from target; and,
- closing 2007-08 distances from target.

Figure 6.7: Primary Care Trusts' Distances from Unified Target – Opening 2003-04 and Closing 2007-08



Primary Medical Services Allocations

6.16 From 2006-07, the primary medical services (PMedS) funding, which covers general medical services (GMS) and personal medical services (PMS) has been integrated into the revenue allocations to PCTs – see below on baseline changes.

Revenue Allocation 2006-07 and 2007-08 – Changes

Baseline Changes

6.17 It is not possible to compare the 2006-2008 revenue allocation figures to allocation figures from previous years. This is because of changes to the funding included in PCT allocations. These are known as baseline changes.

6.18 There have been a number of changes to 2006-07 PCT baselines, the most significant of which are:

- devolution of funding from central budgets. For example, almost £600 million for NHS funded nursing care and the PMedS allocation referred to above; and,
- technical changes. For example, the addition of £1.4 billion to PCT allocations to fund the increase in pensions indexation from 7 per cent to 14 per cent.

6.19 These changes are summarised in **Figure 6.8**.

Figure 6.8: Changes to 2006-07 PCT Baselines

	£ million
2005-06 recurrent allocation	53,560
Primary medical services allocation	3,815
NHS funded nursing care	584
Special allocations	365
Other central budgets	81
Pensions indexation	1,367
Cost of capital rebasing (6% to 3.5%)	-879
2006-07 PCT baseline	**58,892**

Footnotes:
(1) Figures may not sum due to rounding.

Weighted Capitation Formula Changes

6.20 For 2006-07 and 2007-08 revenue allocations, the following changes were made:

- population data that includes an adjustment for population growth was used as a basis for allocations to PCTs;
- a primary medical services component was incorporated into the allocations. This component replaces the GMS cash-limited and GMS non-discretionary components; and,
- changes were made to the market forces factor (MFF) to support the implementation of payment by results (PbR), namely the number of zones have been increased from 119 to 303 and an adjustment to the weights for multi-site trusts in the land and buildings indices.

Advisory Committee on Resource Allocation

6.21 The development of the weighted capitation formula, used to inform the revenue allocations to PCTs, is overseen by the Advisory Committee on Resource Allocation (ACRA). ACRA's membership comprises NHS management, GPs and academics.

CENTRALLY FUNDED INITIATIVES AND SERVICES AND SPECIAL ALLOCATIONS (CFISSA)

6.22 The CFISSA programme provides central revenue funding to implement the *NHS Plan* and other initiatives. **Figure 6.9** provides details of the CFISSA programme with 2005-06 budget levels. The figures take into account all changes made to the programmes since the original announcement in 2003.

Figure 6.9: Centrally Funded Initiatives and Services and Special Allocations

Budgets	£000s 2005-06
Improving Access to all Services:	
Better emergency care	249,774
Waiting, booking and choice	256,218
Improving Services and Outcomes in:	
Cancer	29,624
Coronary Heart Disease	33,666
Mental Health	68,786
Older People	2,402
Children	21,261
Improving Patient Experience	138,351
Reducing Health Inequalities	205,805
Contribution to a reduction in Drug Misuse	308,396
Workforce	4,680,606
IM&T	387,816
Other CFISSA budgets:	
R&D	635,820
Statutory Bodies	511,828
Special Health Services (e.g. Audiology Services, Dentistry, Ophthalmic)	1,028,300
Modernisation Agency	137,989
Primary Care	187,064
Public Health	101,738
Central Payments made on behalf of DH (e.g. Injury Allowances)	37,910
Residual CFISSA budgets (e.g. SHA Running Costs, NHS Bank)	1,606,132
CFISSA budgets issued with PCT allocations	5,817,500
Cost of Living Supplement	108,787
Non Cash CFISSA budgets (including Capital Charges, Provisions etc)	1,744,318
TOTAL	**18,300,091**

FAMILY HEALTH SERVICES (FHS)

6.23 Family health services are services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department following consultation with representatives of the relevant professions, and administered locally by primary care trusts (PCTs).

6.24 Funding of the FHS is demand led and not subject to in year cash limits at PCT level, though FHS expenditure has to be managed within overall NHS resources. The exceptions to this are certain reimbursements of GMS GPs' practice staff, premises, out of hours and IM&T expenses payable to doctors in general practice (GMS discretionary spending), the costs of administration, and expenditure on drugs and appliances by GPs. Funding for these items is included in PCTs' (HCHS) discretionary allocations. From 2004-05 the GMS non-discretionary element has ceased to exist and GMS funding has become part of the overall PCT allocation as part of the new GMS contract.

FHS Gross Expenditure

6.25 **Figure 6.10** (FHS table) shows the gross cash FHS expenditure by services in England, the real terms increase and the year-on-year growth of expenditure. Gross expenditure means that figures are not net of pharmaceutical price regulation scheme (PPRS) receipts and dental and prescription charge income.

Figure 6.10: Family Health Services Gross Expenditure (Cash and Resource), 1994-95 to 2004-05, England

£ million

	1994-95	1995-96	1996-97	1997-98	1998-99	1999 -2000	2000-01	2000-01	2001-02	2002-03	2003-04	2004-05	% real terms growth 1994-95 to 2004-05[6]	% growth 2003-04 to 2004-05
	Cash							Resource						
Total Drugs[1]	**3,252**	**3,506**	**3,808**	**4,107**	**4,356**	**4,852**	**5,168**	**5,160**	**5,714**	**6,345**	**6,963**	**7,376**	**75.4%**	**5.9%**
GMS Non-Discretionary	1,902	1,965	2,073	2,198	2,243	2,451	2,510	2,507	2,271	2,068	1,903	n/a[8]		
GMS Discretionary	723	754	800	835	878	885	940	1,024	959	864	781	n/a[8]		
PMS (discretionary)[2]	n/a	n/a	n/a	n/a	37	84	174	203	689	1,152	1,939	n/a[8]		
Total GMS & PMS	**2,625**	**2,719**	**2,873**	**3,033**	**3,158**	**3,420**	**3,623**	**3,734**	**3,919**	**4,084**	**4,623**	**n/a**[8]		
GDS[4]	1,281	1,292	1,325	1,349	1,439	1,479	1,556	1,561	1,638	1,709	1,767	1,671	n/a	n/a
PDS (discretionary)[2][3][7]	n/a	n/a	n/a	n/a	4	12	21	21	36	41	48	280	n/a	n/a
GOS	213	223	237	241	240	281	292	290	302	304	322	340	23.5%	5.6%
Dispensing Costs[5]	679	706	746	768	781	808	856	857	879	919	959	965	9.9%	0.6%
Total (excluding GMS and PMS elements)	**5,425**	**5,727**	**6,116**	**6,465**	**6,820**	**7,432**	**7,893**	**7,889**	**8,569**	**9,318**	**10,059**	**10,632**	**51.6%**	**5.7%**
Total FHS	**8,050**	**8,446**	**8,989**	**9,498**	**9,978**	**10,852**	**11,516**	**11,623**	**12,488**	**13,402**	**14,682**	**10,632**	**2.1%**	**-27.6%**

Footnotes:

(1) Drugs data source: Prescription Pricing Authority, England. Figures include amounts paid to pharmacy and appliance contractors by the PPA and amounts authorised for dispensing doctors and personal administration in England, for financial years April to March. The data do not cover costs for drugs prescribed in hospital but dispensed in the community or private prescriptions.

(2) Personal medical services (PMS) and personal dental services (PDS) schemes are Primary Care Act pilots designed to test locally-managed approaches to the delivery of primary care. PDS and PMS expenditure figures exclude any related capital investment by NHS trusts.

(3) PDS expenditure figures are also gross of patient charge income.

(4) The gross GDS costs include the cost of refunds to patients who incorrectly paid dental charges.

(5) Growth in dispensing costs is affected by the inclusion of an increasing element (around £30 million in 2003-04) in PMS discretionary expenditure.

(6) Figures have been converted into real terms using the December 2005 GDP deflator.

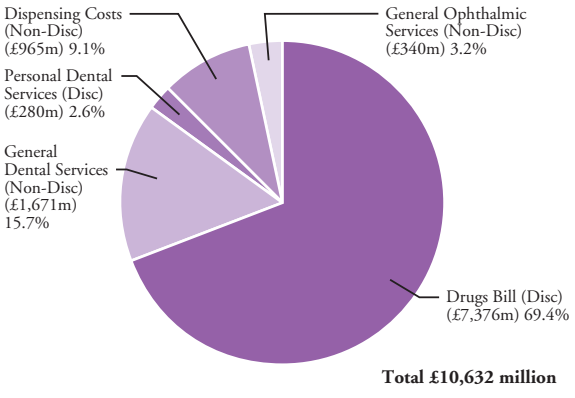
(7) PDS schemes are based mainly on dental practices which have converted from general dental service (GDS) to PDS terms of service.

(8) Following new GP contract status from 1 April 2004, G/PMS practice based data is not comparable with former GP only 2003-04 GMS figures. All GMS/PMS discretionary and non-discretionary figures reported up to 2003-04 are based on contract arrangements for GP only pay prior to the new GMS Contract new practice based contract arrangement which commenced 1 April 2004. New GMS arrangements are wholly discretionary (Unified budget) funded. Please see paragraphs 6.32 to 6.38 on latest new GMS contract arrangements.

Family Health and Personal Medical and Dental Services Resource

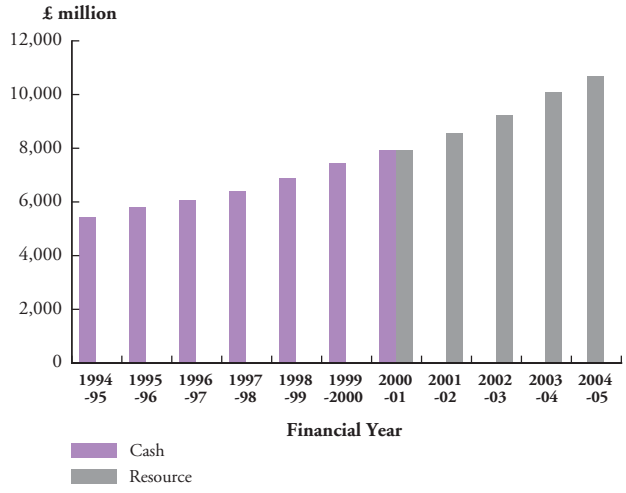
6.26 **Figure 6.11** shows the distribution of gross resource expenditure for FHS of £10,632 million in 2004-05 among the constituent family health services, England.

Figure 6.11: Family Health and Personal Medical and Dental Services Gross Expenditure in 2004-05, England



6.27 **Figure 6.12** charts the total FHS gross cash expenditure for 1994-95 to 2004-05.

Figure 6.12: Total FHS Gross Expenditure, 1994-95 to 2004-05, England (excludes GMS/PMS expenditure)



6.28 The real term growth between 1994-95 and 2004-05 is 51.6 per cent.

Family Health and new General Medical Services (nGMS) Contract

6.29 **Figure 6.13** charts the nGMS spend for 2004-05 to 2005-06.

Figure 6.13: Family Health Services, new General Medical Services Expenditure, 2004-05 to 2005-06

	£ billion	
	2004-05 outturn	2005-06[1] forecast outturn
nGMS	6.9	7.5

Footnotes:
(1) Forecast outturn i.e. still subject to validation.

6.30 All GMS/PMS figures previously reported up to 2003-04 were based on former statement of financial allowance (SFA) GP contract arrangements prior to the introduction of the new GMS contract from 1 April 2004. New arrangements for 2004-05 and future years are not comparable against, or reconcilable to, the figures shown up to 2003-04.

6.31 The introduction of the nGMS contract represented a fundamental change in the way in which practices are incentivised to deliver patient care. Whilst GPs retain their independent contractor status, there is a movement from the idea of remuneration based on individual GPs workloads to a system based on a practice workload.

6.32 Key 'tools' introduced within these new contracting arrangements are:

- Global Sum – allocated through the Carr-Hill formula, is intended to allocate funds for the delivery of essential and additional services, including its staff costs, distributed in line with relative needs and costs of the patients to reflect GP and practice workload and complexity. Global sums are calculated quarterly and paid monthly at practice level;
- Quality and Outcomes Framework (QOF) – improving quality of care to patients through financial incentives to practices for achieving a structured range of standards. Practices receive payments at the start of the annual quality cycle, based upon the level of quality targeted with subsequent correctional payments made at the end of the cycle based on outcomes; and,
- Enhanced Services – used to expand the range of local services to meet local need, improve convenience and choice and ensure value for money. PCTs are free to commission enhanced services as they choose, but are expected to spend up to a local floor. All payments, except for a minority of specific directed services e.g. childhood immunisation targets, are determined locally.

6.33 The new GMS contracting arrangements are backed by a guaranteed 36 per cent increase in resources for primary medical care services in England, rising from £5 billion in 2002-03 to £6.8 billion in 2005-06. Such increases for primary care are unprecedented.

6.34 Evidence from PCT expenditure forecasts shows primary care trusts having made available additional resources to secure the range of services and improvements in care, in order to meet national and local priorities. The overall increase in resources is now forecast to total more than 40 per cent for the three-year period to 2005-06 equating to spend on primary medical care services of around £7.5 billion in 2005-06. See **Figure 6.13**.

6.35 Increased investment of this scale within primary care is not only very good news for those who deliver services, it also improves services for patients:

- higher levels of investment in the Quality and Outcomes Framework (where we have seen average achievement levels of 91 per cent at a cost of £653 million in 2004-05) will help provide better care for those with long-term conditions;
- more Enhanced Services (spend of £588 million in 2004-05) will benefit patients through improvements in the quality and range of services that are available in the local community; and,
- through a 57 per cent increase in investment in premises (£459 million in 2003-04 to £721 million by 2005-06), the quality of the facilities and environment within which primary care is delivered is enhanced considerably.

DRUGS BILL

6.36 Drugs bill gross expenditure is the cash amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs, medicines and certain listed appliances that have been prescribed by GPs. Net drugs bill expenditure is total gross expenditure minus pharmaceutical price regulation scheme (PPRS) receipts.

6.37 In resource terms, the 2004-05 FHS drugs bill outturn for England was £7,376 million, this represents a growth of 5.9 per cent in the FHS drugs bill over the preceding year. In 2004-05, prescribing volume showed a contrast between the growth in the total number of items dispensed at 5.0 per cent, and a higher rise in some areas linked to national service frameworks (NSFs) – such as diabetes, 9 per cent, and statins, 28 per cent, which is over 6 million more items than the previous financial year. Of the 2004-05 growth in the drugs bill about 87 per cent was due to volume increases and 13 per cent to cost increases, in comparison about 60 per cent of the 2003-04 growth was due to volume increases and 40 per cent due to cost. This change reflects the drop in price per item of four of the leading six drug types e.g. lipid regulating drugs (statins) were £27.59 per item in 2003-04 compared to £22.59 per item in 2004-05. See **Figure 6.14** and **Figure 6.15**.

Figure 6.14: Gross Family Health Services Drugs Bill: Cash 1994-95 to 2000-01 and Resource 2000-01 to 2004-05, England

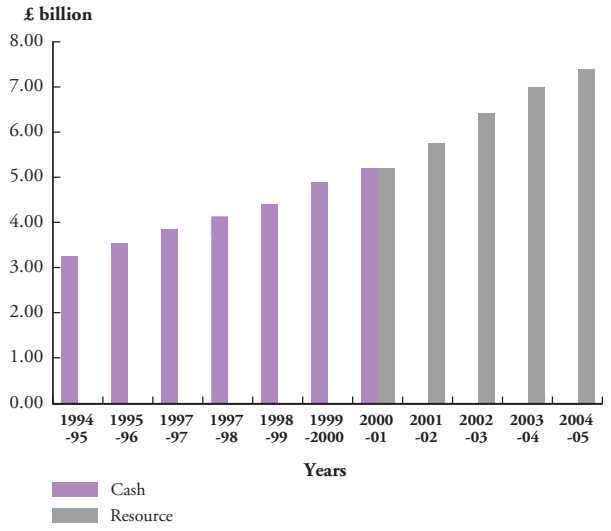
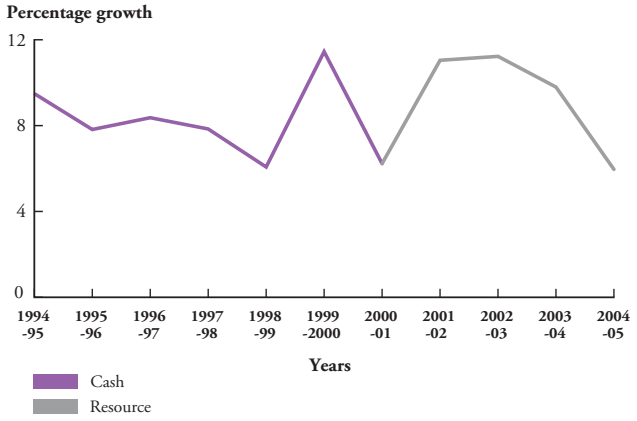


Figure 6.15: Gross Family Health Services Drugs Bill – Percentage Growth: Cash 1994-95 to 2000-01 and Resource 2000-01 to 2004-05, England



6.38 The difference between cash and resource growths are due to Prescription Pricing Authority (PPA) processing and payment calculation delays. Cash expenditure represents the amounts paid between April to March to contractors for drugs, medicines and appliances that have been prescribed by GPs and nurses and, therefore, due to the delays relate to February to January prescribing. Resource expenditure represents the actual cost of the prescriptions for drugs, medicines and appliances prescribed by a GP or nurse in the period April to March.

Branded Medicines

6.39 The 2005 Pharmaceutical Price Regulation Scheme (PPRS), a new voluntary five-year agreement, negotiated with the Association of the British Pharmaceutical Industry (ABPI), replaced the 1999 PPRS from 1 January 2005. It controls the prices of branded prescription medicines supplied to the NHS by regulating the profits that companies can make on these sales.

6.40 The new scheme includes a 7 per cent price reduction for branded prescription medicines, which will save the NHS more than £1.8 billion over the next five years. The 4.5 per cent price reduction achieved as part of the 1999 PPRS has produced estimated savings to the NHS of £1.3 billion to the year ended 31 December 2004.

6.41 During 2005, the Department carried out a consultation on proposals that 'standard' branded generics should be removed from the PPRS and transferred to the new arrangements for the reimbursement of generic medicines. It is analysing responses to a second consultation on detailed proposals to remove oral solid dose (OSD) 'standard' branded generic medicines from the PPRS.

6.42 In September 2005, the Office of Fair Trading (OFT) announced a market study of the PPRS to assess whether the scheme provides an effective way of meeting its stated aims. The study will last at least until spring 2006 and may continue to the end of the year.

Generic Medicines

6.43 In April 2005, the Department introduced new long-term arrangements for the reimbursement of generic medicines. The drug tariff introduced a new category 'M' of generic medicines under Part VIII. The basic prices of category 'M' medicines reflect the average manufacturers' market prices after discount and data to amend prices in line with market changes is provided by members of two new voluntary Schemes ('M' and 'W'), backed by section 33 of the *Health Act 1999*[6.1]. Scheme 'M' applies to manufacturers and scheme 'W' applies to wholesalers. Category 'M' will remove some £300 million from the distribution chain to be channelled back to pharmacy services as part of the new pharmacy contract arrangements. The new arrangements replace the Maximum Price Scheme, which had secured annual savings of some £330 million when compared with expenditure that would have been incurred if prices had remained at March 2000 levels. The actions taken by the Department in 2003 and 2004 to reduce the reimbursement prices of four new generic medicines to align them more closely with widely available market prices, continue to deliver annual savings of some £300 million.

CENTRAL HEALTH AND MISCELLANEOUS SERVICES (CHMS)

6.44 The CHMS revenue budget programme includes:

- the Welfare Food Scheme;
- EEA medical costs for treatment given to United Kingdom nationals by other member states;
- funding for medical, scientific and technical services, including the National Biological Standards Board, the National Radiological Protection Board and the Health Protection Agency; and,
- grants to voluntary organisations, mainly at a national level, across the spectrum of health and social services activity.

6.45 **Figure 6.16** provides details of the CHMS programme for 2005-06. The figures take into account all changes made to the programmes since the original announcement in 2003.

Figure 6.16: Central Health and Miscellaneous Services CHMS

Budgets	£000s 2005-06
Improving Services and Outcome in:	
Cancer	5,087
Children	11,322
Reducing Health Inequalities	15,453
Contribution to a reduction in Drug Misuse	2,236
Other CHMS budgets:	
Central Payments made on behalf of DH (e.g. EEA Medical Costs)	601,974
Public Health (e.g. Welfare Foods)	117,164
Statutory Bodies (e.g. Health Protection Agency)	289,680
R&D	31,844
Residual CHMS budgets (e.g. Communications, grants to voluntary organisations)	93,565
TOTAL	**1,168,325**

PERSONAL SOCIAL SERVICES

Personal Social Services Revenue Provision

6.46 As part of the Local Government Finance Settlement 2005, announced in Parliament on 5 December 2005, the Department has allocated the following resources to local authorities:

- for 2006-07, £1,590 million for adults' social services and the child and adolescent mental health services element of children's services; and,
- for 2007-08, £1,608 million for adults' social services and the child and adolescent mental health services element of children's services.

6.47 This move to a multi-year settlement is intended to encourage both certainty of funding and opportunities for improved budget planning within councils with social care responsibilities. From 2008-09, full three-year settlements will be allocated in line with each spending review cycle, aligning social care allocations with the pattern of funding already in place for the NHS.

6.48 **Figure 6.17** sets out revenue and capital resources to be made available for adults' social services in 2006-07 and 2007-08, with funding levels for 2005-06 included for comparative purposes. Adults' PSS specific grant funding has decreased by just over £300 million between 2005-06 and 2006-07. There are two principal reasons for this:

- unlike in 2005-06, an additional £100 million transfer will not be made from the NHS to the 'Access and Systems Capacity' grant (in either of the next two years); and,
- the 'Residential Allowance' grant funding has been completely rolled into formula spending share (FSS) (now the relative needs formula control total).

Figure 6.17: Personal Social Services Provision for Adults, 2005-06 to 2007-08

	£ million 2005-06	2006-07	2007-08
Specific Revenue Grants:			
Preserved Rights	348.2	297.6	275.2
Residential Allowance	214.5		
Access and Systems Capacity[1]	642.0	546.0	546.0
Delayed Discharges	100.0	100.0	100.0
Carers	185.0	185.0	185.0
Mental Health	133.0	132.9	132.9
AIDS Support	16.5	16.5	16.5
National Training Strategy	94.9	107.9	107.9
Human Resources Development Strategy	62.8	49.8	49.8
Child and Adolescent Mental Health Services	90.5	90.5	90.5
CSCI Reimbursement[2]	0.8	0.8	0.8
Individual Budget Pilots		6.0	6.0
Partnerships for older people projects (POPP)		20.0	40.0
Preventative Technology		30.0	50.0
DH funded. Allocated by other Government Depts.[3]	*8.5*	*7.5*	*7.5*
Total Revenue Grants	**1,896.5**	**1,590.4**	**1,608.0**
Capital Resources			
Single Capital Pot SCE(R)	27.7	27.7	27.7
Ringfenced SCE(R) for mental health	22.6	22.6	22.6
Ringfenced SCE(R) for AIDS/HIV	3.1	3.1	3.1
Improving Information Management Grant	25.0	25.0	25.0
Extra Care Housing Grant		20.0	40.0
Total Capital Resources	**78.4**	**98.4**	**118.4**
Total PSS Provision[4]	**1,975.0**	**1,688.8**	**1,726.5**

Footnotes:
(1) The 2005-06 Access & Systems Capacity funding included an additional £100 million agreed by the Government. This non-recurrent addition was not made in 2006-07 or 2007-08.
(2) This is the reimbursement of the top-slice agreed to fund the CSCI review panel stage. It will be issued as one specific grant in 2006-07 and 2007-08, whereas it was issued as two separate grants in 2005-06
(3) Funding allocated by other Government departments includes:
– CAMHS £3 million transfer to DfES for each of the years 2005-06, 2006-07 and 2007-08.
– Young People's Substance Misuse £4.5 million transfer to Home Office recurring in 2005-06, 2006-07 and 2007-08.
(4) FSS has now been removed from PSS allocations (see 6.50). For comparative purposes the 2005-06 FSS has been removed from the table.

6.49 Adult social services are funded by the general 'Formula' grant, distributed by the Office of the Deputy Prime Minister (ODPM), by each council's ability to raise revenue through council tax and by specific grant allocation from central Government departments. From 2006-07, a new method of allocating 'Formula' grant will be used. This new allocation model, developed by ODPM, contains four funding blocks:

- the central allocation;
- relative needs amounts;
- relative resource element; and,
- floor damping blocks.

6.50 To avoid any potentially misleading inference that formula spending share (FSS) could approximate to required expenditure at local authority level, FSS has been replaced by relative needs formulae (RNF) for each service block (e.g. older people, younger adults, children). Each local authority now receives a proportionate share of the overall control total for a service block, where that share is expressed as a proportion and not in monetary terms.

6.51 The new needs-based RNF allocation formulae for adults' social care incorporate the latest available 2001 census data, and have been developed following a rigorous process of academic research. These formulae will better reflect actual need for services, and therefore allocate resources, more accurately and equitably. DH also recognised that the new model has produced significant step-changes in allocations for some councils, and have therefore applied appropriate floor damping mechanisms to help local authorities manage any redistributive effect.

Personal Social Services Capital Resources

6.52 In each of 2006-07 and 2007-08, the Department will make available a total of £27.727 million for the Adults' PSS single capital pot element of supported capital expenditure (Revenue). SCE(R) is a defined limit for the period, which supports the cost of a certain level of capital borrowing. These borrowing costs comprise interest on outstanding debt and repayment of debt. Total capital distribution in this category is allocated using the Department's own distribution formula.

6.53 In addition, a total of £25.7 million will be available to local authorities in both financial years in the form of two ring fenced capital programmes, these being for mental health (£22.6 million) and AIDS/HIV services (£3.1 million).

6.54 A further £25 million will be issued as a specific capital grant as part of the Improving Information Management Programme in 2006-07 and 2007-08. £60 million will be distributed to councils over the two-year period in the form of the new 'Extra Care Housing' capital grant. This will be split in the proportion of £20 million in 2006-07 and £40 million in 2007-08.

6.55 Local authorities can continue to use revenue and receipts from the sale of capital assets to fund their capital programmes, including personal social services.

How the Resources are Used

6.56 The Department's social care allocations support services for three main client groups:

- children and adolescents, insofar as they are supported by the 'Child and Adolescent Mental Health Services' grant and elements of the 'Carers' grant, 'National Training Strategy' grant, 'Human Resources Development Strategy' grant and the 'Improving Information Management' grant;
- younger adults aged 18-64, requiring services ranging from specialist services for those with physical and learning difficulties, mental health problems, and issues relating to drugs or HIV/AIDS; and,
- older people aged 65 and above, requiring principally specialised residential and intensive home care services.

6.57 Funding provided by the Department for adult's social care has a direct impact upon PSA targets set for the SR 2004 period (as described in chapter 2 of this report). By offering improved care in community settings for people with long-term conditions, and providing improved services, quality of life and independence for vulnerable older people, individual PSS grant funding specifically supports PSA targets 4 and 8. Further PSS initiatives can be linked to PSA targets 3, 6 and 7.

6.58 The Department is responsible for establishing overall policy in respect of social care, leaving councils with a significant degree of flexibility in delivering their adult's social care commitments according to local priorities and the needs of the community they represent. The figures provided show the actual expenditure by local authorities on personal social services in 2004-05. **Figure 6.18** shows gross expenditure by client group in 2004-05. **Figure 6.19** displays the breakdown by type of provision.

6.59 In 2004-05, gross expenditure in England on personal social services was £18.2 billion. The largest items of expenditure were for residential care (43 per cent) and day and domiciliary care (41 per cent). Within spending on residential care, most was spent on residential and nursing home care provided by the independent sector.

Figure 6.18: Local Authority Personal Social Services Gross Expenditure by Client Group, 2004-05

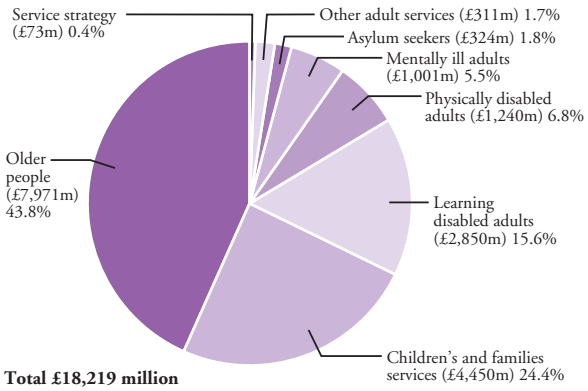
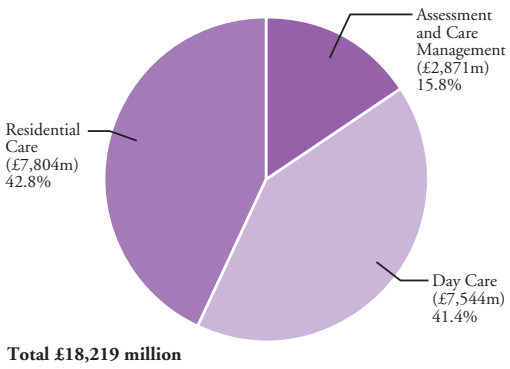


Figure 6.19: Local Authority Personal Social Services Gross Expenditure by Type of Service, 2004-05



7. Activity, Performance and Efficiency

Figure 7.1: Hospital Activity Trends, 1992-93 to 2004-05

	1992-93	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	2004-05	% change 2003-04 over 2002-03	% change 2004-05 over 2003-04
General and acute (thousands of episodes)											
Elective admissions[1]	4,031	4,412	4,827	4,891	5,001	5,036	5,262	5,445	5,554	3.5%	2.0%
Emergency and other admissions (non-elective admissions)[1]	3,526	3,729	3,849	3,887	3,943	3,961	4,007	4,274	4,497	6.7%	5.2%
Total admissions (first finished consultant episodes)[1]	7,557	8,141	8,676	8,778	8,944	8,997	9,269	9,719	10,050	4.8%	3.4%
Geriatrics (thousands of episodes)											
Total admissions (first finished consultant episodes)[2]	459	401	399	383	359	347	357	357	368	0.1%	3.1%
Maternity (thousands of episodes)											
Total admissions (first finished consultant episodes)[2]	905	827	880	884	896	877	924	970	1,000	7.1%	3.1%
New outpatients (first attendances) (thousands)											
General and acute[3]	8,488	10,643	10,919	11,294	11,637	11,838	12,080	12,650	12,617	4.7%	-0.3%
- of which, Geriatrics[3]	77	107	108	113	114	115	115	125	122	8.7%	-2.4%
Maternity[3]	612	590	565	554	537	504	522	505	482	-3.3%	-4.7%
Mental Illness[3]	238	290	287	282	285	263	271	267	264	-1.5%	-1.0%
Learning Disabilities[3]	4	6	6	7	7	8	7	8	8	14.3%	-1.8%
All Specialties[3]	9,342	11,529	11,778	12,136	12,466	12,613	12,879	13,431	13,371	4.3%	-0.4%
New A&E (first attenders) (thousands)[4]	10,993	12,794	12,811	13,167	12,953	12,901	13,253	15,313	16,712	15.5%	9.1%
Average length of spell (ordinary admissions) (days)											
General and acute[2]	7.9	7.0	6.8	6.7	6.9	7.1	7.0	6.8	6.3	-3.7%	-7.4%
- of which, Geriatrics[2]	26.9	22.7	22.2	21.8	23.3	23.4	23.1	21.7	20.1	-5.4%	-7.4%

Footnotes:

(1) Source SaFFR quarterly monitoring and current monthly monitoring. Figures are for admissions purchased by the NHS. Figures prior to 2004-05 have been re-based to allow direct comparison. General and acute specialties do not include mental health, learning disabilities or maternity. From 30 June 1998 activity is calculated on the basis of first finished consultant episodes. Elective activity includes waiting list, booked and planned admissions. A corresponding figure for 1992-93 is not available, so the figure in the table is estimated from the Hospital Episode Statistics for the number of admissions to NHS hospitals in England. For 1992-93, admissions where the method of admission is unknown are included in the emergency and other category. Note that some unknown cases may be elective cases. Figures prior to 2001-02 are from health authorities. With the abolition of health authorities, figures for 2001-02 are based on returns from NHS trusts. Data are presented for financial years and are not adjusted for the differing number of working days per year. There were three fewer working days (251) in 2004-05 compared with 2003-04 (254) as a consequence of two Easters in the same financial year.

