Department of Health

Autumn Performance Report 2006

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
December 2006

Cm 6985

£9.00

Department of Health

Autumn Performance Report 2006

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
December 2006

Cm 6985

£9.00

Contents

Introduction

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

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

These PSAs are set out in the White Papers:

2000 Spending Review: Public Service Agreements, July 2000;

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

2004 Spending Review: Public Service Agreements, July 2004.

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

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

- a shift to a system in which standards of quality and care will be the key national driver for improvements;
- a reduced set of national targets to accelerate progress in a focused set of priority areas;
- more headroom for local communities to address local priorities;
- financial and performance assessment incentives aligned to support improvements in the system; and
- local organisations taking a greater lead in service modernisation.

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

The Department of Health's Aims and Objectives SR2004

Aim

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

Objectives and Performance Targets

Objective I: Health of the Population

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

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

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

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

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

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

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

Objective II: Long Term Conditions

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

Objective III: Access to Services

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

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

Objective IV: Patient/User Experience

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

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

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

Departmental Public Service Agreement Targets Analysis SR2004

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

Objective I: Health of the Population

PSA Targets	Measure	Progress
Target 1 Improve the health of the Population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.	**Life expectancy at birth for males and females in England**	**Overall life expectancy – encouraging increase** The latest published data relate to the 3-year period 2003-05. In England in 2003-05, the period life expectancy at birth was as follows: Male – 76.9 years Female – 81.1 years These have risen from a baseline of 75.0 years for males and 79.9 years for females in 1997-99.
Substantially reduce mortality rates by 2010. – from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole;	**Death rate from heart disease, 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. In 2003-05 (3 year average latest available data) the rate had fallen to 90.5 deaths per 100,000 – a fall of 35.9%. 3 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. **Inequality dimension – on course** 3 year average rates have fallen in the Spearhead Group and England as a whole for each period since the baseline. During this period the inequality gap has reduced from a baseline absolute gap of 36.7 deaths per 100,000 population in 1995-97 to 26.4 deaths per 100,000 population in 2003-05. (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 27.9% since the baseline, compared to the required target reduction of at least 40% by 2009-11.

PSA Targets	Measure	Progress
– from cancer by at least 20% in people under 75 with at least a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole;	**Death rate from cancer** amongst people aged under 75.	**Cancer** **Overall mortality – on course** The 1995-97 baseline figure for overall mortality for heart disease in people aged under 75 in England was 141.2 deaths per 100,000 population. In 2003-05 (3 year average, latest available data) the rate had fallen to 119.0 deaths per 100,000 – a fall of 15.7%. 3 year average rates have fallen for each period since the baseline. If the trend of the last 10 years were to continue the target would be met. **Inequality dimension – provisionally met** 3 year average rates have fallen in the Spearhead Group and England as a whole for each period since the baseline. Following a small increase in the inequality gap in the first monitoring period, the gap has reduced from a baseline absolute gap of 20.7 deaths per 100,000 population in 1995-97 to 18.1 deaths per 100,000 population in 2003-05. (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 12.7% since the baseline, compared to the required target reduction of at least 6% by 2009-11.
– from suicide and undetermined injury by at least 20%.	**Death rate from intentional self-harm and undetermined injury** amongst people of all ages. Baseline is average of 1995, 1996 and 1997. (All using ONS mortality statistics age standardised to allow for changes in the age structure of the population.)	**Suicide and injury of undetermined intent – encouraging reduction but more rapid decline required in future years** The 3 year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen and in 2003-05 is now 7.4% below the baseline. Although progress is towards the target, the rate of decline has slowed in recent years and, if the current trend continues, the target would not be met.
Target 2 Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.	**Mortality in infancy by social class:** the gap in infant mortality between "routine and manual" groups and the population as a whole. Baseline is average of 1997,1998 and 1999.	**Infant mortality – challenging target, further work required on delivery chain** Data for 2003-2005 (3 year average) show a slight narrowing in the gap between the "routine and manual" groups and the population as a whole, compared with last year. However, over the period since the target baseline, the gap has widened, and the infant mortality rate among the "routine and manual" group is now 18% higher than in the total population. This compares with 13% higher in the baseline period of 1997-99, although there have been year-on-year fluctuations in intervening years.

