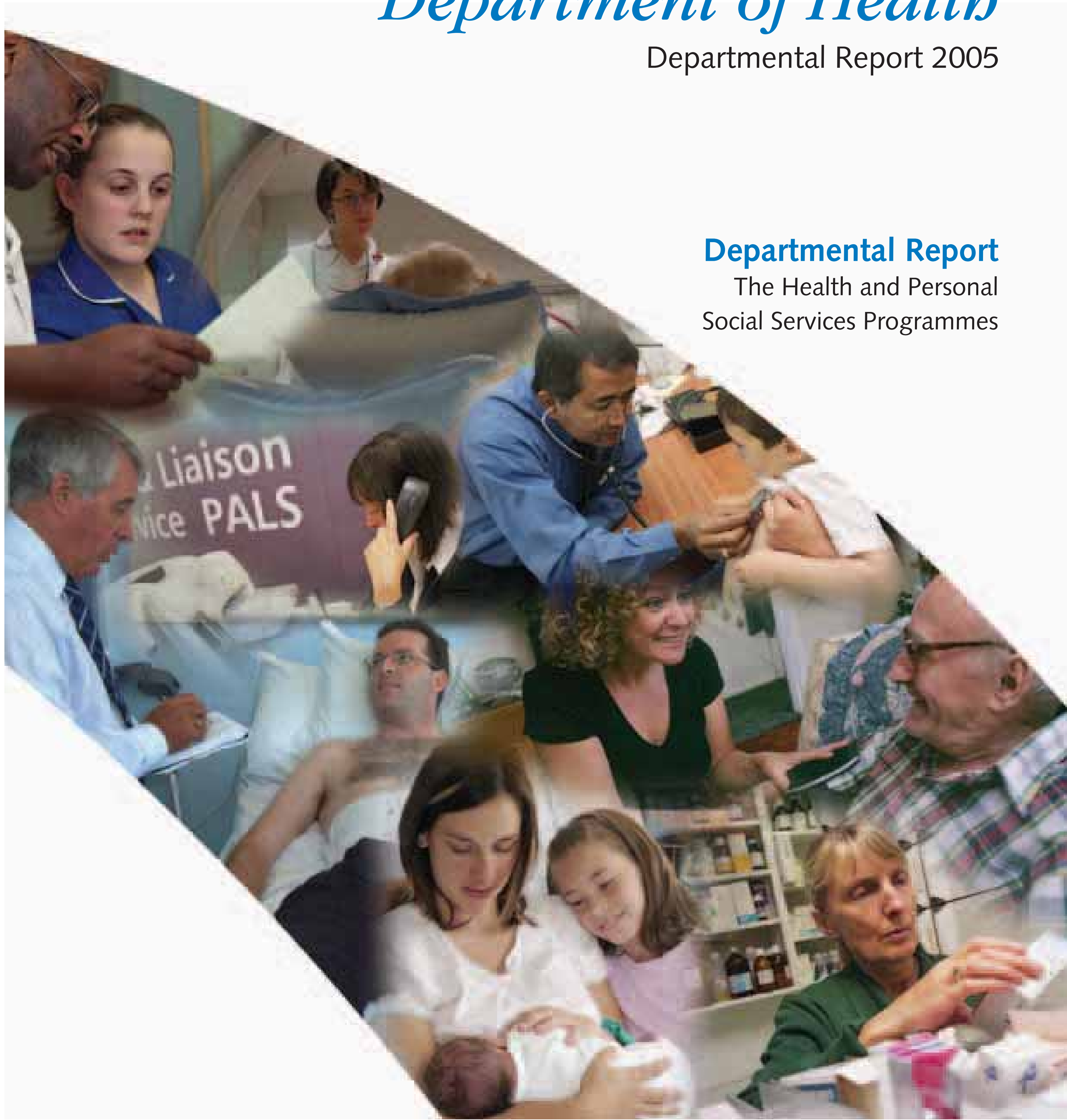
DH Department of Health

Department of Health

Departmental Report 2005

Departmental Report

The Health and Personal Social Services Programmes



This is part of a series of departmental reports (Cm6521 to 6548) which, along with the Main Estimates, the document *Public Expenditure: Statistical Analyses 2005,* and the Supply Estimates 2005-06: Supplementary Budgetary Information, present the Government's expenditure plans for 2005-2008.

Departmental Report 2005

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

June 2005

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Contents

Foreword by the Secretary of State
Ministerial Responsibilities
Structure of the Department of Health
Contents Summary

Chapter 1: Introduction
1.1 Introduction
1.5 Department of Health
1.10 National Health Service (NHS)
1.12 Personal Social Services (PSS)
1.15 Delivering the NHS Plan
1.23 NHS Foundation Trusts
1.26 The Department of Health Change Programme
1.28 Arm's Length Body Review
1.30 Efficiency Programme
1.33 Public Health White Paper

Chapter 2: Delivering Better Public Services–Progress
2.1 Introduction
2.4 The Department of Health Aims and Objectives
Table – Departmental Public Service Agreement Targets Analysis (1998)
Table – Departmental Public Service Agreement Targets Analysis (2000)
Table – Departmental Public Service Agreement Targets Analysis (2002)
2.11 Departmental Public Service Agreement Targets (2004)
Targets from Cross-Departmental Reviews:
2.14 Health Inequalities
2.19 Action Against Illegal Drugs
Cross-Government Initiatives:
2.22 Sure Start
2.37 National Service Framework for Children, Young People and Maternity Services
2.42 Every Child Matters: Change for Children
2.48 Social Exclusion and Neighbourhood Renewal
2.52 Sustainable Development
Modernising Government Action Plans:
2.56 The Policy Hub
2.59 The Policy Collaborative
2.62 Equality and Human Rights
2.63 Race Relations (Amendment) Act 2000
2.92 Rural Proofing
2.99 Better Regulation and Regulatory Impact Assessments (RIAs)
2.117 e-Government and IT in the NHS

Chapter 3: Expenditure
3.1 Introduction
3.4 NHS Expenditure Plans
3.9 Health and Personal Social Services Programmes
3.19 Programme Budgeting
3.31 Regional Breakdown of Spend
3.34 Sources of Finance
3.38 Complementary Sources of Funding
3.49 Invest to Save Budget
3.52 Recovery of NHS costs following Road Traffic Accidents
3.55 Personal Social Services Expenditure

Chapter 4: Investment
4.1 Policy Context
4.7 Priorities for Public Capital Investment in 2005-06
4.21 Vital Supporting Investments
4.29 Direct Capital Allocations to SHAs, NHS Trusts and PCTs
-Capital Investment by NHS Foundation Hospitals
-Restrictions on Capital to Revenue Transfers
-Treasury Capital Modernisation Fund
-Prioritisation of Major Capital Schemes
4.42 Public Private Partnerships and Innovative Investments
4.50 NHS LIFT
4.54 Investment to Contain vCJD
4.56 ProCure21
4.59 Asset Disposal
4.62 Pooled Budget Arrangements and Investment in Social Care

Chapter 5: The NHS Plan – A Plan for Investment, A Plan for Reform
5.1 A Brief Summary of the NHS Plan
5.4 The NHS Plan – Step by Step Reform
Carrying out the Plan's Reforms:
5.7 The NHS Improvement Plan
5.10 Increasing Devolution
-Planning Framework
-Revenue Allocations to PCTs
-NHS Foundation Trusts
-Pay Modernisation in the NHS
5.28 Patient Choice at the Heart of Reform
5.47 Increasing Plurality of Provision
-Treatment Centres
-Use of Spare Capacity in the UK Independent Sector
-Overseas Treatment
5.59 Confidence in Health Service Delivery
-NHS Performance "star" Ratings
-2004-05 Performance Ratings Indicators
-Future Assessment System
-NHS Franchising and Register of Expertise
-Legal Powers
-Patient Prospectus
-The Healthcare Commission
-The Commission for Social Care Inspection(CSCI)
5.91 Payment by Results
5.96 NHS Bank

5.99 Public Health White Paper
-Reducing the Numbers of People who Smoke
-Reducing Obesity
-Increasing Exercise
-Encouraging and Supporting Sensible Drinking
-Improving Sexual Health
-Improving Mental Health and Wellbeing
-Promoting Personal Health
5.109 Support for People with Long-Term Conditions (Chronic Disease Management)
Actions Achieved to Date:
5.118 Access
-Primary Care
-Secondary Care
5.123 More Staff in the NHS Workforce
5.130 Capital and Capacity
5.132 Health Inequalities
5.181 Cancer
5.216 Coronary Heart Disease
5.230 Prevention of Ill Health
5.254 Older People's Services
5.274 Mental Health Services
5.288 Children
5.299 Quality of Care
-PALS
-Patient and Public Involvement in Health
-Overview and Scrutiny Committees
-NHS Healthcare Standards
-National Clinical Audit
-Clinical Governance
-Controls Assurance
-Single-sex Accommodation
5.323 Improving Patient Experience
5.380 NHS Direct
5.388 Modernising Pathology Services
5.392 NHS Dentistry – Reform Programme
5.400 A Vision for Pharmacy
5.421 Audiology Modernisation Project
5.423 Genetics White Paper
5.427 Independent Reconfiguration Panel (IRP)
5.431 Modernisation Agency

Chapter 6: Breakdown of Spending Programme

6.1 Hospital and Community Health Services
-HCHS Resources by Sector
-HCHS Current Resources by Age Group
-Resource Allocation
6.26 Centrally Funded Initiatives and Services and Special Allocations
6.27 Family Health Services
-FHS Gross Expenditure
-Family Health and Personal Medical and Dental Services Resources
6.33 Drugs Bill
6.44 Central Health and Miscellaneous Services
6.46 Personal Social Services
-PSS Revenue Provision
-PSS Capital Resources
-How the Resources are Used

Chapter 7: Activity, Performance and Efficiency

7.1 NHS Hospital Activity Trends
7.2 Inpatient and Outpatient Waiting
7.6 Emergency Care
7.14 Community Nursing, Dental and Cross Sector Therapy Services Activity
7.19 Access to Primary Care
7.31 Family Health Services (Primary Care)
-General and Personal Medical Services
-Pharmaceutical Services
-General and Personal Dental Services
-General Ophthalmic Services
7.36 Performance
-Management Costs
-Reducing Bureaucracy
7.39 Financial Performance
7.54 Efficiency
-Reference Costs
-Unit Costs
7.76 Personal Social Services (PSS)
-Adult Services Activity
7.77 PSS Performance and Performance Assessment

Chapter 8: Managing the Department of Health

8.1 Administration Costs and Staffing Tables
8.7 The Department of Health Change Programme
8.12 Non-Departmental Public Bodies (NDPBs), Special Health Authorities and Executive Agencies
8.19 Public Appointments
8.27 Recruitment
8.30 Senior Civil Service Salaries
8.31 A Healthier Workplace
8.37 Accommodation and ICT (Information and Communication Technology)
8.44 The Environment
List of Annexes
Bibliography
List of Figures
Glossary
Full Contents List

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 2004 are available on the Internet at:
www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports

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

Foreword by the Secretary of State

It gives me great pleasure to present the fifteenth annual report of the Department of Health.