(2) Source Hospital Episode Statistics. Figures are for admissions to NHS hospitals in England. Figures are grossed for coverage, except for 2002-03 and 2003-04 which are not yet adjusted for shortfalls.

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

(4) Source QMAE and KH09. From 2003-04, attendances at walk-in centres included. A large proportion of the 15.5% growth in A&E attendances seen between 2002-03 and 2003-04 is due to the inclusion of NHS Walk-in Centre activity for the first time in 2003-04 and generally improved reporting.

NHS HOSPITAL ACTIVITY TRENDS

7.1 **Figure 7.1** gives details of hospital activity levels for each of the main sectors. Key points are that:

- the percentage increase between 2003-04 and 2004-05 for first outpatient attendances was -0.3 per cent. These figures relate to hospital outpatient attendances. The expansion of services in primary care will see GPs referring increasing numbers of outpatients to a GP with a special interest, rather than to a consultant outpatient clinic in hospital; and,
- final figures for 2004-05 show that there was an increase of 2.0 per cent from 2003-04 for general and acute elective hospital admissions.

IN-PATIENT AND OUTPATIENT WAITING

7.2 In line with the *NHS Plan*[7.1], the the maximum waiting time for in-patient treatment fell to six months and the maximum waiting time for first outpatient fell to 13 weeks at the beginning of 2006.

7.3 As set out in the *NHS Improvement Plan*[7.2], by the end of 2008 no-one will wait more than 18 weeks from GP referral to the start of hospital treatment – and those with urgent conditions will be treated much faster. For the first time, there will be a single target that covers all the stages leading up to treatment, including diagnostic procedures and tests such as MRI scans.

7.4 Latest figures for December 2005 show that around seven out of 10 in-patients are admitted within three months of decision to refer. The average waiting time is now less than seven weeks.

7.5 Although there are a very small number of patients not being seen within these maximum waiting times, this should not detract from the real and significant achievement that the vast majority of trusts have virtually eliminated in-patient waiting times of over six months and outpatient waiting times of over 13 weeks. PCTs and trusts are now concentrating on delivering the 2008 18-week target from GP referral to start of treatment.

EMERGENCY CARE

7.6 Achieving high quality, timely access to emergency care services remains a key priority for the Department. The improvements in recent years to deliver a system of fast, responsive and effective emergency care services for the benefit of NHS patients and staff have been maintained effectively throughout this year.

7.7 The *NHS Plan* set a target of reducing the maximum amount of time spent in accident and emergency (A&E) departments, from arrival to admission, transfer or discharge, to four hours. This was subsequently translated into an operational standard that 98 per cent of patients should be admitted, transferred or discharged within four hours, to allow for a minority of clinical exceptions where patients need more than four hours in A&E. This became a live standard on 1 January 2005.

Accident and Emergency Services Truly Transformed

7.8 The past year has been the greatest test yet for delivery of the four-hour operational standard, in which 98 per cent of all patients should be seen and admitted, transferred or discharged within four hours, as the gains already made had to be sustained across the year. However, it is now possible to suggest that there has truly been a transformation in accident and emergency services as management information indicates the operational standard has been maintained for 2005-06 as a whole year.

7.9 This sustained high level of performance is an impressive achievement and one that has been made possible through the hard work and professionalism of people across the NHS and other organisations and it is heartening to see that this aspect of the *NHS Plan* is being fulfilled on a regular basis.

7.10 Quarterly statistics on A&E performance can be seen at: **www.performance.doh.gov.uk/hospitalactivity/data_requests/**.

A New Chapter for Ambulance Services

7.11 Since 1997, investment in ambulance trusts has increased by over 75 per cent. This has promoted improvement in performance with ambulance trusts now reaching more patients faster than ever before. In 2004-05, 76.2 per cent of patients with immediately life-threatening emergencies (category A) received a response within eight minutes. This is an improvement on 2003-04 (75.7 per cent) in spite of a six per cent increase in demand. In total, in 2004-05 over 2.4 million patients were reached within eight minutes.

7.12 A strategic review of ambulance services, led by Peter Bradley CBE (CEO of London Ambulance Service and National Ambulance Adviser) *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* [7.3] was published in June 2005. This review sets out how ambulance services can be transformed into a mobile health resource for the whole NHS – taking healthcare to the patient in the community. The recommendations were accepted by DH.

7.13 Benefits of the review include:

- patients receiving improved care, receiving the right response, first time, in time;
- more patients treated in the community, and potentially one million fewer unnecessary A&E attendances;
- greater job satisfaction for staff as they use additional knowledge and skills to care for patients;
- more effective and efficient use of NHS resources; and,
- improvements in self care and health promotion.

COMMUNITY NURSING, DENTAL AND CROSS SECTOR THERAPY SERVICES ACTIVITY

7.14 As part of the Department's initiative to reduce the burden of data collection on NHS front-line staff, the activity data returns on community nursing were discontinued from April 2004 and those on cross-sector therapy services from April 2005. Some limited information about these services continues to be collected for reference costing purposes, but this is on a different basis from the discontinued returns. The reference costs information can be accessed at: **http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSReferenceCosts/fs/en**

7.15 Information on community dental services was not collected in 2003-04 and results for 2004-05 are not yet available. It is intended to include these in the 2007 Departmental report.

ACCESS TO PRIMARY CARE

7.16 Primary care is the shop window of the NHS. There are more than 300 million consultations with general practice each year. Alongside consistently high levels of satisfaction with the services provided in primary care, patients have continued to express some dissatisfaction about access to those services.

7.17 The *NHS Plan* set a target of patients being able to see a primary care professional within 24 hours and a GP within 48 hours.

7.18 While this target has led to significant improvements in access to primary care and largely ended the problem of people waiting a week or more to see a GP, a growing number of practices stopped offering advance bookings, a particular problem for people who want to organise their time ahead or whose need is less urgent. The recent *Your Health, Your Care, Your Say* [7.4] consultation showed that the public expects both to be able to see a primary care practitioner quickly, and to have the opportunity the book an appointment in advance. In the 21st century these are reasonable expectations.

7.19 The White Paper *Our Health, Our Care, Our Say* [7.5] commits the Department and the NHS to address these expectations. Changes 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.

7.20 The delivery strategy for these extended aims has three main components.

Incentives

7.21 A new independent national patient experience survey will be introduced in 2006-07, which, over time, will help the Government to improve its understanding, from the patient's perspective, of how well national priorities are being implemented. Patients' responses to the survey will trigger practice awards on:

- the opportunity to consult a GP within 48 hours;
- the opportunity to make advance bookings;
- ease of telephone access to the surgery; and,
- the opportunity to be seen by the GP of preference.

Performance Management

7.22 A managed approach through PCTs which requires PCTs to ensure that the target is delivered and sustained across their area. PCTs have been asked to ensure that all patients cannot only have 24/48 hour access but can also book an appointment for a future date. In 2006-07, performance management arrangements will be improved by placing greater emphasis on what patients say and by improving the monthly survey of practices which provides regular monitoring data. Strengthened checks will include tighter monitoring by PCTs through varying the monthly survey dates and the introduction of the new national independent patient survey which will be conducted and provide information at practice level.

Support

7.23 Support is available to practices from the national primary care development team to develop patient sensitive appointment systems that allow for a balance of same/next day appointments and pre-bookable appointments that meet the needs of their patients.

Out of Hours

7.24 The recently published NAO report on the provision of out-of-hours care in England is a comprehensive review, which highlights some of the problems that surround out-of-hours services in England. The report states that the NHS is making progress towards providing high quality out-of-hours services, whilst highlighting significant scope to reduce the costs of providing out-of-hours services in future.

Urgent Care

7.25 Following the publication of *Our Health, Our Care, Our Say*, the Department is now developing an 'Urgent Care' strategy to focus on improving the patient experience and significantly reduce unnecessary admissions to hospital.

NHS Walk-in Centres

7.26 NHS Walk-in Centres are situated in convenient locations that allow quick and easy access to a range of NHS services including advice, information and treatment for a range of minor injuries and illnesses. Most centres are open from 7am until 10pm Monday to Friday, 9am to 10pm Saturday and Sunday and no appointment is needed.

7.27 Alongside the established NHS Walk-in Centre model a further seven centres are being procured from the independent sector specifically to meet the needs of commuters. These have different and shorter opening hours (0700-1900hrs Monday to Friday only) to reflect their prime users (though the local host PCT may commission longer hours or additional services to meet the needs of local residents). Two of these have already opened near Manchester Piccadilly Station and Liverpool Street Station in London. Further Commuter Walk-in Centres will open this year at London Canary Wharf, London Kings Cross, London Victoria, Leeds (New Station Street) and Newcastle (Central Station).

7.28 There are now 73 NHS Walk-in Centres open. A further 16 sites are under development to bring the total to 89, including the seven centres focused on commuters.

7.29 On average, the centres see around 114 patients a day, i.e. 42,000 patients a year – though this figure varies significantly, depending on their location, with some sites seeing as many as 200 patients a day. This means that NHS Walk-in Centres will see about three million patients this year.

FAMILY HEALTH SERVICES (PRIMARY CARE)

General and Personal Medical Services (GMS and PMS)

7.30 Due to the introduction of the new GMS contract, data associated with key statistics on general and personal medical services (GPMS) is no longer collected. The new GMS data can now be found in chapter 6.

Pharmaceutical Services (PHS)

7.31 **Figure 7.2** provides key information on pharmaceutical services in England.

7.32 Key Points:

- the volume of prescriptions and the average number of prescriptions dispensed by pharmacy and appliance contractors continue to increase. The year-on-year growth in the number of prescriptions in 2004-05 was 5.7 per cent; in comparison a growth of 5.1 per cent was observed in 2003-04;
- the gross cost per prescription decreased by 0.4 per cent in 2004-05;
- the drugs bill continues to rise – see chapter 6 for more information; and,
- the percentage of prescriptions that attract a charge has shown a steady downwards trend over recent years, from 14.9 per cent in 2000-01 to 13.1 per cent in 2004-05.

Figure 7.2: Family Health Services – Key Statistics on Pharmaceutical Services, England

		1993-94	2000-01	2000-01	2001-02	2002-03	2003-04	2004-05	% change 1993-94 to 2004-05	% change 2003-04 to 2004-05
		Cash		Resource						
Pharmaceutical Services [1]										
Prescriptions (millions) [2]		455.3	570.2		603.5	633.4	666.0	703.7	54.6%	5.7%
Number of contracting pharmacies [3] [4]		9,766	9,765		9,756	9,748	9,759	9,742	-0.2%	-0.2%
Average number of prescriptions dispensed by pharmacy and appliance contractors		41,290	52,066		55,238	58,047	60,998	64,539	56.3%	5.8%
Cost of pharmaceutical services per prescription in real terms (2002-03 prices) (£m) [2] [5]	*Gross*	10.49	11.71	11.70	11.82	12.07	12.15	11.85	13.0%	-2.5%
	Drug	8.55	10.05	10.03	10.24	10.55	10.68	10.49	22.7%	-1.8%
	Remuneration	1.94	1.66	1.67	1.58	1.52	1.47	1.36	-29.9%	-7.5%
Net cost of drugs and appliances in real terms (2002-03 prices) (£m) [2] [6] [8]		3,909	5,754	5,750	6,202	6,690	7,109	7,373	88.6%	3.7%
Percentage of all prescription items which attracted a charge [7]		17.9	14.9		14.6	14.3	13.8	13.1		

Footnotes:
(1) Pharmaceutical services are mainly the supply of drugs, medicines and appliances prescribed by NHS practitioners.
(2) Numbers relate to prescription fees; figures relate to the annual period February to January (e.g. relates to the period Feb 2004 to Jan 2005) and include prescriptions dispensed by community pharmacists and appliance contractors, and dispensed or personally administered by GPs.
(3) Excludes appliance contractors and dispensing doctors.
(4) Figures refer to 31 March (e.g. 2004-05 is number as at 31 March 2005).
(5) Gross pharmaceutical expenditure is total payments (drug costs and dispensing fees) to contractors less recoveries from HAs and the Ministry of Defence (in respect of hospital and armed forces prescriptions dispensed in the community) and excluding refunds of prescription charges.
(6) Includes receipts under the Pharmaceutical Price Regulation Scheme.
(7) Prescriptions dispensed to patients who pay prescription charges or hold prescription pre-payment certificates. The analysis is based on a one in 20 sample of all prescriptions submitted to the PPA in the calendar year. Prior to 2001, the analysis is based on prescriptions submitted by community pharmacists and appliance contractors only.
(8) Cost figures have been converted into real terms using the 23 December 2005 GDP deflator.
(9) Costs are shown in cash for 1993-94 and 2000-01 and in resource from 2000-01 onwards. This is to reflect the move to resource accounting in Department of Health accounts from 2000-01.

General and Personal Dental Services (GDS and PDS)

7.33 **Figure 7.3** provides key information on general and personal dental services in England. The most significant feature in 2004-05 was the significant acceleration in the move of dental practices, and the associated dental activity, from the general dental service to the personal dental service. This was consistent with the Department's aim that 25 per cent of dental practices should be operating within the PDS by April 2005, where they could enjoy the benefits of new ways of working under new contracts commissioned by PCTs. Reductions in the numbers of dentists and activity in the GDS in 2004-05 is counter-balanced by significant growth in the scale of PDS activity.

7.34 Key Points:

- the overall volume of activity was broadly stable in 2004-05, taking into account that new ways of working generally result in more preventative care and less intensive throughput of patients;
- the number of general and personal dental practitioners continues to increase, by two per cent in the year to September 2004 and by 24 per cent in the last 10 years but dentists, on average, are doing less GDS work;
- patient registrations in the GDS have decreased with the move of practices to the PDS, where there is no equivalent registration system directly linked to dentists' remuneration;
- there were over 26.5 million courses of treatment for adults during 2004-05 across both the GDS and PDS, a small reduction compared to the number in 2003-04 reflecting the new ways of working in the PDS, but six per cent higher than in 1994-95;
- the average cost of an adult course of treatment within the GDS was £44 in 2004-05, similar in real terms to the level in the previous year. The average cost has reduced in real terms over the last decade by 10 per cent, reflecting a reduction in the amount of complex or advanced treatments. No equivalent figure can be calculated for the PDS as remuneration cannot be similarly itemised and attributed to specific categories of patients; and,
- at 30 September 2004, 2,699 dentists were working in the PDS, 1,857 of whom were not also working in the general dental service. PDS dentists include both salaried dentists working mainly in dental access centres and also contractor-led services from GDS type dental surgeries.

Figure 7.3: Family Health Services – Key Statistics on General and Personal Dental Services, England

	1994-95	2000-01	2001-02	2002-03	2003-04	2004-05	% Change 1994-95 to 2004-05	% Change 2003-04 to 2004-05
General Dental Services[1][2]								
Number of general dental practitioners[3]	15,885	18,049	18,354	18,400	18,537	17,865	12%	-4%
Adult courses of treatment (thousands)	24,913	26,353	26,318	26,284	26,507	23,826	-4%	-10%
Adults registered into continuing care (thousands)[4,5]	21,050	16,813	16,793	16,739	16,650	14,852	-29%	-11%
Children registered into capitation (thousands)[4,5]	7,367	6,845	6,784	6,733	6,671	6,053	-18%	-9%
Average gross cost of an adult course of treatment (2004-05 prices) (£)[6][7]	48	44	44	45	43	44	-10%	0
Personal Dental Services[2]								
Number of personal dental practitioners[8]	n/a	326	707	997	1,190	2,699	n/a	127%
Number of personal dental practitioners not working in the general dental service[8]	n/a	192	467	656	802	1,857	n/a	132%
Adult courses of treatment (thousands)	n/a	218	319	442	542	2,662	n/a	391%
Child courses of treatment (thousands)	n/a	94	161	217	257	945	n/a	268%
Total Dental Services								
Number of general and personal dental practitioners	15,885	18,241	18,821	19,056	19,339	19,722	24%	2%

Footnotes:
(1) General dental services are the care and treatment provided by independent high street dentists who provide services under arrangements made with primary care trusts.
(2) The introduction of the personal dental service in October 1998 and its subsequent growth has progressively affected general dental service activity.
(3) Principals, assistants and vocational trainees at 30 September.
(4) Number of patients registered as at 30 September. Registrations began with the introduction of the new dental contract from 1 October 1990 with a 24 month registration period for adults whilst children's registrations lasted until the end of the following calendar year unless renewed. From September 1996, new registrations were reduced to a 15 month period unless renewed, affecting registration numbers from December 1997.
(5) Since May 1994 the Dental Practice Board has improved procedures for eliminating duplicate registrations. This reduced registration numbers after this period.
(6) Based on item of service fees and adult continuing care payments. Average gross costs are converted to 2004-05 prices using the GDP deflator. Changes in the average cost are affected by changes in the dental work carried out in a course of treatment.
(7) Data on courses of treatment represents completed treatment claims processed by the Dental Practice Board within the relevant year, rather than only courses of treatment conducted within the year.
(8) Number of personal dental service practitioners at 30 September.

General Ophthalmic Services (GOS)

7.35 **Figure 7.4** provides key information on general ophthalmic services in England.

7.36 Key Points:

- the number of NHS sight tests has risen substantially by some 59 per cent over the ten years from 1994-95 to 2004-05, driven mainly by the Government's decision to extend eligibility for free NHS sight tests to everyone aged 60 and over from 1 April 1999. Since April 1999, the underlying trend has been for an average annual increase of about 1.6 per cent in the volume of tests;
- the volume of NHS optical vouchers has shown a slight decrease over the past 10 years, averaging out as a fall of 0.3 per cent per year. However, there have also been some moderate fluctuations year-on-year, reflecting changes in factors such as the number of adults claiming income support and job seeker's allowance (the main category of people who qualify for vouchers). The fact that the volume of vouchers in 2004-05 was three per cent higher than the previous year, and yet was three per cent lower than 10 years ago, reflects these fluctuations;
- activity is affected by variations in the size of the population groups eligible for NHS primary care optical services, as well as variations in the take up rates for services; and,
- the number of opticians has grown significantly. The 2004-05 total of 8,472 represented an increase of two per cent over the previous year's figure, and an increase of 28 per cent over the numbers in 1994-95.

Figure 7.4: Family Health Services – Key Statistics on General Ophthalmic Services, England

General Ophthalmic Services	1994-95	2000-01	2001-02	2002-03	2003-04	2004-05	% Change 1994-95 to 2004-05	% Change 2003-04 to 2004-05
NHS sight tests (thousands)[1]	6,383	9,567	9,807	9,662	9,845	10,149	59%	3%
Optical vouchers (thousands)[2]	3,741	3,575	3,607	3,472	3,520	3,624	-3%	3%
Number of opticians[3]	6,622	7,824	8,103	8,096	8,331	8,472	28%	2%

Footnotes:
(1) From 1 April 1999, the eligibilty criteria for NHS sight tests was extended to include all patients aged 60 and over. Figures are based on the number of sight test claims where the date of payment fell within the financial year, rather than the date the sight test was conducted.
(2) The voucher scheme was introduced on 1 July 1986 to help certain priority groups with the provision of spectacles. Figures are based on the number of vouchers reimbursed to practitioners in the year, including payments for complex appliances, rather than the date when the vouchers were exchanged by patients for glasses.
(3) Optometrists and Ophthalmic Medical Practitioners at 31 December.

PERFORMANCE

Management Costs

7.37 The cost of managers in the NHS, as a percentage of overall spend, continues to fall. In 2004-05, NHS management costs stood at 3.7 per cent of the total NHS budget compared with 3.8 per cent in 2003-04 and 4.7 per cent in 1998-99. In addition, NHS organisations are currently working towards producing a recurrent saving of £250 million in the costs of administration and management across the NHS, to be reinvested in services in 2008-09.

Reducing Bureaucracy

7.38 Further to the Departmental change programme and a 38 per cent reduction in staffing, the Department is now leading a number of changes in the NHS through *Commissioning a Patient-led NHS* [7.6], whereby the streamlining of NHS organisations will result in a more efficient and joined up service for patients and improve access to healthcare outside hospitals.

7.39 We continue to make significant progress in delivering the Prime Minister's 'Six Point' strategy to reduce bureaucracy in public services, for example:

- NHS organisations are currently working towards producing a recurrent saving of £250 million in the costs of administration and management across the NHS, to be reinvested in services in 2008-09;
- delivering over 95 per cent of the outcomes in the joint Cabinet Office/Department of Health *Making a Difference* [7.7] reports, which take action to remove specific NHS burdens;
- maintaining the 2004 target of a 50 per cent reduction in the volume of communications to NHS and social care;
- a data streamlining exercise resulting in the reduction or removal of 61 central data returns;
- there are now 32 NHS foundation trusts in operation and further waves will follow;
- engagement in a programme of Cabinet Office led work to measure and cost the administrative burden of compliance with regulation on both the public and private sector; and,
- responding to the Better Regulation Task Force report *Less is More* [7.8] by developing an overarching simplification plan setting out a range of deregulation, consolidation, rationalisation and administrative burden reduction measures covering both public and private sector.

FINANCIAL PERFORMANCE

Overall NHS Performance

7.40 In 2004-05, primary care trusts, NHS trusts and strategic health authorities reported an overall revenue resource overspend of £221 million and a capital resource underspend of £172 million. This reported position does not include 25 NHS foundation trusts that were established in 2004-05.

7.41 Ten NHS foundations trusts were established on 1 April 2004, while 15 NHS trusts achieved NHS foundation trust status during the year. The performance of the fifteen NHS trusts for the part of the year prior to their move to NHS foundation trust status is included in this report. NHS foundation trusts are not subject to direction by the Secretary of State for Health but they are subject to directions from the NHS foundation trust regulator with the approval of Treasury and are accountable to their local community.

Strategic Health Authorities

7.42 SHAs were established in 2002-03 to become the local headquarters of the NHS. There are 28 SHAs. They have responsibility for performance managing the NHS locally on behalf of the Department. This includes the performance management of NHS trusts and primary care trusts.

7.43 SHAs are subject to financial controls over both cash spending and revenue and capital resource consumption. They have a statutory duty to contain revenue and capital resource expenditure, measured on an accruals basis, within approved revenue and capital resource limits. They also have a statutory duty to contain cash spending within an approved cash limit. SHAs are also required to achieve financial balance across their economy and to manage the provision of planned support.

7.44 In 2004-05, 27 SHAs achieved their statutory financial duty to remain within approved revenue resource, capital resource and cash limits. One SHA reported an overspend against the revenue resource limit.

Primary Care Trusts

7.45 PCTs are responsible for the commissioning of health care on behalf of their resident population and some PCTs are also responsible for providing community services to their population. PCTs are accountable to strategic health authorities who are responsible for their performance management. There were 303 PCTs in 2004-05.

7.46 In the same way as strategic health authorities, PCTs are subject to revenue and capital resource limit and cash limit control.

7.47 In 2004-05, there were 213 PCTs that achieved their statutory financial duty to remain within their revenue resource limit, and 90 which reported an overspend. On capital, 300 PCTs contained spending within their capital resource limit, and three breached the limit, one by more than the de minimus limit of £50,000. No PCTs breached their cash limit in 2004-05.

NHS Trusts

7.48 NHS trusts are responsible for the provision of health care. They receive most of their income from commissioners of health care, mainly primary care trusts. NHS trusts aim to deliver improved healthcare outcomes with increasing efficiency and effectiveness within the resources available to the health service.

7.49 There were 259 operational NHS trusts in 2004-05. Fifteen of these achieved NHS foundation trust status during the year. Their performance for the part of the year prior to their move to NHS foundation trusts status is included in the report.

7.50 NHS trusts have five main financial duties, which are:

- to break-even on an income and expenditure basis. NHS trusts have a statutory duty to break-even taking one financial year with another – NHS trusts normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. A run of three years is normally used to test the break-even duty, but in exceptional cases the recovery period can be extended to five years if agreement has been reached with the relevant SHA;
- to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets;
- a duty under resource accounting and budgeting to break-even each and every year;
- to remain within the capital resource limit (CRL) set for each NHS trust by the Department of Health; and,
- to remain within the external financing limit (EFL) set for each NHS trust by the Department of Health.

7.51 In aggregate, NHS trusts reported an income and expenditure deficit, on an accruals basis, of £322 million in 2004-05, compared to a £138 million deficit in 2003-04. There were 191 NHS trusts that achieved financial balance or better and 68 that made a deficit. One NHS trust breached its statutory financial duty to break-even, 'taking one financial year with another'.

7.52 In 2004-05, after adjustment for immaterial results, 219 NHS trusts achieved their financial duty to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets and 40 absorbed less than the required return.

7.53 There were 247 NHS trusts that contained capital expenditure within the capital resource limit after taking account of de minimus overshoots.

7.54 Also, 247 NHS trusts remained within their external financing limit, after taking account of de minimus overshoots.

Payment of Bills by NHS

7.55 All health bodies are expected to conform to Government Accounting Regulations and the *Better Payment Practice Code* [7.9]. They should, unless covered by other agreed payment terms, pay external suppliers within 30 days of the receipt of goods, or a valid invoice, whichever is the later.

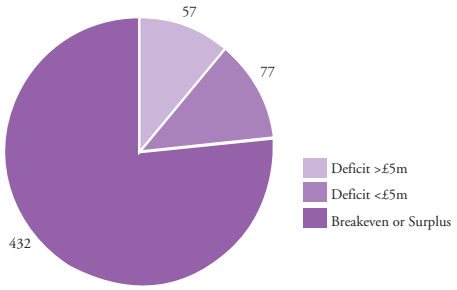
7.56 In 2004-05, NHS trusts, PCTs and SHAs processed and paid nearly 14.8 million invoices. The national average for 2004-05 is around 83 per cent of bills paid on time.

Forecast Financial Position – 2005-06

7.57 The unaudited forecast mid-year figures for 2005-06 collected from NHS trusts and PCTs forecast net overspending of around £620 million, and a gross deficit of £948 million.

7.58 This net deficit represents less than 1 per cent of turnover for the NHS. **Figure 7.5** shows that at mid-year around a quarter of organisations are forecasting a deficit in 2005-06, and around 10 per cent are forecasting a deficit of £5 million or more. Well over half of the gross deficit is accounted for by around 7 per cent of organisations (41 organisations).

Figure 7.5: Analysis of 2005-06 Month 6 Forecast Outturn by Size of Deficit



Note: Data excludes Foundation Trusts

Organisational support

7.59 NHS organisations have faced substantial new cost pressures over the last two years, including areas such as pay reform where the increased expenditure has been higher than original estimates. However, this to a certain extent has been offset by lower than expected costs elsewhere – such as expenditure on primary care drugs – and the record levels of additional funding should be sufficient to deliver the Government's service improvement programme for the NHS.

7.60 To improve the level of understanding of the deficits, the Department commissioned a major exercise by KPMG to conduct an assessment of the most challenged organisations. An assessment was made of 98 organisations, including PCTs and NHS trusts, during December 2005 and January 2006. This was not an audit of the organisations and should not be interpreted as such.

7.61 Across the organisations reviewed, KPMG observed slippage in the cost improvement programmes that had been introduced to help control expenditure, in particular they noted:

- a failure to implement cost improvement programmes early enough with a lack of consideration for lead times;
- a lack of detailed implementation plans and unrealistic plans;
- a lack of ownership of plans within the organisation; and,
- a simple assumption that savings would be delivered evenly, month by month across the year.

7.62 Based on their experience of commercial organisations of a similar size and in similar circumstances, for a number of organisations they concluded:

- the capacity of the management was inadequate to deal with the challenges of their current financial position. Although they could manage the organisation effectively in a steady state they would need support to deliver turnaround;
- the quality of information would impede the turnaround process; and,
- in some cases SHAs were allowing unproductive behaviour between trusts and PCTs.

7.63 Following the assessment by KPMG, each of the Transition SHAs have been assigned a Turnaround Director to support the SHA and oversee turnaround activity of PCTs and trusts within the SHA. In addition, the most challenged organisations, as assessed by KPMG, have appointed turnaround teams to support the organisation's management team. The overall turnaround activity is being overseen by a turnaround programme office in the Department.