PSA Targets	Measure	Progress
	Life expectancy by local authority: the gap between the fifth of areas with the "worst health and deprivation indicators" (the Spearhead Group) and the population as a whole. Baseline year is average of 1995,1996 and 1997.	**Life expectancy at birth – challenging target, further work required on delivery chain** Data for 2003-05 (3 year average – latest available data) indicate that since the target baseline (1995-97), 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 2%, for females by 8%. Although the new data for 2003-05 indicate a widening in the relative gap between England and the Spearhead Group since the target baseline, the gap shows little change over 2002-04 figures with a very small widening for men and no further widening for women. Some 60% of Spearhead areas are showing signs of progress to narrow their share of the life expectancy gap by 10% in 2010. In 2002-04, 19% of Spearheads were on track to narrow their share of the life expectancy gap for both men and women, and a further 41% were on track for either men or women. In 2003-05 11% of Spearheads are on track for both men and women with a further 48% on track for either men or women.
Target 3 Tackle the underlying determinants of health and health inequalities by:		
– Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.	**Smoking:** reduction in numbers of adult and routine/manual groups of smokers. Prevalence from General Household survey.	**Adult smoking rates – on course** The percentage of adults smoking has fallen by 3 percentage points since 2001. Whilst 27% of the whole population smoked in 2001, this figure had fallen to 24% in 2005. **Reduction in prevalence among routine and manual groups – encouraging reduction, but more rapid decline required in future years** The routine and manual figures were 33% in 2001 and 31% in 2005.
– Halting the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole **(Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport)**.	**Obesity:** Prevalence of obesity as defined by National BMI percentile classification for children aged between 2 and 10 years (inclusive) measured through the Health Survey for England. Baseline year is weighted average for 3 year period 2002/03/04.	**Obesity – awaiting figures** Progress against the target will be measured through the Health Survey for England. Comparisons will be made annually by comparing childhood obesity figures for aggregate 3-year periods, ie 2002-04 against 2003-05, 2003-05 against 2004-06 and so on until 2008-10. Three-year aggregates are used to account for the limited sample size. The lag between the end of the collecting period and data being published is around 12-15 months. Currently, 14.9% of children aged 2-10 in England being Obese (based on the Health Survey for England during 3-year period 2002/04). Halting the increase would mean no significant change in prevalence between the two 3-year periods 2005/06/07 and 2008/09/10.

PSA Targets	Measure	Progress
– Reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. **(Joint target with the Department for Education and Skills)**.	**Teenage Conceptions:** The under-18 conception rate is the number of conceptions to under 18 year olds per thousand females aged 15-17. Baseline year is 1998. ONS Conception Statistics.	**Teenage conceptions – encouraging reduction, but more rapid decline required in future years** The under-18 conception target is now a shared PSA target between the Department of Health and DfES in light of the move of the Teenage Pregnancy Unit to DfES in June 2003. Teenage pregnancy rates are falling. Between the 1998 baseline year and 2004 (the latest year for which data are available) the under-18 conception rate has fallen by 11.1% and the under-16 rate has fallen by 15.2%. Both rates are now at their lowest level for 20 years, but we need to accelerate progress to achieve our target to halve the conception rate by 2010. While there has been steady progress nationally, there is huge variation in performance between local areas. The best have seen reductions of over 40%, while in some areas rates have increased.

Objective II: Long Term Conditions

PSA Targets	Measure	Progress
Target 4 To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.	**Reduction in number of emergency bed days** as measured through Hospital Episode Statistics. Reduction in numbers of very high intensive uses of care.	**Reduction in number of emergency bed days – on course** Between 2003/04 and 2004/05, the number of emergency bed days decreased by 1.8%, from 32,450,854 to 31,868,191. 2005/06 Hospital Episode Statistics data will be published on 15th December 2006.

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.	**18 weeks** will be measured in two ways: a. Waiting times for individual stages of treatment. b. Waiting times for referral to treatment. To ensure delivery, plans will be monitored and performance managed against trajectories for both.	**18 weeks – on course, challenging target** Until now the NHS has only measured stages of a patient's overall waiting time from referral to the start of treatment. Developmental work with a set of pioneer sites has delivered systems for measuring referral to treatment times that can be adopted locally. This data collection will be mandatory from January 2007 for admitted patients and from April 2007 for patients who are treated without being admitted. The NHS completed a referral to treatment (RTT) Baseline Exercise in October 2006. This exercise estimated the overall position on RTT times and highlighted key challenges to delivering the 18 Week pathway. It will inform forward planning to deliver 18 Weeks. About 35% of patients admitted for inpatient or day case treatment completed their pathways within 18 weeks. Between 70% and 80% of patients who were not admitted for treatment completed their pathways within 18 weeks. Local Delivery Plans are being refreshed to ensure that the NHS has robust plans and monitoring arrangements in place to deliver 18 weeks.
Target 6 Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.	Annual returns from the **National Drug Treatment Monitoring Service (NDTMS)**, which provides details on the number of drug misusers entering in, successfully completing and sustaining treatment.	**Participation in drug treatment – provisionally met** The results from the National Drug Monitoring System (NDTMS), reveal that 181,390 people received specialist, structured drug treatment in England during 2005/06, an increase of 13% on 2004/05 (160,453) and 113% on the 1998/99 baseline of 85,000. In addition, 141,511 people had either successfully completed or been retained in treatment on March 2006, an increase from 120,697 in March 2005.