In July 2004, the Chancellor announced the outcome of the spending review which set out spending plans up to 2007-08. For the NHS this confirmed the historic levels of sustained growth in the 5-year settlement announced in 2002. This gives the NHS an average increase of 7.1% over inflation for the period 2005-06 to 2007-08. The settlement also delivered a further average annual real terms increase for Personal Social Services of 2.7% over the same three years. This demonstrates the Government's continued commitment to investment in health and social care services to deliver better quality care for the whole population.

It is vital that we deliver maximum benefit from this funding. Therefore, in the 2004 Budget, the Chancellor announced the outcome of the Gershon report which detailed efficiency savings across Government. In this, the Department is committed to making savings of £6.5 billion a year by 2007-08 which will be recycled into frontline services. Savings will be delivered through:

- reduced bureaucracy through savings in Department of Health running costs and reducing the numbers of arm's length bodies;
- more effective procurement of goods and services; and,
- improvements in staff productive time through investment in pay reform and new IT systems.

The generous settlement for health and social care will be used to deliver our new public service agreement. This reflects our continued drive to reduce waiting times, reduce inequalities, improve the health of the nation and ensure care is delivered to those who need it, when they need it and in a setting that is most appropriate to them.

Our plans mean that waiting for treatment will reduce to the point where waiting time for elective care is no longer the major issue for patients. By 2008, the maximum wait for the whole of a patient's journey from GP referral to treatment will be 18 weeks, with most people being treated much quicker.

We have also introduced a target to improve outcomes for people with long-term conditions by providing more proactive care, through case managers, including community matrons, in primary and community settings. Early intervention and management of long-term conditions will both improve patients' overall health and prevent acute episodes of illness requiring emergency admission to hospital.

The public is naturally concerned about healthcare associated infections. It is a top priority for my Department to reduce the risk of infection, and this is why in 2004 we set a target for acute trusts to halve their numbers of MRSA bloodstream infections by 2008. Measures put in place are already having an effect, and in March 2005 we were able to announce a 6% decrease for the period April to October 2004 by comparison with the same period in 2003. This is a difficult challenge for the NHS, but I am confident that continued action in NHS hospitals will result in further reductions in MRSA bloodstream infections.

We are addressing the difficult issue of the long-term health of the whole nation. We have targets to reduce smoking, to halt the rise in childhood obesity, to reduce mortality rates from heart disease and stroke, and to reduce health inequalities. These are supported by the plans set out in the Public Health White Paper *Choosing Health*

published in November 2004. This is a genuine and fundamental shift in the health policy for this country – from simply providing a sickness service to a true health service where prevention is as important as cure.

We are also revolutionising the way patients access services with every patient being offered a choice of providers, both NHS and independent sector, and being able to book their appointment at the point of referral. Patients will be able to choose from a range of providers funded by the NHS and regulated by the Healthcare Commission as well as have access to a wider range of services in primary care.

As we increase investment in social services we need to ensure that services are provided in a way that gives maximum benefits to clients. This is why in March 2005 we published our consultation paper *Independence, Wellbeing and Choice*. This set out our vision for the future of social care for adults in England and asked for views on our proposals, so we can build a shared vision and create a social care environment right for the 21st Century. Our vision includes proposals on individual budgets; developing new models of care including telecare; and how to better support carers and build the capacity of the voluntary and community sector to engage in the wider agenda of social inclusion. It also emphasises the need for social and health care to work together better to support those with complex needs.

This Government has demonstrated our belief in strong public services through sustained real terms investment in health and social care. The values that underpin these vital public services remain unchanged: in particular, the founding principle of the NHS that healthcare should be funded through general taxation and available to all on the basis of need not ability to pay. But, we must not be tied to old structures and ways of delivering these services. As society progresses and public expectations change it is vital that we reform services to meet growing needs whilst delivering maximum benefit from the public funding with which we are entrusted. Only through reform will we deliver the high standards of quality and responsiveness that are demanded of modern health and social care services.

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 and diabetes; mental health (including Mental Health Bill); prison healthcare; dentistry; patient and public involvement; renal services and equality and diversity issues.

Minister of State for Quality and Patient Safety, MS(Q):
The Right Honourable Jane Kennedy MP

Responsibilities include: Standards and inspection and performance ratings; patient safety; clinical governance and quality issues; clinical negligence; MRSA; reducing bureaucracy; NICE; genetics; MHRA and medicines; pharmaceutical industry and pharmacy; R&D; counter fraud and departmental management.

Ministerial Responsibilities

Minister of State for NHS Delivery, MS(D): Lord Warner

Responsibilities include: NHS finance issues; NHS workforce issues; primary care; chronic disease; NHS Foundation Trusts; IT; access and delivery; Winter planning and PFI and NHS LIFT.

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

Responsibilities include: Public Health White Paper (including Health Improvement and Protection Bill); health inequalities; drugs; tobacco; alcohol; physical activity; diet and nutrition; communicable disease; 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; CSCI and SCIE; children's health; maternity services; CAMHS; older people's services; physical and learning disabilities; allied health professionals and voluntary sector.

Chief Executive: Sir Nigel Crisp

DH Department of Health

Health and Social Care DELIVERY GROUP & NHS Connecting for Health

Director: John Bacon

Access
Director: Margaret Edwards
Works across the whole health system with NHS colleagues and key stakeholders, to improve access and choice for faster, more patient-responsive care.
- Primary care
- Secondary care
- Access policy development & capacity planning
- Dental and optical

Finance & Investment
Director: Richard Douglas
Delivers the department's financial functions and discharges its financial responsibilities.
- NHS and social care finance (resource acquisition and allocation, financial planning and management)
- Accounting and governance
- Capital investment
- Financial system reform programme

Workforce
Director: Andrew Foster
Ensures the NHS and social care have a world-class workforce, able to deliver high-quality services.
- Workforce capacity
- Model employer
- Model career

Programmes & Performance
Director: Duncan Selbie
Leads negotiation and delivery of the Public Service Agreement, and hosts the department's Primary Care Trust adviser.
- Planning and performance reports
- Central Programme Office
- Department of Health Gateway
- NHS Foundation Trusts

Commercial
Director: Ken Anderson
Secures best value and greater levels of effectiveness for the department and the NHS through best commercial practices and commercial relationships.
- Ensures commercial and procurement excellence across the department and the NHS
- Promotes the adoption of best commercial practices, where they significantly improve NHS effectiveness and efficiency
- Develops and manages links with the independent sector
- Provides commercial input to departmental strategic reviews and policy decisions

Strategic Development
Director: Kate Barnard
- Development of NHS leadership, organisational development and management

Group Business Team
Head: Julie Taylor
- HR, finance, development & communications, project & programme management, forward planning and governance support
- Delivery Analytical Team

NHS Connecting for Health
Director General for IT: Richard Granger (reports to chief executive)
Service implementation: Richard Jeavons
Chief operating officer: Gordon Hextall
Develops, procures and implements modern, integrated IT infrastructure and systems for all NHS organisations in England by 2010.

STRATEGY & BUSINESS DEVELOPMENT GROUP

Director: Hugh Taylor

Corporate Management & Development
Director: Hugh Taylor
- Private Offices for ministers
- Corporate HR
- The Secretariat
- Policy hub
- Equalities and human rights
- Honours
- Medicines, Pharmacy & Industry
- Knowledge management, including Freedom of Information, data protection issues
- Information services
- Customer Service Centre
- Departmental security issues
- Legislation
- Departmental change programme
- Information Centre
- Facilities

Group Business Team
Head: Peter Allanson
- HR, finance, development & communications, project & programme management forward planning and governance support

User Experience & Involvement/Professional Leadership
Director/Chief Nursing Officer: Christine Beasley
- Professional advice on all policy issues relating to nursing, midwifery, health visiting, allied health professions and healthcare scientists
- Improving patient experience
- Patient and public involvement
- Information and choice
- Complaints and clinical negligence
- Self-care
- The voluntary sector
- Cleaner hospitals/reduced healthcare-acquired infections

Communications
Director: Sian Jarvis
- Media relations and communications strategy and planning
- External relations
- Media initiatives
- Campaigns
- Publishing
- Marketing
- Events
- Internal communications
- Branding
- Ministerial visits

Strategy
Director: Stephen O'Brien
- Strategy development and evaluation
- Understanding of user and healthcare trends
- Objective analysis and research to support the strategy and the department
- Whole-system strategy across national and local government for social care
- Professional analytical services including the Corporate Analytical Team

Organisation review
Director: Chris Outram
- Review of arm's-length bodies

Health and Social Care STANDARDS & QUALITY GROUP

Director and Chief Medical Officer: Sir Liam Donaldson

Healthcare Quality
Director and Deputy Chief Medical Officer: Dr Bill Kirkup (acting)
- Standards and investigation
- Quality strategy
- Clinical governance
- Patient safety
- Modernising medical careers
- Screening and specialist services
- National Service Frameworks and service reviews

Programmes
Director: Alan Doran
- Coronary heart disease
- Cancer

Research & Development
Director: Professor Sally Davies
- Research policy and strategy
- Funding and managing Department of Health and NHS research

Care Services
Director: Professor Antony Sheehan
- Prison health
- Older people and disabilities
- Children and Mental Health

Health Improvement
Director and Deputy Chief Medical Officer: Dr Fiona Adshead
- Public Health White Paper
- Sexual health and substance misuse
- Health improvement and prevention
- Public health development and inequalities

Health Protection, International Health & Scientific Development
Director and Chief Scientist: David Harper
- International health
- Health protection
- Scientific development
- Emergency preparedness

Regional Directors for Public Health
Each of the nine directors is located in the regional offices of government and provides leadership on key public health issues

Group Business Team
Director: Alan Doran
- HR, finance, development & communications, project & programme management, forward planning and governance support
- Standards & Quality Analytical Team

EXECUTIVE AGENCIES:

Medicines and Healthcare products Regulatory Agency
NHS Purchasing & Supply Agency
NHS Estates

Contents Summary

This report provides 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 1 – Introduction

Introduces the report and the Department's overarching direction.

Chapter 2 – Delivering Better Public Services

This section outlines the aims and objectives of the Department. We also list the progress against those targets 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. 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 2003-04. 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*[0.1] and the *Departmental Investment Strategy*[0.2] 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*[0.3] 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.*[0.4] This document set out the priorities for the NHS up to 2008. It supports the ongoing commitment to the 10-year reform process first set out in *The NHS Plan*.

Chapter 6 – Breakdown of Spending Programme

This provides a breakdown of spending across our main programme areas (NHS, Family Health Services and Personal Social Services 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 4 main areas: Activity; Performance; Efficiency and Personal Social Services activity, performance and efficiency. It provides such activity data as hospital activity, inpatient 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 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 of Health's spend on publicity, advertising and sponsorship. The Annexes also contain tables that are supplementary to other sections in this report.