Financial System Changes

7.64 In addition to the turnaround support for individual organisations, the Department has also introduced a number of changes to the financial system in 2006-07 to support the return of the NHS to financial stability:

- increased detail and transparency of reporting so that the problems are identified and tackled promptly;
- establishing the right culture for financial correction:
    - changing the incentives e.g. increasing emphasis in the ratings system on financial management; moving forward with the reform programme of payment by results, practice based commissioning and foundation trusts;
    - emphasising the accountability of Boards (executives and non-executives) for financial as well as service performance; and,
    - strengthening the financial challenge function in the Department to ensure that we do not add to the cost burdens.
- The new strategic health authorities will take the lead locally in developing and implementing a service and financial strategy for 2006-07 to manage the financial position within their locality. This will include creating local reserves to deal with local problems. The size of the reserves and the contribution from each PCT will vary according to local circumstances. But the underlying principle will be fairness:
    - we expect SHAs to maintain the integrity of the allocations system with PCTs entitled to repayment of any contributions over a reasonable period not usually exceeding the three year allocation cycle;
    - we expect SHAs to have full regard to the financial and service position of each organisation in determining how reserves are generated and applied; and,
    - we expect transparency both in the creation and use of reserves.

7.65 All organisations that are overspending will be expected to show improvement during 2006-07 and by the end of the year everyone should have monthly income covering monthly expenditure.

7.66 Some SHAs may not be able to deliver a financially balanced position in 2006-07 without unacceptable service consequences. Where this is the case we will incentivise others to deliver a surplus to cover this. The money will not be moved and the underspending SHAs will retain the resources for spend in future years. But the system as a whole will balance.

EFFICIENCY

Gershon Efficiency Targets

Efficiency Programme

7.67 The Gershon report *Releasing Resources to the Front Line* [7.10], published in March 2004, committed the Department to achieving the following targets as part of the 2004 spending review:

- annual efficiency gains of £6.5 billion by March 2008, at least half of which should be cashable;
- a reduction in whole time equivalent civil servants of 720 by March 2008; and,
- the relocation of 1,110 whole time equivalent posts out of London and the South East by March 2010.

Efficiency Gains

Programme Structure

7.68 The programme comprises 6 main work streams on which progress is reported:

- Productive Time: Modernising the provision of front-line services to be more efficient and also improving the quality of patient treatment and service, by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce;
- Procurement: Making better use of NHS buying power at a national level to get better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies and other consumables and pharmaceuticals;
- Corporate Services: Ensuring NHS organisations can share and rationalise back office services, such as finance, ICT and human resources;
- Social Care: Improving commissioning of social care and other cash releasing and non cash releasing gains from the design of social care processes by local authorities;
- Policy Funding and Regulation: Reducing operating costs of the Department, arm's length bodies, strategic health authorities and primary care trusts through reducing processes and functions and restructuring, merging or abolishing existing organisations; and,
- Central Budgets: Reducing or eliminating centrally managed budgets where they do not provide value for money, and releasing to front-line NHS organisations.

Measurement Processes

7.69 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 the Office of Government Commerce.

7.70 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 work-streams and projects. These include patient readmissions (for front-line service changes) and product specifications (for procurement).

7.71 Details of agreed measurement processes and quality assurance are provided in an efficiency technical note (ETN) available on the Department's web site **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.

7.72 Reported benefits have been calculated in accordance with processes set out in the ETN. Some benefits, particularly mid-year calculations, may be subject to final verification. A formal process of sign off for both benefits and service quality for efficiency programmes is being agreed with the Office of Government Commerce and will be used to confirm 2004-05 and 2005-06 returns following the year-end.

Reported Gains to Date

7.73 **Figure 7.6** shows the gains that have been recorded for 2004-05 and up to quarter 3, 2005-06.

Figure 7.6: Reported Gains to Date

		£ million
Workstream	**2004-05**	**2005-06 Quarter 3**
Productive time	671	879
Procurement	333	1,048
Corporate services	14	36
Social care	0	179
Policy funding and regulation	13	63
Central budgets	0	0
Total	**1,031**	**2,205**

Footnotes:
(1) Calculation of mid-year (Q3) gains excludes some benefits where performance data is only available on an annual basis or where there are significant unavoidable time lags. 2004-05 gains were calculated after the year-end and include the impact of data time lags.
(2) Of the total reported gains, £2,072 million are cashable, resulting in either additional cash within the total DH budget being released from non front-line to front-line services, or cash freed within existing front-line services that can be reallocated for additional patient treatments or extension of services.
(3) Benefits have been calculated using methodologies as set out in the Efficiency Technical Note (ETN). 2005-06 savings are subject to final adjustment and confirmation that will take into account: (a) final audited year-end performance data where in-year estimates or proxies have been used; (b) impact of measurement processes still under development (as noted in the ETN), including possible offsetting costs of acute sector savings; and (c) year-end review of service quality assurance measures and processes.

Progress Highlights

Productive Time

- better management of patient admissions has reduced the average hospital length of stay cutting treatment costs by over £300 million and freeing up more than one 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 per cent of all planned procedures are now done this way, reducing treatment costs in the last year by £20 million and enabling more patients to go home earlier;
- improved proactive care of patients, particularly those with chronic conditions resulted in almost four per cent fewer emergency bed days since March 2004, releasing over £300 million for additional patient treatments;
- reduced levels of staff sickness and reduced use of agency staff in 2004-05 has meant that about £65 million 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 front line efficiency gains; and,
- significant opportunities to minimise variances in care and encourage a shift towards best practice has been launched covering five 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.

Procurement

- price reductions for branded (PPRS) and generic drugs effective in 2004 and early 2005 have realised £833 million, rising to an annual £975 million by March 2006;
- recently renegotiated national procurement contracts for NHS supplies and services are already providing annualised savings of £140 million; and,
- the first three regional procurement hubs have been established successfully and cover over 15 per cent of NHS organisations.

Shared Services

- A Shared Services Joint Venture Company was established in April 2005 between the Department and Xansa. It will have over 100 NHS organisations contracted for finance and accounting services from April 2006. Payroll and e-procurement services are also now operational.

Policy Funding & Regulation (PFR)

- the consultation process on proposals for restructuring and reducing the number of SHAs and PCTs will complete in March 2006. The programme is on track for completion by March 2007 realising operating cost reductions of at least £250 million per year; and,

- the first phase of DH arm's length bodies reduction and restructuring has reduced the number of bodies from 38 to 32. Overall ALB operating costs have reduced by a predicted £56 million for the current year. The programme remains on track to deliver annual savings of £250 million from March 2008.

Social Care

- a nationally coordinated, but locally led, programme of major business improvement opportunities is being launched to support continued efficiency gains through to 2008. The first product ('Homecare Monitoring') was launched in November 2005. 'Contact Centres' and 'Direct Payments' will be launched by March 2006. These opportunities are aimed at improving patient service as well as delivering cost efficiencies.

Expected Progress in the Next Year

7.74 The Department expects to achieve a further £2 billion of annual efficiency gains towards our 2008 target. Achievement will be under-pinned by key deliverables in each work-stream:

Productive Time

- continued process improvement by local organisations under-pinned by the ISIP framework and resulting in particular in further reductions in length of stay and emergency bed days;
- inclusion of financial gains accruing from improvements in workforce skill mix and in service quality and patient outcomes;
- development and launch of comprehensive performance benchmarking providing organisations with information to identify scope for service improvement and efficiencies; and,
- development and launch of *Productivity Top Tips* and a further set of improvement guides for key health resource groups.

Procurement

- completion of second wave of national contracts procurement and increased local uptake of existing contracts supported by benchmarking information; and,
- establishment of second wave of regional procurement hubs.

Corporate Services

- continued sign up of NHS organisations to the Shared Services Joint Venture, expansion of payroll services and testing of HR services.

Social Care

- launch of further business improvement opportunities enabling local authorities to build on gains achieved to date.

Policy Funding and Regulation

- further reduction in ALBs from 32 to 26 in March 2006 and the establishment of new operating budgets reflecting efficiency gains realised by remaining ALBs; and,
- implementation plans to align SHAs and PCTs to agreed new alignment structure and operating budgets from 2007.

Central Budgets

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

Reduced Civil Service Headcount

7.75 The Department committed to a gross reduction of 1,400 full time equivalent civil servant posts in the core departments through its change programme launched in early 2003. Of these approximately half (680) were expected to be transfers to other NHS bodies and the remainder (720) were net reductions as defined in the Gershon target.

7.76 The original change programme is now complete except for a small number of outstanding transfers. There is an ongoing process of review to ensure that skills and resources align to latest operational needs. At December 2005, the net reduction in full time equivalent headcount is 633. This is subject to formal verification with HM Treasury and OGC.

Lyons Relocations

7.77 The Department is committed to the relocation of 1,110 posts out of London and the South East by March 2010.

7.78 By December 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).

7.79 Relocation processes are underway for posts in the NHS Institute and the Health and Social Care Information Centre. These will all be complete by March 2006, increasing completed Lyons relocations to around 550.

Reference Costs

7.80 *NHS Reference Costs 2005* [7.11] details the national average unit costs across the NHS for a range of treatments and procedures for the 2004-05 financial year.

7.81 The publication illustrates the changing structure of the NHS, from both an organisational and delivery perspective. The development of more locally based health services through primary care trusts, is reflected by the document.

7.82 The 2004-05 publication covers over £36 billion of NHS expenditure, compared with approximately £33 billion in 2003-04. This accounts for around 90 per cent of hospital and community health services expenditure.

Productivity

7.83 To measure progress against the 2002 spending review value for money PSA target, the Department developed an interim cost efficiency measure. The measure is calculated by comparing increases in NHS expenditure adjusted for both input cost inflation and increases in expenditure on improving the quality of NHS services, with increases in NHS outputs as calculated by the NHS output index. This latter index is derived using data published in the *National Schedule of Reference Costs* using over 1,900 activity categories. In 2004-05, we estimated that value for

money through cost efficiency increased by around 0.8 per cent. The cost efficiency measure was always regarded as an interim measure to be used whilst further development work was undertaken.

7.84 One of the principal recommendations of the *Atkinson Review of the Measurement of Government Output and Productivity for the National Accounts* [7.12] was that quality of care should be included in NHS output and productivity measures. In response to the Atkinson review, on 7 December 2005, the Department published *Healthcare Output and Productivity: Accounting for Quality Change* [7.13], a technical paper which explains progress in developing more accurate methods of measuring healthcare output and productivity, including quality change. The paper builds on the key recommendations of the Atkinson review, research by the University of York, National Institute of Economic and Social Research (NIESR) and by the Department.

7.85 On 27 February 2006, the Office for National Statistics (ONS) published their second article on health productivity *Public Service Productivity: Health* [7.14]. ONS estimate that including adjustments for quality (originally outlined in *Accounting for Quality Change*) such as lower hospital mortality, estimated benefits from hospital treatment, shorter waiting times, improved blood pressure control, lives saved from statins, in addition to the increasing value of health, NHS productivity has risen on average by up to 1.6 per cent a year between 1999 and 2004.

PERSONAL SOCIAL SERVICES

Adults' Services Activity

7.86 **Figure 7.7** gives a summary of personal social services provided to adults. Adults' services include services provided to those who have just reached adulthood through to those provided to the oldest people.

7.87 Key points to note:

- the largest group of adult users of social services is people aged 65 or over, although among younger adults other groups receiving services include people with learning disabilities, people with physical or sensory disabilities and people with mental health problems;
- while the number of households receiving care in their own homes continues to fall, the number and proportion of households receiving intensive home care continues to increase. 641,900 older people (aged 65 or over) were helped to live at home in 2004-05 by means of community-based services, which includes home care and other services. The number of younger adults (aged 18-64) helped to live at home was 327,000 in 2004-05. Data on the number of people helped to live at home in 2004-05 is not comparable to data for previous years as restated guidance was issued to exclude people receiving services from grant-funded organisations who had not had a community care assessment;
- around 92,300 households (26 per cent of households receiving home care) received intensive home help/home care in 2004 (defined as more than 10 contact hours and six or more visits during the week). This represents a six per cent increase from the 2003 figure of 87,100;
- the number of people supported by councils in residential or nursing care has decreased by four per cent in 2004-05. This followed a steady increase up to 2002-03 since the implementation of community care in 1993, when councils took over responsibility which had previously been shared with the Department for Social Security. In particular, councils had not previously been able to support people in nursing care. The large increase in 2002-03 was due to the transfer of residents formally in receipt of preserved rights; and,
- the PSA target – to increase the number of those supported intensively to live at home as a percentage of all those being supported by social services at home or in residential care to 30 per cent by March 2006 and 34 per cent by March 2008 – has been exceeded with a rise from 30 per cent in 2003-04 to 32 per cent in 2004-05.

PSS PERFORMANCE AND PERFORMANCE ASSESSMENT

Performance Ratings for Social Services

7.88 In October 2001, the then Secretary of State, the Rt Hon Alan Milburn MP, announced the introduction of performance ratings for social services. The former Social Services Inspectorate published ratings in 2002, and again in 2003. Responsibility for assessing and rating social services performance became the responsibility of the newly formed Commission for Social Care Inspection (CSCI) from April 2004.

7.89 The information below is extracted from the CSCI publication *Performance Ratings for Social Services in England: December 2005* [7.15] – updated March 2006 – which presents the social services performance ratings for English councils with social services responsibilities for the year 2004-05. The report includes 150 assessments for adult and children's social care and the overall ratings.

7.90 This year, the assessment of children's social care services has, for the first time, been undertaken within the context of a broader assessment of local children's services with Ofsted. The assessment used the new framework set out in *Every Child Matters* [7.16]. The broader assessment makes judgements related to five outcomes for children and service management. CSCI draws its assessment from the key judgements relevant to social care.

Why Are Ratings Being Published?

7.91 The ratings aim to improve public information about the current performance of services, and to promote improvement at local, regional, and national levels. Social services have wide responsibilities for the care and support of families in difficulty, the protection of children at risk of harm, helping older people to live as independently as possible, and for supporting people with disabilities. People have a right to know how well their councils are performing in meeting these responsibilities, whether they are receiving such services themselves, have a family member receiving such services, or are a council tax payer. Central

Figure 7.7: Adults Receiving Personal Social Services – a summary

Numbers and rates

	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	2004-05
All adults aged 18 or over												
Households receiving fairly intensive home care [1,2]	61,800	86,800	107,900	107,100	117,600	133,800	143,500	151,700	156,800	160,800	165,200[10]	171,500
Households receiving intensive home care [1a]	..	..	..	..	..	60,700	68,700	73,300[10]	77,400	81,400	87,100[10]	92,300
People supported in residential care [3,4]	119,200	137,500	153,200	170,300	176,500	181,200	185,800	184,400	186,600	200,500	196,500	189,100
People supported in nursing care [3,4]	25,200	43,200	57,200	66,100	72,900	73,500	73,900	71,800	72,600	78,400	75,800	74,000
People aged 18-64												
with physical/sensory disabilities												
helped to live at home per 1000 pop [5]	..	..	..	2.2	2.3	2.0	..	..	..			
helped to live at home per 1000 pop [6,7,9]	..	..	..	..	..	3.6	3.8	3.8	3.8	4.1	4.2	4.2
supported in residential care [3,4]	6,300	7,100	6,700	7,200	5,900	5,900	6,300	6,100	6,000	6,900	6,500	6,100
supported in nursing care [3,4]	1,500	2,300	2,700	3,200	2,800	3,200	3,400	3,400	3,700	4,500	4,400	4,300
with mental health problems												
helped to live at home per 1000 pop [5]	..	..	..	1.2	1.2	1.2	..	..	..			
helped to live at home per 1000 pop [6,7,9]	..	..	..	..	..	1.8	2.2	2.7	3.1	3.3	3.4	3.7
supported in residential care [3,4]	4,200	5,200	6,500	6,800	7,900	8,700	8,900	9,300	9,500	10,300	9,900	9,800
supported in nursing care [3,4]	270	600	850	1,130	1,370	1,500	1,600	1,700	1,800	2,500	2,400	2,300
with learning disabilities												
helped to live at home per 1000 pop [5]	..	..	..	2.3	2.2	2.2	..	..	..			
helped to live at home per 1000 pop [6,7,9]	..	..	..	..	..	2.5	2.4	2.5	2.6	2.6	2.7	2.7
supported in residential care [3,4]	17,500	20,300	22,200	24,800	25,100	26,900	28,500	28,700	29,200	33,400	32,600	32,200
supported in nursing care [3,4]	190	300	640	690	930	930	1,010	990	1,090	1,860	1,860	2,000
in other groups												
supported in residential care [3,4]	1,400	1,800	1,700	2,100	2,300	2,000	1,800	1,700	1,500	1,500	1,500	1,600
supported in nursing care [3,4]	140	190	230	280	340	300	260	270	200	240	170	150
People aged 65 or over												
helped to live at home per 1000 pop [5]	..	..	..	83	81	71	..	..	..			
helped to live at home per 1000 pop [6,7,9]	..	..	..	..	..	82	86	84	84	84	84	80
number helped to live at home [7,8,9]	..	..	..	..	729,600	637,600	662,000	649,700	660,200	660,700	662,100	641,900
supported in residential care [3,4]	89,800	103,100	116,100	129,400	135,300	137,800	140,400	138,600	140,400	148,400	146,100	139,300
supported in nursing care [3,4]	23,100	39,900	52,800	60,800	67,500	67,500	67,600	65,500	65,800	69,300	67,000	65,300

Source: Care in own homes comes from a survey week in September, care in residential/nursing homes is at 31 March.

Footnotes:

(1) Intensive is defined here as receiving more than five hours of home care and six or more visits during a survey week in September/October.
(1a) Intensive is defined here as receiving more than 10 hours of home care and six or more visits during a survey week in September/October.
(2) The total number of households is calculated differently for 2000-01 and onwards than in previous years.
(3) Data from 2002-03 includes clients formerly in receipt of preserved rights.
(4) Data from 2003-04 includes Boyd loophole residents.
(5) Helped to live at home by means of home care, day care and meals services. This is an Audit Commission indicator. For 1997-98 and earlier years England figures are based on an unweighted average of authority figures.
(6) Helped to live at home by means of any service recorded on Referrals, Assessments and Packages of Care (RAP) return P2s. This includes planned short term breaks, direct payments, professional support, transport and equipment and adaptations as well as home care, day care and meals services. Data for 1998-99 on this basis are estimated as are data for 1999-2000 for around a quarter of the 150 local authorities.
(7) Data as at March each year.
(8) Some of the increase over the years may reflect improvements in data quality.
(9) Data on the number of people helped to live at home in 2004-05 is not comparable to data for previous years. In 2004-05 restated guidance was issued to exclude people receiving services from grant-funded organisations who had not had a community care assessment.
(10) Figure has been revised.

government needs to know how well each council is meeting the aims and objectives it has set for social services.

What Do The Ratings Mean For Councils?

7.92 The ratings provide an objective starting point for reviewing and planning improvements to services. This is important for all councils, whether their performance is good or poor. The best performing councils have an increasing level of freedom in the way they use centrally provided grant funds. They also have a reduced programme of inspection and monitoring, and reduced requirements for information. Councils with zero stars receive additional support, return fuller information, and are subject to more frequent monitoring.

How The Ratings Are Presented

7.93 As well as the overall star rating, judgements for children's and adults' social care services are given, and these carry equal weight. In each case, a judgement for both current performance and capacity to improve is also shown. The categories for judging current performance ("serving people well") are 'no', 'some', 'most' and 'yes'. The categories for judging capacity to improve are 'poor', 'uncertain', 'promising', and 'excellent'. Current performance is afforded more weight than capacity to improve. This results in a total of four judgements underpinning the overall rating, as shown in **Figure 7.8**. Once the judgements have been reached, a set of rules is used to combine them with the weightings to produce a final star rating. The rules are detailed in the CSCI *Operating Policies 2005* [7.17].

Figure 7.8: Judgements for Children's and Adult's Social Care Services

	Performance rating	Children's social care services		Adults' social care services	
		Serving people well?	Capacity to improve?	Serving people well?	Capacity to improve?
Council 1	Zero stars	No	Poor	Most	Promising
Council 2	1 star	Some	Uncertain	Some	Promising
Council 3	2 stars	Most	Promising	Yes	Uncertain
Council 4	3 stars	Most	Excellent	Yes	Promising

Additional Information About Local Performance

7.94 In addition to the judgements and star ratings, background reports of CSCI's assessments of each council's improvement and performance are published on the CSCI website. These reports are sent by CSCI to the council following annual review and annual performance assessment meetings, and are placed on the website once they have been seen and considered by local councillors. The reports highlight performance strengths, areas for development, and priorities to improve in the coming year.

How The Ratings Have Been Produced

7.95 Star ratings are a product of a wider performance assessment process, bringing CSCI and the councils into continuous contact throughout the year. Assessments include evidence from inspections and reviews, monitoring and performance indicators, to form an overall picture of performance over time of both qualitative and quantitative aspects of performance. The assessments culminate in meetings with each council during the summer. These meetings are used to discuss the evidence of improved outcomes, review past performance and consider the priorities for further improvement. Following the assessments, provisional judgements of performance are formed and then subjected to a series of consistency checks before the chief inspector of CSCI makes a final determination.

7.96 This year CSCI introduced a written representation procedure for local councils who may dispute their social care performance or capacity rating (children's or adults'). The representation enables a review of the rating to be undertaken by staff independent of the original proposed judgement.

Criteria Used In Reaching Performance Judgements

7.97 For children's services, the criteria used are the key judgements which underpin the five outcomes and a service management published as the *Framework for Inspection of Children's Services* [7.18] under *Every Child Matters*. The standards and criteria used for adults' social care judgements were published in March 2005. These were slightly revised from last year's set. They describe good and poor performance in six areas, and are used by CSCI as a framework for organising and reviewing the evidence. The specific local evidence sources for 2004-05 are set out for each council in performance reports sent after the annual review and APA meetings.

The Role of Key Thresholds

7.98 To ensure that performance indicators have sufficient weight in the rating system, and to provide an additional check that councils are treated in the same way, a set of performance indicators are defined as the "Key Thresholds" and are approved by ministers. For these, a council cannot be judged to be performing well if it fails to reach a specified level of performance.

Proportionate Approach To Inspection

7.99 The Government's policy to implement a proportionate approach to inspection means that the highest performing councils have experienced fewer inspections, reduced monitoring, and a lighter touch to the annual assessment process for adults' social care. This reduced regime also means that in such cases, less evidence is now available to CSCI to inform judgements about changes in performance over time.

Links With Performance Ratings For NHS And Other Local Government Services

7.100 Social services are provided or arranged by local councils, but are often planned and delivered in partnership with the NHS and other council services. The social services star rating is designed to be compatible with performance information for both the NHS and other local government services. A comprehensive performance assessment (CPA) for all local government services was introduced in 2003. This fulfils the same function as the social services stars, but for all local government services. The social services star rating judgements contribute to the local government CPA.

Changes To Performance Ratings In-year

7.101 CSCI's policy on star ratings is that they will be published each year, and for the most part will not be changed during the year. For councils with a zero star rating, a higher rating may be awarded later, if robust and substantial evidence of improvement becomes available. Conversely, if serious concerns about performance arise during the year, a council's rating may be adjusted to zero stars, and special monitoring arrangements put in place.

Coasting Councils

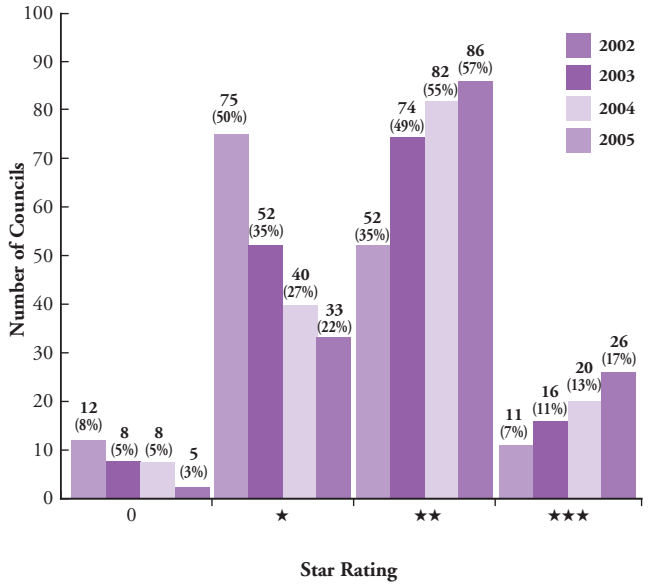
7.102 Coasting councils are defined primarily by reference to their star rating performance over the past three years. In relation to star rating performance since 2002-03, one or two star councils currently falling into any of the following categories can be regarded as coasting:

- councils that have been judged "some/uncertain", for either adult or children's services for each of the past three years;
- councils that have been judged as serving "some" for either adult or children's services for each of the past three years, and have falling capacity judgements; and,
- councils that have been judged as "some/promising" or "some/excellent" for either adult or children's services for each of the past three years.

How Well Are Councils Performing Overall?

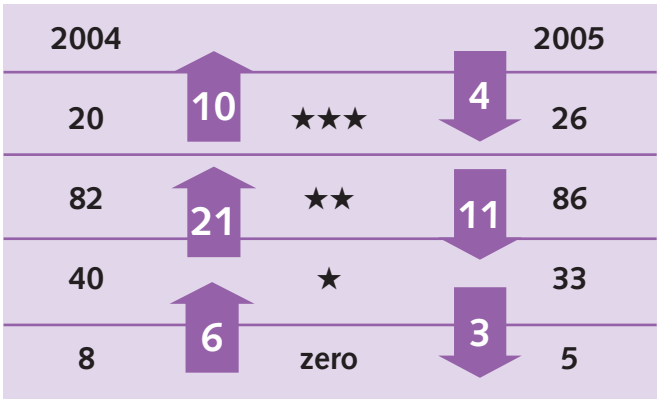
7.103 Since 2002, the national trend for all councils shows a year-on-year improvement in their performance ratings. The average star score this year is 1.89, up from 1.76 in 2004, 1.65 in 2003 and 1.41 in 2002. The number of councils with each star rating is now: five councils (3 per cent) with zero stars, 33 (22 per cent) with one star, 86 (57 per cent) with two stars and 26 (17 per cent) with three stars. There are now 112 councils (75 per cent) with two or three stars for their social services. See **Figure 7.9**.

Figure 7.9: Distribution of Star Ratings Between 2002 and 2005



7.104 Since last year, the star rating has changed for 55 councils (37 per cent of all councils). Of these, 37 (67 per cent) have improved and 18 (33 per cent) have deteriorated. **Figure 7.10** shows the number of movements between each star rating.

Figure 7.10: Changes in Rating from 2004 to 2005



7.105 The majority of councils changing rating (58 per cent) have moved between one and two stars. Whilst ten councils improved their performance sufficiently in 2004-05 to be awarded three stars, four of the councils awarded three stars last year are now two star councils. Six of the eight councils on zero stars in 2004-05 have improved sufficiently to be awarded a star, but the performance of three councils has deteriorated to such an extent that they are now classed as zero star councils.

Capacity To Improve – Services For Adults And Children

7.106 The capacity judgements continue to reflect confidence that substantial further progress can be made to both adults' and children's services in over 85 per cent of councils. There have been modest gains overall since 2004.

7.107 For adults' services the areas relating to capacity to improve in which councils perform particularly well are:

- clear strategy and vision linked to resourcing;
- effective partnerships; and,
- organisational structure and management arrangements.

7.108 Councils perform less well at:

- having a strategy supported by clear policies and planning framework; and,
- having a workforce that reflects local diversity and is well trained.

7.109 Areas which have been highlighted as requiring attention from councils are:

- staffing issues – recruitment, retention and sickness levels;
- responding to the needs of people from ethnic and other minorities; and,
- having an overall social care strategy supported by clear policies and planning framework.

Councils With Zero Stars

7.110 Since 2002, a total of 20 councils have been on zero stars, fifteen of which have improved sufficiently to be removed from the zero star category. Councils take a varying amount of time to improve: 11 councils were on zero stars for one year; five councils were on zero stars for two years and four remained on zero stars for three years. None of those with a zero star rating in 2002 remain so in 2005. Of the eight councils that were rated at zero stars in November 2004, six improved sufficiently to gain one star, while three councils have fallen from one to zero stars, reducing the number of zero rated councils to five.

Coasting Councils

7.111 All councils, irrespective of their star rating, should strive continually to deliver better, more effective services in response to the diverse and changing needs of their specific communities. The ability of councils to deliver this dynamic agenda is variable. While many can demonstrate steady progress over time, others have faltered. However, for a number of councils, performance has remained static or moved up and down and better progress could and should have been achieved. In 2004, there were 54 councils that were classed as 'coasting' because of lack of improvement either to adults' or to children's services; of these, 24 (or 44 per cent) are still classed as coasting in 2005. For these remaining 'coasting' councils there is an urgent need to deliver tangible improvement to social care services or capacity and CSCI and the Department will be working with councils to achieve this.

Characteristics of High Performing Councils

7.112 Twenty-six councils are now judged to be performing at a level indicative of three stars, the highest achievable social services rating. Although each of these councils is unique, there are a number of working practices which are common to many or most of these and which enable these councils to provide an exceptionally high level of service. Areas which define some of the strengths of councils achieving three stars include:

- a political and corporate commitment to social services;
- strong leadership and management;
- 'Modernised' thinking regarding strategic commissioning and purchasing functions and openness to learning from others;
- effective relationships with partner agencies, particularly health;
- a skilled and stable workforce;
- a good level of knowledge and ongoing training;
- councils who understand their performance and have good reporting mechanisms in place with feedback and action plans for all staff;
- ability to demonstrate assurance of the quality of service provision, through methods such as file audits and independent scrutiny;
- people requiring services receiving prompt responses to service requests;
- involvement of those using services in planning the assistance they receive, from assessments through service planning and consultation; and,
- success in engaging all sectors of their community, such as people with disabilities and those from ethnic minority backgrounds.

8. Managing the Department of Health

ADMINISTRATION COSTS AND STAFFING TABLES

8.1 Until the start of 2006, the Department was organised into three business groups, responsible for Standards and Quality, Delivery and Strategy, and Business Development. Group Directors reported to the Chief Executive/Permanent Secretary. There were also two Executive Agencies – NHS Purchasing and Supplies Agency, and the Medicines and Healthcare products Regulatory Agency.

8.2 In January 2006, following a review of the Department's top structure and capability, the Secretary of State and Chief Executive/Permanent Secretary announced some changes in the Department's structure and associated arrangements. These are designed in particular to support delivery primarily through commissioning rather than through performance management, to strengthen policy planning and coordination, to enhance the challenge role of finance and to raise the profile of social care in the Department.