Objective IV: Patient/User Experience

PSA Target	Measure	Progress
Target 7 Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.	**The national survey programme** (under the administration of the Healthcare Commission) will gather feedback from patients on different aspect of their experience of care in NHS trusts.	**Improving the patient experience – Improvements have been recorded across 3 of the 5 settings** Survey improvements have been recorded in: • Inpatient (75.7 in 2003/04 to 76.2 in 2005/06) • primary care (76.9 in 2003/04 to 77.4 in 2004/05) • community mental health services (74.2 in 2003/04 to 74.7 in 2004/05) There has been a small decline in the outpatient survey (76.9 in 2002/03 to 76.7 in 2004/05). Scores are an average score out of 100 – calculated by aggregating scores from 5 domains of patient experience: • Improving access and waiting • Building closer relationships • Better information more choice • Safe, high quality coordinated care • Clean, friendly comfortable place to be Results from the emergency care survey cannot be compared due to changes to survey questions. Since the first survey was conducted in 2001/02, around 1.2 million patients have taken part in 16 surveys across 7 different NHS settings. In 2005/06, two Healthcare Commission administered surveys were conducted: an adult inpatient survey (results published in May 2006) and a community mental health services survey (published in September 2006). The results for each NHS organisation participating in these surveys – and nationally aggregated data – are available on the Healthcare Commission website at: http://www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys.cfm In 2006, the Department of Health and the Healthcare Commission conducted a joint review of the methodological issues involved in using the national patient survey programme to calculate national scores for the PSA. This work produced a final set of results for all surveys conducted to date. A technical paper summarising the work of the review and the PSA results are published on the DH website at: http://www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/NationalSurveyOfNHSPatients/fs/en

PSA Target	Measure	Progress
Target 8 Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:		
– increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and	**Those being helped to live at home** are those that receive community based services but are not in residential or nursing care. Only those that are care managed by social services, ie are assessed by social services and have a care plan, will be included in the target.	**Older people supported to live at home – on course** The baseline year for this target is 2005/06. The first national comparison is now available and shows a national increase averaging 0.9% compared to 2004/05. While the national average increase almost meets the PSA target, there is variation between councils. To recognise the crucial voluntary and community sector (VCS) contribution to non-intensive home care, a related data collection to assess the VCS contribution to this target has commenced this year. The first results will be available in spring 2007.
– Increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	**Those people receiving more than 10 contact hours of home care and 6 or more visits per week** divided by the population of people supported by councils in residential care and nursing homes.	**Older people supported Intensively to live at home – on course** In England, the number of older people supported intensively to live at home in 2005/06 shows a strong upward trend, increasing to 33.8% of the total supported by councils in residential care and in their own homes, 0.2 percentage points below the target of 34% by March 2008. The continual rise in the PSA value is due in part to the increasing number of households receiving intensive home care (ie the target has not been met simply by reducing numbers of care home residents). In September 2005, 98,200 households received an intensive home care service, a rise of 6% from the same period in 2004.

Departmental SR2004 Standards

The following Standards were adopted by the Department at SR2004. They are part of the PSA agreed with HM Treasury at SR2002.

PSA Targets	Measure	Progress
Standard 1: Reduce to 4 hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004. Note: Following discussions with clinicians' representatives, a 2% tolerance was introduced during 2003 for the minority of patients that clinically require more than four hours in A&E. This meant that providers were performance managed to ensure that 98% of patients were seen, diagnosed and treated within four hours of their arrival at A&E. The target became an operational standard during 2005.	**Total time patients spend in accident and emergency (A&E)** from arrival to admission, transfer or discharge. This includes major A&E departments, walk-in centres and minor injury units.	**A&E total time – met (for 2005/06 as a whole) and sustained** Between July and September 2006, 98.5% of attenders at all types of A&E department in England were admitted, transferred or discharged within four hours of arrival. This follows on from the excellent performance level achieved for 2005/06 as a whole, where 98.2% of patients were seen, diagnosed and treated within four hours of their arrival at A&E.