1. Introduction

1.1 INTRODUCTION
1.5 DEPARTMENT OF HEALTH
1.10 NATIONAL HEALTH SERVICE (NHS)
1.12 PERSONAL SOCIAL SERVICES (PSS)
1.15 DELIVERING THE NHS PLAN
1.23 NHS FOUNDATION TRUSTS
1.26 THE DEPARTMENT OF HEALTH CHANGE PROGRAMME
1.28 ARM'S LENGTH BODY REVIEW
1.30 EFFICIENCY PROGRAMME
1.33 PUBLIC HEALTH WHITE PAPER

INTRODUCTION

1.1 This is the Department of Health's fifteenth annual report. In it, you will find a wide range of information about our spending programme.

1.2 The Department of Health (DH) is responsible for the stewardship of almost £70 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 contributes to Parliamentary accountability and ensures that there is full and open reporting to the general public.

1.3 Chapter 3 of this report provides information on the Government's spending plans for 2005-06, Chapter 6 has a detailed breakdown of the spending programme and Chapter 7 provides an analysis of the resources which have been used under the headings of activity, performance and efficiency.

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

DEPARTMENT OF HEALTH

1.5 The Department of Health (DH) sets overall policy on all health issues, including public health matters and the health consequences of environmental and food issues.

1.6 DH is also responsible for the provision of health services through the National Health Service (NHS).

1.7 The NHS includes independent contractors such as General Medical Practitioners (GPs), dentists, pharmacists and opticians.

1.8 The Department of Health is also responsible for managing performance against its statutory responsibilities.

1.9 The Department of Health sets the overall policy for the delivery of Adults' Personal Social Services (PSS) and gives advice and guidance to local authorities, whose responsibility it is to manage PSS in their areas.

NATIONAL HEALTH SERVICE (NHS)

1.10 In the 2004 Spending Review, the Chancellor confirmed the five-year settlement for the NHS announced in his 2002 budget.

1.11 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)

1.12 In its Spending Review 2004, the Government has allowed for continued, substantial growth in Personal Social Services (PSS) resources in England.

1.13 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.

1.14 This good settlement means that over the three years of the Spending Review (2005-06 to 2007-08), there will be an increase of nearly £2 billion, taking total net PSS resources to £12.5 billion.

DELIVERING THE NHS PLAN

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

1.15 *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.

1.16 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*.

1.17 *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.

1.18 In June 2004, the Department of Health 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*.

1.19 *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 and more focus on the treatment of patients with chronic illness and prevention of disease and tackling ill health through public health.

1.20 *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

1.21 In support of the NHS Improvement Plan the Department of Health published *Creating a Patient-led NHS – Delivering the NHS Improvement Plan*[1.4] on the 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.

1.22 *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 the leaders of the NHS to provide clarity on how to carry forward to transform 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.

NHS FOUNDATION TRUSTS

1.23 NHS Foundation Trusts were set up under powers in the *Health and Social Care (Community Health and Standards) Act 2003*[1.5]. There are now 31 NHS Foundation Trusts in operation and further waves will follow. By 2008, all NHS trusts will be in a position to apply to become NHS Foundation Trusts.

1.24 Within a clear framework that outlines national standards and subject to independent inspection, power is being devolved to locally-run services with the freedom to innovate and improve care for NHS patients.

1.25 NHS Foundation Trusts are governed by boards that include people elected by members of the public, patients and staff. NHS Foundation Trusts are accountable directly to their local communities and to Parliament.

THE DEPARTMENT OF HEALTH CHANGE PROGRAMME

1.26 Over the past 18 months, the Department has undergone its Change Programme to enable it to provide leadership that is more effective to the NHS and social care, and a better service to Ministers and the public.

1.27 It has been reshaped, reducing by 1,400 posts and creating a smaller, more strategic, organisation with operational responsibility devolved throughout the system.

ARM'S LENGTH BODY REVIEW

1.28 In 2003, we announced that the Department was to review its arm's length bodies (ALBs). The Secretary of State published the outcome of the Review in July 2004 and proposals for implementation in November 2004. The ALB Review implementation programme is 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 frontline 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.

1.29 The ALB Review changes will deliver a redistribution to the front line of at least £0.5 billion a year by the end of 2007-08. The number of arm's length bodies will be reduced to 20 from the base year of 2003-04, despite the sector assuming new functions under statutes approved by Parliament. Even with these new functions, which bring new costs, we will be setting the 2005-06 budget for the ALB sector so that it will cost about £100 million a year less to run than in 2003-04. A further £200 million a year will become available for redistribution to the front line by the end of 2006-07 and again in 2007-08. This will inevitably mean significant changes in the organisation, staffing, financing and governance of the ALB sector: these changes are set out in detail in Chapter 8.

EFFICIENCY PROGRAMME

1.30 It is essential that we get maximum benefit from the funding allocated to the NHS and social care. This is why the Department of Health, the NHS and Social Services are to make very significant efficiency gains over the next three years. These will total over £6.5 billion by 2007-08, equivalent to 2.7 per cent per year. This is 30 per cent of the total projected savings across government.

1.31 To measure progress against value for money targets, the Department of Health has developed an interim value for money measure, which measures value for money in terms of improvements in cost efficiency. In 2003-04, this measure suggests that value for money through cost efficiency increased by 2.1 per cent.

1.32 One of the principal recommendations of the Atkinson Review of the Measurement of Government Output and Productivity was that quality of care should be included in the measurement of NHS output and productivity measures. The Department of Health will therefore be working with the Office for National Statistics to further improve NHS output and productivity measures and in particular, measures of quality improvements.

PUBLIC HEALTH WHITE PAPER

1.33 The White Paper *Choosing Health: Making Healthier Choices Easier*[1.6], signals the Government's intention to transform the NHS into a true service for improving health, as well as a service to treat sickness. It sets out how Government will make it easier for people to adopt healthier lifestyles. This will also make good economic sense with fewer unnecessary deaths and less unpreventable disease.

1.34 *Choosing health* marks a step change in how the NHS will plan and deliver improvements in the health of the population. Health improvement will become an integral part of the mainstream planning and performance system and will be core to NHS business.

2. Delivering Better Public Services – Progress

2.1 INTRODUCTION

2.4 THE DEPARTMENT OF HEALTH AIMS AND OBJECTIVES

TABLE – DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS (1998)

TABLE – DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS (2000)

TABLE – DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS (2002)

2.11 DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (2004)

TARGETS FROM CROSS-DEPARTMENTAL REVIEWS:

2.14 HEALTH INEQUALITIES

2.19 ACTION AGAINST ILLEGAL DRUGS

CROSS-GOVERNMENT INITIATIVES:

2.22 SURE START

2.37 NATIONAL SERVICE FRAMEWORK FOR CHILDREN, YOUNG PEOPLE AND MATERNITY SERVICES

2.42 EVERY CHILD MATTERS: CHANGE FOR CHILDREN

2.48 SOCIAL EXCLUSION AND NEIGHBOURHOOD RENEWAL

2.52 SUSTAINABLE DEVELOPMENT

MODERNISING GOVERNMENT ACTION PLANS:

2.56 THE POLICY HUB

2.59 THE POLICY COLLABORATIVE

2.62 EQUALITY AND HUMAN RIGHTS

2.63 RACE RELATIONS (AMENDMENT) ACT 2000

2.92 RURAL PROOFING

2.99 BETTER REGULATION AND REGULATORY IMPACT ASSESSMENTS (RIAs)

2.117 E-GOVERNMENT AND IT IN THE NHS

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.

THE DEPARTMENT OF HEALTH AIMS AND OBJECTIVES

Aims

2.4 The Department of Health's overall aim is to improve the health and wellbeing of the population.

2.5 The distinctive role of the Department includes:

- 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;
- setting some standards and ensuring others are set;
- securing and allocating resources; and,
- ensuring accountability to the public and Parliament.

2.6 To carry out this role, the Department is organised into three Business Groups, responsible for Standards and Quality, Delivery, and Strategy and Business Development [see organisation chart on page 5]. The Departmental Management Board, under Sir Nigel Crisp's chairmanship, coordinates the leadership and management of the department, in support of Ministers.

Objectives

2.7 The Department's objectives, which derive from its Public Service Agreement with HM Treasury, are to:

- 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 (CSR 1998) ANALYSIS

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

PSA Target	Measure	Progress
Target 1 Reduction in the death rate from cancer amongst people aged under 75 by at least 20% 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 (SR2002) Target 6** As a result of information from the 2001 Census, and subsequent ONS Local Authority Population Studies, the population denominator has changed and rates for all years up to 2000 have been recalculated. Baseline data have been reset in accordance with these changes.
Target 2 Reduction in death rate from heart disease and stroke and related illnesses amongst people aged under 75 years by at least 40% 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 (SR2002) Target 6** As a result of information from the 2001 Census, and subsequent ONS Local Authority Population Studies, the population denominator has changed and rates for all years up to 2000 have been recalculated. Baseline data have been reset in accordance with these changes.
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 three years 1995 to 1997.	Death rate from accidents.	**Slippage:** Data for 2001-03 (3 year average) show a rate of 16.0 deaths per 100,000 population – a rise of 0.8% from the baseline (1995-97). However other datasets (eg from HSE and DfT) indicate a downward trend in certain accidents. The Report of a cross-Government Task Force on Accidental Injuries was published on 11 October 2002, and action is being taken to implement its recommendations. As a result of information from the 2001 Census, and subsequent ONS Local Authority Population Studies, the population denominator has changed and rates for all years up to 2000 have been recalculated. Baseline data have been reset in accordance with these changes.
Target 4 Reduction in the rate of hospital admission for serious accidental injury by at least 10% 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% from the baseline estimate (1995-96). As a result of information from the 2001 Census, and subsequent ONS Local Authority Population Studies, the population denominator has changed and rates for all years up to 2000 have been recalculated. Baseline data have been reset in accordance with these changes.
Target 5 Reduction in the death rate from suicide and undetermined injury by at least 20% 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 (SR2002) Target 7 (part)** A National Suicide Prevention Strategy was published in September 2002 led by the National Director for Mental Health. As this is implemented it will contribute to reducing the suicide rate. As a result of information from the 2001 Census, and subsequent ONS Local Authority Population Studies, the population denominator has changed and rates for all years up to 2000 have been recalculated. Baseline data have been reset in accordance with these changes.

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 2 weeks.	**Nearly met:** 99.5% of all patients referred urgently with suspected cancer were seen by a specialist within 2 weeks during July to September 2004. The Department now measures a maximum one month wait from diagnosis to first treatment for breast cancer. Between July to December 2004, 97.5% of women with breast cancer received first treatment within one month of diagnosis. The Department also measures the number of women with suspected breast cancer who receive treatment within two months of urgent referral by their GP. During July to September 2004, 96.6% of patients received treatment within two months.