8.3 The administration costs agreed in the 2004 Spending Review reflected the reduction in size and shape of the Department as a consequence of the Departmental change programme commenced in 2003. The changes support the ongoing transformation of the whole NHS and social care system. The transitional costs of these changes were met by re-profiling the administration spending review figures for 2004-05, 2005-06 and 2006-07. A total of £23 million was brought forward from 2005-06 (£12 million) and 2006-07 (£11 million) to meet the early transitional costs. These changes are reflected at **Figure 8.1** which gives detailed information on Departmental administration costs. Information on staffing levels is provided in **Figure 8.2**.

8.4 No maladministration payments were made in 2005.

MANAGING THE DEPARTMENT OF HEALTH

8.5 During the first half of 2006, the Department is in a period of transition, with changed posts at board level to ensure it is best placed to lead change in health and social care, creating the future as well as managing today. It is moving from delivery through performance management to delivery primarily through commissioning, whilst enhancing the challenge role of finance and raising the profile of social care in the light of the *Our Health, Our Care, Our Say*[8.1] White Paper on community based services.

DH RISK REGISTER

8.6 During the last year, the Department has maintained a high-level risk register which has been reviewed by the Departmental Board on a quarterly basis. Departmental Board members take ownership of individual risks, to promote personal responsibility.

8.7 The risks on the register are updated regularly through the Department's programme and project management arrangements. These mechanisms, together with the Department's forward planning exercise, can identify new risks which are, or may be, emerging. Risks are also identified by the Board itself. Mitigation strategies are in place for each risk.

8.8 During the year, areas covered by the risk register have included:

- improving the health of the population, for example work on inequalities;
- quality and safety of services, for example preparedness to control healthcare related infection, and patient safety issues;
- improving capacity, capability and efficiency, for example financial management, securing benefits from infrastructure changes and IT issues; and,
- services as a Department of State, for example the implementation of the Department's arms' length body review, and the Department's own change programme.

NON-DEPARTMENTAL PUBLIC BODIES (NDPBS), SPECIAL HEALTH AUTHORITIES AND EXECUTIVE AGENCIES

8.9 The Department's arm's length bodies (NDPBs, executive agencies and special health authorities) continue to operate under measures introduced by the government in 1998. These policies have increased the public accountability of the Department's arm's length bodies and strengthened public confidence in them. These bodies have members' codes, published registers of members' interests and Internet sites. Where possible, and appropriate, they also hold open meetings, and summary reports of meetings are published on Internet sites, in annual reports or press releases.

8.10 Last year we reported that the Department had reviewed its arm's length bodies and published proposals for implementation as part of a wider programme of change to improve efficiency and cut bureaucracy in the management of the NHS. The objective of all these activities is to reduce the burden on the front line and free up more resources for the delivery of front-line services to patients and users. This wider programme is to ensure that the increased investment in the NHS – 42 per cent in real terms from 2003-04 to 2007-08 – is accompanied by modernisation that cuts out waste.

8.11 The ALB change programme itself is delivering a redistribution to the front line of at least £0.5 billion a year by the end of 2007-08, including a £250 million contribution through better procurement by the NHS Purchasing and Supply Agency (see section on Efficiency in chapter 7). Despite the sector assuming functions under statutes approved by Parliament, the number of bodies has already been reduced to 26 from 38 in the base year of 2003-04 and will reduce further to 20 by the end of 2007-08. Even with these new functions, which bring new costs, we were able to set the 2005-06 budget for the ALB sector so that costs were about £150 million a year less than in 2003-04. Further significant savings will be achieved in 2006-07 and 2007-08.

Figure 8.1: Department of Health Administration Costs

£ million

	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 plan	2006-07 plan	2007-08 plan
Administration Expenditure								
Paybill	141	151	142	140	113	116	115	103
Other	122	135	162	155	165	162	116	126
Total Administration Expenditure	**263**	**286**	**304**	**295**	**278**	**278**	**231**	**229**
Administration Income	-4	-8	-8	-13	-10	-15	-4	-4
Total Administration Budget	**259**	**278**	**296**	**283**	**268**	**263**	**227**	**225**
Analysis by activity:								
Central Department	254	278	296	283	268	263	227	225
Youth Treatment Service	5	-	-	-	-	-	-	-
Total Administration Budget	**259**	**278**	**296**	**283**	**268**	**263**	**227**	**225**

Figure 8.2: Staff Numbers

Staff-years

	2001-02 actual	2002-03 actual	2003-04 actual	2004-05 actual	2005-06 plan	2005-06 estimated outturn	2006-07 plan[6]	2007-08 plan[6]
Department of Health (Gross Control Area)[1]								
CORE DH (Full Time Equivalents)	3,809	3,390	2,964	2,050	2,245	2,224	2,245	2,245
Designated to transfer from DH (Full Time Equivalents)				139	119	152	149	nil
NHS Pensions Agency (Full Time Equivalents)[2]	466	268	258	nil	nil	nil	nil	nil
MHRA (Full Time Equivalents)[3]	nil	nil	747	781	863	824	877	877
Medical Devices Agency[3]	149	156	nil	nil	nil	nil	nil	nil
Medicines Control Agency[3]	574	519	nil	nil	nil	nil	nil	nil
NHS Purchasing and Supplies Agency (Full Time Equivalents)[4]	291	309	318	332	328	351	348	331
NHS Estates[5]	435	390	375	314	nil	nil	nil	nil
TOTAL DEPARTMENT OF HEALTH	**5,724**	**5,032**	**4,672**	**3,616**	**3,555**	**3,551**	**3,613**	**3,447**

Source: DH (core) - Personnel and Related Information System (PARIS) MHRA - HR System. NHS PASA - HR System.
Footnotes:
(1) Core DH figures shown are staff-in-post at the year end and not staff years.
(2) The NHS Pensions Agency became a special health authority (part of the NHS) in April 2004.
(3) The Medicines Control Agency (MCA) and Medical Devices Agency (MDA) merged with effect from 1 April 2003 to become the Medicines and Healthcare Products Regulatory Agency (MHRA). The MHRA staff number for 2004-05 has been revised from last year. The variance between the 2005-06 plan and estimated outturn is due to the MHRA managed policy on staff headcount numbers.
(4) NHS PASA has revised its 2003-04 staff number following an internal review of records. The change to 2004-05 and the variance between 2005-06 plan and estimated outturn have arisen from the organisational restructure which saw the Procurement Policy Advisory Unit (PPAU) and the Centre for Evidence Based Purchasing (CEP) join PASA from the core Department.
(5) NHS Estates became a Trading Fund on 1 April 1999. Figures from 2003-04 include staff in Inventures. NHS Estates was abolished on 31 March 2005.
(6) Future planned staff numbers are subject to change.

There have already been significant changes in the organisation, staffing and financing of the ALB sector and further changes are still to come. These changes are set out in more detail in the November 2004 implementation framework document.

8.12 A wider review of regulation in health and social care was put in hand following the Chancellor's March 2005 Budget speech in which he announced plans to merge the Healthcare Commission and Commission for Social Care Inspection by 2008. This is part of the Government's overall strategy to rationalise public services inspection being driven by the Better Regulation Executive. A wide range of stakeholders sent submissions to the review. Officials have reported to Ministers who are now considering options for reforming the regulatory regime to ensure it functions cohesively and effectively across health and social care. Ministers are committed to updating Parliament on progress early in the new year. The budgets of the inspection sector are now being carefully controlled, so that the inspection burden can be better contained than in the past. Full cost recovery will be pursued for independent sector inspection to reduce in stages the burden of their costs falling on the NHS and a contained regulatory and inspection system will place fewer demands from the centre on the NHS.

8.13 The Department's own change programme reduced the size of the centre by 38 per cent. The ALB change programme is reducing the staffing of the ALB sector by 25 per cent. This will help us to keep management costs under control across the whole health sector and ensure that the local NHS gets efficient, better value-for-money response from central services.

8.14 Ministers are determined to secure the changes set out in the ALB review within the timescales it proposes. They are fully supported in that purpose by the Accounting Officer, the Departmental Management Board and by Christine Outram, the programme director.

PUBLIC APPOINTMENTS

8.15 The Department is responsible for public appointments in a wide range of bodies, as detailed in **Figure 8.3**.

Figure 8.3: Public Appointments Sponsored by the Department: Members in Post at 1 January 2006

Type of Body	Chairs	Members	Total
Strategic Health Authorities	28	168	196
NHS Trusts	229	1,158	1,387
Primary Care Trusts	288	1,661	1,949
Special Health Authorities	18	238	256
Advisory Non-Departmental Public Bodies	25	409	434
Executive Non-Departmental Public Bodies	10	125	135
Other Bodies	3	27	30
Total	**601**	**3,786**	**4,387**

8.16 More comprehensive information on Departmental appointments can be found in the public appointments database at: **www.knowledgenetwork.gov.uk/ndpb/ndpb.nsf**

8.17 Information can also be obtained by contacting the NHS Appointments Commission at:

Blenheim House
West One
Duncombe Street
LEEDS
LS1 4PL
Tel: 0113 394 2950
Email: **info@apcomm.nhs.uk**

Code of practice

8.18 All appointments to local NHS bodies, special health authorities, executive non-departmental bodies (ENDPBs) and advisory non-departmental public bodies (ANDPBs) which are sponsored by the Department, are made according to a code of practice laid down by the Commissioner for Public Appointments. The code requires that all appointments are made on merit, after an open and transparent recruitment and with a selection process involving independent assessment.

NHS Appointments Commission

8.19 The NHS Appointments Commission is responsible for the recruitment, selection and appointment of all public appointments to all local NHS boards (NHS trusts, primary care trusts and strategic health authorities) and to the Department's non-departmental public bodies (NDPBs) and special health authorities.

8.20 The Commission has continued to work to ensure that the chairs and non-executive members of NHS boards are properly equipped to face the challenges ahead. It has put in place a comprehensive appraisal programme for all of those it appoints, and has ensured that they have access to the training and support programmes they need in order to be fully effective in their roles.

8.21 There are a number of key developments affecting the future of the Commission itself. The *Health Bill*[8.2] includes provision for the creation of a new organisation, The Appointments Commission, to which the Commission's current responsibilities will be transferred. The new organisation will have wider functions than those of the current Commission, although its main focus will remain the provision of support to the Department in relation to public appointments and board governance. However, it will also be to provide these services to other Government departments so that they too are able to benefit from the Commission's unique expertise in public appointment recruitment and selection.

Gender and ethnic balance

8.22 As at 1 January 2006, the gender and ethnic balance and the proportion of non-executive board members who are disabled on the boards of public bodies for which the Department is responsible, is set out in **Figure 8.4**.

Figure 8.4: Public Appointments – Progress by Gender and Ethnic Balance[(1)]

Total number of appointments	**4,387**
% of board members (including chairs) who are women	43.4
% of board members (including chairs) from black and ethnic minorities	11.5
% of board members (including chairs) who are disabled	6.1

Footnote:
(1) Figures as at 1 January 2006

Annual Appointments Plan

8.23 The Department's annual appointments plan, which sets out the Departments strategy in relation to public appointments, including its plans on diversity, to the public bodies for which it is responsible, will be published within the next few weeks on the Department's website.

RECRUITMENT

8.24 The main focus of the Department's external recruitment was on filling those posts in the Department's new structure which had not been filled with internal candidates during the restructuring and redeployment stages of the change programme.

8.25 External recruitment was conducted on the basis of fair and open competition in accordance with the provisions of the *Civil Service Commissioners' Recruitment Code*[8.3]. A number of measures were taken to promote compliance with the Code, including the publication of new guidance for selection panels and the establishment of a forum for HR practitioners to share good practice and encourage consistency of practice across the devolved structure.

8.26 The number of appointments in external competitions is shown in **Figure 8.5**, broken down by gender. Exceptions permitted under the Code were exercised on the following number of occasions:

- eight extensions, up to a maximum of 24 months, of appointments originally made for up to 12 months. These appointments were extended to enable the completion of work that required more time than originally estimated;
- 27 secondments;
- 10 extensions of secondments;
- two re-appointments of former civil servants; and,
- one appointment of a disabled candidate under modified selection arrangements.

Figure 8.5: Recruitment into the Department of Health 2005

	Total	Male	Female
Permanent staff joining in 2005 who were still employed by the Department on 31 March 2006			
Senior Civil Service	9	2	7
Fast Stream	23	13	10
Posts at former UG6 and below	186	61	125
Total	**218**	**76**	**142**
Permanent staff joining in 2005 who were no longer employed by the Department on 31 March 2006			
Total	**35**	**15**	**20**
All permanent staff joining in 2005			
Senior Civil Service	9	2	7
Fast Stream	23	13	10
Posts at former UG6 and below	221	76	145
Total	**253**	**91**	**162**

Source: Personnel and Related Information System (PARIS).

SENIOR CIVIL SERVICE SALARIES

8.27 Details of Senior Civil Service salaries for the Department are given in **Figure 8.6**.

Figure 8.6: Salaries of Senior Civil Service Staff-in-Post in the Department of Health at 1 April 2005

Payband (per annum)	Number of Staff
£55,000 - £59,999	17
£60,000 - £64,999	21
£65,000 - £69,999	44
£70,000 - £74,999	45
£75,000 - £79,999	28
£80,000 - £84,999	24
£85,000 - £89,999	15
£90,000 - £94,999	13
£95,000 - £99,999	8
£100,000 - £104,999	9
£105,000 - £109,999	11
£110,000 - £114,999	7
£115,000 - £119,999	14
£120,000 - £124,999	1
£125,000 - £129,999	6
£130,000 - £134,999	6
£135,000 - £139,999	2
£140,000 - £144,999	2
£145,000 - £149,999	1
Over £150,000	12
Total	**286**

Source: DH Payroll System.
Footnotes:
(1) Figures include staff on secondment out of the Department and exclude staff on secondment into the Department.
(2) Salaries include all pay-related allowances.

PERFORMANCE IN RESPONDING TO CORRESPONDENCE FROM THE PUBLIC

8.28 The Department takes very seriously the communications it receives from members of the public and MPs, by telephone, letter and email. The Customer Service Centre was formed following the change programme to ensure that we offer high quality responses on time. Our performance targets for replies were as follows in 2005:

- 90 per cent of all letters and emails received through the Department's website to receive a reply within 20 working days;
- 95 per cent of telephone calls to be responded to within 30 seconds; and,
- 100 per cent of Freedom of Information requests to be responded to in 20 days.

8.29 **Figure 8.7** shows the numbers of letters addressed to Ministers, emails received through the website and telephone calls received in the Customer Service Call Centre in 2005, and the performance targets we achieved in each year.

Figure 8.7: Correspondence from the Public – achievement against performance targets

Type of correspondence	2002	2003	2004	2005
				Percentage
Private office case[1]	29.0	54.0	80.9	90.1
Treat Official case[2]	35.6	67.2	88.0	97.3
Departmental e-mail[3]	8.0	87.1	95.4	96.6
Calls[4]	n/a	n/a	42.0	76.1

Source:
1 Correspondence: 2002-03 figures based on Cabinet Office Annual Report for POs and cases recorded electronically since July 2002 for TOs and DEs. From 2004 onwards, all PO TO and DE cases from Department of Health (DH) Correspondence Database. Figures include all cases with Whitehall Standard target date in the month and exclude cases where no reply is required. Figures do not include cases for other Government Departments (OGDs), or Agencies which are reported separately.
2 Calls: Department of Health (DH) CALLSCAN SYSTEM. Figures include all calls taken in the period. Data not available before 2004.
Footnotes:
(1) Letters signed by Ministers.
(2) Letters signed by officials on behalf of Ministers.
(3) E-mails received throughout the Department's website.
(4) Telephone calls received in the call centre.

A HEALTHIER WORKPLACE

8.30 Following the publication of the *Choosing Health*[8.4] White Paper, the Department developed several initiatives along the themes of the White Paper to help improve the health and well-being of its workforce. This included launching several urban walks around its main buildings to help staff get out for their recommended 30 minutes exercise a day, a new healthier menu in the staff restaurants and a pedometer for all staff. In addition, two employee health events were run to remind staff of existing facilities such as the 24-hour confidential counselling service, occupational health and HASSRA.

8.31 In addition to this, the Department has also recently developed a new absence management procedure designed to maximise attendance by promoting pro-active measures and encouraging staff to tackle issues early on.

Health and Safety Policy

8.32 The Health and Safety Unit has now been incorporated into the Business Services Unit, Estates branch. We continue to provide health and safety advice and guidance to all our employees. Facilities management have a role in ensuring our buildings are safe for our employees to work in and this is administered by the Business Services Unit through the facilities management contract.

8.33 We continue to revise our health and safety policy in line with current regulations and good practices, and as part of this we are currently updating our emergency evacuation procedures and to comply with the new Fire Reform Order.

8.34 Training activities, including fire warden, workstation risk assessor and first aid training, have been promoted and delivered. The Health and Safety Unit actively participated in the successful employee health road-shows, providing health and safety advice and guidance to staff, together with an in-house free eyesight testing service. This service is to be provided on a regular basis.

8.35 A system of regular inspection and meetings involving the trades union side, staff representatives and the Health and Safety Unit continues to operate with success in the Department's buildings.

8.36 An electronic accident reporting system has been operational since 1 July 2005.

Figure 8.8: Department of Health Accident Statistics for 2005

	Number
Total reported accidents	52
Of which;	
Resulting in absence[1]	7
Total reported near misses[2]	11

Footnotes:
(1) Two absences were RIDDORS. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations. Reports are sent to the Health and Safety Incident Centre.
(2) Near misses are any unplanned occurrence that does not lead to injury of personnel or damage to property, plant or equipment, but may have done in different circumstances

ACCOMMODATION AND ICT (INFORMATION AND COMMUNICATION TECHNOLOGY)

8.37 The Department's HQ buildings in London and Leeds continue to operate at, or near, capacity, although key refurbishments have increased this capacity by incorporating the principles of flexibility and de-cellularisation outlined in best practice guides such as *Working Without Walls*[8.5]. These principles have been used to good effect in partial refurbishments of Richmond House and Skipton House, wholesale refurbishment of Wellington House and the initial fitting-out of New Kings Beam House, which has been progressively occupied since 2003.

8.38 During 2005, the strategy of rationalisation was completed with the London HQ estate reduced to four buildings, all offering a quality, working environment. A major project to refurbish the space in Quarry House, Leeds commenced in January 2006.

Relocation

8.39 The Department remains committed to relocating around 1,110 posts by 2010 in response to the Lyons Review, with the majority coming from arm's length bodies. Posts transferred to date are given in chapter 7.

Information Technology

8.40 The Department has commenced a major programme to restructure the Information Services division that will deliver a more strategic and corporate approach to systems commissioning and delivery. A key objective of the new structure is the provision of improved customer service and operational support for staff in their use of information technology.

8.41 As part of the programme, the Department is reviewing the contract with CSC (Computer Sciences Corporation) for the supply and operation of its ICT infrastructure that was signed in 2002 for a period of seven years. The review will ensure that the services provided within the contract continue to deliver value for money and best meet the needs of the Department.

KNOWLEDGE MANAGEMENT

8.42 Over the last year, a knowledge management engagement programme has been rolled out across the Department. This comprised workshops, training sessions and action plans for staff designed to increase knowledge management awareness and capacity for individuals and workgroups.

8.43 Basic measurement criteria were established at the start of the programme and reviewed as each workgroup completed the six to nine month cycle to indicate progress and areas for further improvement. Activities included improvements to information sharing, document and records management, email protocols, and local induction procedures.

8.44 A network of knowledge management champions has been established to share experience and best practice, and facilitate continued momentum for the programme.

SUSTAINABLE OPERATIONS

8.45 The Department's *Sustainable Development Action Plan*[8.6] is due to be published in early 2006. This commits the Department to sustainable action on its operational performance, as well as on policy issues (which are set out in Chapter 2 of this document).

8.46 The Department continues to develop its operational response to the *Framework for Sustainable Development on the Government Estate*[8.7]. The framework targets now cover travel, water, waste, energy, estates management, procurement, biodiversity and social impacts.

8.47 Details of the Department's progress against these targets are maintained on the Department's sustainable development webpage at:
http://www.dh.gov.uk/AboutUs/HowDHWorks/ServiceStandardsAndCommitments/SustainableDevelopment/fs/en

8.48 Significant achievements include:

- continuing to reduce our water consumption. Further water conserving measures have been implemented across the London estate, resulting in a reduction per person from an average of 10.12m^3 in 2001-02 to 6.17m^3 in 2004-05. This considerably exceeds the framework target of 7.7m^3 per person by March 2004, and was the lowest consumption per person of any central Government department;
- we installed a total of 12 new video conference facilities throughout the estate in 2004-05, thus reducing the need for business travel. More new facilities are planned for the current year;
- our new cleaning contract has a strong emphasis on continuous environmental improvement, with a commitment to increasing the Department's recycling/recovery rate from the current 65 per cent to more than 90 per cent. Currently, all paper, cans, glass, plastic and fluorescent tubes discarded from our London buildings are recycled. We also have in place arrangements for recycling printer and toner cartridges and redundant IT equipment; and,
- we have continued to purchase renewable energy for consumption on the London estate. In 2004-05, 100 per cent of the electricity purchased for our London offices was from renewable sources.

8.49 The framework is currently being reviewed by a cross-departmental senior level Sustainable Operations Board. The board is tasked with implementing the commitments contained within the UK Government SD Strategy in relation to the way departments operate their land and buildings. Indications are that the new framework will be less prescriptive, allowing departments more flexibility in the way they implement good environmental/SD practice.

8.50 The Department's official sustainable operations contacts are:

- Martin Chaplin, Head of Contract Management; and,
- Julia Armstrong, Sustainable Operations Manager.

EU DEVELOPMENTS

8.51 The Department's 'Forward Plan' for 2005 included two EU-based projects:

- the European Health Insurance Card (EHIC); and,
- the UK Presidency of the EU.

European Health Insurance Card

8.52 The EHIC is a driving-licence sized card, which allows UK residents travelling in most European countries to show that they are entitled to receive treatment that becomes necessary during their trip. It allows UK citizens to be treated as if they were enrolled in the health system of the country in which they are travelling. The EHIC card has now replaced the old E111 forms that the Post Office used to issue.

8.53 The EHIC project has been the responsibility of a small project team based in the Department and the Prescription Pricing Authority. By the end of January 2006, the EHIC project had delivered 15 million cards to people in the UK, to time and budget, using modern (e-auction) procurement techniques. It has been the largest single card-issuing operation in the UK this year. It is the most successful Government project to date in encouraging on-line applications. There has been significant positive feedback from the public as well as incidental benefits, including a significant increase in the number of people registering as organ donors.

UK Presidency of the European Union

8.54 The UK held the Presidency of the EU between July and December of 2005. In health, we set ourselves an ambitious agenda both in taking forward EU legislation and influencing the strategic direction of health policy at EU level.

8.55 There were two themes for the work of the EU Presidency:

- health inequalities; and,
- patient safety.

8.56 On health inequalities, the Department organised a high level EU summit which considered a range of issues that impact on health inequalities such as alcohol, nutrition and tobacco, as well as highlighting the need for evolving EU information, and knowledge systems that include information on the patterns and trends in health inequalities. The work started under the Presidency will develop further in a policy group that the Commission has set up on the social determinants of health to take this work forward.

8.57 The work on patient safety built on work during the preceding Luxembourg Presidency and also included a high level summit for EU patient safety experts. A programme of future work has been agreed by the member states and the Commission to support member states in establishing national patient safety programmes (including patient safety reporting and learning systems).

8.58 During the UK Presidency, two Ministerial meetings were held. The informal meeting of Health Ministers in Hertfordshire brought together Health Ministers from all 25 member states and candidate countries to discuss high profile issues, including human pandemic preparedness and patient mobility at the EU level. The clear and consistent messages that Health Ministers were able to take from discussion were valuable in addressing the high levels of media interest in pandemic flu during the Presidency. Health Ministers also explored the impact of EU treaties on healthcare services and signalled clear support for the idea to work up a statement of the common values that underpin health systems within the EU.

8.59 The formal Health Council achieved political agreement amongst the 25 EU health ministers on proposals relating to paediatric medicines. These proposals improve the safety of healthcare for children. Health Ministers also took forward their work on the human health aspects of pandemic flu, emphasising the importance of national planning but also identifying interest from member states in a feasibility study of EU action on stockpiling anti-virals for targeted use in the event of a pandemic.

EMERGENCY PREPAREDNESS

8.60 In the field of emergency preparedness, the Department continues to develop and improve its capacity and capability to fulfil its responsibilities as a part of the central government response and to provide effective leadership, guidance and direction to the NHS. This work is a part of the Department's role in cross-Government and international collaboration on the response to terrorism. In particular, work to strengthen UK defences and build UK resilience to manage the consequences of major emergencies. The Department's Emergency Preparedness Division works closely with the NHS and other key stakeholders to deliver the health elements of this major Government agenda.

8.61 Work in 2006 will focus on personal protective equipment (PPE), hot zone working, children's needs, clinical leadership and reassessing the training needs for emergency services. Improved PPE suits for use by emergency service staff will be issued – this equipment will enhance the NHS's ability to provide an effective on-site response (including the point of scene 'hot zone') to major incidents. A review of the adequacy of the provision of children's needs in the event of an emergency, including chemical, biological, radio-nuclear (CBRN) countermeasures, will be undertaken – this work will result in paediatric equipment and drug doses being available in sufficient quantities. The expert Emergency Planning Clinical Advisory Group will continue to provide specialist advice to DH on issues relating to the delivery of clinical care within the NHS's response to a major incident. The training of emergency responders to CBRN incidents will also continue to be a focus.

List of Annexes

ANNEX A1

TOTAL CAPITAL EMPLOYED BY THE DEPARTMENT

£ million

	1998-99 outturn	1999 -2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 projected	2006-07 projected	2007-08 projected
Within the Departmental Account [1][2]	17,896	15,813	15,146	12,574	12,290	44,491	141,926	438,550	1,508,613	5,521,523
Investment outside Accounting Boundary [3][4][5][6]	15,853	22,529	23,011	23,112	24,849	89,952	286,946	886,662	3,050,118	11,163,432
Total Capital Employed	**33,749**	**38,342**	**38,157**	**35,686**	**37,139**	**134,442**	**428,871**	**1,325,212**	**4,558,731**	**16,684,954**

Footnotes:

(1) This includes all entities within the DH resource accounting boundary, such as the central DH, and Health Authorities.

(2) Source: DH consolidated resource accounts. For 2003-04 and beyond figures are uplifted in line with GDP deflator of 23 December 2005.

(3) Figures up to 1999-2000 include the NHS Litigation Authority which moved inside the accounting boundary in 2000-01.

(4) Figures up to 2001-02 include the Health Development Agency which moved inside the accounting boundary in 2002-03.

(5) This includes, for example, NHS trusts and the National Blood Authority.

(6) In 2000-01 part of NHS supplies (the Purchasing and Supply Agency) moved inside the boundary and, from 2001-02, Rampton, Broadmoor and Ashworth Special Health Authorities moved outside the accounting boundary.

ANNEX A2

DEPARTMENT OF HEALTH RESOURCE BUDGET

£ million

	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 estimated outturn	2006-07 plan	2007-08 plan
Consumption of Resources by activity								
National Health Service (NHS)	**45,020**	**52,070**	**55,501**	**61,965**	**66,942**	**74,081**	**79,997**	**87,062**
of which								
Hospital and Community Health Services[1]	**42,330**	**49,158**	**52,543**	**58,512**	**63,443**	**70,726**	**77,422**	**84,291**
of which								
Health Authorities unified budget and central allocations and grants to local authorities	42,330	49,158	52,543	58,512	63,443	70,726	77,422	84,291
Family Health Services	**1,875**	**1,951**	**2,024**	**2,141**	**2,129**	**2,011**	**1,099**	**1,162**
of which:								
General dental services	1,109	1,166	1,221	1,283	1,246	1,012	50	0
General ophthalmic services	290	302	304	322	341	352	361	375
Pharmaceutical services	869	893	919	962	966	1,099	1,152	1,238
Prescription charges income	-393	-411	-421	-426	-422	-452	-463	-452
Central Health and Miscellaneous Services	**526**	**649**	**600**	**994**	**1,062**	**1,045**	**1,199**	**1,335**
of which								
Welfare Foods DEL	102	101	102	138	119	119	120	120
EEA Medical Costs	192	207	251	390	429	577	678	760
Other Central Health and Miscellaneous Services	232	341	246	466	514	348	402	456
Departmental Administration including agencies	**289**	**312**	**334**	**319**	**308**	**299**	**277**	**275**
Personal Social Services (PSS)	**482**	**730**	**1,591**	**1,618**	**2,128**	**2,140**	**1,846**	**1,886**
of which								
Personal Social Services	11	46	159	193	257	252	263	286
Local Authority personal social services grants	470	684	1,432	1,425	1,871	1,887	1,583	1,601
of which								
Training Support programme for social services staff	43	47	58	57	55			
Grants for adults	425	540	1,130	1,203	1,727	1,734	1,437	1,454
Grants for children	1	95	194	60	65	91	91	91
Human resources development strategy				10	24	63	50	50
Grants funded from the invest to save fund	2	1	2					
Performance fund			48	96				
NHS – Superannuations – England & Wales	**3,782**	**3,949**	**4,569**	**6,194**	**6,396**	**8,892**	**10,182**	**11,072**
Credit Guarantee Finance[2]					**3**	**-3**		
Total Department of Health Resource Budget	49,284	56,750	61,661	69,777	75,469	85,110	92,021	100,021

Footnotes:

(1) Figures for HCFHS expenditure in 2005-06 excludes funding for successive waves of Personal Dental Services pilots and are, therefore, not directly comparable to the figures for 1989-90 to 2004-05.

(2) HM Treasury funding available for Private Finance Initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with Treasury.

(3) Figures may not sum due to rounding.