PSA Targets	Measure	Progress
Standard 2: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.	**PCT performance** is measured through the monthly Primary Care Access Survey (PCAS), one of the LDPRs. Monitoring the national access target we are now developing indicators based on: • results of the new GP Patient Experience Survey • PCAS – as revised	**Primary Care Access – met, but work ongoing** Since December 2004, PCTs have reported through the Primary Care Access Survey (PCAS) each month that 99+% of patients could be offered an appointment within two working days to see a GP. Patient surveys typically show success levels of between 80 and 90%. The Department has made changes to PCAS to strengthen it. Since July 2006, PCTs have been asked to survey each practice on a random day within a three week envelope rather than all practices on the same pre-notified day. PCTs are also asking for the 3rd as well as the 1st available GP appointment – to get a better idea of the depth of access. PCTs reported in the September 2006 PCAS that: • 99.6% (based on 1st available appointment) or 97.6% (based on 3rd available appointment) of patients were able to be offered a GP appointment within two working days • 99.7% of patients were able to be offered a primary care professional appointment within 1 working day. The 3rd available appointment results also show greater variation at PCT level than those for 1st – which is more consistent with what patients report. The intention is now to use 3rd available appointment as the survey measure. However, PCAS data indicate that not all PCTs have yet fully implemented the July changes. DH is focusing SHAs on ensuring all new PCTs are implementing the survey changes before shifting fully to 3rd available appointment for 2007/08.

PSA Targets	Measure	Progress
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.	**DH monthly central data collection** measures percentage of patients given the opportunity to choose most convenient date from a range of dates.	**Booking – met** Figures for September 2006 show that there has been a percentage point increase of 1.5% in the number of day cases booked over the past year. • September 2003 – 76% • September 2004 – 98% • September 2005 – 98.3% • September 2006 – 99.8% The number of inpatients' appointments booked (day cases & ordinary admissions) has increased by a percentage point change of 3.9% over the past year. • September 2003 – 64% • September 2004 – 92% • September 2005 – 95.8% • September 2006 – 99.7% Outpatient booking has increased over the past year; by a percentage point change of 12.9%. • September 2003 – 40% • September 2004 – 80% • September 2005 – 87.1% • September 2006 – 99.0% **Electronic booking** The "Choose and Book" system was launched in Summer 2004, and enables patients to book initial hospital appointments at a time and place of their choice whilst in the GP surgery, or later either on the Internet or on the telephone through the Choose and Book Appointments Line. Choose and Book will continue to be rolled out through 2006 and 2007. **Choice – good early progress** To monitor implementation of choice at referral, we are carrying out surveys to measure whether patients recall being offered choice when their GP refers them to hospital. These are carried out every two months. July figures indicate that around 35% of patients who are eligible recall being offered choice We expect future results to show that the percentage of patients who recalled being offered choice will increase as the process will be more embedded.

PSA Targets	Measure	Progress
Standard 4: Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and CAMHS services, and reduce the mortality rates from suicide and undetermined injury by at least 20% by 2010.	**Annual mapping of CAMHS to monitor success.** For crisis services there are 2 main forms of measurement: i) Number of patients who are subject to at least 1 consultant episode (acute home-based) per annum is measured. ii) Number of Crisis Resolution teams established.	**Access to CAMHS – continuing progress** Progress towards this target is being measured by the percentage of PCTs which have care pathways to three essential elements of comprehensive CAMHS. The position as at September 2006 is set out below: – 24/7 emergency assessment: 86% – CAMHS for children and young people with a learning disability: 62% – CAMHS for 16/17 year olds: 77% **Access to Crisis Services – key delivery point** The key enabler for improving access to crisis services is the implementation of sufficient numbers of Crisis Resolution Teams and their achieving the full caseload. Number of Crisis Resolution Teams in place: • September 2002 – 62 • March 2003 – 102 • September 2003 – 137 • March 2004 – 179 • September 2004 – 212 • March 2005 – 343 • January 2006 – 343 Number of people receiving crisis resolution services: • 2002/3 (Q4 2002/3) – 28,500 • 2003/4 (Q4 2003/4) – 45,800 • 2004/5 (Q4 2004/5) – 68,800 • 2005/6 (Q4 2005/6) – 83,800[1]

[1] In Q3 2005/06 the guidance was revised. Q4 data shows the number of home treatment episodes. Figures are not comparable to previous years.