Objective III: To enable people who are unable to perform essential activities of daily living, including those with chronic illness, disability or terminal illness, to live as full and normal lives as possible.

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 3% over the five years up to 2002-03, compared with an annual average rate of 3.5% 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%. Target has been revised – see PSA(SR2000) 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 2 percentage points by 2002 from the 1997-98 baseline of 14.3%.	Average emergency psychiatric admission rate.	**Nearly met:** Psychiatric re-admission rate in 2001-02, the last year data was collected on a re-admissions within 90 day basis, was 12.7% narrowly missing the target by 0.4 percentage points. Implementation of new service models such as assertive outreach, early intervention and crisis resolution, mean that further falls in re-admission rates are expected, though changes in data definition and sources do not allow comparison with earlier years.

Objective IV: To maximise the social development of children within stable family settings.

PSA Target	Measure	Progress
Target 24 Improve the continuity of care given to children looked after by local authorities by reducing to no more than 16% in all authorities, the proportion of such children who have three or more placements in one year by March 2001. As many as 30% of children currently experience 3 or more placements per year in some authorities, within a national average of 20%.	Percentage of authorities with more than 16% of children looked after who have three or more placements.	Responsibility for PSA Targets 24-26 (CSR1998) 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% by 2001 the proportion of children leaving care aged 16 or above with a GCSE or GNVQ qualification and to 75% by 2003. Data published for the first time in October 2000 set a baseline figure of 30%.	The percentage of children leaving care at age 16+ with a GCSE or GNVQ qualification.	
Target 26 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. To reduce the proportion from 10.8% to 7.2%.	PAF Performance Indicator C18, which compares the prevalence of final warnings and convictions among looked after children with their peers.	

DEPARTMENTAL OPERATIONS AND PSA PRODUCTIVITY TARGETS ANALYSIS

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 (measured by percentage of payments paid on time).	Percentage of payments made on time.	**Nearly met:** At the end of March 2005 (full year figures), the Department had a total of 92.5% of its undisputed invoices paid within 30 days. The major reorganisation of the Department, combined with the implementation of a new e-business system and processes has caused a temporary worsening of the performance. However, the Department is now paying over 95% of its bills on time and this will be reflected in the 2005-06 figures.
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 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:** Targets have been set for managing violence and sickness absence: 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. Sickness figures collected by calendar year. In 2000, the national sickness absence level was 4.68%, which remained virtually at the same level in 2002 and 2003. Figures on reported incidents of violence and verbal abuse for 2001-2002 were published with the results of the NAO survey on violence on 27 March 2003, and for 2002-03 on the DH website on 15 September 2003.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS (2000)

2.8 The 1998 Comprehensive Spending Review (CSR) made an important step forward in delivering improvements in services, through the innovation of Public Service Agreements (PSAs).

2.9 The 2000 Spending Review continued that process by setting out further targets including targets on improving value for money and efficiency.

Aim: To transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

Objective I: Improving health outcomes for everyone.

PSA Target	Measure	Progress
Target 1: Reduce substantially the mortality rates from major killers by 2010: from **circulatory disease** by at least 40% in people under 75; from **cancer** by at least 20% in people under 75; and from **suicide and undetermined injury** by at least 20%. 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 (SR2002) Targets 6 and 7 (part)**

PSA Target	Measure	Progress
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):*		
1. Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole.	1. Mortality in infancy by social class.	**Infant mortality** See PSA (SR2002) Target 11
2. Starting with local authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.	2. Life expectancy by Local Authority.	**Life expectancy** See PSA (SR2002) Target 11
3. By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter.	3. 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 (SR2002) Target 9 (part)

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

PSA Target	Measure	Progress
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 inpatient elective admissions will be pre-booked by 2003-04 on the way to 100% pre-booking by 2005.	DH monthly central data collection from January 2003. Supersedes the Modernisation Agency monthly project progress reports.	**On course:** A monthly DH central data collection was introduced in January 2003. The monthly data collection captures full bookings and partial bookings as they are added to the waiting list. This allows rigorous monitoring of progress towards booking milestones and targets. A Data Set Change Notice was issued in 2000 to the service in support of the new monitoring arrangements. From April 2003, Strategic Health Authorities have been responsible for managing and developing booking locally as part of their Local Delivery Plan. A new electronic booking system, Choose and Book, has been developed to modernise outpatient booking systems and to enable delivery of choice at referral. This is currently being rolled out across the country and will be available across England by December 2005.
Target 4: Reduce the maximum wait for an outpatient appointment to three months and the maximum wait for inpatient treatment to six months by the end of 2005.	Number of patients on NHS waiting lists.	**See PSA (SR2002) Target 1**
Target 5: To secure year-on-year improvements in patient satisfaction/experience, including: (i) Standards of cleanliness and food, as measured by independently audited local surveys. (ii) 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 (SR2002) Target 5 **Patient Advocacy Liaison Services (PALs)** 100% of Trusts now have PALs in place.

Objective III: Effective delivery of appropriate care.

PSA Target	Measure	Progress
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% of those achieved by all young people in the same area by March 2004.	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.	Responsibility for PSA Target 7 (SR2000) now lies with DfES following "Machinery of Government" changes.
• Improving the educational attainment of children and young people in care by increasing from 4% in 1998 to 15% by 2003-04 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*-C.	OC1 data collection – the percentage of children leaving care at 16+ with 5 or more 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% to 7.2%. This target has also been adopted as part of the Department of Health's SR2002 PSA target.	Youth Offending. PAF C18: Final Warnings and Convictions of Children Looked After.	
• 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% the number of looked after children who are adopted, and aim to exceed this by achieving, if possible, a 50% increase, up from 2,700 in 1999-2000; – to increase to 95% 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% in 2000-01.	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.)* The percentage of those looked after children whose placement for adoption ended during the year, whose placement ended as a result of an adoption order being made. *(Measured through the SSDA 903 return.)*	
Target 8: Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 and increase year-on-year the proportion of users successfully sustaining or completing training programmes.	Returns from the National Drug Treatment Monitoring System, which provides details on the number of drug misusers entering treatment.	**See PSA (SR2002) Target 10**

Objective IV: Fair Access.

PSA Target	Measure	Progress
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 (SR2002) Target 3**

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:** 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% in 1999-2000, to 21% in 2000-01, to 17% in 2001-02; to 15% in 2002-03; and to 12% in 2003-04.

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (SR 2002) ANALYSIS

2.10 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.

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 inpatient treatment to six months by the end of 2005; and to achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to three months by 2008.	Number of patients on NHS waiting lists.	**Outpatient waits – on course:** Interim milestone by March 2004 is a maximum wait of four months (17 weeks). Numbers of English residents waiting over four months – quarterly figures: • March 2004 – 2,847 • March 2005 – 2,058 **Inpatient waits – on course:** Interim milestone by March 2004 is a maximum wait of nine months. Number of English residents waiting more than nine months – monthly figures: • March 2004 – 223 • March 2005 – 41 **At the end of March 2005 there were 24 English residents** waiting longer than 12 months for inpatient treatment. Number waiting more than six months – monthly figures • March 2004 – 80,125 • March 2005 – 40,806

PSA Target	Measure	Progress
Target 2: Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004; and reduce the proportion waiting over one hour.	Total time from arrival to admission, discharge or transfer for patients attending all types of A&E (including Walk in Centres and Minor Injury Units).	**A&E Waits – on course:** During January to March 2005, 97 per cent of attenders at all types of A&E were admitted, transferred or discharged within four hours of arrival. In the period January to March 2004 the equivalent figure was 93 per cent.
Target 3: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.	PCT performance is measured through the Local Delivery Plans Report (LDPR) and has previously been reflected in the PCT performance ratings (performance ratings for 2003-04 have yet to be agreed with CHAI). The Primary Care Access Survey is one of the LDPR returns and requires PCTs to contact all of their practices on a specific day to monitor the national access target.	**Primary Care Access – on course:** Almost all patients can now get quick access to a PCP or GP. March 2005 performance data show that more than 99% of patients could get access to a PCP /GP within 24/48 hours if they wanted.

PSA Target	Measure	Progress
Target 4: Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.	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 – on course:** Milestone by March 2004 is that 100% of day cases are booked. Latest figures: • March 2004 – 97% • September 2004 – 98% • March 2005 - 99% Interim milestones for March 2004 are that 66% of inpatients' appointments (day cases & ordinary admissions) are booked. There are no interim milestones for March 2005. Latest figures: • April 2003 – 59% • March 2004 – 90% • September 2004 – 92% • March 2005 - 95% The second March 2004 milestone is for 66% booking of outpatients' appointments. There are no interim milestones for March 2005. Latest Figures: • April 2003 – 33% • March 2004 – 76% • September 2004 – 80% • March 2005 - 87% **Choice – on course** By the end of the year all eligible patients will be offered the choice of 4-5 providers at the point of GP referral into secondary care. Some patients are already benefiting from choice of hospital. Since the end of August 2004, patients waiting longer than six months for elective surgery are already being offered the choice of having faster treatment at an alternative provider. Since April 2004, when this was rolled out across the NHS, some 30,000 patients have accepted such a choice offer. Since the end of January, cataract patients are being offered the choice of two or more providers at the point of referral, this will increase to 4-5 by December 2005. From April 2005, patients needing cardiac surgery will be given the choice of two or more providers at the point of referral by the cardiologist. **Choose and Book** The 'Choose and Book' initiative, which enables patients to book initial hospital appointments from the GP surgery at a time and place of their choice, was launched in summer 2004. This is now being rolled out and will be available across England by December 2005.

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	**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. The service areas covered so far are: inpatients, including children and young people, primary care, outpatients and A&E, ambulance services and mental health services. The results of the surveys are analysed under five patient experience themes: • Access and waiting; • Better information, more choice; • Building closer relationships; • A clean, comfortable, friendly place to be; and, • Safe, high quality, co-ordinated care. Detailed results can be viewed at: www.healthcarecommission.org.uk/National Findings **The Commission for Patient and Public Involvement in Health (CPPIH):** The Commission will be abolished as part of the Department's review of its arm's length bodies. Alternative arrangements will be put in place to support Patient and Public Involvement (PPI) forums which include transferring responsibility for appointments to forums to the NHS Appointments Commission. The CPPIH was established on 1 January 2003. It is responsible for setting up, providing staff support and training and guidance for PPI forums. By the 1 December 2003 it had set up forums for every NHS trust and PCT in England and appointed around 5,000 members to forums. The Commission also promotes the involvement of the general public in policies and decisions affecting its health. **Patients Forums – on course:** Since patients' forums have been in place they have been carrying out their functions to monitor and review services from the patient's perspective and seek the views of the public about those services. **Complaints – on course:** The Independent Complaints Advocacy Service (ICAS) was launched on 1 September 2003. ICAS provides independent support to patients making formal complaints against the NHS. ICAS is the first statutory complaints support service delivered to national standards. **Local Authority Overview and Scrutiny Committees (OSCs) – on course:** 1 January 2003 saw the start of new powers for Local Authority OSCs to review and scrutinise health services. All local authorities with social services responsibilities – London borough councils, county councils and unitary authorities – now have powers to call NHS managers to meetings and to request information. They must also be consulted on proposals to substantially develop or vary health services. All local authorities with these powers must put in place OSCs to review health services. **Cleanliness – on course:** Standards of cleanliness continue to improve. Independent Patient Environment Action Team (PEAT) inspections show over 97% of hospitals are rated "acceptable" or better, with 49% rated as "good" or "excellent". The 3% of hospitals which failed to meet acceptable standards have implemented improvements and are now rated as "acceptable". **Hospital Food – on course:** We continue to see significant progress in the choice and availability of high-quality hospital food. The PEAT inspections in 2004 found that 93% of hospitals provided food rated as "acceptable" or better, with 58% rated as "good" or "excellent". **Housekeeping – met** The target to introduce ward housekeepers into 50% of all hospitals by December 2004 was met ahead of schedule. Ward housekeepers are now working in over 53% of all hospitals and in larger hospitals, where the majority of patients receive treatment, 70% have established ward housekeepers.