ANNEX A3

DEPARTMENT OF HEALTH – CAPITAL BUDGET

£ million

	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 estimated outturn	2006-07 plan	2007-08 plan
National Health Service (NHS)	**1,238**	**1,719**	**2,073**	**2,602**	**2,835**	**4,411**	**5,227**	**6,199**
of which								
Hospital and Community Health Services [1]	**1,220**	**1,693**	**2,043**	**2,566**	**2,804**	**4,381**	**5,180**	**6,167**
of which								
Health Authorities unified budget and central allocations and grants to local authorities	1,220	1,693	2,043	2,566	2,804	4,381	5,180	6,167
Central Health and Miscellaneous Services	**9**	**13**	**20**	**13**	**16**	**11**	**23**	**11**
Departmental Administration including agencies	**9**	**13**	**9**	**23**	**16**	**19**	**23**	**21**
Personal Social Services (PSS)	**48**	**93**	**72**	**84**	**83**	**87**	**102**	**121**
of which								
Personal Social Services (including Credit Approvals)	47	90	47	59	58	62	53	56
Local Authority Personal Social Services Grants	1	3	25	25	25	25	48	65
of which								
Grants funded from the Invest to Save Fund	1	0	0					
Improving Information Management		3	25	25	25	25	25	25
Credit Guarantee Finance (AME) [2]	**0**	**0**	**0**	**0**	**0**	**377**	**84**	**0**
Total Department of Health Capital Budget	**1,286**	**1,812**	**2,144**	**2,686**	**2,919**	**4,875**	**5,412**	**6,320**

Footnotes:

(1) Includes funding available to NHS foundation trusts for 2004-05.

(2) HM Treasury funding available for Private Finance Initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with Treasury.

(3) Figures may not sum due to rounding.

(4) Amount below £0.5 million are not shown but indicated by a #.

ANNEX B

EXECUTIVE AGENCIES OF THE DEPARTMENT OF HEALTH

Medicines and Healthcare products Regulatory Agency

The Medicines and Healthcare products Regulatory Agency (MHRA) helps safeguard public health through the regulation of medicines and medical devices. It does this by ensuring that they meet the standards of safety, quality, performance and effectiveness and are used safely.

The agency has around 850 staff, a total budget of around £70 million and operates as a trading fund. Its main sources of funding are from fees from the pharmaceutical industry for the licensing of medicines and funding from the Department of Health for the regulation of medical devices.

The main tasks carried out by the MHRA are to assess medicines before they can be used in the UK and ensure the compliance with statutory requirements for the manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices. The agency also operate systems for recording, monitoring and investigating adverse reports and incidents, and taking enforcement action to safeguard public health. The agency provides advice and support to the Department of Health ministers on policy issues and represents the UK in European and other international areas concerning the regulation of medicines and medical devices.

The MHRA has also recently taken on the authorising and inspecting of blood establishments, monitoring compliance of hospital blood banks and the assessment of serious adverse events and reactions associated with blood and blood components (haemovigilance).

NHS Purchasing and Supply Agency

The NHS Purchasing and Supply Agency (NHS PASA) acts as the centre of advice and expertise on matters of purchasing and supply for the NHS for the benefit of patients and the public. NHS PASA is both an advisory and co-ordinating body with an active role in developing purchasing and supply policy for the NHS. NHS PASA will also lead and implement fundamental change in the management of purchasing and supply across the NHS in England.

NHS PASA also provides advice to individual NHS bodies and negotiates contracts for goods and services on behalf of the NHS. NHS PASA employs over 300 people and its gross running costs from 1 April 2005 to 31 March 2006 were £27.6 million.

NHS PASA has been closely involved with the implementation of the Supply Chain Excellence Programme (SCEP). SCEP aims to gain the best value for the money the NHS spends each year on goods and services. Securing best value for money for the NHS that reflects product quality, innovation, price, patient safety and choice. This will ensure the greatest possible share of NHS funding is directed towards improving clinical capacity, and ultimately patient care. The programme is on target to deliver over £500 million in annualised savings by 2007-08. SCEP's benefits to date are £115 million annualised.

The National Contracts Procurement (NCP) project is focused on driving rigorous and robust sourcing of new national framework agreements, and the Commercial Directorate is working with NHS PASA and NHS Logistics to engage trusts and encourage them to use the new agreements to help them get the best savings for their budgets. NCP wave 1 has achieved £91 million annualised benefits to date, and is on course to deliver £183 million of savings by 2007-08.

The Collaborative Procurement Hubs (CPH) project is working with trusts and confederations in a phased approach to develop CPHs across the NHS that provide a regional procurement focus. CPHs will help optimise all commercial spend through collaborative working across all trusts in the local health economy and ensure a strong clinical interface to deliver the right product for local health economies. It is also supporting NHS Logistics and the new national framework agreements within the NCP project to maximise the purchasing scale provided by the CPH approach.

NHS PASA and the SCEP team will continue to support the development of CPHs to ensure they have the capabilities to drive forward the modernisation of NHS procurement. The CPH model has been tested and refined, and three pathfinder hubs are fully mobilised and to date they have benefited from annualised savings of £24 million.

As part of SCEP the proposed outsourcing of NHS consumables' supply chain and procurement service continues to be market tested. Two bidders are being taken forward to the next stage, which involves due diligence and negotiations with both bidders. If the decision is made to go ahead with outsourcing, it is likely the contract would be awarded in the second quarter of 2006.

As a result of the recommendations of the Healthcare Industries Task Force NHS PASA has taken the following initial steps:

- Procurement processes – purchasing and supply must reflect the views and needs of users of goods and services. By establishing action groups and engaging appropriate stakeholders NHS PASA will seek to ensure that NHS procurement strategic and implementation plans are able to do this and also provide greater emphasis in assessing value from innovations which may improve health and social care delivery.

- Developing a new centre for Evidence-based Purchasing which will initially evaluate medical technologies to support their rapid introduction into the NHS. This will be further developed to provide evidence to support procurement intervention in NHS markets and provide evidence based advice to NHS purchasers.

NHS PASA will continue to seek to ensure that contracted activities support the Government's policy programmes for better health and to reduce health inequalities working in many cross-government initiatives and in regular dialogue with counterparts from the home countries.

ANNEX C

OTHER BODIES (INCLUDING EXECUTIVE NON-DEPARTMENTAL PUBLIC BODIES AND SPECIAL HEALTH AUTHORITIES)

Executive Non-Departmental Public Bodies:

Commission for Patient and Public Involvement in Health (CPPIH)

The Commission for Patient and Public Involvement in Health was set up on the 1 January 2003. The chair of the CPPIH is Sharon Grant and the chief executive is Steve Lowden – there are currently seven commissioners.

The main functions of the CPPIH are:

- to support and maintain Patients' Forums; and,
- to ensure that they have staff support available to them so that they can carry out their functions.

For further information about the Commission visit **www.cppih.org**, or contact The Help Desk, 7th Floor, 120 Edmund Street, Birmingham B3 2ES. Telephone 0845 120 7111.

The CPPIH will be abolished as a result of the Department's review of its arm's length bodies. Primary legislation is required to abolish the CPPIH so the timing of abolition will be dependent on the Parliamentary timetable in the next Parliamentary session.

Commission for Social Care Inspection (CSCI)

The Commission for Social Care Inspection became fully operational on 1 April 2004. It:

- promotes improvement in social care;
- inspects all social care – for adults and children – public, private and voluntary;
- registers services that meet national standards;
- inspects council social services;
- publishes an annual report to Parliament on social care;
- holds performance statistics on social care; and,
- publishes the 'star ratings' for council social services.

It has taken on the work of regulating independent social care providers from the National Care Standards Commission, which was abolished on 31 March 2004. It has combined that with the function formerly carried out by the Social Services Inspectorate (SSI) of assessing local authorities' provision of social services. It also carries out certain work, previously within the remit of the Audit Commission, on studies about the economy, efficiency and effectiveness of local authorities in providing social care.

For further information about the Commission visit **www.csci.org.uk**, or contact CSCI Head Office, 33 Greycoat Street, London, SW1P 2QF. Telephone 020 7979 2000.

General Social Care Council (GSCC)

The *Care Standards Act 2000* [C1] brought into being, among other regulatory bodies, the General Social Care Council. In line with its sister councils in Scotland, Wales and Northern Ireland the GSCC has the remit to:

- establish a comprehensive and up-to-date register of qualifying social care workers;
- establish transparent and fair rules for achieving and retaining registration;
- develop and enforce professional standards of conduct and practice;
- ensure high levels of training for social workers;
- as a consequence of these actions, promote the status of social care workers; and,
- be a forward looking and pro-active public sector body with committed staff, responsive management, sound corporate governance and effective delivery of its remit.

For further information about the Council visit **www.gscc.org.uk**, or contact The Council at Goldings House, 2 Hay's Lane, London, SE1 2HB. Telephone 020 7397 5100.

Healthcare Commission (Commission for Healthcare Audit and Inspection)

The Healthcare Commission is an independent body that operates at arm's length from Government, reporting directly to Parliament on the state of healthcare in England and Wales. It was established by the *Health and Social Care (Community Health and Standards) Act 2003* [C2] and started operating on 1 April 2004 as an Executive Non-Departmental Public Body. The Commission took on functions previously carried out by the Commission for Health Improvement and the National Care Standards Commission as well as some responsibilities from the Audit Commission.

The Commission's overarching remit is to encourage improvement in the provision of NHS care and to promote improvements in the quality of healthcare and public health through independent, authoritative, patient-centred assessments of the performance of those who provide services. The Commission is required to pay particular attention to:

- the availability of, access to, quality and effectiveness of healthcare;
- the economy and efficiency of the provision of healthcare;
- the availability and quality of information provided to the public about healthcare; and,
- the need to safeguard and promote the rights and welfare of children and the effectiveness of measures taken to do this.

The Commission has a full time Chairman and a Chief Executive. At the beginning of January 2006, the Commission had 684 whole time equivalent staff on its payroll plus 176 interim and temporary staff. The Commission's gross income in 2004-05, including fee income of £4.7 million, was £62.7 million.

Further information about the Healthcare Commission is available on its website: **www.healthcarecommission.org.uk**

Health Protection Agency

The *Health Protection Agency Act 2004* [C3] established the Health Protection Agency (HPA) as a new UK-wide non-departmental public body (NDPB) on 1 April 2005. The HPA NDPB assumed all the functions previously carried out by the HPA Special Health Authority and the National Radiological Protection Board (NRPB), which were both wound up on the same date. The UK Government, and each of the devolved administrations, looks to the HPA to provide an authoritative source of advice and support in health protection matters. Its core functions, taken from the *Health Protection Agency Act 2004*, are:

- the protection of the community against infectious disease and other dangers to health;
- the prevention of the spread of infectious disease;
- the provision of assistance to any other person who exercises functions in relation to these functions;
- the advancement of knowledge about protection from risks connected with ionising or non-ionising radiation; and,
- the provision of information and advice, in relation to the protection of the community from risks connected with ionising or non-ionising radiation.

The HPA's total expenditure in 2004-05 was £204 million, of which £128 million was provided by Government grant in aid. The HPA employed 2,611 staff as at 31 March 2005. In addition to this, approximately 260 staff were engaged on various agency, secondment and similar arrangements during the previous 12 months.

Contacts: HPA: Michael Harker, Health Protection Agency; Central Office, 7th Floor, Holborn Gate, 330 High Holborn, London WC1V 7PP, 020 7758 2710; or see the HPA's website at: **www.hpa.org.uk**

DH: Brian Bradley, Department of Health, Room 513, Wellington House, 135-155 Waterloo Road, London SE1 8UG. Tel: 020 7972 4709

Human Fertilisation and Embryology Authority (HFEA)

The Authority was established by the *Human Fertilisation and Embryology Act 1990* [C4] and began its work in August 1991.

Its main responsibilities are to license and monitor:

- clinics that carry out IVF;
- donor insemination; and,
- research projects involving the creation of embryos in vitro.

It also regulates the storage of gametes and embryos.

It has 19 members (including the chairman and deputy chairman) and has approximately 100 staff.

The Authority's total expenditure in 2004-05 was £8,565,056. Approximately 48 per cent of the Authority's income was raised from licensing and other income, with the remaining 52 per cent from the Department of Health. Particular issues considered by the Authority were a review of its policies on sperm, egg and embryo donation and clinic procedures for carrying out a 'welfare of the child' assessment when deciding whether to offer fertility treatment to potential patients.

Further information about the work of the Authority and its accounts can be found in its Annual Report, which is available on the HFEA's website **http://www.hfea.gov.uk**. Otherwise, information can be obtained from Mr Ted Webb at the Department of Health, Room 609, Wellington House, 133-155 Waterloo Road, London SE1 8UG Tel: 020 7972 4553.

Human Tissue Authority

The Human Tissue Authority was established by the *Human Tissue Act 2004* [C5] and began its work on 1 April 2005.

Its main responsibilities include:

- giving advice on, and overseeing, compliance with the Act;
- the issue of good practice guidance in statutory codes of practice; and,
- licensing and inspection of post-mortem activities for hospitals and coroners, anatomical examinations, public display of human remains and storage of human tissue.

The Authority has 17 members (including the chair) and approximately 17 members of staff. The Authority received grant in aid budget of £1 million and is due to publish its inaugural Annual Report and Accounts during 2006. It is intended that the Annual Report and Accounts will be published on the Authority's website **www.hta.gov.uk**, which also sets out in more detail the work of the Authority.

Further information can be obtained from Mr Hugh Whittall at the Department of Health, Room 611, Wellington House, 133-155 Waterloo Road, London, SE1 8UG.

National Institute for Biological Standards & Control (NIBSC) & National Biological Standards Board (NBSB)

The NBSB, set up in 1976, functions through its executive arm, the National Institute for Biological Standards and Control (NIBSC). The Board's prime function is to assure the potency, purity and related efficacy and safety of biological substances used in human medicine (e.g. vaccines, hormones, blood products). NIBSC collaborates with the World Health Organisation (WHO), the European Commission and other international bodies. It is important to the Government's public health

programme and to the pharmaceutical industry in assisting with licensing and with on-going product testing and quality assurance of biological substances. NIBSC's activities have a significant research element, directed towards designing and improving assay, test and standardisation methods. The Department's 2004 review of its arm's length bodies proposed transferring the management of the NIBSC to the Health Protection Agency, thus allowing for the abolition of the NBSB. Subject to the passage of legislation, this is expected to be implemented by April 2008. The Board's gross expenditure in 2004-05 was £22.8 million, of which the Government funded £13.2 million. It employed 301 staff over this period. NBSB's corporate aims and strategy together with its performance against key targets can be found in the Annual Report and Accounts.

Contacts: NIBSC: Victor Knight, National Institute for Biological Standards and Control, Blanche Lane, South Mimms, Herts EN6 3QG; 01707 641000; or see the NIBSC website at **http://www.nibsc.ac.uk**

DH: Brian Bradley, Department of Health, room 513, Wellington House, 135-155 Waterloo Road, London SE1 8UG; 020 7972 4709.

Other NHS Bodies:

Dental Practice Board

The DPB is an independent statutory body supporting dentistry in England and Wales. Its main tasks are to handle payment claims and remunerate dentists providing general dental services and personal dental services under the NHS. It provides an important check to detect and prevent potential fraud or abuse of the dental payments system. It also manages the Dental Reference Service, which provides independent professional dental patient examinations. In 2004-05, the DPB employed an average of 299 full time staff and during the year approved fees of over £1,815 million to 21,465 dentists at a gross administration cost of £26.44 million.

As a result of the Department's review of its arm's length bodies, the DPB will be merged with other constituent bodies into the new NHS Business Services Authority from 1 April 2006.

For further information contact the Chief Executive, Dental Practice Board, Compton Place Road, Eastbourne BN20 8AD; 01323 417000 or **www.dpb.nhs.uk**

Plasma Resources UK Limited

Plasma Resources UK Limited (PRUK) is the UK holding company for DCI Biologicals Inc (DCI). The Department has wholly owned DCI, a US plasma collection company, since 2002. It was acquired to secure access to sustainable long-term supplies of blood plasma in accordance with vCJD risk mitigation strategies. Life-saving plasma products, such as immunoglobulins and clotting factors, are constantly used by NHS patients.

DCI is run as a commercial operation. It continues to trade profitably and in the Departments accounting period for 2005-06 DCI paid £3.5 million in interest to the Department of Health in accordance with its contractual obligations.

The Secretary of State owns all the shares in PRUK. PRUK has no employees. For 2005-06, costs were limited to statutory functions only; ie company audit and associated company secretarial work.

For further information contact Richard Lawes (**richard.lawes@dh.gsi.gov.uk**)

Special Health Authorities:

Health & Social Care Information Centre

The Health & Social Care Information Centre (now to be known as The Information Centre) was established as a special health authority on 1 April 2005 following the arm's length body review.

The Information Centre was established to:

- make information more accessible (including the publication and procurement of information and analytic services);
- reduce the burden of information requests on front-line organisations; and,
- strengthen the capacity for informed decision-making throughout the health and social care system in England.

A key focus for the Information Centre is to engage in a new and leading way with system reform and new policy/system-led information requirements across health and social care and to be the recognised source of authoritative comparative data, providing an independent perspective on the quality, validity and application of information to support improvement in health and social care.

The Information Centre is developing important partnerships with central bodies such as Connecting for Health and the Healthcare Commission to take full advantage of new IT infrastructure and to deliver better information in better ways to front-line organisations throughout health and social care. It has also recently taken a 50 per cent holding in Dr Foster Intelligence, a private sector company specialising in delivering health information to the public and to front-line organisations.

For more information about The Information Centre you can contact us by telephone on 0845 300 6016 or via our website **www.ic.nhs.uk**

Mental Health Act Commission

The Commission was set up in 1983 as an SHA with responsibility under the *Mental Health Act 1983* [C6] for keeping under review the exercise of powers and discharge of duties conferred or imposed by the Act in respect of detained patients. It, therefore, seeks to safeguard the interests of all people detained under the *Mental Health Act 1983*. Commissioners visit all hospital and mental nursing homes where patients are detained to make sure that the powers of the Act are being used properly, and to meet with detained patients to discuss their concerns. The Commission reports on its visits to hospital managers and requires follow-up action on issues of concern.

The Commission's complaints remit allows it to investigate complaints made by or about detained patients where it feels this is appropriate. In general, the Commission helps patients and others to make their complaints through the NHS complaints procedure, and monitors the progress of such complaints. The Commission is notified of the deaths of detained patients and will often attend inquests as an interested party.

On behalf of the Secretary of State, the Commission administers the provision of Second Opinion Appointed Doctors (SOADs), whose authorisation is required for the administration of certain treatments without consent. It also receives and monitors reports on SOADs work. The Commission arranges over 10,000 SOAD visits each year.

The Commission advises the Secretary of State on changes to be made in the *Mental Health Act* Code of Practice and is an important source of general and specific guidance on the operation of the powers of the 1983 Act. It publishes Practice and Guidance Notes on specific issues and answers many queries from patients and practitioners.

The Commission led, in collaboration with the National Institute for Mental Health in England (NIIMHE) and the Healthcare Commission, the first Census of all mental health inpatients – *Count Me In; National Mental Health and Ethnicity Census, England and Wales* [C7]. This census is a key element of the Delivering Race Equality programme to improve services for users experiencing mental illness and distress, and their relatives and carers, from black and minority ethnic communities.

The Commission is required to publish an Annual Report (September 2005) summarising the Commission's activities and expenditure, and has a statutory duty under the 1983 Act to publish and lay before Parliament a Biennial Report. *The Eleventh Biennial Report 'In place of fear'* [C8] covered the period 2004-05 and was published on 11 January 2006 detailing the Commission's functions, the discharge of that function and its findings on general issues in relation to detained patients. The Department of Health directly funds the Commission. Its budget in 2004-05 was £5.3 million. The Commission employs 44 staff. For further information, contact Jo Clewes (Communications Manager), Mental Health Act Commission, Maid Marion House, 56 Hounds Gate, Nottingham NG1 6BG; 0115 9437123. The Commission's email address is **chief.executive@mhac.org.uk** and its website address is **www.mhac.org.uk**.

National Institute for Health & Clinical Excellence (NICE)

The National Institute for Health & Clinical Excellence (NICE) is a SHA which was formally established in February 1999 to provide guidance for the NHS, patients and their carers on medicines, medical equipment and clinical procedures based on evidence of both clinical and cost effectiveness. NICE's work programme is set by the Department of Health.

On 1 April 2005, NICE merged with the Health Development Agency. The Institute now has responsibility for publishing guidance on public health issues, in line with the aims of the White Paper on public health – *Choosing Health* [C9].

NICE develops both clinical and public health guidance. The three forms of clinical guidance the Institute publishes are:

- clinical guidelines – management of particular conditions;
- appraisal guidance – guidance on specific health interventions, including pharmaceuticals; and,
- guidance on the safety and efficacy of interventional procedures.

NICE also develops two forms of public health guidance:

- public health intervention – guidance on clear types of activity, ie: interventions provided by local organisations; and,
- public health programme – guidance that deals with broader activities eg; strategies to help people give up smoking, or advice to particular populations such as young people or pregnant women or on a specific setting such as the workplace.

NICE has a board consisting of four executive members (Chief Executive, Director of Resources and Planning, Implementation Systems Director and Clinical and Public Health Director), the chair and ten non-executive members. A Partners' Council of over 40 members representing the health professions, patient and carer interests, industry and academic bodies works with NICE to monitor progress against its work programme. NICE has issued 95 technology appraisals and 31 Clinical Guidelines as of January 2006.

NICE has a Citizens Council, which brings the views of the public to NICE decision-making about guidance on the promotion of good health and the prevention and treatment of ill health. A group of 30 people drawn from all walks of life, the Citizens Council tackles challenging questions about values – such as fairness and need.

NICE has seven collaborating centres in Acute Care, Chronic Disease, Nursing and Supportive Care, Mental Health, Primary Care, Women and Children and Cancer. These centres enable NICE to produce clinical guidelines. NICE has also established the Centre for Public Health Excellence, which commissions research to support evidence on how to improve the public's health. It draws together data from a range of sources, maintains an up-to-date map of the evidence base and disseminates examples of good practice.

For further information contact Catriona Gregory at the Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 5636 or the NICE website at **http:// www.nice.org.uk**

National Patient Safety Agency (NPSA)

The National Patient Safety Agency (NPSA) is a special health authority established by the Department in 2001 to help take forward the recommendations set out in the Chief Medical Officer's seminal report *An Organisation with a Memory* [C10]. Its role

is to coordinate the efforts of all those involved in healthcare, and more importantly to learn from, patient safety incidents occurring in the NHS.

The NPSA's total budget for 2005-06 is £35.154 million with a WTE staff of 316.

Following the reconfiguration of the Department's arm's length bodies in July 2004, from 1 April 2005 the NPSA assumed responsibility for:

- the National Clinical Assessment Service (NCAS, formerly the National Clinical Assessment Authority);
- the Central Office for Research Ethics Committees (COREC);
- the Better Hospital Food Programme, some aspects of cleanliness in the NHS, the safety of hospital design (transferred from NHS Estates); and,
- contracts with the confidential enquiries into maternal and child health (CEMACH), patient outcome and death (NCEPOD) and suicide and homicide by people with mental illness (NCISH) – which moved from the National Institute for Clinical Excellence and Health.

All trusts are now reporting the NPSA's National Reporting and Learning System (NRLS) and the NPSA published its first report on patient safety information derived from the NRLS and its Patient Safety Observatory in July 2005. Reporting levels continue to increase significantly and the NPSA is receiving on a monthly basis around 60,000-70,000 reports. Learning from patient safety problems has been translated into nine practical solutions for safer care that warranted a national response in 2005. The Agency continues to work with other key stakeholders to take forward a system-wide approach to safety addressing issues such as medication safety for children and adults and hospital design. In addition, the NPSA has released a number of very well-received guidance materials, training and other practical tools to help ensure the NHS can provide safer care. This includes a revised version of *Seven Steps to Patient Safety*[C11] with a focus on primary care and the casebook *Medical Error* which is being developed to promote reporting amongst junior doctors.

For further information about the Agency visit **www.npsa.nhs.uk**, or contact the Agency at 4-8 Maple Street, London, W1T 5HD. Telephone 020 7927 9500.

National Treatment Agency for Substance Misuse (NTA)

The National Treatment Agency for Substance Misuse was established on 1 April 2001 as a special health authority as a result of joint working between the Department of Health and the Home Office. The NTA's strap line is 'more treatment, better treatment, fairer treatment'.

The NTA works closely with the Healthcare Commission and other inspectorates, SHAs and regional bodies to challenge and support Drug Action Teams (DATs) to improve local treatment standards and delivery.

To support a programme of improvements the Department of Health established the pooled drug treatment budget, which has risen from £129 million in 2001-02 to £300 million in 2005-06. This budget has increased significantly and is matched locally by expenditure by PCTs, local authorities and criminal justice agencies.

The NTA employs 146 staff, with a number of their regional staff funded by the Home Office, which reflects the crucial role that the NTA have in supporting the delivery of the Home Office target of 1,000 offenders a week entering treatment by March 2008. Similarly, to reflect the cross Government nature of their work they are jointly accountable to both DH and HO ministers.

For further information about the Agency visit **www.nta-nhs.org.uk**, or contact the Agency's chief executive, Mr Paul Hayes, at 8th Floor, Hercules House, Hercules Road, London, SE1 7DU. Telephone 020 7261 8854.

NHS Appointments Commission

The Commission was established in 2001 as a special health authority to:

- exercise powers delegated by the Secretary of State to appoint the chairs and non-executive directors of local NHS organisations; and,
- ensure that they have access to appropriate training and support and have regular appraisals.

In 2003, its remit was extended and it now also makes appointments to the Department's national bodies.

In any one year, the Commission is responsible for the recruitment, selection and appointments of over 1,000 people and offers 5,000 training places to those serving on NHS boards. It also provides the Department with expert advice and support on a range of public appointments and governance related issues.

The Commission currently comprises a chair, up to eight regional commissioners and the chief executive. It employs 53 staff and has offices in Leeds and London.

Under provisions included in the *Health Bill*[C12], the work of the NHS Appointments Commission will transfer to a new ENDPB – The Appointments Commission. As well as providing an expert public appointments service to the Department, the new Commission will be able to provide support services across Whitehall.

For further information about the Commission visit **www.appointments.org.uk**, or contact the Commission's chief executive at NHS Appointments Commission, Blenheim House, Leeds, LS1 4PL. Telephone 0113 394 2951.

NHS Blood & Transplant (NHSBT)

The National Blood Authority and UK Transplant merged on the 1 October 2005, as part of the Department's review of it's arm's length bodies, to form the new NHS Blood and Transplant. NHSBT's new role includes:

- encouraging the voluntary donation of organs, blood and tissues;
- maintaining the safety and supply of blood organs and tissues;
- increasing the availability of organs for transplant and facilitating their effective and equitable distribution;
- operating and maintaining the Organ Donor Register of people who wish to donate an organ in the event of their death;
- processing, testing and supplying hospitals with blood products, tissues and cells;
- matching and allocating solid organs for transplantation;
- helping to raise the quality, effectiveness and clinical outcomes of blood and transplant services;
- operating Bio-Products Laboratories (BPL) which makes therapeutic products from blood plasma and makes and issues diagnostic materials;
- providing expert advice to other NHS organisations, the Department of Health Ministers and devolved administrations;
- providing appropriate advice and support to health services in other countries;
- commissioning and conducting research and development;
- actively engaging in implementing relevant EU Statutory frameworks and guidance; and,
- involvement in broader international developments.

Initially the new body is functioning as three operating divisions within NHSBT, which are the National Blood Service, UK Transplant and Bio-Products Laboratories. Total Department of Health funding for NHSBT in 2005-06 is £50.407 million.

For further information about the NHSBT visit **www.nhsbt.nhs.uk**, or contact the Authority at NHS Blood and Transplant, Oak House, Reeds Crescent, Watford, Hertfordshire, WD24 4QN. Telephone 01923 486800.

NHS Business Services Authority

The NHSBSA, established on 1 October 2005, was created as part of the Department's arm's length body review. On 1 April 2006, the Counter Fraud and Security Management Services, Dental Practice Board, NHS Logistics Authority, NHS Pensions Agency and Prescription Pricing Authority will cease to operate and the NHSBSA will take on their functions. Additionally, the NHSBSA will take on a small part of the function of the Dental Vocational Training Authority when it ceases to operate.

Between its establishment and 1 April 2006, the NHSBSA has been preparing its infrastructure for the merger. A chair, a chief executive officer and non-executive officers are appointed. Other key executive officer appointments are progressing well. The NHSBSA has set its business direction and is agreeing detailed business plans with its sponsors. It is also implementing other necessary infrastructure arrangements such as governance frameworks, finance/HR policies and processes.

For further information contact Peter Coates, 11th Floor, New Kings Beam House, London SE1 9BW; **Peter.Coates@dh.gsi.gov.uk**; 020 7633 4234

NHS Counter Fraud and Security Management Service (CFSMS)

The CFSMS is a special health authority with responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption in the Department of Health and in the NHS and to the management of security in the NHS.

The high-level aims of CFSMS are:

- to protect the NHS by ensuring that resources made available for patient care and services are not lost to fraud or corruption, attaching the highest importance to working within a clearly defined professional and ethical framework and to winning the support of all those who provide or use NHS services; and,
- the delivery of an environment for those who use, or work, in the NHS that is properly secure so that the highest possible standard of clinical care can be made available to patients.

As a result of the Department's review of it's arm's length bodies, from 1 April 2006 the CFSMS, together with the Dental Practice Board, NHS Pensions Agency and the Prescription Pricing Authority, will merge into a new organisation called the NHS Business Services Authority (BSA).

For further information on the CFSMS contact Steve Phillips at the Department of Health at FID-CFSM, New Kings Beam House, 22 Upper Ground, London SE1 9BW, 020 7633 7448; the CFSMS Executive Office at Weston House, 246 High Holborn, London WC1V 7EX, 020 7895 4500; or see the CFSMS website at **www.cfsms.nhs.uk**

NHS Dental Vocational Training Authority (DVTA)

The DVTA exercises the functions of health authorities by reviewing and advising on the vocational training curriculum, and allocating vocational training numbers to dentists who wish to practise unsupervised in the NHS general dental services to demonstrate that they satisfy the vocational training requirements.

As a result of the Department's review of its arm's length bodies; the functions of the DVTA will be delegated to primary care trusts from April 2006.

The DVTA's gross expenditure in 2003-04 was £255,000. The authority is funded entirely by Government. From April 2003 to March 2004, the DVTA issued 1,312 vocational training numbers and rejected 113 applications for a vocational training number. The authority has four staff.

For further information, contact Trevor Homewood, Dental Vocational Training Authority, Master's House, Temple Grove, Compton Place, Eastbourne, East Sussex BN20 8AD; 01323 431189.

NHS Direct

The NHS Direct Special Health Authority was established under the *NHS Direct (Establishment and Constitution) Order 2004* [C13] which came into force on 1 April 2004.