Gershon Efficiency Targets

Efficiency Programme

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

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

Efficiency Gains

Programme Structure

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

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

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

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

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

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

Measurement Processes

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

Details of agreed measurement processes are provided in an Efficiency Technical Note (ETN) available on the Department of Health website: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124041&chk=0thlAD

The Health Efficiency Programme continues to evolve to underpin gains up to and beyond 2008. During 2006 we have developed and applied additional measurement processes to capture a number of outstanding areas of efficiency gain that were highlighted in the published ETN as planned or work in progress. These include productive time staff skill mix and procurement savings for product groups that do not form part of the Supply Chain Excellence (SCEP) programme. We are currently finalising measurement processes relating to variation in clinical interventions and GP & Outpatient Referrals, the reduction in SHAs and PCTs, and improved quality in patient care. The ETN will then be updated to incorporate these additions.

Reported Gains to Date

The following gains have been recorded for 2004/05, 2005/06 and up to Quarter 2 2006/07:

Workstream	**2004/05 (£m)**	**2005/06 (£m)**	**2006/07 Q2 (£m)**
Productive Time	508	963	1,292
Procurement	333	1,319	1,893
Corporate Services	14	38	42
Social Care	0	179	306
Public Funding & Regulation	13	77	167
Total Health	**868**	**2,576**	**3,700**

Notes:

Of the total reported gains £2,311m (62%) are cashable.

Reported gains are annual recurrent gains against the 2004 baseline – the amount by which annual (cashable) operating costs have been reduced permanently plus the annual value of non-cashable gains.

Productive time calculations have been revised to correct a previous error identified in patient length of stay saving, reducing the level of savings from that previously calculated.

Value for money savings realised by the 2006 review of central budgets as Gershon efficiency savings are no longer included in the budgets.

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

The calculation of cashable no longer includes savings attributable to reducing the cost of patient stays which would require local capacity planning changes to realise the savings as cash. These gains are counted as non-cashable.

Assurance of Reported Gains

For each separate efficiency project or area of gain, we are required to demonstrate that service quality has at least been maintained. These measurement processes can be constrained by available data sources and the extent to which quality change can be attributed solely or directly to the 'efficiency change'.

We have developed balancing quality measures appropriate to most individual workstreams and projects and these are set out in the Efficiency Technical Note. We are still developing a fully robust measurement process for service quality relating to Public Funding & Regulation (covering the Department Change Programme, Arms Length Body programme and SHA/PCT restructuring), where available specific quality measures to evaluate service before and after delivery of the change are limited. Further analysis has still to be completed on the relationship of different quality measures relating to Productive Time service redesign to be able to confirm fully that quality has been maintained.

In 2006, OGC introduced a new process of classifying reported efficiency gains. Declared gains are now separated into preliminary, interim and final. None of the gains are preliminary (based solely on estimates). The 'interim' category includes those where calculations are based on data which may change (for example when using interim mid-year source data which may be validated or reconciled at the year-end), or where balancing service quality has not yet been confirmed. Using this classification £2,459m of the declared gains to date are final and the remaining £1,241m are interim. The proportion of finalised gains is likely to increase after the next year-end.

Progress Highlights

1. Productive Time

- The average length of stay (case weighted) for hospital in-stay patients has reduced significantly since March 2004 as a result of service redesign and more effective management of patient treatment pathways. The reduced average cost of hospital stays has cut costs by over £500m per year since the start of the Productive Time programme.
- There has been a reduction of over 1.5 million emergency bed days per year since March 2004 and this trend should increase as the strategies for treatment of long-term conditions and *Our Health, Our Care, Our Say* (keeping patients out of hospital) is fully embedded.
- Over 850 Emergency Care Practitioners (ECPs) have now been employed by Ambulance Trusts. ECPs treat emergency patients in situ, reducing the number of A&E admissions and a net saving over £20m per year following their introduction in 2004.
- Over 7 million patient appointments in GP surgeries were administered by Nurse Practitioners in the last year, freeing GPs to spend more time with patients suffering more urgent and complex illnesses.