Objective II: Improve health and social care outcomes for everyone.

PSA Target	Measure	Progress
Target 6: Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75.	Death rate from heart disease, strokes and related illnesses amongst people aged under 75.	**Heart Disease – on course:** Data for 2001-2003 (three-year average) show a rate of 102.8 deaths per 100,000 population – a reduction of 27.1% from the baseline (1995-97). Three-year average rates have fallen for each period since the baseline. **Cancer – on course:** Data for 2001-2003 (three-year average) show a rate of 124.1 deaths per 100,000 population – a reduction of 12.2% from the baseline (1995-97). As with circulatory diseases, three-year average rates have fallen for each period since the baseline.
Target 7: Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and CAMHS(Children and Adolescent Mental Health Services) services, and reduce the mortality rates from suicide and undetermined injury by at least 20% by 2010.	Annual mapping of CAMHS to monitor success.	**Access to CAMHS – early stages of delivery:** CAMHS Regional Development Workers continue to help both commissioners and providers to expand and improve services in line with guidance set out in the CAMHS standard of the Children's National Service Framework. Provisional analysis of the 2004 CAMHS Mapping data shows that the percentage increase in expenditure, staffing and activity on CAMHS over 2003 levels is significantly above the minimum 10% increase set as an objective in the Planning and Priorities Framework.
	For crisis services there are two main forms of measurement: 1. Number of patients who are subject to at least one consultant episode (acute home-based) per annum is measured. 2. Number of Crisis Resolution teams established.	**Access to crisis services – early stages of delivery:** The latest available data (January to March 2005) shows 68,763 people receiving a Crisis Resolution/Home Treatment service. This is 115% of the planned 59,638. However, the updated plans show a rise from 59,638 people to be given a service by 31 March 2005 to a plan to serve 104,751 by 31 March 2006. Local Delivery Plans and performance against them remain under the required trajectory to achieve the Planning and Priorities Framework (PPF) target. Work continues with Strategic Health Authorities to achieve the PPF targets. The key enabler for improving access to crisis services is the implementation of sufficient numbers of crisis resolution teams. January to March 2005 Local Delivery Plan Returns (LDPR) indicated 304 crisis resolution teams have been set up (91% of the PPF requirement of 335 by December 2004). This equates to 92% of the 331 forecast in LDPs by March 2005. Definitive measure for team numbers from the Durham Mapping exercise will be available in June 2005.
	Death rate from suicide and undetermined injury. Baseline of 9.2 deaths per 100,000 population for the three years 1995 to 1997.	**Suicide and Undetermined Injury – on course:** Data for 2001-2003 (three-year average) show a rate of 8.6 deaths per 100,000 population – a reduction of 6.0% from the 1995-97 baseline (9.2). A National Suicide Prevention Strategy was published in September 2002 led by the National Director for Mental Health. As this is implemented it will contribute to further reducing the suicide rate. On 21 January 2004, NIMHE published the second annual report on progress on the national suicide prevention strategy for England. This report sets out what has been achieved so far and what further actions need to be taken in the medium and longer term. It is the second in a series of progress reports that will be published as the strategy is implemented and new figures and findings become known.
Target 8: Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.	Those people receiving more than 10 contact hours of home care and 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 – met:** The number of older people supported intensively to live at home increased to 30.1% in 2003-04. This target has therefore been met two years early.

PSA Target	Measure	Progress
Target 9: Reducing the under 18 conception rate by 50% by 2010.	The under 18 conception rate is the number of conceptions to under 18 years old per thousand females aged 15-17. Baseline year is 1998.	**Under 18 conception rate – slippage:** **The Teenage Pregnancy target is now a shared PSA target between Department of Health and DfES in light of the move of the Teenage Pregnancy Unit to DfES in June.** The under 18 conception rate fell by 9.8% between 1998 and 2003. Every top tier local authority is implementing a 10-year local teenage pregnancy strategy. These strategies and annual forward action plans set out to deliver under 18 conception rate reduction targets of between 40% and 60% by 2010. The fourth full year of implementation of local strategies ended in March 2005. All 30 action points set out in the Teenage Pregnancy Strategy are being implemented. To achieve the accelerated decline required to meet targets, local areas are being supported to intensify delivery of the Strategy to meet the needs of young people most at risk. In November 2005, the third annual report of the Independent Advisory Group on Teenage Pregnancy was published and made recommendations to ensure the continued progress of the strategy.
Target 10: Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 and increase year-on-year the proportion of users successfully sustaining or completing training programmes.	Annual returns from the National Drug Treatment Monitoring Service (NDTMS), which provides details on the number of drug misusers entering, in, successfully completing and sustained in treatment. Monthly data collection from lead Primary Care Trusts/Drug Action Teams introduced from October 2003.	**Participation in drug treatment programmes – on course:** NDTMS data for 2003-04, published September 2004 confirmed that achieving the target to double the numbers in treatment by 2008, was still on course, although the 2004 target of increasing the numbers in treatment by 55% by 2004, was just missed. Based as much as possible on the methodology used when the original baseline was set it was estimated that there were 154,000 in treatment in 2003-04 and 140,928 in 2002-03. This reflects an almost 10% increase in numbers on treatment between 2002-03 and 2003-04 and a 54% increase between 1998 and 2003-04. NOTE: In 2003-04 the methodology used for counting the numbers in drug treatment in England was revised to reflect numbers in treatment more accurately. The definition of structured drug treatment has also tightened with the implementation of *Models of care for the treatment of adult drug misusers*, which was published in 2002. The figure for the number of people in treatment at any point in the year based on the new methodology was 126,000. However, to ensure that the numbers in treatment could be compared with previous years an estimate was made of the numbers in treatment based, as far as possible, on the methodology used in previous years. The estimate made was 154,000.
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 – slippage:** The gap between the mortality rate for routine and manual groups and the whole population widened slightly over the years since the target baseline, although the trend has fluctuated over the period. The infant mortality rate among the "routine and manual" group was 19% higher than in the total population in 2001-03. This compares with 13% higher in the baseline period of 1997-99. **Life expectancy – challenging target, further work needed on delivery chain:** The latest available data relate to the three years 2001-2003. Between the baseline of 1997-1999 and 2001-2003, the relative gap in life expectancy between England and the lowest fifth of local authorities increased for both males and females, with a larger increase for females. For males the relative gap increased by nearly 2%, for females by 5%.

Objective III: Improve Value for Money.

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

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS (SR 2004)

2.11 Further to the earlier Spending Reviews, the 2004 Review carried forward some existing targets. The targets from the 2004 Review are laid out below.

Priority I: Health of the Population

Target 1

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

Substantially reduce mortality rates by 2010 (from the *Our Healthier Nation*[2,3] baseline, 1995-97)

- 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 and the population as a whole;
- 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 and the population as a whole; and,
- from suicide and undetermined injury by at least 20 per cent.

Target 2

Reduce health inequalities by 10 per cent by 2010 (from a 1997-99 baseline) as measured by infant mortality and life expectancy at birth.

Target 3

Tackle the underlying determinants of health and health inequalities by:

- reducing adult smoking rates (from 26 per cent in 2002) to 21 per cent or less by 2010, with a reduction in smoking prevalence among routine and manual groups (from 31 per cent in 2002) to 26 per cent or less;
- halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) 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); and
- reducing the under-18 conception rate by 50 per cent by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health. (Joint target with the Department for Education and Skills.)

Priority II: Long-Term Conditions

Target 4

To improve health outcomes for people with long-term conditions by offering a personalised care plan for the most at risk vulnerable people; and to reduce overall emergency bed days by 5 per cent by 2008 (from the expected 2003-04 baseline), through improved care in primary care and community settings for people with long-term conditions.

Priority III: Access to Services

Target 5

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

Target 6

Increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008 (from a 1998 baseline); and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

Priority IV: Improving the Patient/User Experience

Target 7

Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensure that individuals are fully involved in decisions about

their healthcare, including choice of provider, as measured by independently validated 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 1 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 of those being supported at home or in residential care.

TARGETS FROM CROSS-DEPARTMENTAL REVIEWS

2.12 The 2000 Spending Review was informed by fifteen cross-departmental reviews of issues that might benefit from a joint approach involving two or more Government departments. Some of these reviews resulted in targets which appeared in the Department's Public Service Agreement (PSA). The 2002 Spending Review involved a further seven cross-departmental reviews, including a review on health inequalities.

2.13 Health inequalities secured a higher profile in the SR2004 PSA targets, not only in DH but across Government. Tackling them is a key pillar of the Choosing Health White Paper.

Health Inequalities

2.14 Work on tackling health inequalities is led by the Health Inequalities Unit (HIU) in the Department of Health. It is responsible for driving delivery of the Government's national PSA health inequalities target on life expectancy. SR2004 PSA targets include a higher profile for inequalities:

- retaining an overall target to reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy;
- introducing 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 6 per cent for cancer;
- reducing adult smoking prevalence in routine and manual groups to 26 per cent or less by 2010 is now a PSA target;
- a new target to halt the year-on-year rise in obesity among children under 11 by 2010; and,
- retaining a target to reduce the under-18 conception rate by 50 per cent by 2010.

2.15 The PSA target for life expectancy inequalities and the inequalities elements of the cancer and heart disease targets aim to narrow the gap between the population as a whole and the "fifth of areas with the worst health and deprivation indicators". This is the Spearhead Group of areas that contains 70 Local Authorities mapped to 88 PCTs, announced by the Secretary of State on 19 November 2004. Achievement of the targets will be assessed on the outcomes for this Group in 2010.