NHS Direct is responsible for delivering all NHS Direct services in England. This includes:

- NHS Direct telephone service;
- NHS Direct Online website;
- NHS Direct Interactive digital TV; and,
- NHS Direct self-help guide.

The NHS Direct principle is to provide people at home with easier and faster advice and information about health and the NHS. NHS Direct nurses are highly experienced, trained professionals who provide patients with the same high quality, consistent, safe level of service across the country. The benefits apply not only to patients who get fast and appropriate advice on the best way of tackling health problems, but also to the NHS because it is an efficient way of using NHS resources. It allows other services, such as GP co-operatives and accident and emergency departments, to concentrate their efforts where they are most needed.

For further information on NHS Direct visit **www.nhsdirect.nhs.uk**, or contact the chief executive at NHS Direct, 7th Floor, 207 Old Street, London EC1 9PS. Or, telephone 0845 46 47.

NHS Institute

The NHS Institute was established in July 2005 as a special health authority under section 11 of the *NHS Act 1977* [C14]. It operates as an arm's length body (ALB) as part of the NHS and is located at the University of Warwick.

The *NHS Plan,* published by Government in 2000, describes a fundamental reform of the NHS and the immediate agenda, priorities and expectations are set out in the *NHS Operating Framework 2006-07* [C15]. Funding of the service has increased significantly and, in return, the service must achieve increases in efficiency and effectiveness. A fundamental challenge to the service is to speed improvements and transform services, adopting best practice across the board, in order to deliver the level and quality of health care society requires.

The NHS Institute for Innovation and Improvement has been established to support the transformation of the NHS by dedicated focus on leveraging innovation and adopting best practice across the service.

The NHS Institute's mission is to improve health outcomes and raise the quality of delivery in the NHS by accelerating the uptake of proven innovation and improvements in healthcare delivery models and processes, medical products and devices and healthcare leadership. This will be accomplished by deploying innovation and improvement that has a direct impact on:

- improving health outcomes across the NHS;
- improving the operating performance of the health service, both in quality and cost; and,
- building capability and change capacity in the health service.

For more information on the NHS Institute visit **www.institute.nhs.uk**, or contact Andy King, Department of Health, Room G32 Richmond House, 79 Whitehall, London, SW1A 2NS. Telephone 020 7210 5552.

NHS Litigation Authority

The National Health Service Litigation Authority ('the Authority') is a special health authority set up under Section 11 of the *NHS Act 1977*. Its date of commencement was 21 November 1995. The principal task of the Authority is to administer schemes set up under Section 21 of the *National Health Service and Community Care Act 1990* [C16]. This enables the Secretary of State to set up one or more schemes to help NHS bodies pool the costs of any "loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of [their] functions". There are currently five schemes:

- the Clinical Negligence Scheme for Trusts (CNST) covering liabilities for alleged clinical negligence where the original incident occurred on or after 1 April 1995;
- the Existing Liabilities Scheme (ELS) covering liabilities for clinical negligence incidents which occurred before 1 April 1995;
- the Ex RHA Scheme where the NHSLA acts as defendant covering the outstanding liabilities for clinical negligence in respect of the former Regional Health Authorities when they were abolished in April 1996;
- the Liability to Third Party Scheme (LTPS) relating to any liability to any third party where the original incident occurred on or after 1 April 1999; and,
- the Property Expenses Scheme (PES) relating to any expenses incurred from any loss or damage to property where the original loss occurred on or after 1 April 1999.

As well as overseeing the schemes in such a way as to ensure that public money is used appropriately, the Authority is expected to promote the highest possible standards of patient care and to minimize suffering resulting from those adverse incidents that do nevertheless occur.

As a result of the Department's review of its arm's length bodies, the Authority absorbed the functions of the Family Health Services Appeal Authority SHA from 1 April 2005. The Authority's role here is to perform quasi-judicial appellate and other functions, devolved to it by the Secretary of State, in connection with primary care trust decisions on family health services. The legal procedures for an appeal or application for dispute resolution are contained in the relevant regulations. The Authority also provides support to the Family Health Services Appeal Authority, which was introduced by the Health and Social Care Act 2001.

With effect from 1 August 2005, the NHSLA has been charged with coordinating equal pay claims on behalf of the NHS in

England. The powers leading to these new responsibilities were implemented via the *National Health Service Litigation Authority (Establishment and Constitution) Amendment (No.2) Order 2005* [C17], which came into effect on 1 July 2005.

The Authority's administration costs for 2004-05 amounted to £12.6 million. At December 2005, it employed 155 whole time equivalent permanent staff. For further information on the NHSLA contact Tom Fothergill, Director of Finance, NHS Litigation Authority, Napier House, 24 High Holborn, London, WC1V 6AZ; 0207 430 8706.

NHS Logistics Authority

The NHS Logistics Authority was set up as a special health authority on 1 April 2000. Its purpose is to deliver a comprehensive range of health care products and high quality supply chain services, which are essential to promote improved patient care in the English NHS.

This is achieved through three main activity areas:

- operational activity – providing the main supply channel for consumable healthcare products to the English NHS;
- tactical activity – providing a range of modern supply chain services to support the delivery of quality health care; and,
- strategic activity – supporting the development of a world class supply chain across the NHS.

With an annual turnover of over £730 million in 2004-05, NHS Logistics' catalogue service contains over 43,000 product lines. The organisation serves all NHS bodies across the whole of England, offering a 'pick and pack' customised service to over 120,000 individual requisition points. It operates from six distribution centres and directly employs around 1,340 staff.

In line with the Department's review of its arm's length bodies the Authority will be dissolved on 31 March 2006. NHS Logistics will become a business division within the new DH ALB called the NHS Business Services Authority (NHS BSA). In April 2006, the NHS BSA will take on the responsibilities currently discharged by the Prescription Pricing Authority, the Dental Practice Board, the NHS Pensions Agency and the NHS Counter Fraud and Security Management Service, as well as the NHS Logistics Authority.

Details of NHS Logistics' key achievements can be found in its annual report. More information about the Authority's activities is available by visiting **www.logistics.nhs.uk**.

Further information and copies of up-to-date corporate information can be obtained by writing to Carole Appleby, Head of Communications and Corporate Affairs, NHS Logistics Authority, West Way, Cotes Park Industrial Estate, Alfreton, DE55 4QJ; telephone 01773 724261, or by email to **carole.appleby@logistics.nhs.uk**.

NHS Pensions Agency

The NHS Pensions Agency (NHSPA) administers the NHS Pension Scheme for England and Wales, the NHS Injury Benefit Scheme and the Student Grants Bursary Scheme for the NHS funded students at English Higher Education Institutions.

- the Pension Scheme is an un-funded statutory scheme backed by the Exchequer, which is open to all NHS employees and employees of other approved organisations. NHS employers and employees pay a combined contribution rate of 20 per cent to the scheme to defray the cost of benefits and pensions increase;
- the Authority is responsible for administering the Injury Benefit Scheme, which is open to all NHS staff. The Scheme provides a guaranteed level of income for those staff who have suffered a permanent loss of earning ability as the result of an illness or injury which is attributable to their NHS employment; and,
- the NHS Bursary Scheme for England is also administered by the Authority. They are responsible for the assessment and review of NHS funded bursaries and practice placement costs of NHS funded students attending pre-registration courses at English Higher Education Institutions.

The Board of the Authority is made up of a non-executive chair, five non-executive members and four executive members.

As a result of the Department's review of its arm's length bodies, the Authority will be merged into the NHS Business Services Authority on 1 April 2006.

The Authority maintains financial information on the annual accounts of their expenditure, including administration costs. The Chief Executive, as Accountable Officer and Accounting Officer for the NHS Pension Scheme, is responsible for producing and signing off an audited Annual Report and Accounts for the NHS Pensions Agency Special Health Authority, (including the NHS Bursary Scheme) and separately the NHS Pension Scheme. Information about the special health authority accounts is available from the NHS website **www.nhspa.gov.uk**. Copies are available from: The NHS Pensions Agency Special Health Authority, Business Centre, Hesketh House, 200-220 Broadway, Fleetwood Lancashire FY7 8LG.

NHS Professionals

NHS Professionals, established in 2004, provides strategic management of the flexible labour market within the NHS. Working in partnership with NHS employers, it aims to supply healthcare staff of the highest quality to acute trusts and PCTs throughout England.

Its key objectives are:

- to improve the quality of patient care and the performance of temporary staff by investing in NHS staff and setting common standards for quality and clinical governance; and,
- to achieve better value for money and control over temporary staff costs.

NHS Professionals also offers savings to the NHS by managing demand and by controlling costs through managing the Agency Framework Agreements in partnership with NHS Purchasing and Supply Agency.

NHS Professionals provides a service that:

- has a positive influence on the cost and quality of temporary staffing;
- maximises the use of NHS staff to fill temporary positions and shifts;
- is based on effective national systems that minimise cost and maximise the use of modern technology;
- is responsive to the needs of NHS trusts at a local level;
- is attractive to staff wishing to work flexibly in the NHS; and,
- ensures that patients are treated or cared for by staff suitably qualified for the role and professionally managed.

NHS Professionals has an independent Board and chief executive, reporting directly to the Department of Health. For further information visit **www.nhsprofessionals.nhs.uk**, or contact NHS Professionals, Riverside House, 2a Southwark Bridge Road, London, SE1 9HA. Telephone 0845 373 3434.

Prescription Pricing Authority (PPA)

The PPA was established under the *National Health Service Act 1977*. Its purpose is to manage a range of services on behalf of the NHS that cannot be undertaken effectively by other types of health bodies. The Authority's main functions are to:

- calculate and make payments for amounts due to pharmacies and appliance contractors, and calculate amounts due to general practitioners, for supplying drugs and appliances prescribed under the NHS (over 690 million prescription items were processed in 2004-05);
- produce information for General Practitioners (GPs), Primary Care Groups/Trusts (PCGs/PCTs), the Department of Health (DH) and other NHS stakeholders about prescribing volumes, trends and costs;
- administer the NHS Low Income Scheme (LIS);
- issue Prescription Pre-payment Certificates (PPCs), medical, maternity and tax credit exemption certificates;
- issue European Health Insurance Cards (EHIC);
- produce the Drug Tariff containing the reimbursement prices of a range of prescribable items and other remuneration rules and approve Drug Tariff items; and,
- provide enquiry and analytical services on prescribing to the NHS to inform and facilitate their monitoring role.

The Authority's gross expenditure in 2004-05 was £76,260 million, of which the Department funded £72,672 million. During 2003-04, the average number of employees was 2,747 staff (WTE) in nine locations in the North of England and the West Midlands. The Authority's corporate aims and strategy, together with performance against key targets, can be found in their *Annual Report* [C18].

For further information on the Authority contact Mr John Roberts, PPA Business Manager, 4th Floor, Skipton House, 80 London Road, London SE1 6LH; john.roberts@dh.gsi.gov.uk. Telephone 020 7972 2928. Or, visit the PPA website **www.ppa.org.uk**.

As a result of the Department's review of its arm's length bodies, the PPA will be merged into the NHS Business Services Authority on 1 April 2006.

Tribunal Non-Departmental Public Bodies:

Care Standards Tribunal

The Care Standards Tribunal is an independent judicial body that became operational from 1 April 2002. Although legally it is the Tribunal established under the *Protection of Children Act 1999* [C19], the functions of the tribunal provided under that Act were extended by other legislation. This includes the *Care Standards Act 2000* [C20], the *Children Act 1989* [C21] (as amended by the Care Standards Act and the Education Act 2002); the *Criminal Justice and Court Services Act 2000* [C22] and; the *Education Act 2002* [C23].

The Care Standards Tribunal hears appeals in relation to:

- decisions made by the Commission for Social Care Inspection, and the National Assembly for Wales in respect of the registration of establishments and agencies and refusal to waive disqualification from running or being involved in a children's home;
- decisions of the Chief Inspector of Schools in England and the National Assembly for Wales in respect of the registration of child minders and day care providers for children;
- decisions of the Secretary of State in respect of inclusion on the list of those considered unsuitable to work with children and inclusion on the list of those considered unsuitable to work with vulnerable adults;
- decisions of the Secretary of State in respect of prohibition or restriction of employment in schools;
- decisions of the General Social Care Council and the Care Council for Wales in respect of the registration of social workers and social care workers;
- decisions of the body responsible for the approval of Home Child Care Providers; and,
- decisions of the Secretary of State for Education and Skills in respect of the registration of independent schools.

The Tribunal also has responsibility for considering applications from those wishing to have their names removed from the PoCA list, the PoVA list, their prohibition from working with children in schools lifted and their court order banning them from working with children revoked. Such applications may be made from January 2006.

The Tribunal has a full time President appointed by the Lord Chancellor. The Lord Chancellor also appoints the legal and lay members of the Tribunal. The Department of Health provides the Secretariat for the Tribunal, which is located in central London.

In the period 1 April 2004 to 31 March 2005, the Tribunal received 182 appeals, 75 of which were withdrawn by the appellant. The Tribunal heard 84 appeals (including preliminary and costs hearings) in this period. The budget for 2004-05 was £1.2 million. Outturn costs for the year were £769,000. The budget includes expenditure on accommodation and services, training costs for members and administration costs. For further information, contact Barbara Erne, Secretary to the Tribunal, Care Standards Tribunal, 18 Pocock Street, London SE1 0BW. Telephone 0207 960 0664.

Mental Health Review Tribunals (MHRTs)

MHRT's are independent judicial bodies and their role is to review the continued compulsory detention of patients under the *Mental Health Act 1983*. The Lord Chancellor appoints members of the Tribunal. There are two legally qualified Regional Chairmen for the two 'Tribunal Regions' (North and South) in England.

They are responsible for the members within their region. The operational tribunal office and business support office are based in London. The MHRT employs a total of 80 Department of Health staff who arrange hearings for patients detained in hospitals and units throughout England. In 2004-05, there were 21,065 applications and 13,861 hearings. Administrative running costs, including salaries were £2.2 million. The costs for the membership were £20 million. The Tribunal will transfer to the Department for Constitutional Affairs (DCA) on 31 March 2006 as part of the creation of the Tribunal Service.

For more information about MHRT, contact Jack Fargher, Head of the MHRT, 5th Floor, 11 Belgrave Road, Victoria, London, SW1V 1RS. Telephone 020 7592 1053.

Pharmaceutical Price Control Tribunal

The Tribunal is an independent body with judicial powers derived from *The Health Service Medicines (Price Control Appeals) Regulations 2000* as amended [C24]. The Council on Tribunals supervises it.

Its purpose is to determine appeals from suppliers or manufacturers of NHS medicines against decisions made by the Secretary of State pursuant to sections 33 to 37 of the *Health Act 1999* which:

- require a specific manufacturer or supplier to provide information to him;
- limit, in respect of any specific manufacturer or supplier, any price or profit;
- refuse to give his approval to a price increase made by a specific manufacturer or supplier; and,
- require a specific manufacturer or supplier to pay any amount (including an amount by way of penalty) to him.

The Tribunal has one permanent employee, the Clerk to the Tribunal, who is paid an annual retainer of £3,700. There have been no appeals to the Tribunal.

For further information contact Mat Otton-Goulder, Medicines Pricing & Supply, Skipton House, 80 London Road, London SE1 6LH.

ANNEX D

PUBLIC ACCOUNTS COMMITTEE : REPORTS PUBLISHED IN 2005

Four PAC reports were published in the calendar year of 2005. For each report a Treasury Minute has been produced (a Treasury Minute is the Government's considered response to a PAC report).

The list of PAC reports, with date of publication, is as follows:

1. *Tackling Cancer in England: Saving More Lives* [D1] – **25 January 2005**
2. *Improving Emergency Care in England* [D2] – **30 March 2005**
3. *Improving Patient Care by Reducing the Risk of Hospital Acquired Infection: a progress report* [D3] – **23 June 2005**
4. *Reforming NHS Dentistry* [D4] – **14 July 2005**

Tackling Cancer in England: Saving More Lives

The Committee concluded that progress has been made in improving early detection of some cancers through screening and in meeting the target for urgent referral to a specialist for those with suspected cancer. It also noted that much has been done to improve the quality of cancer care through multidisciplinary-team working and that problems with radiotherapy waits are being addressed by greatly increasing capacity through more staff and equipment. However, it also noted differences in survival between the UK and some other countries and regional variations in cancer survival and mortality rates within England. Recommendations included ending the wide variations in prescribing anti-cancer drugs and working towards greater equity in provision of staff across the country.

Action taken on PAC conclusions and recommendations includes:

- carrying out a repeat analysis of the uptake of NICE approved cancer drugs to see if variations have reduced since the production of cancer network action plans. An update should be issued later this year;
- 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 although some specific actions have also been lead centrally; and,
- a National Radiotherapy Advisory Group is considering all aspects of planning and delivery of radiotherapy services.

Improving Emergency Care in England

The Committee concluded that demand for emergency care continues to grow and that the Department should be commended for providing innovative new services such as Walk-in Centres. It recommended that emergency care providers benchmark their performance and monitor their processes to ensure patients, particularly the elderly and vulnerable, spend no more time in A&E than is clinically necessary.

Action taken on PAC conclusions and recommendations includes:

- the Department will continue to work with emergency care networks to help assess patterns of demand and ensure services are effectively commissioned and delivered;
- all trusts are encouraged to follow best practice and make use of the Department's guidance on bed management, specialist opinion and assessment in A&E; and,
- the Department continues to monitor the operational standard that no patient should wait more than four hours in A&E from arrival to admission, discharge or transfer, set at 98 per cent.

Improving Patient Care by Reducing the Risk of Hospital Acquired Infection: A Progress Report

The Committee concluded that despite the previous PAC report, in 2001, there was still limited information on the extent and cost of HAI and that progress in implementing many of its predecessor's recommendations was patchy. It contained a number of detailed recommendations for the Department on issues such as improving national mandatory surveillance, the requirements of national IT systems, production of guidance and education and training.

Action taken on PAC conclusions and recommendations include:

- *Saving Lives* [D5], a delivery programme to reduce healthcare associated infections, including MRSA, provides a toolkit to help the NHS improve infection control, was issued in June 2005;
- in October 2005, an enhanced MRSA surveillance system was rolled out to all acute trusts. Over time, enhanced surveillance will enable us to show specialty-specific rates of incidence of MRSA, thus enabling trusts to compare performance within similar groups of treatments and patients rather than whole trusts. In addition, a national prevalence survey to give a snapshot of all hospital acquired infections has been commissioned. We have also commissioned the Health Protection Agency and the Office for National Statistics to conduct an audit of healthcare associated infection and death certification. This project has started and will report in 2007;
- the Department's Healthcare Acquired Infection and Connecting for Health teams are exploring ways to ensure that the necessary output specifications for health protection and infection control have received sufficient recognition;
- NHS acute trusts have implemented the 'clean your hands' campaign and research to evaluate the implementation is underway; and,
- The National Resource for Infection Control, launched in May 2005, provides professionals with key guidance, on infection control, through a 'one stop shop' electronic portal.

Reforming NHS Dentistry

The Committee concluded the Department had set itself an ambitious programme for reforming NHS dentistry and had not implemented the reforms in line with the original anticipated timescale. The lack of experience in primary care trusts (PCTs) of commissioning dental services added further concern. The Committee underlined the importance of strategic health authorities and PCTs improving their understanding of both need and demand for NHS dentistry. Although the Committee found English children had healthier teeth than their European counterparts, it recommended further work to identify suitable measures of oral health. The Committee also called for effective accountability arrangements for dental performance under the new remuneration system, a communications programme to explain the new dental recall guidelines to patients, and further work to identify how to incentivise dentists to stay in the NHS.

Action taken on PAC conclusions and recommendations includes:

- The Department has managed a wide-ranging programme of work to support PCTs in implementing the new local commissioning arrangements from April 2006 and to ensure that dentists have full information about the impact of the reforms;
- The Department published a new oral health plan for England – *Choosing Better Oral Health* [D6] – in November 2005; and,
- The Department is supporting the NHS in undertaking a national communications programme to explain the dental reforms to patients and the public, focusing on the new system of patient charges, the new guidelines on patient recall intervals and the benefits of local commissioning.

ANNEX E

SPENDING ON PUBLICITY AND ADVERTISING AND INCOME FROM SPONSORSHIP 2005-06 (ESTIMATE)

The Department runs a number of publicity campaigns each year and the forecast outturn for 2005-06 is estimated to be £42.5 million. The main components included in this total are given in **Figure E1**.

Activities in 2005-06 included:

Sustained activity on the tobacco control marketing campaign, including:

- new advertising to encourage younger adults to quit, with separate advertisements designed to address both young men and young women;
- continuation of the real-life testimonial campaign, focusing on the tragic effects smoking can have on an individual and their family. The Department has also produced advertising featuring testimonials from successful quitters, and run these to help support awareness and use of local stop smoking services;
- continued use of 'third party voices' – via the new 'under my skin' advertisement produced through the British Heart Foundation; and,
- new advertising to warn of the dangers of second hand smoke.

The Department has also continued to run the 'Frank' drugs misuse campaign, in partnership with the Home Office.

Advertising and other supporting marketing has encouraged take-up of the European Health Insurance Card. 13.5 million cards had been issued by December 2005.

National TV and press advertising ran again in March 2006 to recruit social care workers.

The Department ran national advertising, combined with local marketing, to support the flu immunisation programme. This targeted people 65 years and over, and all age-groups who are clinically at risk. The campaign also addressed parents and carers of young children in at-risk groups.

Sponsorship Guidelines

Under Guidelines published by the Cabinet Office in July 2000, Government departments are required to disclose sponsorship amounts of more than £5,000 in their departmental annual reports. For these purposes, 'Sponsorship' is defined as: 'The payment of a fee or payment in kind by a company in return for the rights to a public association with an activity, item, person or property for mutual commercial benefit'.

The following amounts have been donated or received in the past financial year as sponsorship 'in kind'.

Figure E1: Departmental Spending on Publicity and Advertising and Sponsorship 2005-06

Campaigns run by the Department	£ million
Smoking (Tobacco Control)	28.70
NHS recruitment	0.34
Flu immunisation	2.30
Get the right treatment	0.86
Keep Warm Keep Well	0.60
EHIC	1.64
Drugs prevention	1.28
Sexual health	0.52
Social work/care recruitment	3.26
Five A Day	1.77
Immunisation	0.75
Breastfeeding awareness	0.38
Alcohol	0.18
Total	**42.58**

Sponsorship Received by DH from Other Organisations 2005-06

Sponsor/partner	Amount received	Support received
Topman Reading and Leeds festival	£11,500	Provision of condoms to support sexual health campaign
LA fitness	£14,450	Provision of condoms to support sexual health campaign
Yates Group	£16,000	Promotion of adult sexual health campaign.
Escapades	£44,000	Promotion in support of adult sexual health campaign
Club 18-30	£62,500	Promotion and condom distribution in support of adult sexual health campaign
2wentys	£39,000	Promotion in support of adult sexual health campaign
Ann Summers	£197,000	Promotion in support of adult sexual health campaign
Club 18-30 Reunions	£10,000	Provision of free condoms in support of adult sexual health campaign
Escapades Reunions	£8,000	Provision of free condoms in support of adult sexual health campaign

Sponsor	Amount received	Support received
2twentys Reunions	£8,000	Provision of free condoms in support of adult sexual health campaign
Club 18-30	£5,000	Promotion in support of adult sexual health campaign
Speed-dater activity	£36,000	Promotion in support of adult sexual health campaign
Jumpin' Jaks/ Chicago Rock Cafe	£30,000	Provision of condoms and promotional activity in support of adult sexual health campaign.
Superdrug	£55,000	Promotion in support of tobacco control campaign
Jazzy Media	£364,900	Poster sites in support of FRANK drugs prevention campaign
CD WOW	£5,500	Promotion in support of FRANK drugs prevention campaign
Club 18-30 Big Reunion	£187,000	Promotional activity in support of FRANK drugs prevention campaign
Habbo Hotel	£124,000	Online promotional activity for FRANK drugs prevention campaign
BT	£99,900	Banner advertising in support of FRANK drugs prevention campaign
Addictive Interactive	£70,000	Promotional activity in support of FRANK drugs prevention campaign
Equator Media	£34,000	Promotional activity in support of FRANK drugs prevention campaign
Livity Communications Consultancy	£79,000	Promotional activity in support of FRANK drugs prevention campaign
Wrigleys Oral Healthcare Programme	£20,000	Sponsorship of EU Presidency Dental Programme Events
AstraZeneca	£200,000	Sponsorship of NHS Live
Boots	£50,000	Sponsorship of NHS Live
Oracle	£200,000	Sponsorship of NHS Live
Olympus	£50,000	Sponsorship of NHS Live
BT	£200,000	Sponsorship of NHS Live
GE Healthcare	£100,000	Sponsorship of NHS Live

Sponsorship Paid by DH to Other Organisations 2005-06

Recipient	Amount sponsored	Support donated
HOPE (Standing Committee of the Hospitals of the European Union)	£20,000	Sponsorship of Patient Safety Conference
EMS Research Forum	£12,000	Materials in support of research-based best practice in emergency services.

ANNEX F

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS – TARGETS ALREADY ACHIEVED (CURRENT POSITION WHERE APPROPRIATE)

Departmental Public Service Agreement Targets – CSR 1998

PSA Target	Measure	Progress
Target 1: Reduction in the death rate from cancer amongst people aged under-75 by at least 20 per cent by 2010 from a baseline of 141.2 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from cancer amongst people aged under-75.	**See PSA (SR 2002) Target 6.**
Target 2: Reduction in death rate from heart disease and stroke and related illnesses amongst people aged under-75 years by at least 40 per cent by 2010, from a baseline of 141.0 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from circulatory disease amongst people aged under-75.	**See PSA (SR 2002) Target 6.**
Target 5: Reduction in the death rate from suicide and undetermined injury by at least 20 per cent by 2010, from a revised baseline of 9.2 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from intentional self harm and injury of undetermined intent.	**See PSA (SR 2002) Target 7 (part).**
Target 6: Achieve the Government's commitment to reduce NHS in-patient waiting lists by 100,000 over the lifetime of the Parliament from the March 1997 position of 1.16 million, and deliver a consequential reduction in average waiting times.	Number of patients on NHS waiting lists.	**Met:** Total waiting list is 789,761 at the end of February 2006.
Target 8: Establish NHS Direct, so that everyone in England has access to a 24-hour telephone advice line staffed by nurses by December 2000.	Percentage of the population with access to NHS Direct.	**Met:** NHS Direct has been national since 22 September 2000. NHS Direct has in excess of two million patient contacts per month.
Target 9: Improve access to and quality of primary care services through investment in line with locally agreed Primary Care Investment Plans. Key targets are:		
a) Increase equity in the national distribution of GPs. From growth of approximately 0.6 per cent whole-time-equivalent GPs in 1997 over 1996, there will be progress towards a national average annual increase of one per cent whole-time-equivalent GPs by 2002, using a range of new initiatives and with local variations to take account of the need to concentrate on deprived and remote areas;	Percentage national average annual increase in GPs.	**Met:** Based on the September 2002 census data growth between September 2001 and September 2002 was 1.0 per cent full-time equivalent (fte) for all general medical practitioners (excluding GP retainers). Between September 2002 and September 2003 the increase was 1,037 (fte) (3.6 per cent) and between September 2003 and September 2004 the increase was 985 (fte) (3.3 per cent).
b) Increase investment in practice staff – 500 new practice nurses will be appointed by 2002.	Number of new practice nurses.	**Met:** Based on the September 2002 census data there was an increase of 1,639 (fte), 2,089 (headcount) practice nurses between September 1998 and September 2002. Between September 2002 and September 2003 the increase was 969 (fte) and 684 (headcount), and between September 2003 and September 2004 the increase was 596 (fte) and 477 (headcount). There are now 13,563 (fte) and 22,144 (headcount) practice nurses employed by GP practices.
Target 10: Improve the quality of primary care premises targeted towards areas of deprivation, resulting in improvements to 1,000 premises nationally by 2002.	Number of GP premises improved.	**Met:** Year-end 1999-2000 indicated that 598 improvements had been made, and year end 2000-01 indicated a further 566. The PSA target was, therefore, met a year early with 1,164 improvements having taken place by April 2001. A total of 2,848 schemes were completed by March 2005.

Departmental Public Service Agreement Targets Analysis – Targets Already Achieved

PSA Target	Measure	Progress
Target 11: Connect all GP surgeries which use clinical computer systems to the NHSnet by the end of 1999 and all other surgeries by the end of 2002, so that more information and services can be offered closer to people's homes. As at November 1998, less than 10 per cent of GP practices were directly connected to NHSnet.	Percentage of GP surgeries connected to NHSnet.	**Met:** Virtually all computerised GP practices have now been connected to NHSnet. Work is now underway on a New National Network (N3) to replace NHSnet. N3 is a broadband network to link all NHS organisations in England. N3 will increase the number of sites served from 10,000 to 18,000 and will significantly speed up the transfer of clinical data between NHS organisations. Connections to N3 commenced in 2004.
Target 12: Improve the quality and effectiveness of treatment and care in the NHS by establishing the National Institute for Clinical Excellence by 1 April 1999, with a view to it producing at least 30 appraisals of new or existing technologies per annum and guidance from 2000-01. The impact of the appraisals and guidance will be assessed by the use of performance indicators.	Number of appraisals of new or existing technologies.	**Met:** Between its formation in 1999 and 2003, NICE undertook and completed 73 technology appraisals or reviews of technology appraisals, many of which covered more than one technology. During the same period, NICE completed eight inherited guidelines, and published three pieces of cancer service guidance and eight clinical guidelines. In 2004, NICE published 13 technology appraisals (including one review), 15 clinical guidelines and three pieces of cancer service guidance. A further 22 technology appraisals, nine clinical guidelines and four pieces of cancer service guidance are due to be published in 2005.
Target 13: Improve the responsiveness of NHS services by taking account of the views of patients and other users obtained through annual surveys of patient and carer experience. Surveys of different client groups and services will be repeated at appropriate intervals. The first survey focuses on patient experience of both general practice and hospital services and started during 1998.	Results of Surveys.	**Met:** **See current progress PSA (SR 2002) Target 5.**
Target 14: Achieve efficiency and other value for money gains in the NHS equivalent to three per cent per annum of health authority unified allocations a year for the next three years.	Overall delivery of PSA targets.	**Met:** The best measure of health authority efficiency is the extent to which other targets have been achieved. New target and progress on value for money is reported in chapter 2 under PSA (SR 2000) Target 12.
Target 15: The Department to ensure that all NHS trusts set a target of at least three per cent in 2000-01 for procurement savings and that delivery of these savings is monitored.	Assessed as part of the national efficiency targets (unit costs) and calculated on a regional basis.	**Met:** NHS trusts had their non-pay budgets reduced by an equivalent amount. The NHS Purchasing and Supplies Agency monitored delivery, in conjunction with the Audit Commission. A target on national reference costs is in chapter 2 under PSA (SR 2000) Target 10.
Target 16: Increase the average generic prescribing rate of all practices in England to 72 per cent by the end of March 2002, compared to the position at the quarter ending September 1998 of 63 per cent.	Percentage generic prescribing rate of GP practices.	**Met:** In 2002, 76.0 per cent of prescription items dispensed in the community in England were written generically. In 2002-03, the generic prescribing rate was 76.4 per cent. Since then the Department no longer monitors this target.
Target 17: Move at least half of those practices with a generic prescribing rate currently below 40 per cent to above that level by the end of March 2002, from a baseline of 598 practices < 40 per cent to 295 practices < 40 per cent.	Proportion of GP practices with a generic prescribing rate below 40 per cent moved above 40 per cent.	**Met:** 75 practices < 40 per cent, December 2000 data. 34 practices < 40 per cent, April 2002 to January 2003 data. The Department no longer monitors this target.
Target 18: A 50 per cent reduction in prescription charge evasion (compared to 1998 levels) by the end of 2002-03.	Percentage reduction in prescription charge evasion.	**Met:** Between 1998-99 and 2002-03 losses from patient prescription charge evasion has fallen from £117 million per year to £47 million. This major reduction easily exceeds the 50 per cent target.
Target 19: £15 million savings from action on contractor fraud (representing £6 million in cash recoveries and £9 million in prevention savings) over the period 1999-2000 to 2001-02.	Increase in amount recovered from action on contractor fraud and reduction in money lost through prescription fraud perpetrated by NHS contractors.	**Met:** Between December 1998 and February 2002, £7.47 million was recovered from action on contractor fraud. Prevention savings of £9.3 million have been made between December 1998 and March 2002.