- Improving medical techniques, technology and associated process redesign means that an increasing number of treatments are being done as day cases. Almost 70% of all planned procedures are now done this way, reducing treatment costs by almost £30m in the last year and enabling more patients to go home earlier.
- NHS organisations are now provided with quarterly performance information on key measures of service efficiency. This enables them to benchmark their performance against similar providers and identify further potential opportunities for improvement. The metrics are supplemented by productivity guidance setting out the best practices associated with high efficiency performance.

2. *Procurement*

- Recently renegotiated national procurement contracts for NHS supplies and services are already providing annualised savings of £200m. A further wave of procurement negotiation became operational in July.
- Three of the new SHAs now have fully operational Procurement Hubs, realising annualised savings of £60m. Business cases and plans are being developed for further hubs to be operational in all remaining SHAs before 2008, except for London (which has already instigated collaborative working but is likely to take until 2008 to establish a full formal hub).
- The contract with DHL to take over procurement and distribution activities previously managed by NHS Logistics became operational from 1st October and should result in further efficiency gains of at least £50m per year by 2008.
- We have achieved a further £300m per full year of savings as part of the annual negotiation of the pharmacy contract achieved by reduced drug reimbursement costs.

3. *Shared Services*

- The Shared Services Joint Venture Company established in 2005 had over 100 NHS organisations contracted for financial services by April 2006. A Payroll processing service is now operational. Plans and resources are in place to contract additional organisations. Following a recent feasibility study, plans are advanced to pilot HR administration services.

4. *Public Funding & Regulation (PFR)*

- New SHAs and PCTs are now fully operational. The programme overall is on track for completion by March 2007 realising operating cost reductions of at least £250m per year.
- The second phase of NHS Arms Length Bodies reduction and restructuring has reduced the number of bodies from 33 to 26, effective from April 2006. Overall ALB operating costs reduced by £54m in 2005/06 and are on track to deliver annual savings of £250m from March 2008.

5. Social Care

– Local Councils with responsibility for social services (CSSRs) have continued to deliver significant efficiency gains through their specific local efficiency programmes. In addition, the Care Services Efficiency Delivery Team (CSED) are working closely with Local Councils, Offices of the Regions and the Association of Directors of Social Services (ADSS) to identify, develop and promote major efficiency opportunities based on leading edge practices. A number of initiatives are in process:

  - Effective Monitoring of Homecare is now well advanced with nearly 100 councils taking the initiative forward in 10 regional learning set forums.
  - Assessment and Care Management process re-engineering coupled with improved service delivery was successfully piloted in six pilot sites. CSED is now working with all 14 councils in the ADSS West Midlands region and has an invitation to work on a similar basis with two other regions. As an early quick win in this programme, improvements to Blue Badge delivery have been shared with all 150 CSSRs.
  - CSED is working with councils across the country to develop implementation plans for Demand Forecasting, Homecare Reablement and Process Improvement & Buying. Developed solutions will then be offered to all other CSSRs.

Expected Progress and Deliverables in the next 12 Months

The Department of Health expects to achieve at least £1,800m of annual efficiency gains towards our 2008 target in the period up to September 2007. Achievement will be under-pinned by key deliverables in each workstream:

1. Productive Time

– Continued process improvement resulting in particular in further reductions in length of stay and emergency bed days. These will be incentivised by ongoing publication of benchmark efficiency metrics and the planned publication of a further tranche of best practice clinical service provision centring around ten more high volume Health Resource Groups (HRGs).

2. Procurement

– Maximising the take up of national contracts, particularly Wave 2 categories that have just been launched. Realising the expected gains from the DHL contract through reduced prices and increased take up.

– Progressing the planning and implementation of procurement hubs in remaining new SHAs.

3. *Social Care*

   – Continued delivery of local efficiency programmes by individual Local Authorities, supplemented by national support and rollout of Effective Monitoring of Homecare, Assessment & Care Management and Homecare Reablement.

   – Further development and launch of nationally coordinated initiatives for Process Improvement Planning & Buying, and Demand Forecasting & Capacity Planning.

4. *Public Funding & Regulation*

   – Driving operational efficiency savings from reconfigured ALBs, including the realisation of productivity savings in bodies providing chargeable services to the NHS.

   – Completion of PCT restructuring and full year implementation of reduced operating cost budgets for the SHA and PCT sector.

Reduced Civil Service Headcount

The Department committed to a gross reduction of 1,400 full time equivalent civil servant posts in the central departments through its Change Programme launched in early 2003. This reduction was based on our budgeted headcount prior to the start of our Change Programme. Just under half (680) of the overall reduction was planned transfers to other NHS Bodies and 720 was net reductions as defined in the Gershon target.