2.16 The Public Health White Paper *Choosing Health: Making Healthier Choices Easier*[2.4] sets out the importance of ensuring that as the country strives to improve its health a priority must be given to tackling health inequalities so that all groups in society benefit from improvements in public health. Actions in the White Paper to address inequalities include health literacy, health trainers, NHS Stop Smoking Services and health and wellbeing equity audits.

2.17 *Tackling Health Inequalities: A Programme for Action*[2.5] remains extant and is referred to in *Choosing Health: Making Healthier Choices Easier*. The Programme for Action identified four key areas for progress:

- supporting families, mothers and children;
- engaging communities and individuals;
- preventing illness and providing effective treatment and care; and,
- addressing the underlying determinants of health.

2.18 A follow up report on progress against the Programme for Action will be published this year. This will look at the national health inequalities target on life expectancy and infant mortality, together with progress against 12 national health inequalities headline indicators.

Action Against Illegal Drugs

2.19 The aim of this initiative is 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 In 2003-04, the methodology used for counting the number of drug users in treatment was revised to reflect numbers in treatment more accurately. The definition of structured drug treatment has also been tightened with the implementation of *Models of Care for the treatment of adult drug misusers*[2.6], which was published in 2002. Based on the new methodology the figure for the number of individuals in treatment during the year was 126,000. However, to ensure that the numbers in treatment could be compared with previous years an estimate was made of the numbers in treatment, based, as far as possible, on the methodology used in previous years:

- it is estimated that in 2003-04 there were around 154,000 problem drug misusers in treatment at drug treatment agencies and general practitioners in England, compared to around 140,900 in 2002-03 (an increase of almost 10 per cent); and,

- it is estimated that in 2003-04 the total number of individuals successfully completing treatment in 2003-04, or retained in treatment on 31 March 2004, was 90,511. This is an increase from the 80,600 problem drug misusers who successfully completed treatment in 2002-03.

2.21 These figures show that we continue to be on track to meet our target for 2008.

CROSS-GOVERNMENT INITIATIVES

Sure Start

2.22 Sure Start programmes, which include 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.

2.23 The Sure Start Unit, part of both DfES and DWP, 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.

2.24 The substantial additional funding agreed in the Spending Review 2004, and the Pre Budget Report (PBR) for 2004, will enable Government spending on Sure Start to reach £1.8 billion in 2007-08, more than double the figure for 2004-05. This represents an average annual increase of 24 per cent in real terms.

2.25 We published a Ten-year Strategy in December 2004 to build on the substantial expansion of services for young children and families over the last few years and deliver universal affordable childcare for 3-14 year olds and a Sure Start children's centre for every community; so early years services become a permanent, mainstream part of the welfare state.

2.26 524 Sure Start Local Programmes (SSLPs) are now up and running, 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.

2.27 In addition, a further 46 'mini' Local Programmes have been established in rural communities and areas with pockets of deprivation. These are aimed at reaching around 7,500 children under four and are linked with other existing early years' services.

2.28 Provision of childcare, early education and health and family services is increasingly integrated, 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 will build on earlier initiatives, including SSLPs, to spread this approach to all communities.

2.29 2,500 children's centres will be established in 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. 211 centres have been designated at the start of February 2005, with more expected in the coming months.

2.30 All three and four-year olds in England are now guaranteed a free part-time early education place for 2½ hours a day, 5 days per week, 33 weeks a year. We will extend this entitlement so that, from 2007, 3 and 4 year olds will begin to receive 15 hours per week, with all of them receiving it by 2010. Our longer-term goal is an entitlement to 20 hours early education per week.

2.31 In addition, we will pilot an extension of free, part-time early education to 12,000 two-year olds in disadvantaged areas by 2008.

2.32 The expansion of childcare provision continues, and at December 2004, more than 1.2 million new childcare places had been created since 1997, benefiting over 2 million children. In terms of net growth in provision, taking into account turnover, over 529,000 new OFSTED registered childcare places have been created since 1997, benefiting around 950,000 children.

2.33 Key childcare commitments in the Ten-year Strategy include: a childcare place for all children aged between 3 and 14, between the hours of 8am to 6pm each weekday, by 2010; and that legislation will be in place by 2008 to impose a new duty on local authorities to secure sufficient supply of childcare in their areas to meet the needs of families.

2.34 A great deal of our childcare funding and support has been targeted at expanding provision in the most disadvantaged areas, where provision can be less extensive, through SSLPs, children's centres, our Neighbourhood Nursery initiative, and out of school and childminder support programmes.

2.35 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.

2.36 More information can be found at: **www.surestart.gov.uk**

National Service Framework for Children, Young People and Maternity Services

2.37 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. This followed publication of the hospital standard in April 2003. The NSF sets standards across health and social care and some education services. The NSF forms an integral part of the Government's strategy for children and young people, *'Every Child Matters: Change for Children'*[2.7].

2.38 Five standards have been set which apply to all children. These cover promoting health and wellbeing; supporting parenting; child-centred care; growing-up into adulthood and safeguarding and promoting the welfare of children and young people. The other standards cover children who are ill, disabled children and those with complex health needs, the mental health and psychological wellbeing of children, medicines and maternity services.

2.39 Alongside the standards, exemplars were published which illustrate what the standards mean for children with specific conditions and are presented as a child's journey through services. Those published so far include autistic spectrum disorder, asthma, chronic fatigue syndrome/ME and acquired brain injury. Further exemplars will be published covering a child with mental health difficulties, the care pathway for a pregnant woman and a child with complex needs.

2.40 The NSF Information Strategy was published at the same time which included the national and the local actions that will be needed to deliver the NSF standards. Particular projects will be the development of datasets for child health, maternity and child and adolescent mental health, and the development of a methodology to map child health and maternity services (see **www.childhealthmapping.org.uk**) comparable to the work that has already been done to map child and adolescent mental health services (**www.camhsmapping.org.uk**).

2.41 The NSF Delivery Strategy, *Supporting Local Delivery*[2.8], was published in December 2004. It places the health agenda for children in the context of *Every Child Matters: Change for Children*, and also sets out the action which the Government will take to support implementation of the NSF.

Every Child Matters: Change for Children

An Outcomes Driven Programme

2.42 Following the publication of the *Every Child Matters* Green Paper, Government Departments, including the Department of Health, have been working together to support local organisations to improve the five key outcomes for children identified by the Green Paper:

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

Children Act 2004

2.43 These outcomes were set in statutory form by the Children Act 2004, and local bodies, including PCTs, were placed under a duty by the Act to co-operate with each other to improve the outcomes. The Children Act 2004 included the following key reforms:

- a Children's Commissioner to champion the views and interests of children and young people;
- a duty on key agencies to safeguard and promote the welfare of children;
- establishment of statutory Local Safeguarding Children's Boards to replace the current Area Child Protection Committees; and,
- creation of an integrated inspection framework and the conduct of Joint Area Reviews to assess local areas' progress in improving outcomes.

Chief Nursing Officer's Review

2.44 In response to a recommendation in *Every Child Matters: Change for Children*, the Chief Nursing Officer published a review of the nursing, midwifery and health visiting contribution to the health and wellbeing of vulnerable children and young people in August 2004. The review included recommendations on: service planning and integration; workforce issues; health visiting; general practice; school nursing; secondary care; midwifery; child protection; information technology; and professional practice.

Development of Children's Trusts

2.45 Thirty-five 'pathfinder' children's trusts have been integrating health, social care, education and other services for children and young people. The Children Act provides a legislative basis for the extension of children's trust arrangements across all 150 local authority areas.

Regional Change Advisors

2.46 The Department of Health and the Department for Education and Skills have appointed 12 'Regional Change Advisors' to work across health, social care and education to ensure that the *Every Child Matters: Change for Children* agenda, and the five outcomes it is built around are delivered effectively in partnership.

Joint Inspection Arrangements

2.47 The Healthcare Commission has joined 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 outcomes.

Social Exclusion and Neighbourhood Renewal

2.48 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.

2.49 The Department continues to meet its NHS Plan commitment by supporting the Neighbourhood Renewal Unit to implement the Government's National Strategy for

Neighbourhood Renewal, which 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.

2.50 The Department and the Neighbourhood Renewal Unit are revising their guidance on health and neighbourhood renewal 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.

2.51 The Department is also working with other departments to develop Local Strategic Partnerships. These are key to neighbourhood renewal, and also implementation of the Choosing Health White Paper and the development of Local Area Agreements.

Sustainable Development

2.52 The Government continues to be strongly committed to placing sustainable development at the heart of its activities and strongly supports the important links between health and sustainable development. The Department of Health is committed to the Government's new Sustainable Development Strategy as shown by initiatives such as the 'NHS as a good corporate citizen', and recent work on the 'Ecological Footprint of the NHS'.

2.53 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 by promising to fund 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.

2.54 Examples of the Department's sustainable development performance are described at: **www.pasa.nhs.uk/sustainabledevelopment/2004/**. For the first time this includes not just environmental (e.g. consumption of 29 per cent less electricity than in 1999-2000) but also sustainable social (e.g. development of new framework agreements in consultation with stakeholders, for the provision of authentic, ethnically and culturally appropriate meals for Halal, Kosher, Afro-Caribbean and Chinese patients. The new agreements will also be set up to encourage regional supply, enabling small to medium enterprises (SMEs) as well as large suppliers to compete for the contract award) and sustainable economic dimensions (e.g. 92 per cent of suppliers' invoices paid within 30 days).

2.55 Caroline Flint MP is the Department's 'Green Minister'; a member of the Cabinet sub-committee ENV(G) and of the Government's Sustainable Development Taskforce established to ensure an effective follow up of the UK's World Summit on Sustainable Development (WSSD) commitments.

MODERNISING GOVERNMENT ACTION PLANS

The Policy Hub

2.56 The Policy Hub was set up in February 2004 as a central policy team within the Department. It has three broad functions. The first is to oversee large-scale emerging policy development work across the Department of Health. It aims to ensure that new work is properly aligned with the strategic direction of the Department and wider government, and that different policies are effectively prioritised so that neither the Department, nor the NHS or social care systems, are overburdened. The Policy Hub has sought to challenge and amend policy proposals which have not been fully scoped.

2.57 The second function is to take forward cross cutting or otherwise novel work where there is no obvious home within the Department. Examples include providing the Department's input into the Identity Cards programme and coordinating work on the potential impact of auto-identification data capture (bar codes, etc) on the NHS.

2.58 The third is to promote good policy-making. The Policy Hub is developing improved guidance for policy-makers, building on good practice such as the Policy Collaborative.

The Policy Collaborative

2.59 Building on the programme's successes from 2003-04, the Department's Policy Collaborative has worked with six teams to further pilot new ways of working, with the aim of pursuing excellence in policy making. Focusing on creating greater transparency in the policy making process, the Collaborative has facilitated early and continuous stakeholder involvement to build the trusting relationships on which genuine partnership working depends.

2.60 The six teams – Cancer, Child Health and Maternity, Pharmacy, Long Term Conditions, Telecare, and Transplants – have taken tools and techniques which have delivered widespread service improvements in the NHS and adapted them for policy development. Robust measures have tracked progress.