Departmental Public Service Agreement Targets Analysis – Targets Already Achieved

PSA Target	Measure	Progress
Target 20: Promote independence by reducing nationally the per capita rate of growth in emergency admissions of people aged over-75 to an annual average of three per cent over the five years up to 2002-03, compared with an annual average rate of 3.5 per cent over the last five years.	Annual average per capita rate of growth in emergency admissions of over-75 year-olds.	**On course:** From year-end 1997-98 to year-end 2001-02, annual average per capita growth rate of emergency admissions of people aged 75 and over was 0.8 per cent. **Target has been revised – see PSA (SR 2000) Target 6.**
Target 21: Improve the delivery of appropriate care and treatment to patients with mental illness who are discharged from hospital and reduce the national average emergency psychiatric re-admission rate by two percentage points by 2002 from the 1997-98 baseline of 14.3 per cent.	Average emergency psychiatric admission rate.	**Nearly met:** Psychiatric re-admission rate in 2001-02, the last year data was collected on re-admissions within a 90 day basis, was 12.7 per cent narrowly missing the target by 0.4 percentage points. Implementation of new service models, such as assertive outreach, early intervention and crisis resolution, means that further falls in re-admission rates are expected, though changes in data definition and sources do not allow comparison with earlier years.
Target 22: Achieve efficiency and other value for money gains in personal social services expenditure equivalent of two per cent in 1999-2000 and 2000-01 and three per cent in 2001-02.	Value of efficiency and other value for money savings.	**Nearly met:** The estimated efficiency gains for the three years were 2.1 per cent, 2.3 per cent and 2.5 per cent, totalling 7.1 per cent against a three-year target of 7.2 per cent. For 2002-03, there was no target as such, but the Service Delivery Agreement included an expectation of 2.5 per cent efficiency gains. Estimated gains of 2.0 per cent were made, meaning that the four year total was 9.2 per cent, just short of the cumulative target/expectation of 9.8 per cent.
Target 23: Prevent the unnecessary loss of independence amongst older people by, as a first step, putting in place action plans in all local authorities, to be jointly agreed with the NHS and other local partners, covering prevention services, including respite care, by October 1999.	Percentage of local authorities with action plans.	**Met:** All local authorities had action plans in place by October 1999 in accordance with the terms of the 'The Promoting Independence Grant'.
Target 24: Improve the continuity of care given to children looked after by local authorities by reducing to no more than 16 per cent in all authorities, the proportion of such children who have three or more placements in one year by March 2001. As many as 30 per cent of children currently experience three or more placements per year in some authorities, within a national average of 20 per cent.	Percentage of authorities with more than 16 per cent of children looked after who have three or more placements.	**Responsibility for PSA Targets 24-26 (CSR 1998) now lies with DfES following "Machinery of Government" changes.**
Target 25: Improve the educational attainment of children looked after by local authorities, by increasing to at least 50 per cent by 2001 the proportion of children leaving care aged 16 or above with a GCSE or GNVQ qualification and to 75 per cent by 2003. Data published for the first time in October 2000 set a baseline figure of 30 per cent.	The percentage of children leaving care at age 16+ with a GCSE or GNVQ qualification.	**Responsibility for PSA Targets 24-26 (CSR 1998) now lies with DfES following "Machinery of Government" changes.**
Target 26: By 2004, the proportion of children aged 10-17 and looked after continuously for a least a year, who have received a final warning or conviction, should be reduced by one third from September 2000 position. To reduce the proportion from 10.8 per cent to 7.2 per cent.	PAF Performance Indicator C18, which compares the prevalence of final warnings and convictions among looked after children with their peers.	**Responsibility for PSA Targets 24-26 (CSR 1998) now lies with DfES following "Machinery of Government" changes.**
Target 27: Reduce the proportion of children who are re-registered on the child protection register by 10 per cent by 2002 from the baseline for the year ending March 1997 of 18 per cent of children on the child protection register being re-registered (i.e. target of 17.2 per cent re-registrations to be reached by 2002).	The proportion of children registered during the year on the Child Protection Register who had been previously registered.	**Met:** During 2002-03, there were 13 per cent re-registrations.

Departmental Public Service Agreement Targets Analysis – Targets Already Achieved

PSA Target	Measure	Progress
Target 28: Achieve efficiency and other value for money gains in Departmental operations equivalent of 2.5 per cent in 1999-2000, 2000-01 and 2001-02 while fulfilling the Department's business plan within the running costs total (measured by the annual rate of gain).	Delivery of the Business Plan objectives within the running costs settlement.	**Met:** The Department met its Business Plan objectives within the three-year running cost settlement agreed. A new value for money target is given in chapter 2 PSA (SR 2000) Target 12.
Target 30: To continue to regularly and systematically review services and operations over a five-year period, in line with Government policy in the handbook Better Quality Services. It will agree a programme by September 1999, setting out which services will be reviewed each year, with the intention to review at least 60 per cent of services by March 2003.	Percentage of services reviewed.	**Partly met:** Specific Better Quality Services reviews were overtaken by a fundamental review of services and activities within the Department carried out in the spirit of BQS, which generated a programme of incremental and on-going change that focuses on our Delivery Contract and aims to improve efficiency and effectiveness.
Target 31: To put forward proposals by 31 March 1999, on measures to increase the proportion of the Department's business undertaken electronically in line with the Government's commitment to increase such business to 25 per cent by 2002.	Percentage of business undertaken electronically.	**Met:** There were originally 41 Electronic Service Delivery (ESD) services identified by the Department as suitable for electronic delivery and progress reports are made on a quarterly basis to the Office of the e-Envoy. Two of these were transferred to the Home Office in March 2002, and are no longer the responsibility of the Department of Health. A third was passed to the DWP on 1 April 2003. Five additional services have been added; of the current total of 43 key ESD services, some 49 per cent (a total of 21 services) are able to be delivered electronically as at 2 February 2005. A further nine services are planned to be e-enabled during 2005.
Target 33: To propose targets for reducing staff sickness absence as agreed with the Cabinet Office.	The number of sick days per staff year.	**Met:** The Department agreed with Cabinet Office and the Treasury targets for reducing its levels of sickness absence. We aimed to bring the absence levels down to 7.9 days per staff year by 2001 and down to 6.8 days per staff year by 2003. In 2002, the average sickness absence working days per staff-year was 4.7. This low figure may indicate a level of under-reporting. To help combat this, the Department introduced a new, and more accessible, electronic system for reporting sickness absence in April 2003. The 2003 figure increased to 5.4 days. Further work will take place during 2005 to improve data systems, reporting rates and attendance.
Target 34: The Department of Health will also be taking steps to improve the effectiveness of internal purchasing, based on the recommendations of the CSR report on improving civil government procurement. New IT systems will be introduced to improve procurement, and better training and guidance will be given to staff. Key targets are:		
a) Decisions on best use of the Government Procurement Card in the Department by January 1999;	Decision made within time scale.	**Met:** Following a pilot scheme, the Government Procurement Card is now available to all cost centre managers within the Department.
b) Creation of a procurement database giving information on suppliers to the Department of Health staff by March 1999;	Establishment of a database onto which suppliers can enter details through the Internet.	**Met Late:** Database was established by April 2000.
c) Creation of a website giving information on Department of Health procurement to suppliers by December 1999.	Establishment of a website that is accessible, by suppliers, through the Internet.	**Met:** Website went live in December 1999.

Departmental Public Service Agreement Targets – SR 2000

PSA Target	Measure	Progress
Target 1: Reduce substantially the mortality rates from major killers by 2010: from circulatory disease by at least 40 per cent in people under-75; from cancer by at least 20 per cent in people under-75; and from suicide and undetermined injury by at least 20 per cent. Key to the delivery of this target will be implementing the National Service Frameworks for coronary heart disease and mental health and the NHS Cancer Plan.	Death rate from circulatory disease amongst people aged under-75. Death rate from cancer amongst people aged under-75. Death rate from intentional self harm and injury of undetermined intent.	**See PSA (SR 2002) Target 6 and 7 (part).**
Target 2: Our objective is to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country. *Specific national targets were announced in February 2001 (based on 1997-99 figures):*		
Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole.	Mortality in infancy by social class.	Infant mortality **See PSA (SR 2002) Target 11.**
Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.	Life expectancy by local authority.	Life expectancy **See PSA (SR 2002) Target 11.**
By achieving agreed local conception reduction targets, to reduce the national under-18 conception rate by 15 per cent by 2004 and 50 per cent by 2010, while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter.	The under-18 conception rate. (Number of conceptions to under-18 year-olds, per thousand females aged 15-17).	Under-18 conception rate – on course: **See PSA (SR 2002) Target 9 (part).**
Target 3: Patients will receive treatment at a time that suits them in accordance with their clinical need: two thirds of all outpatient appointments and in-patient elective admissions will be pre-booked by 2003-04 on the way to 100 per cent pre-booking by 2005.	DH monthly central data collection from January 2003. Supersedes the Modernisation Agency monthly project progress reports.	**See PSA (SR 2002) Target 4.**
Target 4: Reduce the maximum wait for an outpatient appointment to three months and the maximum wait for in-patient treatment to six months by the end of 2005.	Number of patients on NHS waiting lists.	**See PSA (SR 2002) Target 1.**
Target 5: To secure year-on-year improvements in patient satisfaction/experience, including: Standards of cleanliness and food, as measured by independently audited local surveys. PALs coming on-stream (by end April 2002).	Results of Surveys Findings of Surveys 'converted' into summer 2002 Performance Ratings. Patient prospectus to convey local findings. Findings used locally, nationally and within cancer networks.	Surveys, Cleanliness, Hospital Food, and Housekeeping – **see PSA (SR 2002) Target 5.** Patient Advocacy Liaison Services (PALs) – 100 per cent of Trusts now have PALs in place.

Departmental Public Service Agreement Targets – SR 2000

PSA Target	Measure	Progress
Target 6: Provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over-75 on from hospital. We expect at least 130,000 people to benefit and we shall monitor progress in the Performance Assessment Framework.	i) Reducing preventable hospitalisation: reducing growth of the per capita rate of emergency admissions and ensuring that the rate of emergency re-admissions within 28 days of discharge from hospital does not increase. ii) Reduction in delay: reduction in the average number of beds occupied by people aged 75 and over who have their discharge delayed.	**Emergency Admissions – met** In 2002-03, the target for Emergency Admissions, Delayed Transfer of Care and Emergency Re-admissions shifted from being for over-75s to being for patients of all ages. The number of admissions is estimated to be 88.6 admissions of patients of all ages per 1,000 population in 2004-05. This estimate is based on the latest admissions data and the latest available mid-year 2003 population estimate. **Delayed transfer of care and emergency re-admissions – met:** Both elements of this target have been met. Between December 2004 and December 2005, the proportion of 'acute' beds occupied by patients aged over-75 for which the patient's transfer was delayed decreased 0.1 percentage points from 1.7 per cent to 1.6 per cent. Between December 2004 and December 2005, the proportion of 'acute' beds occupied by patients of all ages for which the patient's transfer was delayed decreased 0.2 percentage points from 2.3 per cent to 2.1 per cent. The rate of Emergency Re-admissions within 28 days for patients of all ages for October to December 2005 was 6.7 per cent.
Target 7: Improve the life chances for children in care by: Improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004. Improving the educational attainment of children and young people in care by increasing from 4 per cent in 1998 to 15 per cent by 2003-04 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*-C. Giving them the care and guidance needed to narrow the gap in offending between looked after children and their peers. By 2004, the proportion of children aged 10-17 and looked after continuously for at least a year, who have received a final warning or conviction, should be reduced by one third from September 2000 position. This provides a target to reduce the proportion from 10.8 per cent to 7.2 per cent. This target has also been adopted as part of the Department of Health's SR2002 PSA target.	The percentage of employment training or education amongst young people aged 19 who were looked after by councils on 1 April in their 17th year as a percentage of all young people of the same age in their area. OC1 data collection – the percentage of children leaving care at 16+ with 5 or more GCSEs at grade A*-C. Youth Offending. PAF C18: Final Warnings and Convictions of Children Looked After. The number of looked after children adopted during the year. The percentage of those looked after children who are adopted during the year who were placed for adoption within 12 months of the best interest decision. *(Measured using AD1 data collection.)*	**Responsibility for PSA Target 7 (SR 2000) now lies with DfES following "Machinery of Government"changes.**
Maximising the contribution adoption can make to providing permanent families for children, without compromising on quality, so maintaining current levels of adoptive placement stability. Specifically, by bringing councils' practice up to the level of the best, by 2004: – to increase by 40 per cent the number of looked after children who are adopted, and aim to exceed this by achieving, if possible, a 50 per cent increase, up from 2,700 in 1999-2000; – to increase to 95 per cent the proportion of looked after children placed for adoption within 12 months of the decision that adoption is in the child's best interests, up from 81 per cent in 2000-01.	The percentage of those looked after children whose placement for adoption ended during the year as a result of an adoption order being made. *(Measured through the SSDA 903 return.)*	

Departmental Public Service Agreement Targets – SR 2000

PSA Target	Measure	Progress
Target 8: Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008 and increase year-on-year the proportion of users successfully sustaining or completing training programmes.	Returns from the National Drug Treatment Monitoring System, which provides details on the number of drug misusers entering treatment.	**See PSA (SR 2002) Target 10.**
Target 9: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.	PCT progress towards meeting the target is measured through the SaFFR process and will be reflected in the PCT star ratings. The SaFFR incorporates the Primary Care Access Survey which requires PCTs to contact all of their practices on a specific day to monitor the national access target.	**See PSA (SR 2002) Target 3.**

Departmental Public Service Agreement Targets – SR 2002

PSA Target	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 Healthcare Commission.	**Enhanced accountability** To conclude our review of Patient and Public Involvement (PPI), we have established an Expert Panel to consider the evidence collected so far on how the arrangements for ensuring a strong local voice in health and social care can be strengthened. The group, who are all experienced in the field of empowering people to get involved in local decision-making, will meet twice to hear from a range of witnesses. They will then make final recommendations to Ministers about the future direction of patient and public involvement in the NHS. These recommendations will be based on the principles set out in the White Paper, 'Our Health, Our Care, Our Say'. They will also build on findings from patients' experiences and user involvement in health and social care, and the specific work of Patient Forums and Overview and Scrutiny Committees. The Panel will make their final recommendations at the end of April. Surveys: on course. **See SR 2004 PSA target 7.**
Target 6: Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40 per cent in people under-75; from cancer by at least 20 per cent 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 mortality statistics age standardised to allow for changes in the age structure of the population.	**On course:** **See SR 2004 PSA target 1.**

Departmental Public Service Agreement Targets – SR 2002

PSA Target	Measure	Progress
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 per cent 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 six or more visits per week, divided by the population of people supported by councils in residential care and nursing homes.	**Met** Older people supported intensively to live at home. **See SR 2004 PSA Target 8.**
Target 9: Reducing the under-18 conception rate by 50 per cent by 2010.	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.	Under-18 conception rate – encouraging reduction but more rapid decline required in future years. **See SR 2004 PSA Target 3.**
Target 10: Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent 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 SR 2004 PSA target Target 6.**
Target 11: By 2010 reduce inequalities in health outcomes by 10 per cent 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 SR 2004 PSA Target 2.**

Bibliography

1.1
Department of Health
The NHS Plan, A Plan for Investment, A Plan for Reform
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002960&chk=07GL5R
July 2000

1.2
Department of Health
Delivering the NHS Plan
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4005818&chk=zN/Moe
April 2002

1.3
Department of Health
The NHS Improvement Plan – Putting People at the Heart of Public Services
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4084516&chk=MaSAWY
June 2004

1.4
Department of Health
Creating a Patient-led NHS – Delivering the NHS Improvement Plan
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4106506&chk=ftV6vA
March 2005

1.5
Department of Health
Health Reform in England: Update and Next Steps
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4125573&chk=NbDeF2
December 2005

1.6
Department of Health
Independence, Well-being and Choice: Our Vision for the Future of Adult Social Care in England
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108773&chk=zDHdXw
March 2003

1.7
Department of Health
Your Health, Your Care, Your Say
http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4116889&chk=MvDbep
July 2005

1.8
Department of Health
Our Health, Our Care, Our Say: A New Direction for Community Services
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/OurHealthOurCareOurSay/OurHealthOurCareOurSayArticle/fs/en?CONTENT_ID=4127375&chk=Eq%2BTr5
January 2006

1.9
Department of Health
Departmental Investment Strategy
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010068&chk=WQ4a2D
November 2000

2.1
HM Treasury
Public Services for the Future: Modernisation, Reform, Accountability
http://www.hm-treasury.gov.uk./media/730/67/13.pdf
December 1998

2.2
HM Treasury
Supplement – Public Services for the Future: Modernisation, Reform, Accountability: comprehensive spending review: public service agreements 1999-2002
Cm 4315 – The Stationery Office
March 1999

2.3
Department of Health
Choosing Health: Making Healthy Choices Easier
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor
2005

2.4
Department of Health
Programme for Action
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/ProgramForAction/fs/en
July 2003

2.5
Department of Health
A Status Report on the Programme for Action
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI
August 2005

2.6
Department of Health
Ten Year Childcare Strategy: Choice for parents, the best start for children
http://www.surestart.gov.uk/aboutsurestart/about/strategy/
December 2004

2.7
Department of Health
The Childcare Bill
http://www.publications.parliament.uk/pa/cm200506/cmbills/080/2006080.pdf
November 2005

2.8
Department for Education and Skills
Every Child Matters: Change for Children
http://www.everychildmatters.gov.uk/
December 2004

2.9
Department for Education and Skills
The 2004 Children Act
http://www.opsi.gov.uk/acts/acts2004/20040031.htm
November 2004

2.10
Department of Health
Supporting Local Delivery (National Service Framework (NSF) for Children, Young People and Maternity Services)
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098299&chk=dKtpA3
December 2004

2.11
See 1.1

2.12
Department of Health /Neighbourhood Renewal Unit
Creating Healthier Communities: A Resource Pack for Local Partnerships
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4106520&chk=RnNpT9
March 2005

2.13
ODPM
Local Strategic Partnerships: Shaping Their Future
http://www.odpm.gov.uk/index.asp?id=1162320
December 2005

2.14
Department of Health
Sustainable Development (SD) Action Plan
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4132222&chk=xJKIe7
March 2006

2.15
Department of Health
New Environmental Strategy for the NHS in England
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4119249&chk=Mfwc8e
2002

2.16
Department of Health
Sustainable Development for the NHS in England
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4119249&chk=Mfwc8e
2002

2.17
Department of Health
Energy/Carbon Management
(Available in hard copy only from TSO)
ISBN 0-11-322681-0
2004

2.18
Department of Health
Waste Management
(Available in hard copy only from TSO)
ISBN 0-11-322493-1
2004

2.19
Department of Health
Encode – Making Energy Work in Healthcare
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127754&chk=Ub9BmO
2004

2.20
Department of Health
Transport and Car Park Management
(Available in hard copy only from TSO)
ISBN 0-11-322729-9
2004

2.21
Department of Health
Safe Management of Healthcare Waste
http://www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4127832&chk=R0aGW1
2006

2.22
NHS PASA
Towards Sustainability – Facing the Future 2004-05
http://www.pasa.nhs.uk/sustainabledevelopment/2005/
2005

2.23
Legislation
Health Bill 2005-06
http://www.publications.parliament.uk/pa/ld200506/ldbills/076/2006076.htm
February 2006

2.24
Legislation
NHS Redress Bill
http://www.publications.parliament.uk/pa/ld200506/ldbills/022/2006022.pdf
October 2005

2.25
Better Regulation Task Force
Regulation – Less is More
http://www.brc.gov.uk/publications/lessismoreentry.asp
March 2005

2.26
Office of the Deputy Prime Minister
Regulatory Reform Act 2001
http://www.opsi.gov.uk/acts/en2001/2001en06.htm

2.27
Cancer Act 1939
Copies supplied by the Stationery Offices On-Demand service
Publication Date: 1st January 1939
ISBN: **0105164879**

2.28
See 1.6

2.29
Department of Health
The Welsh Language Act
http://www.opsi.gov.uk/acts/acts1993/Ukpga_19930038_en_1.htm
1993

2.30
See 1.8

2.31
The Race Relations (Amendment) Act 2000
http://www.opsi.gov.uk/acts/acts2000/20000034.htm
December 2000

2.32
Department of Health
Race Equality Scheme
www.dh.gov.uk/assetRoot/04/11/21/59/04112159.pdf
May 2005

2.33
Department of Health
The Leadership and Race Equality Action Plan
http://www.dh.gov.uk/PublicationsAndStatistics/Bulletins/BulletinArticle/fs/en?CONTENT_ID=4072494&chk=1e/oI7
November 2004

2.34
Department of Health
Practical guide to ethnic monitoring in the NHS and social care
http://www.dh.gov.uk/assetRoot/04/11/68/43/04116843.pdf
July 2005

2.35
Department of Health
The Equality Bill
http://www.publications.parliament.uk/pa/ld200506/ldbills/002/2006002.htm
May 2005

2.36
Legislation
The Disability Discrimination Act 2005
http://www.opsi.gov.uk/acts/acts2005/20050013.htm

2.37
Stonewall
Stonewall Corporate Equality Index 2006
http://www.stonewall.org.uk/workplace/33.asp
January 2006

2.38
Department of Health
Delivering Race Equality in Mental Health Care Action Plan
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100773&chk=grJd1N
January 2005

2.39
Department of Health
Promoting Equality and Human Rights in the NHS: A Guide for Non-Executive Directors of NHS Boards
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116328&chk=RxnXSr
July 2005

2.40
Medically and Dentally Qualified Academic Staff: Recommendations for Training the Researchers and Educators of the Future (The Walport report)
http://www.wellcome.ac.uk/assets/wtd003184.pdf
April 2004

2.41
Department of Health
The 'Research Governance' framework 2005
http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/ResearchAndDevelopmentAZ/ResearchGovernance/ResearchGovernanceArticle/fs/en?CONTENT_ID=4002112&chk=PJlaGg
April 2005

2.42
Department of Health
Best Research for Best Health: A New National Health Research Strategy
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127127&chk=uSh6qN
January 2006

3.1
Department of Health
The Road Traffic (NHS Charges) Act 1999
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/RoadTrafficAct1999/fs/en
1999

3.2
Legislation
Health and Social Care (Community Health and Standards) Act 2003
www.opsi.gov.uk/acts/acts2003/20030043.htm

4.1
Department of Health
The Mental Health Act 1983
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthList/fs/en?CONTENT_ID=4001816&chk=Tg1/Et

4.2
See 1.8

4.3
The Laming Report
http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm
January 2003

4.4
Office of the Deputy Prime Minister/Department for Trade and Industry
Rethinking Construction
www.dti.gov.uk/construction/rethink/report/
July 1998

4.5
Office of Government Commerce/HM Treasury
Achieving Excellence
www.ogc.gov.uk/index.asp?id=218
March 1999

4.6
See 1.1

4.7
Department of Health
Private Finance Initiative
http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/PrivateFinanceInitiative/fs/en

4.8
Department of Health
The NHS in England: The Operating Framework for 2006-07
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/HealthReform/fs/en
January 2006

4.9
NHS Estates
The 2001 Sold on Health Report
http://www.soldonhealth.gov.uk/page2a.htm

4.10
1999 Health Act Partnership Arrangements
http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/ActsAndBills/ActsAndBillsArticle/fs/en?CONTENT_ID=4002304&chk=AaojV3
April 2000

5.1
See 1.1

5.2
See 1.3

5.3
See 1.4

5.4
Department of Health
Commissioning a Patient-Led NHS
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116716&chk=/%2Bb2QD
July 2005

5.5
See 1.8

5.6
See 1.6

5.7
Department of Health
National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005-06 – 2007-08
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086057&chk=ypFWoL
July 2004

5.8
Department of Health
The NHS In England: The Operating Framework for 2006-07
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127117&chk=BgslVK
January 2006

5.9
Department of Health
Final Agreement
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4095943&chk=eSkZFK
December 2004

5.10
Department of Health
The Care Record Guarantee
http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4111988&chk=PumBe6
May 2005

5.11
Department of Health
A First Class Service
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006902&chk=j2Tt7C
1998

5.12
Department of Health
An Organisation with a Memory
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4098184&chk=u1I0ex
2000

5.13
See 1.5

5.14
Department of Health
Standards for Better Health
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086665&chk=jXDWU6
July 2004

5.15
Department of Health
The New NHS – Modern, Reliable
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010326&chk=b/XgFo
1997

5.16
National Audit Office
A Safer Place for Patients: Learning to Improve Patient Safety
http://www.nao.org.uk/publications/nao_reports/05-06/0506456.pdf
November 2005

5.17
See 3.2

5.18
Department of Health
Practice Based Commissioning: Achieving Universal Coverage
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4127123&chk=CU%2Bwae
January 2006

5.19
Department of Health
Practice Based Commissioning: Early Wins and Top Tips
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4128102&chk=IM%2BV1Y
February 2006

5.20
See 1.7

5.21
See 2.3

5.22
Department of Health
Better Information, Better Choices, Better Health
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098576&chk=hXI1Uf
December 2004

5.23
Department of Health
The Nurse Prescribers Extended Formulary (NPEF)
http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/NonmedicalPrescribing/NursePrescribing/fs/en
January 2006

5.24
Department of Health
Code of Conduct for Payment by Results
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127045&chk=hSHlRr
January 2006

5.25
See 3.3

5.26
Department of Health
NHS Cancer Plan 2000
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009609&chk=n4LXTU
September 2000

5.27
Department of Health
The NHS Cancer Plan and the New NHS
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4092531&chk=2OgU1i
October 2004

5.28
Department of Health
Making Progress on Prostate Cancer
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4093866&chk=oTkFPA
November 2004

5.29
Department of Health/Charitable Organisations
Prostate Cancer Charter for Action
http://www.prostate-cancer.org.uk/what/charter.asp
January 2003

5.30
Nice
Improving Outcomes
http://www.nice.org.uk/page.aspx?o=csg.completed
March 2006

5.31
National Cancer Director's Report
http://www.cancer.gov/newscenter/pressreleases/ReportNation2004release/print?page=&keyword
June 2004

5.32
NICE
Supportive and Palliative Care
http://www.nice.org.uk/catgd.aspx?o=20102
March 2004

5.33
Public Accounts Committee
Tackling cancer: improving the patient journey
http://www.publications.parliament.uk/pa/cm200506/cmselect/cmpubacc/790/790.pdf
January 2006

5.34
Department of Health
A National Framework for the Development of Positron Emission Tomography Services in England
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4121029&chk=Ss%2B4KW
October 2005

5.35
DWP
Opportunity Age
http://www.dwp.gov.uk/opportunity_age/

5.36
Healthcare Commission, Commission for Social Care Inspection (CSCI) and Audit Commission
Living well in later life: A review of progress against the National Service
http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?ProdID=4C4C40BE-6383-40E0-8B26-48D7FAF39A56&fromREPORTSANDDATA=NATIONAL-REPORT&page=index.asp&area=hped

5.37
Legislation
Community Care (Delayed Discharges) Act 2003
www.opsi.gov.uk/acts/acts2003/20030005.htm
April 2003

5.38
Prime Minister's Strategy Unit/Department of Work and Pensions/Department of Health/Department for Education and Skills and Office of the Deputy Prime Minister
Improving the Life Chances of Disabled People
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4101751&chk=LeTuVM
January 2005

5.39
Department of Health
National Service Framework for Mental Health
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009598&chk=jmAMLk
September 1999

5.40
See 4.1

5.41
Mental Health Act Commission
Count Me In: Mental Health and Ethnicity Census
http://www.mhac.org.uk/census2006/docs/FINAL_web_pdf_censusreport_5th__1-0.pdf
December 2005

5.42
See 2.38

5.43
Department of Health
New Ways of Working
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4122342&chk=RbKb2y
October 2005

5.44
Department of Health
Procedures for the Transfer of Prisoners to and from Hospital Under Sections 47 and 48 of the Mental Health Act 1983
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4123628&chk=6xTVN%2B
November 2005

5.45
See 2.8

5.46
Department of Health
A Guide To Promote A Shared Understanding Of The Benefits Of Managed Clinical Networks
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4114364&chk=ebDqj9
2005

5.47
Department of Health
Commissioning Children's and Young People's Palliative Care Services: A Practical Guide for Primary Care Trusts and Practice-based Commissioners
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4123874&chk=CKADiz
November 2005