The Change Programme is now complete except for a small number of outstanding transfers. At September 2006, the provisional net reduction in full time equivalent headcount was 679. We expect the remaining posts to be achieved through ongoing resource management within the constraints of our reducing Department expenditure limit in 2006/07 and 2007/08.

Lyons Relocations

The Department and its Arms Length Bodies (ALBs) are committed to the relocation of a total of 1,030 posts out of London & South East by March 2010. (80 out of the original target of 1,110 have transferred to the Department for Constitutional Affairs who have assumed responsibility for the Mental Health Review Tribunal)

By September 2006, 567 relocations had been completed. Between September 2005 and September 2006 relocations comprised the Health & Social Care Information Centre (76 posts to Leeds), the NHS Institute (128 posts to Coventry) and the National Institute for Clinical Excellence (20 posts to Manchester).

Relocation processes are underway for posts in the General Social Care Council, NHS Professionals and a second wave of relocation for the Health & Social Care Information Centre. These should all be complete by early to mid 2007, increasing completed Lyons relocations to around 660. Further plans are being developed for the core Department (transferring additional posts to Leeds) plus further ALB moves, to deliver the 1,030 target by 2010.

Annex A
Departmental Public Service Agreement Targets (SR2002) Analysis

Targets 2, 3, 4 and part of 7 have been adopted into the SR2004 Standards. Targets 5, 6, 8, 9, 10 and parts of 7 and 11 have been subsumed into SR2004 Targets. Information on the remaining Targets 1, 12 and part of 11 is provided below.

Objective I: Improve Service Standards

PSA Targets	Measure	Progress
Target 1: Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to 3 months by 2008.	**Number of patients waiting**	**Outpatient Waiting Times – met:** Number waiting more than 3 months (13 weeks) – Quarterly figures • September 2002 – 257,613 • September 2003 – 160,745 • October 2004 – 72,464 • October 2005 – 28,374 • October 2006 – 161[1] **Inpatient Waiting Times – met:** Number waiting more than 6 months – Monthly figures • October 2001 – 258,945 • October 2002 – 242,516 • October 2003 – 163,230 • October 2004 – 69,948 • October 2005 – 24,847[2] • October 2006 – 353[3]

1 Of the 161, 139 were English residents waiting in Welsh hospitals
2 Figure revised since publication of the Autumn Performance Report 2005
3 Of the 353, 16 were English residents waiting in Welsh hospitals

Objective II: Improve Health and Social Care Outcomes for Everyone

PSA Targets	Measure	Progress
Target 11: By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.	**Mortality in infancy by social class:** the gap in infant mortality between "routine and manual" groups and the population as a whole. Life expectancy by Local Authority: the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. Baseline year is average of 1997, 1998 and 1999.	**Infant mortality – See SR2004 PSA Target 2** **Life expectancy at birth – challenging target, further work required on delivery chain** For females, in 2003-2005 the relative gap in life expectancy between England and the fifth of Local Authorities with the lowest life expectancy was 7% higher than at the baseline (1997-1999) (compared to 6% in 2002-2004). For males, the relative gap is now the same as in the baseline year (as in 2002-2004, but the gap increased above the baseline gap in the interim period). The data are subject to year-on-year fluctuation and it is too early to say if this reflects a persistent trend. In addition, for health inequalities in life expectancy please see progress report under **SR2004 Target 2.**

Objective III: Improve Value for Money

PSA Target	Measure	Progress
Target 12: Value for money in the NHS and personal social services will improve by at least 2% per annum, with annual improvements of 1%, in both cost efficiency and service effectiveness.	**Value for money based on unit costs of procedures and services**, adjusted for quality, underlying inflation and mix of cases. Service effectiveness element of target based on quality indicators published by the Department.	**Value for money – too early to assess** Using our interim value for money measure, in 2004/05 Value for Money through cost efficiency increased by around 0.8%. However, earlier this year, ONS produced *Public Service Productivity: Health* which estimates that, when adjusting for quality such as including lives saved from statins, lower hospital mortality, estimated benefits from hospital treatment and blood pressure control in addition to the increasing value of health, NHS productivity has risen on average by up to 1.6% a year between 1999 and 2004. As before, we are continuing to work with the relevant experts at ONS to expand our efficiency measures so that they take account of a greater range of quality improvements that the NHS is delivering.