2.61 A policy making 'Improvement Guide' has been produced, drawing on the lessons learned and turning these into practical help and advice. The Collaborative is being independently evaluated.

Equality and Human Rights

2.62 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 was appointed in October 2004. Surinder Sharma, who has a long and successful track record in the field, came to the Department from the Ford Motor Company. He has two major tasks: firstly, to make sure that appropriate services are available to anyone in the population, regardless of their background, and secondly, to ensure that the NHS can draw on the skills and talent of all parts of the community.

Race Relations (Amendment) Act 2000

– *Ensuring the Department meets its reponsibilities*

Background

2.63 The Race Relations (Amendment) Act 2000 (RR(A)A) 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.

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

2.65 The Department's Race Equality Scheme (RES), a requirement of the specific duties of the RR(A)A, was published in May 2002. This included an Action Plan and a commitment to include in the Departmental Report a summary report on progress on the Scheme's implementation. The current Race Equality Scheme is available at **www.dh.gov.uk/assetRoot/04/05/50/58/04055058.pdf**. The progress on the implementation of the Department's Scheme is outlined below.

The Department's New Race Equality Scheme 2005

2.66 The RR(A)A requires all public authorities to review their Race Equality Scheme every three years. The Equality and Human Rights Group (EHRG) published the Department's new scheme on 27 May 2005 **(www.dh.gov.uk/assetRoot/04/11/21/59/04112159.pdf)**. This new scheme focuses on race equality in designing and delivering health and social care services. It includes a review of the Department's Race Equality Scheme 2002-2005, coverage of the 2005-08 scheme, its implementation and monitoring as well as information on action plans.

NHS compliance Race Relations legislation

2.67 Strategic Health Authorities with support from the Department of Health, Commission for Racial Equality (CRE) and local NHS organisations produced the SHA Race Equality Guide 2004 in July last year. This was in response to criticisms made by the CRE that the NHS was not complying with the RR(A)A. The guide (**www.cre.gov.uk/pdfs/sha_race_equality_guide.pdf**) is aimed at helping NHS organisations meet their duties under the RR(A)A to promote race equality, provide fair and accessible patient services and to improve equal opportunities for staff. The guide also contains a performance framework to help managers and health professionals agree goals for race equality and assess organisational performance. A conference was held on 7 March 2005 to review progress against the Guide and how this could support production of revised Race Equality Schemes by May 2005.

Raising awareness of the contribution of Black and Minority Ethnic (BME) and other minority groups to the health sector

2.68 The Department celebrated Black History Month in October last year to highlight the contribution of BME people to the health sector. The NHS is the largest single employer of BME staff in England, and the need to understand the health needs of all communities and groups is a top priority for both the Department and NHS.

2.69 The Leadership and Race Equality Action Plan (LREAP) launched by Sir Nigel Crisp last February challenges all NHS leaders to address race equality and the needs of minority ethnic communities in a systematic and professional way. The LREAP addresses both service delivery and workforce issues and aims to ensure that equality and diversity are fundamental to NHS strategies, and that the needs of minority ethnic communities are effectively addressed. The LREAP complements and supports a range of other initiatives DH has taken, in collaboration with the NHS, to promote equality in healthcare.

2.70 An Independent Panel has been set up to help keep the Action Plan under review, provide advice and challenge progress on the plan. The panel is chaired by Trevor Phillips, Chair of the CRE. It provides external scrutiny that will be constructive and creative and support NHS leaders in promoting race equality in all functions. In January 2005, the members of the Panel met with about 80 NHS leaders to involve them in their work.

2.71 Further information about the LREAP can be found at: **www.dh.gov.uk/PublicationsAndStatistics/Bulletins/BulletinArticle/fs/en?CONTENT_ID=4072494&chk=1e/oI7**.

2.72 The Equality and Human Rights Group 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 13 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.

2.73 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.

2.74 In July last year, DH and the London Health Observatory produced a literature review of studies into ethnic disparities in health and health care, including good practice examples of where disparities are being addressed. This review is available at the London Health Observatory website: **www.lho.org.uk/Publications/Attachments/PDF_Files/Ethnic_Disparities_Report.pdf**

2.75 The Department celebrated the first-ever Lesbian, Gay, Bisexual and Transgender (LGBT) History Month in February 2005. Nigel Crisp and Surinder Sharma (National Director for Equality and Human Rights) addressed a special event held on 22 February at the Skipton House Atrium. This event offered an opportunity to celebrate the contributions made by LGBT people to the Department, the NHS and Social Care, and considered the implications of policy and service issues for LGBT people.

Communication/Information for 'hard to reach' groups

2.76 The Department's Communications Directorate has reviewed the general principles of all consultation processes. It uses the best and most effective media to promote consultation to stakeholder groups and decides which languages should be a priority for translation. Both the 'Choosing Health' consultation document and the resulting Public Health White Paper, for example, were translated into a range of languages to support the needs of Black and Minority Ethnic groups (BME).

2.77 Consultations are published on the DH website and care is taken to ensure that DH web publishing meets accessibility standards. All consultations are reviewed by the DH Gateway Team and by the DH Consultations co-ordinator before issue and the needs of those likely to be affected by the content of the consultation is taken into account.

2.78 Whilst much progress has been made on accessibility for people with disabilities, more needs to be done to better understand the needs of BME communities and to embed the principles we adopt for high-profile consultations across all our policies. The Communications Directorate will during the coming year, review how to better meet the needs of BME groups across DH publications and this will inform practice for consultations too.

2.79 In March 2004, the Department of Health announced a national contract to provide NHS Direct's translation and interpreting service. The service commenced in April 2004 and provides greater access for all NHS organisations to a high-quality telephone-based interpretation and translation service. The new service includes monitoring of the language requested. NHS Direct is seeking to improve access to information for those who do not speak English as their first language by establishing an Ethnic Health Information Resource Centre, which will hold stocks of all materials available in languages other than English.

Improving ethnic origin information

2.80 To improve the quality of ethnic monitoring, the Department of Health is currently updating the guidance for gathering this information and is planning to re-launch it in due course. The Department is also producing examples of good practice, and the intention is to launch the two together.

2.81 The Department is supporting the National Institute for Mental Health, the Healthcare Commission and the Mental Health Act Commission in England in making ethnic monitoring one of the focuses for the forthcoming Mental Health and Ethnicity Census. This will also have the effect of training those people collecting that data in the collection of reliable ethnicity information.

2.82 In addition to the above, the Department has recently started analysing the results of the 2004 Health Survey for England (due to be published in December 2005), which will be the largest study on the health of ethnic minorities ever undertaken in England.

Black and minority ethnic mental health

2.83 The Department's programme of action on race equality in mental health is based on three building blocks – providing more appropriate and responsive services, community engagement and better information. *Delivering Race Equality in Mental Health Care* (DRE)[2.9] was published on 11 January 2005, together with the formal response to the independent inquiry into the death of David Bennett. This is a five-year action plan for tackling the persistent inequalities in care suffered by black and minority ethnic (BME) health service users. The DRE action plan is available on the DH web site at **www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100773&chk=grJd1N**.

Disability

2.84 DH has developed a programme of joint action with the Disability Rights Commission (DRC), which is aimed at delivering real improvements for disabled people as users and providers of health and social care services and the wider disabled community. Our objective is to improve the rights, independence, choice and inclusion of disabled people through ongoing development of the health and social care system.

2.85 As part of this programme of joint working, DH has formed a Disability Access Working Group with colleagues from DRC and the NHS. The remit of the group is to develop and steer initiatives aimed at improving access to information and services, communications and levels of awareness of disability issues, in particular by supporting NHS and social care providers to meet the requirements of existing and forthcoming disability legislation. The Group has published several documents aimed at helping frontline staff improve the way services are delivered to disabled people. These documents are available at: **www.dh.gov.uk/PolicyAndGuidance/EqualityAndHumanRights/EqualityAndHumanRightsArticle/fs/en?CONTENT_ID=4089269&chk=MnDYP/**

Employment and ethnicity data in DH

2.86 Since the Race Equality Scheme was published, the Department has undergone a Change programme. A significant element of this programme has been the restructuring of work and functions to achieve an overall reduction of 38 per cent in posts by October 2004.

2.87 The Department commissioned an independent consultant to undertake an Equality Impact Assessment on the restructuring

elements of the Departmental Change Programme (DCP). 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.

2.88 The recommendations from that report have now been 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 will be included in the Department's new Race Equality Scheme to be published in May 2005.

2.89 The Department has delivered Valuing Diversity training to all its staff during 2002 and 2003. This included awareness raising and information on the specific implications of the Race Relations (Amendment) Act. The Department will be launching a new interactive Diversity training tool to all staff in 2005.

2.90 Individual Directorates introduced monitoring systems to report to their boards the implications and outcomes of HR processes on their staff. In addition, a restructure of the HR function has provided the opportunity to create a specific workforce planning team that is working with business groups to improve the current Personnel Information System and bring together the work that has begun on improving monitoring data on diversity. For example, reviewing the monitoring information on recruitment and the introduction of monitoring for grievances and disciplinaries.

2.91 Aggregate workforce information for the Department that will include Diversity analysis will be presented to the Departmental Board each month. Monitoring information for 2004 will be published later this year.

Rural Proofing

2.92 Our modernisation of the NHS, underpinned by a sustained investment programme, is delivering more staff, faster treatment, more hospitals, a new focus on quality and, crucially, more choice for patients. By the end of the year 2005, all patients, whether they live in rural or urban areas, will be able to choose from four or five healthcare providers and book a hospital appointment at a time and date convenient to them. We have devolved powers to the front line NHS – around 80 per cent of the NHS budget in England is now devolved to local Primary Care Trusts (PCTs), and central targets have been dramatically reduced to give the local NHS in rural and urban areas alike the headroom to address local priorities. Therefore, PCTs in rural areas now have the resources and the authority to make a difference locally and address rural needs.

2.93 The Department of Health is committed to the process of 'rural proofing'. We have provided guidance to policy officials in the form of a 'policy makers' checklist published by the Countryside Agency, and report regularly to the Cabinet Committee on Rural Renewal. To further support the rural proofing agenda, last year the Government incorporated rural proofing within the Regulatory Impact Assessment framework. At a local level, we are funding the Institute of Rural Health for the production of a rural proofing toolkit, which will be a resource for Primary Care Organisations to help ensure that all healthcare delivery is accessible and appropriate for people living in rural areas.