5.48
See 2.9

5.49
DFES
Working Together
http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/
April 2006

5.50
Department of Health
An NHS and social care model to support local innovation and integration
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100252&chk=f7nOXn
January 2005

5.51
Supporting People with Long Term Conditions to Self Care – A Guide to Developing Local Strategies and Best Practice
http://www.diabetes.nhs.uk/downloads/supporting_people_with_LTC_to_self_care.pdf?bcsi_scan_22F071C7F07ABBC7=0&bcsi_scan_filename=supporting_people_with_LTC_to_self_care.pdf
February 2006

5.52
Department of Health
The NSF for Long-term Conditions
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4105361&chk=jl7dri
March 2005

5.53
Department of Health
Standards for Better Health
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086665&chk=jXDWU6
July 2004

5.54
Department of Health
The National Service Framework for Renal Services
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Renal/fs/en
January 2005

5.55
Department of Health
Delivering the National Service Framework for Renal Services
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4119716&chk=dC0b6i
September 2005

5.56
See 2.3

5.57
Department of Health
The Priorities and Planning Framework 2003 – 2006
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008430&chk=lXp8vH
October 2002

5.58
Department of Health
Diabetes NSF Delivery Strategy
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003246&chk=lKNg9r
January 2003

5.59
NICE
Health Technology Appraisal #60 – Guidance on the Use of Patient-education Models for Diabetes
http://www.ncchta.org/ProjectData/1_project_record_published.asp?PjtId=1313&status=6
September 2003

5.60
Department of Health
National Service Framework for Children, Young People and Maternity Services
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en
September 2004

5.61
Department of Health
Your Guide to Local Health Services
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116233&chk=gLia6w
July 2005

5.62
Legislation
Health and Social Care Act 2001
http://www.opsi.gov.uk/acts/acts2001/20010015.htm

5.63
Department of Health
Reward and Recognition
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4126863&chk=phQ4Mv
January 2006

5.64
Department of Health
Making Partnerships Work for Patients, Carers and Service Users – Strategic Agreement
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4089515&chk=KvDHnR
September 2004

5.65
Department of Health
Self Care – A Real Choice: Self Care Support – A Practical Option
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100717&chk=Khgu1l
2005

5.66
Department of Health
Matron's Charter: An Action Plan for Cleaner Hospitals
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4091506&chk=L2Id5d
October 2004

5.67
Department of Health
Towards cleaner hospitals and lower rates of infection: A summary of action
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4085649&chk=yph9nL
July 2004

5.68
Department of Health
Modernising Pathology Services: Building a Service Responsive to Patients
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4118881&chk=AwsR2V
September 2005

5.69
Department of Health
A Vision for Pharmacy in the New NHS
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4070097&chk=%2B%2BtWyV
July 2003

5.70
Department of Health
Pharmacy in the Future
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4098182&chk=ZnXV%2BR
September 2000

5.71
Department of Health
NHS (Pharmaceutical Services) Regulations
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4107573&chk=5TqNtc
August 2005

5.72
Department of Health
Building on the Best: Choice Responsiveness and Equity in the NHS
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4075292&chk=xhE5pS
December 2003

5.73
Department of Health
Choosing Health Through Pharmacy: A Programme for Pharmaceutical Public Health 2005 – 2015
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4107796&chk=cmOTxs
April 2005

5.74
Department of Health
Our Inheritance, Our Future – Realising the Potential of Genetics in the NHS
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006538&chk=enskFb
June 2003

5.75
Department of Health
Programme for Action
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008268&chk=Ad%2BpLD
July 2003

5.76
See 4.8

5.77
Department of Health
Tackling health inequalities: Status report on the Programme for Action
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI
August 2005

5.78
Department of Health
Delivering Choosing Health
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4105355&chk=gFTjxL
March 2005

5.79
Department of Health
National Service Framework (NSF) for Coronary Heart Disease 2000
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094275&chk=eTacxC
March 2000

5.80
Department of Health
Arrhythmias and Sudden Cardiac Death
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/CoronaryHeartDisease/CoronaryArticle/fs/en?CONTENT_ID=4117048&chk=gUd0zQ
March 2005

5.81
Department of Health
Older People's NSF
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003066&chk=wg3bg0
May 2001

5.82
See 2.23

5.83
The Society for the Study of Addiction
Addiction
http://www.blackwell-synergy.com/doi/full/10.1111/j.1360-0443.2005.01022.x
April 2005

5.84
European Parliament
European Tobacco Advertising Directive - 2003/33/EC
http://europa.eu.int/eur-lex/pri/en/oj/dat/2003/l_152/l_15220030620en00160019.pdf
July 2005

5.85
Tobacco Advertising and Promotion Act 2002
http://www.opsi.gov.uk/acts/acts2002/20020036.htm
November 2002

5.86
Department of Health
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http://www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4124410&chk=BYnWjG
Spring 2006

5.87
Department of Health
Choosing a Better Diet: A Food and Health Action Plan
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4105356&chk=Dm0eqU
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5.88
Department of Health/Chief Medical Officer
At Least Five A Week
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4080994&chk=1Ft1Of
April 2004

5.89
Department of Health
Choosing Activity: A Physical Activity Action Plan
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4105354&chk=ixYz2B
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5.90
Children and Young People Plan
http://www.everychildmatters.gov.uk/strategy/planningandcommissioning/cypp/
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5.91
Department of Health/Teenage Pregnancy Unit
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http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4121562&chk=NqnrFt
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Sure Start
Sure Start Children's Centres Practice Guidance
http://www.surestart.gov.uk/improvingquality/guidance/practiceguidance/
November 2005

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Cabinet Office
Alcohol Harm Reduction Strategy for England
www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp
March 2004

5.95
Department of Health
Alcohol Misuse Interventions: guidance on developing a local programme of improvement
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4123297&chk=lLGV84
November 2005

5.96
Department of Health
Models of Care for Alcohol Misusers (MoCAM)
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/AlcoholMisuse/AlcoholMisuseGeneralInformation/AlcoholMisuseGeneralArticle/fs/en?CONTENT_ID=4130659&chk=FYGAPf
February 2006

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http://www.nta.nhs.uk/
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5.98
Department of Health/Department for Work and Pensions/Health and Safety Executive
'Health, Work and Wellbeing' strategy
http://www.dwp.gov.uk/publications/dwp/2005/health_and_wellbeing.pdf
October 2005

5.99
Department of Health
Choosing Better Oral Health – An Oral Health Plan for England
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4123251&chk=63f8EG
November 2005

5.100
Legislation
The Water Act 2003
www.opsi.gov.uk/acts/acts2003/20030037.htm
November 2003

6.1
Legislation
Health Act 1999
http://www.opsi.gov.uk/acts/acts1999/19990008.htm

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7.3
London Ambulance Service
Taking Healthcare to the Patient: Transforming NHS Ambulance Services
http://www.dh.gov.uk/assetRoot/04/11/42/70/04114270.pdf
June 2005

7.4
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7.5
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7.6
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7.7
Cabinet Office/Department of Health
Making a Difference: reducing burdens in healthcare inspection and monitoring
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4082658&chk=IX3iJg
July 2003

7.8
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7.9
Pay on Time
Better Payment Practice Code
http://www.payontime.co.uk/whypay/about_the_code.html
1998

7.10
Department of Health
The Gershon Report: Releasing Resources to the Front Line
http://www.hm-treasury.gov.uk./media/B2C/11/efficiency_review120704.pdf
March 2004

7.11
Department of Health
Reference Costs 2005
www.dh.gov.uk/refcosts
March 2005

7.12
Office for National Statistics
Atkinson Review of the Measurement of Government Output and Productivity for the National Accounts
http://www.statistics.gov.uk/about/data/methodology/specific/PublicSector/atkinson/final_report.asp
January 2005

7.13
Department of Health
Healthcare Output and Productivity: Accounting for Quality Change
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124266&chk=5QmbY7
December 2005

7.14
Office for National Statistics
Public Service Productivity: Health
http://www.statistics.gov.uk/articles/economic_trends/ET628_Productivity_Heath.pdf
March 2006

7.15
CSCI Office for National Statistics
Performance Ratings for Social Services in England
http://www.csci.org.uk/council_performance/star_ratings/star_ratings_2005.pdf
December 2005

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CSCI
Operating Policies 2005
http://www.csci.org.uk/council_performance/paf/operating_policies.htm
January 2006

7.18
Department of Health
The Framework for Inspection of Children's Services
http://www.ofsted.gov.uk/publications/index.cfm?fuseaction=pubs.displayfile&id=3765&type=pdf
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www.civilservicecommissioners.gov.uk/publications_and_forms/recruitment_code/index.asp

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Office of Government Commerce
Working Without Walls
http://www.ogc.gov.uk/index.asp?id=1002885&app=latest_news.asp&process=full_record&recordid=116
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Department of Health
Framework for Sustainable Development on the Government Estate
www.dh.gov.uk/AboutUs/HowDHWorks/ServiceStandardsAndCommitments/SustainableDevelopment/SustainableDevelopmentArticle/fs/en?CONTENT_ID=4105876&chk=8tkAAK
March 2005

C1
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Health Protection Agency Act 2004
http://www.opsi.gov.uk/acts/acts2004/20040017.htm

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Human Fertilisation and Embryology Act 1990
http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900037_en_1.htm

C5
Legislation
Human Tissue Act 2004
http://www.opsi.gov.uk/acts/acts2004/20040030.htm

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Mental Health Act Commission
The Eleventh Biennial Report 'In place of fear'
http://www.mhac.org.uk/Pages/documents/publications/MHAC%2011%20TEXT%20FA.pdf
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Seven Steps to Patient Safety
http://www.npsa.nhs.uk/site/media/documents/362_7Steps.pdf

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NHS Direct
NHS Direct (Establishment and Constitution) Order 2004
http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1173
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NHS Act 1977
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4094212&chk=qcCqJO
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C15
Department of Health
NHS Operating Framework 2006-07
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127117&chk=BgslVK
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National Health Service and Community Care Act 1990
http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900019_en_1.htm

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National Health Service Litigation Authority (Establishment and Constitution) Amendment (No.2) Order 2005
http://www.opsi.gov.uk/si/si2005/20051445.htm
July 2005

C18
Prescription Pricing Authority
Annual Report
http://www.ppa.org.uk/index.htm
July 2005

C19
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Protection of Children Act 1999
http://www.opsi.gov.uk/acts/acts1999/19990014.htm

C20
Legislation
Care Standards Act 2000
http://www.nwtdt.u-net.com/pdfs/carestan.PDF

C21
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http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4081540&chk=OKx33X

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http://www.opsi.gov.uk/acts/acts2000/20000043.htm

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http://www.opsi.gov.uk/acts/acts2002/20020032.htm

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Legislation
Health Service Medicines (Price Control Appeals) Regulations 2000 as amended
http://www.opsi.gov.uk/si/si2000/20000124.htm

D1
Tackling Cancer in England: Saving More Lives
http://www.policyhub.gov.uk/news_item/health_cancer_pac.asp
25 January 2005

D2
Improving Emergency Care in England
http://www.policyhub.gov.uk/news_item/nhs_emergency_care05.asp
30 March 2005

D3
Improving Patient Care by Reducing the Risk of Hospital Acquired Infection: a progress report
http://www.policyhub.gov.uk/news_item/health_infections_pac05.asp
23 June 2005

D4
Reforming NHS Dentistry
http://www.publications.parliament.uk/pa/cm200405/cmselect/cmpubacc/167/167.pdf
14 July 2005

D5
Department of Health
'Saving Lives'
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Glossary

A&E

Accident and emergency services.

Acute Services

Medical and surgical interventions provided in hospitals.

Accruals accounting

Accruals accounting recognises *assets* or *liabilities* when goods or services are provided or received – whether or not cash changes hands at the same time. Also known as "the matching concept", this form of accounting ensures that income and expenditure is scored in the accounting period when the "benefit" derived from services is received or when supplied goods are "consumed", rather than when payment is made.

Alternative Provider of Medical Services (APMS)

Under nGMS contract arrangements, this is one type of contract Primary Care Trusts (PCTs) can have with primary care providers. This contract is particularly designed to bring in new types of provision such as social enterprise and the voluntary sector.

Annually Managed Expenditure (AME)

In agreeing the longer-term *Departmental Expenditure Limit* (DEL) with the Treasury, it will be found that some areas of a government department's expenditure may be less predictable and liable to fluctuate more in the period covered by the DEL. Because a shorter-term view will be required in such areas, a separate, annual spending limit, will be imposed in such areas. *Subheads* containing this sort of expenditure will be outside of the DEL and categorised separately as Annually Managed Expenditure (AME).

Arm's length bodies (ALB)

Are stand-alone national organisations sponsored by the Department undertaking national functions. There are three main types of ALB:

Executive Agencies;

Executive Non-Departmental Public Bodies; and,

Special Health Authorities.

Atkinson Review

Review of the measurement of Government output and productivity.

Capital

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if it is in excess of £5,000.

Capital Charges

Capital charges are a way of recognising the costs of ownership and use of capital assets and comprise depreciation and interest/target return on capital. Capital charges are funded through a circular flow of money between HM Treasury, the Department of Health, PCTs and NHS trusts.

Central Health and Miscellaneous Services

These are a wide range of activities funded from the Department of Health's spending programmes whose only common feature is that they receive funding direct from the Department of Health, and not via PCTs. Some of these services are managed directly by Departmental staff, others are run by non-Departmental public bodies, or other separate executive organisations.

Community Care

Care, particularly for elderly people, people with learning or physical disabilities or a mental illness, which is provided outside a hospital setting, i.e. in the community.

Consolidated Fund

The Government's general account at the Bank of England. Tax revenues and other current receipts are paid into this Fund. Parliament gives statutory authority for funds to be drawn from the Consolidated Fund to meet most expenditure by the Government.

Corporate governance

System by which organisations are directed and controlled.

Cost of Capital

A charge on the value of assets tied up in an organisation, as a measure of the cost to the economy.

Credit Approvals

Central Government permission for individual local authorities to borrow or raise other forms of credit for capital purposes.

Departmental Expenditure Limit (DEL)

The DEL is the annual spending limit imposed on a government department arising from its agreed, longer-term financial settlement with the Treasury. (*See also Annually Managed Expenditure (AME)).*

Depreciation

The measure of the wearing out, consumption or other loss of value of a fixed asset whether arising from use, passage of time or obsolescence through technology, and market changes.

Distance from target

The difference between a PCT's allocation and its target fair share of resources informed by the weighted capitation formula.

Drugs Bill

Drugs bill gross expenditure is the cash amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs, medicines and certain listed appliances which have been prescribed by NHS practitioners. Net drugs bill expenditure is less Pharmaceutical Price Regulation Scheme (PPRS) receipts. Funding is subject to local resource limits and forms part of PCTs' HCHS discretionary allocations.

Estimated Outturn

The expected level of spending or income for a budget, which will be recorded in the Department's Accounts.

Estimates

See *Supply Estimates.*

European Economic Area

The European Community countries plus Norway, Iceland and Liechtenstein.

Executive Agencies

Executive agencies are self-contained units aimed at improving management in Government. They carry out specific executive functions on behalf of the parent Department within an operational framework agreed by Ministers.

External Financing Limits (EFLs)

NHS trusts are subject to public expenditure controls on their spending. The control is an external financing limit (EFL) issued to each NHS trust by the Department of Health. The EFL represents the difference between the resources a trust can generate internally (principally retained surpluses and depreciation) and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the internal resources are more than the capital spend then the money is used to meet any due repayments of debt principal on the trust's ordinating capital debt and Secretary of State loans, with an excess being invested.

Family Health Services (FHS)

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department of Health with the exception of nGMS contracts which are determined by the various representatives of the relevant professions in consultation with the Department, and are administered locally by PCTs, and PDS contracts which are agreed locally between contractors and PCTs. Funding of FHS services, with the exception of nGMS contract arrangements and PDS contracts, is demand led and not subject to in year cash limits at PCT level, though FHS expenditure has to be managed within overall NHSresources.

New GMS GPs' contract funding arrangements are covered at practice level covering GP pay, reimbursement of practice staff, premises and IT including the cost of non-dispensing doctors personal administration etc. All of which are funded within the PCTs' (Unified Budget/HCHS) discretionary allocations.

PDS contracts are also managed within PCTs' discretionary allocations. From 1 April 2006, full local commissioning for all primary care dental services will be introduced, with all current GDS services also transferring to new contracts managed by PCTs within delegated discretionary allocations.

General Dental Services (GDS)

The GDS offers patients personal dental care via General Dental Practitioners (GDPs), who work as independent contractors from High Street and local surgeries. Although the GDS is administered by PCTs as part of the Family Health Service, GDPs are engaged under a uniform national contract. Funding is provided from the national demand led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

General Medical Services (GMS)

These are services covered by contract arrangements agreed at national level by GPs to provide one-to-one medical services, for example: giving appropriate health promotion advice, offering consultations and physical examinations, offering appropriate examinations and immunisations.

The introduction of the new General Medical Services (nGMS) contract represents a fundamental change in the way in which practices are incentivised to deliver patient care. Whilst it retains the independent contractor status for GPs, it moves away from remunerating individual doctors to a practice based contract. All funding for these are covered through PCTs Unified Budget allocations.

The new contract will provide a range of new mechanisms allowing practices greater flexibility in determining the range of services they wish to provide, including rewards for delivering clinical and organisational quality, modernisation of GP Infrastructure including premises and IT and unprecedented levels of investment through the Gross Investment Guarantee. All these mechanisms are designed to deliver a wider range of quality services, for patients empower patients to make best use of primary care services.

See Also Alternative Provider of Medical Services (APMS) and Primary Medical Services (PMS).

General Ophthalmic Services (GOS)

The GOS offers priority groups of patients free NHS sight tests or vouchers to help with the purchase of glasses. NHS sight tests are mainly available to children, people aged 60 or over, adults on low income, or people suffering from or predisposed to eye disease. NHS optical vouchers are mainly available for children, adults on low incomes, and those who need certain complex lenses. Services are provided by optometrists and ophthalmic medical practitioners who work as independent contractors from High Street opticians. Although the GOS is administered by PCTs as part of the Family Health Service, optical contractors are engaged under a uniform national contract. Funding is provided from the national demand led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation.

Gershon Review

Efficiency review of Whitehall departments looking at common core functions.

Green Paper

Consultation document issued by a Government department.

Gross Domestic Product (GDP) Deflator

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms. The series is produced by HM Treasury, and the one used in this report is that published at the April 2004 budget.

Gross/Net

Gross expenditure is the total expenditure on health services, part of which is funded from other income sources, such as charges for services, receipts from land sales and income generation schemes. **Net** expenditure (gross minus income) is the definition of "public expenditure" most commonly used in this report, since it is the part of the total expenditure funded by the Exchequer.

Health Improvement Programmes

An action programme to improve health and health care locally and led by the PCT. It will involve NHS trusts and other primary care professionals, working in partnership with the local authority and engaging other local interests.

Healthcare Resource Groups

Grouping of similar clinical procedures that require approximately similar levels of resource input.

Hospital and Community Health Services (HCHS)

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by PCTs and provided by NHS trusts. HCHS provision is discretionary and also includes funding for those elements of FHS spending which are discretionary (GMS discretionary expenditure). It also covers related activities such as R&D and education and training purchased centrally from central budgets.

Independent Sector Treatment Centre

The independent sector treatment centre programme provides the NHS with extra capacity quickly, and utilises the talents of some of the world's leading independent healthcare companies to deliver high quality care for NHS patients.

In-patient

A person admitted on to a hospital ward for treatment.

NHS Foundation Trusts

NHS foundation trusts (NHSFTs) are independent Public Benefit Corporations authorised to provide goods and services for the purposes of the health service in England. NHSFTs are free standing, not for profit healthcare organisations. They remain firmly part of the NHS and are subject to NHS standards, performance ratings and systems of inspection. However, NHSFTs are controlled and run locally, not nationally.

The Secretary of State for Health does not have the power to direct NHSFTs. NHSFTs are governed by a Board of Governors comprising of people elected from and by members of the public, patients and staff. Local stakeholders such as PCTs are also represented on the Board of Governors. Monitor (the statutory name of which is the Independent Regulator of NHS Foundation Trusts) authorises NHS trusts as NHSFTs and ensures they abide by their terms of authorisation ('licence' to operate) and the legislation. Accountability for NHSFTs is to local people, commissioning PCTs, Monitor and to Parliament, rather than to central Government.

NHS LIFT

NHS LIFT stands for NHS Local Improvement Finance Trust. A local LIFT will build and refurbish primary care premises which it will own. It will rent accommodation to GPs on a lease basis (as well as other parties such as chemists, opticians, dentists etc).

NHS Trusts

NHS trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as represented by PCTs and GPs.

National Insurance Fund

The statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid, and from which expenditure on most contributory social security benefits is met. The NHS also receives an element of funding from this.

National Service Framework

National Service Frameworks (NSFs) are long-term strategies for improving specific areas of care. They set measurable goals within set timeframes. Each NSF is developed with the assistance of external stakeholders in groups which usually contain health professionals, service users and carers, health service managers, partner agencies, and other advocates, adopting an inclusive process to engage the full range of views.

Non-Discretionary

Expenditure that is not subject to a cash limit, mainly 'demand led' family health services, including the remuneration of general medical practitioners, the cost of general dental and ophthalmic services, dispensing remuneration and income from dental and prescription charges.

Operational Capital

Operational capital is used to maintain NHS organisations' capital stock to a minimum standard, as well as for minor developments and equipment replacement.

It was referred to historically to as 'block capital' and since 2003-04, have been allocated directly to NHS trusts and PCTs.

The allocation uses a formula that is depreciation based and takes into account the levels of building and equipment stock.

Outpatient

A person treated in a hospital but not admitted on to a ward.

Outturn

The actual year end position in cash terms.

Payment by Results (PbR)

A financial framework in which providers are paid according to the level of activity undertaken. Payment is based upon a national tariff system.

Performance indicator

A benchmark measure against which an individual organisation is compared.

Personal Dental Services (PDS)

PDS offers patients personal dental care equivalent to that provided by General Dental Practitioners within the Family Health Services, but within a more flexible framework of local commissioning. PCTs can contract with practitioners or other providers to provide patient services but are free to negotiate and set contract terms which best suit local circumstances and priorities. Where services have converted from GDS contracts, a transfer is made on an annual basis from the General Dental Services non-discretionary budget and allocated to the individual PCT's discretionary budget. PCTs can also commit other funding from their HCHS discretionary allocations or integrate more specialised elements of former Community Dental Services into PDS schemes. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

Personal Medical Services (PMS)

A PMS contract is locally agreed between the commissioner and the provider. This means that primary care service provision is responsive to the local needs of the population. As a result, PMS has been successful in reaching deprived and under-doctored areas. Many PMS pilots focus on the care of vulnerable groups, including homeless, ethnic minorities, and mentally ill patients. A transfer is made on an annual basis, from the General Medical Services Non-discretionary to a PMS discretionary budget. PCTs can also commit other funding for PMS pilots, as appropriate, from their HCHS discretionary allocations.

Personal Social Services (PSS)

Personal care services for vulnerable people, including those with special needs because of old age or physical disability and children in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and social workers who provide help and support for a wide range of people.

Pharmaceutical Services (PhS)

Pharmaceutical Services cover the supply of drugs, medicines and appliances prescribed by NHS practitioners. Gross PhS expenditure includes total drugs bill costs (see Drugs Bill definition) and dispensing costs. Dispensing costs is the remuneration paid to contractors for dispensing prescriptions written by NHS practitioners. This includes payments to pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items. Net PhS expenditure is the gross expenditure less associated income from prescription charges.

As stated in the drugs bill, definition funding for the total drugs bill is subject to local resource limits and forms part of PCTs' HCHS discretionary allocations. However, funding for dispensing costs is provided from the national demand led or

non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation.

Primary Care

Family health services provided by family doctors, dentists, pharmacists, optometrists, and ophthalmic medical practitioners.

Primary Care Trust (PCT)

Primary Care Trusts are responsible within the resources available for identifying the health care needs of its resident population, and of securing, through its contracts with providers, a package of hospital and community health services to reflect those needs. PCTs have a responsibility for ensuring satisfactory collaboration and joint planning with local authorities and other agencies.

Primary Care Trust Medical Services

Under nGMS contract arrangements, this is PCT provided medical services and is a route to provision of primary medical services where PCT employs the GPs, nurses and others in the primary health team and is used for providing care where it has not proved possible to attract GPs to open practices

Private Finance Initiative (PFI)

The use of private finance in capital projects, particularly in relation to the design, construction and operation of buildings and support services.

Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, e.g. estimates for clinical negligence liabilities. Provisions are included in the accounts to comply with the accounting principle of prudence. An estimate of the likely expense is charged to the *income and expenditure* account (for the Department, to the *Operating Cost Statement*) as soon as the issue comes to light, although actual cash payment may not be made for many years, or in some cases never. The expense is matched by a balance sheet provision entry showing the potential *liability* of the organisation.

Public Accounts Committee

A parliamentary select committee. Its main role is the examination of the reports produced by the Comptroller and Auditor General (C&AG) on his value for money (VFM) studies of the economy, efficiency and effectiveness with which Government departments and other bodies have used their resources to further their objectives.

Public Service Agreement

These are agreed output targets detailing the exact outcomes departments will deliver with the money provided.

Real Terms

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

Reference Costs

A schedule of costs of healthcare resource groups that allows direct comparison of the relative costs of different providers.

Regulatory Impact Assessment

A regulatory impact assessment (RIA) is a short structured document which is published with regulatory proposals and new legislation. It briefly describes the issue which has given rise to a need for regulation and compares various possible options for dealing with that issue.

Request for Resources (RfRs)

Under the Resource Budgeting system, a Department's Supply Estimate will contain one or more requests for resources (RfRs). Each request for resources will contain a number of *Subheads*. A request for resource specifies the combined cash and non-cash financing requirement of the Department in order to provide the range of services contained in its *Subheads*.

Resource Accounting and Budgeting (RAB)

Finally introduced in full on 1 April 2001, Resource Accounting and Budgeting (RAB) is a Whitehall wide programme to improve the management of resources across Government. The concept deals with the wider issue of the resources available to government departments and includes consideration of all of their assets and liabilities and not just the level of cash financing which was the principal measure used historically.

Resource Accounting comprises:

- *accruals* accounting to report the expenditure, income and *assets* of a department;
- matching expenditure, income and assets (resource consumption) to the aims and objectives of a department of the appropriate financial year determined by accruals accounting; and
- reporting on outputs and performance.

Resource Budgeting is the extension of Resource Accounting principles and represents the spending plans of the department's programmes and operations measured in resource terms (resource consumed in the financial year rather than just cash spent/received) to reflect the full costs of its activities.

Revenue

Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.

Secondary Care

Care provided in hospitals.

Social Services

Local authority departments that provide direct services in the community to clients.

Special Health Authority (SHA)

SHAs are health authorities which have been set up to take on a delegated responsibility for providing a national service to the NHS or the public. They can only carry out functions already conferred on SofS. They originate under Section 11 of the NHS Act 1977, which gives SofS the power to establish a special body for the purpose of performing certain specified functions on his behalf.

Specific Grants

Grants (usually for current expenditure) allocated by Central Government to local authorities for expenditure on specified services, reflecting Ministerial priorities.

Spending Review

Practice of reviewing and setting Departmental expenditure plans. Normally conducted every two years.

Strategic Capital

Strategic Capital is allocated to support larger capital projects that trusts and PCTs cannot afford to fund from operational capital.

It was formerly known as 'discretionary capital' and is allocated directly to SHAs, whose responsibility is to distribute it to trusts and PCTs according to local priorities.

The formula is capitation based and, in the main, follows the revenue resource allocation formula.

Strategic Health Authority

Twenty-eight new health authorities, covering the whole of England, were established in April 2002. They were renamed Strategic Health Authorities (SHA) by Section 1 of the NHS Reform and Health Care Professions Act 2002, which came into force on 1 October 2002. SHAs serve populations of between 1.2 million and 2.7 million people and have boundaries, which are aligned with the boundaries of one or more local authorities, and which broadly reflect clinical networks. As the headquarters of the local NHS, the Strategic Health Authorities are the main link between Department of Health and the NHS and are responsible for ensuring that all NHS organisations work together to deliver the NHS Plan for modernised patient-centred services. Their main functions include creating a strategic framework for the delivery of the NHS Plan locally; drawing together local delivery plans, and performance management, of local NHS bodies; and building capacity and supporting performance improvement.

Supply Estimate

The term is loosely used for the Main Estimates, a request by the Department of Health to Parliament for funds required in the coming financial year. There are also Supplementary Estimates. Supply Estimates are sub-divided into groups (Classes) which contain provision (usually by a single department) covering services of a broadly similar nature. A sub-division of a Class is known as a "Vote" and covers a narrower range of services. The Department of Health has three Votes which form Class II. Vote 1 covers the Department of Health and contains two *Requests for Resources (RfRs)* – the first covering expenditure on the NHS, the second other Departmental services and programmes. A Supply Estimate does not of itself authorise expenditure of the sums requested. This comes through an Appropriation Act passed by Parliament.

Trading Fund

Trading funds are Government Departments or accountable units within Government Departments set up under the Government Trading Funds Act 1973, as amended by the Government Trading Act 1990. The Acts enable the responsible Minister to set up as a trading fund a body which is performing a statutory and monopoly service whose fees are fixed by or under statute. A trading fund provides a financing framework within which outgoings can be met without detailed cash flows passing through Vote accounting arrangements.

Unified Allocation

Before April 1999, Health Authorities (HAs) received separate revenue funding streams for: hospital and community health services (HCHS); discretionary funding for general practice staff, premises and computers (GMSCL); and family health services prescribing. The White Paper, *The new NHS: Modern, Dependable,* proposed unifying these funding streams. Since April 1999, there has been a single stream of discretionary funds flowing through commissioners.

Voluntary & Community Sector (VCS)

Independent organisations that provide services directly to the community and specific client groups.

Vote

See *Supply Estimate.*

Walk-In Centre

NHS walk-in centres offer the public quick access to advice and treatment for minor ailments and injuries. No appointment is necessary. A key aim of the demonstrator sites is to help PCTs ensure there is adequate local provision to give patients faster access to healthcare.

Weighted Capitation Formula

A formula which uses population projections for resident population which are then weighted as appropriate for the cost of care by age group, for relative need over and above that accounted for by age and to take account of unavoidable geographical variations in the cost of providing services. They are used to determine PCTs target share of available resources.

White Paper

A statement of policy document issued by a Government department.

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NOTES

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