Departmental Public Service Agreement Targets Analysis – SR2000

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

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

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

Objective V: Value for money

PSA Target	Measure	Progress
Target 10: The cost of care commissioned from Trusts that perform well against indicators of fair access, quality and responsiveness, will become the benchmark for the NHS. Everyone will be expected to reach the level of the best over the next 5 years, with agreed milestones for 2003/04.	**Reference Cost Index**	**Reference Cost Index – Not yet met, progress continuing** The NHS Trust National Reference Cost Indices for 1999/00, 2000/01, 2001/02 and 2002/03 provide evidence on the extent to which variation in performance is reducing. The dispersion of costs between NHS Trusts as measured by the coefficient of variation of the trimmed market forces factor adjusted Reference Cost Index (RCI) for NHS Trusts, has been decreasing. The coefficient of variation (defined as standard deviation divided by mean) has fallen from 24% in 1999/00, to 21% in 2000/01, to 17% in 2001/02; to 15% in 2002/03, to 12% in 2003/4 and remaining at 12% in 2004/5.

Departmental Public Service Agreement Targets Analysis – SR1998

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

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

PSA Target	Measure	Progress
Target 3: Reduction in the death rate from accidents by at least 20% by 2010, from a baseline of 15.9 per 100,000 population for the 3 years 1995 to 1997.	**Death rate from accidents**	**Death rate from accidents – slippage** Data for 2003-05 (3 year average – latest available data) show a rate of 16.0 deaths per 100,000 population – a rise of 1.5% from the baseline (1995-97).
Target 4: Reduction in the rate of hospital admission for serious accidental injury by at least 10% by 2010, from a baseline estimate of 315.9 admissions per 100,000 population for the financial year 1995/96.	**Rate of hospital admission for serious accidental injury** requiring a hospital stay of 4 or more days.	**Rate of hospital admissions for serious accidental injury – slippage** These data are single financial year figures, available annually. Single year data for financial year 2004/05 show a rate of 332.4 admissions per 100,000 population – an increase of 5.2% from the baseline estimate (1995/96).

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

PSA Target	Measure	Progress
Target 32: As part of the new Framework for Managing Human Resources in the NHS, targets for managing sickness absence have been set consistent with the Cabinet Office recommendations of a reduction of 20% by April 2000. Performance improvement on targets will also be set for NHS Trusts on Managing Violence to Staff in the NHS aimed at reducing the levels of absence due to sickness or injury caused by violence.	**Measurement of the time staff are absent from work** as a proportion of staff time available.	**Sickness absence – some progress made** The Department of Health NHS sickness absence survey 2005 found that sickness absence rate, defined as the amount of time lost through absences as a percentage of staff time available, was 4.5%, down from 4.6% in 2004. **Managing violence – some progress made** Targets were set for managing violence: To reduce the number of incidences by 20% by the end of 2001/02; and, To reduce the number of incidences by 30% by the end of 2003/04. In November 2003 the NHS Security Management Service, introduced a comprehensive framework of measures to tackle violence against NHS staff. In 2004/05 it is estimated that 85,000 frontline NHS staff received conflict resolution training on how to identify and de-escalate potentially violent situations from occurring in the first place and in 2005/06 this figure has risen to over 250,000. The number of criminal sanctions taken against those that had physically assaulted NHS staff rose by 12% from 759 in 2004/05 to 850 in 2005/06 (a rise of over 1500% from 2003/04). A total of 58,695 physical assaults occurred during 2005/06 on NHS staff working in all health care sectors. This represents a 1,690 or 2.8% reduction in physical assaults compared to the previous total in 2004/05 of 60,385. This includes a 7% increase in confidence of staff reporting incidents of physical assault. Broken down into sectors over the same period, this represents 11,100 assaults in the acute sector, 5,145 in PCTs, 1,104 in ambulance trusts and 41,345 in the mental health and learning disability environments. The Healthcare Commission's staff survey in 2005 saw a 3% reduction in NHS staff saying that they had experienced violence and abuse over that reported for 2004.

Printed in the UK for The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID5478221 12/06

Printed on Paper containing 75% fibre content minimum.

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Order through the Parliamentary Hotline *Lo-call* 0845 7 023474
Fax orders: 0870 600 5533
E-mail: book.orders@tso.co.uk
Textphone 0870 240 3701

TSO Shops
123 Kingsway, London, WC2B 6PQ
020 7242 6393 Fax 020 7242 6394
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

TSO@Blackwell and other Accredited Agents

ISBN 0-10-169852-6

9 780101 698528