2.94 The Department has 'rural proofed' a number of policy areas in order to address problems that geography can play in areas such as health service delivery and access. Our activities in 2004-05 included:

- implementation of a balanced package of measures to reform the overall regulatory system for NHS community pharmacy services from 1 April 2005. This will help raise standards for patients and encourage innovation and excellence in service provision whilst ensuring that services to patients in rural areas do not suffer. We also intend to introduce further measures developed by the Pharmaceutical Services Negotiating Committee and the General Practitioner's Committee of the British Medical Association and the Dispensing Doctors' Association to reform the rules governing NHS rural dispensing at the same time;
- implementation of our national suicide prevention strategy, which is providing specific support for farmers and their families. This has also involved part funding a network of support for people in rural communities who are suffering from stress;
- rural proofing of our *Choosing Health* White Paper October 2004, [and *Vision for Adult Social Care* Green paper March 2005];
- rural proofing of our National Service Frameworks – 'Long Term Conditions' and 'Renal Services – Part 2'; and,
- a contribution to the Department for Environment Food and Rural Affairs' 'Rural Services Review' November 2004 document.

2.95 We have also improved access through new ways of working. For example, Ambulance Trusts have introduced community responder schemes in a number of areas across the country. Any volunteer in a community responder scheme is equipped with a defibrillator, trained in basic life support and acts as part of an ambulance trust's response system. The use of community responders can provide support to areas that may be more remote or inaccessible, allowing patients to receive urgent healthcare quickly from qualified volunteers until an ambulance arrives.

2.96 Our Independent Sector programme is delivering new ways of working and innovative solutions. For example, new surgical procedures for Orthopaedics, Mobile Cataract Units and Mobile MRI Scanners have enabled the delivery of local services, even in the most rural areas, allowing patients to access services closer to home. The NHS has also achieved its aim of ending the long waits for cataract operations through extra NHS operations and the provision of more than 13,000 additional cataract operations by independent sector treatment centres (ISTCs). The ISTC programme includes two ophthalmology mobile units operating throughout England, and a fixed site in Daventry. Recent

research has shown that ISTCs are performing operations at eight times the rate of the NHS due to the modern, purpose-built units concentrating on single procedures.

2.97 Our telemedicine and telecare information technology strategy will enable patients to be treated outside hospital settings, and support GPs and Primary Care teams in providing much greater opportunity for independent living for the elderly and chronically ill. Modern Information Technology is at the heart of the Government's vision for the NHS in the 21st century. Future possibilities include telemedicine in GP surgeries for electrocardiograms and skin disease, ambulance telemonitoring in emergency response vehicles, and home telecare.

2.98 Finally, many more GPs will be working from modern multi-purpose premises alongside nurses, pharmacists, dentists, therapists, opticians, midwives and social care staff. These will include provision for video and telelinks to hospital specialists to help in diagnosis and test results, and direct local booking of operations and outpatients' appointments. An increasing number of consultants will take outpatient sessions in these centres, working alongside GP specialists.

Better Regulation and Regulatory Impact Assessments (RIAs)

2.99 There is a strong commitment throughout the Department of Health (including its agencies) for regulation, which is:

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

2.100 The importance of publishing good quality Regulatory Impact Assessments (RIAs) is accepted as an integral part of the Department's work. It is important for the Department to strike the right balance between protecting public health and safety, the vulnerable and those at risk, whilst avoiding unnecessary burdens on business, charities or voluntary organisations, and frontline services.

2.101 The better regulation agenda is supported by a Department appointed Board-level 'Better Regulation Champion' and two officials in the Department's Regulatory Impact Unit (RIU). To raise awareness of better regulation issues amongst the Departmental Management Board in January, the Board Level Champion invited Simon Virley, Director of the Cabinet Office Regulatory Impact Unit, and David Arculus, Chairman of the Better Regulation Task Force (BRTF), to give a presentation to the Board.

Legislation

2.102 The Department introduced two Bills (Health Protection Agency Bill and the Human Tissue Bill), one draft Bill (the Mental Health Bill) and 112 regulations (including Orders that are not laid before Parliament) during the period April 2004 to March 2005. Only 23 imposed costs on business, charities or voluntary bodies and none resulted in cost savings.

Regulatory Impact Assessments (RIAs)

2.103 Thirty two RIAs were published on the Department of Health website (**www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/fs/en**) and placed in the House Libraries between April 2004 to March 2005. During this period, our compliance with the RIA process was 100 per cent. No legislation introduced by this Department included the sunset clause (sun-setting allows a law to be removed automatically after a fixed period unless action is taken to keep it in place).

2.104 The Department also negotiated the successful inclusion of Health Impact Assessment (a consideration of potential health impacts of a policy) within the RIA framework. This became operational in November 2004.

Helping discussions in Europe

2.105 The use of RIAs also informed the Department's discussions in Europe, including the draft EC Directive on Traditional Herbal Medicinal Products.

Alternatives to prescriptive regulation

2.106 Alongside prescriptive regulations, the Department continues to consider alternatives to regulations. For example:

- we continue working with the food industry to reduce the salt content in processed food;
- as highlighted in the *'Choosing Health – Making Healthier Choices Easier'* White Paper, we will be working with industry, advertisers, consumer groups and other stakeholders to encourage new measures to strengthen existing voluntary codes on the promotion of food to children;
- we have worked with Cancer Research UK and the Sun Bed Association and other stakeholders towards an improved code of practice and improved approach by the Sun Bed Association to informing customers about the dangers of skin cancer; and,
- we agreed our voluntary Pharmaceutical Price Regulation Scheme (PPRS) in November 2004. This is a package of measures negotiated with the Association of the British Pharmaceutical Industry (ABPI), which reward innovation and research but also keeps public expenditure under control. The scheme, which will cover a five year period, came into effect on 1 January 2005.

The Regulation Reform Action Plan (RRAP)

2.107 The Department made good progress with the 22 reform measures it submitted for inclusion in the Government's Regulatory Reform Action Plan (RRAP) published in February 2002, and 24 further measures have been submitted since. Of the 46 reform measures proposed to date, 26 have been completed, 11 are on track, and completion timetables have been delayed on 9. The RRAP can be accessed on the following website: **www.cabinetoffice.gov.uk/regulation/regulatory_reform/act/action_plan.asp**

Consolidation of NHS Law

2.108 We continue to make good progress with our consolidation of our NHS legislation made since 1977. This work should be concluded in early 2006.

Regulatory Reform Orders (RROs)

2.109 A RRO was made on the 29 March 2005 to remove the present double requirement for the accounts of NHS charities to be sent to both the Charities Commission and the Department. In future, copies will be sent only to the Charities Commission.

2.110 We propose to remove the requirement for a local authority to obtain the Attorney General's consent to initiate a prosecution under the Cancer Act 1939 for publishing certain advertisements concerning cancer treatment. We are taking forward this proposal though a Regulatory Reform Order addressing several local authority consent requirements, which is being overseen by the Office of the Deputy Prime Minister. This RRO is scheduled to come into effect in early 2006.

Public Consultations

2.111 The Department undertook 33 consultations since 1 April 2004, 23 [70 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. In spring 2004, the Department's *Choosing Health* consultation built on the foundations put in place during the late 2003 consultation *Building On The Best*[2.10], using eight task groups to encourage wide response in their specific areas, many forms of focus groups, national events and discussions facilitated by existing forums. Discussions associated with *Choosing Health* also included face-to-face interviews with the media and the public (including people with learning disabilities) both during the day and in the evenings, to promote good coverage. A summary of the consultation questions for people to use at local events was also made available in other languages.

Avoiding Regulatory Creep

2.112 The Department began a review of its arm's length bodies (ALBs) with a view to a 50 per cent reduction. The findings of the review, which set out the principles, processes and timescales for implementation, was published in November 2004. [**See Chapter 8**]

2.113 During 2004, the Department promoted the requirement for ALBs to produce RIAs to assess the benefits and burdens of any potential new requirements they intend to issue to the public or private sector. To support and engage ALBs with the RIA process and the Government's wider reducing bureaucracy agenda, the Department held a seminar in February 2005. Lord Norman Warner, David Arculus, and the Department's Board Level Better Regulation Champion addressed the event.

2.114 The Department's Agencies and some independent regulators also demonstrated that they follow principles of better regulation. For example, the Health Care Commission will publish an RIA on the criteria it sets for how it will apply the Health and Social Care Standards.

Reviews of Regulations

2.115 The Department began a review of its *National Minimum Standards* for social care. The Government made a commitment at the time of their introduction to review them after two years. The Department announced the launch of the review in October 2004. The review is considering the suitability of the standards for ensuring the needs of service users are met. It is also considering how the regulatory framework can facilitate more proportionate and cost-effective inspection. The major benefits of the review being: a regulatory system that works in the best interests of service users, and which assesses the effectiveness of services and their outcomes for users; and a regulatory framework which enables the Commission for Social Care Inspection (CSCI) to make its inspection work proportionate to risk, and which avoids unnecessary burdens on service providers who provide good quality services. The review will draw upon the work that CSCI is doing to modernise its own methods, and any changes are expected to be implemented in 2006.

Better Regulation Task Force (BRTF) reports

2.116 The Department contributed to the Government responses to the BRTF's reports *Better Routes to Redress* May 2004 [2.11], and *Avoiding Regulatory Creep* November 2004[2.12]. The Department coordinated the Government response to the Better Regulation Task Force Report *Bridging the Gap – Participation in Social Care* September 2004[2.13] – See website: **www.brtf.gov.uk /responses**

E-Government and IT in the NHS

2.117 The NHS Connecting for Health agency is responsible for delivering and supporting implementation of the national programme for IT in England. The core element of the national programme is the NHS Care Record Service (NHS CRS), which will lead to England's NHS having an integrated, electronic record management service for the first time. The NHS Care Record will be an efficient and confidential means of ensuring that up-to-date patient information is available wherever and whenever it is needed. NHS CRS will underpin electronic appointment booking and the electronic transmission of prescriptions, and provide each patient with a single, comprehensive set of electronic medical and care notes. The first phase of implementation was completed during 2004, and included the infrastructure to enable booking of outpatient appointments and the ability of health and care professionals to view basic patient information. Full implementation will be completed by 2010.

Funding IT development

2.118 Central funding provision for the national programme for IT in the NHS was £730 million in 2004-05 and will be some £1.2 billion in 2005-06. This will be supplemented by local investment, currently running at almost £1 billion a year from baseline allocations progressing towards around 4 per cent of total NHS expenditure, in line with the levels proposed within the Wanless report, *Securing our Future Health*.

Benefits for patients

2.119 NHS CRS will provide a live, interactive patient record service accessible 24 hours a day, seven days a week, by health professionals whether they work in hospital, primary care or community services. It will also hold a summary of a patient's contact with all care providers and will record the patient's consent for care professionals to view their NHS Care Record. It will enable clinicians to access patients' records securely, when and where they are needed, via a nationally maintained information repository. When fully implemented, the NHS CRS will function across care settings and organisations and will support planned, emergency and unscheduled care.

2.120 Patients will benefit because the NHS CRS will improve the quality and convenience of care by ensuring that the right information is available to the right people at the right time. It will also improve choice for patients and, in due course, will allow them easy, secure access to their own medical records, via the NHS *Healthspace* website.

2.121 Clinicians will benefit from being able to access patient information wherever it is needed, improving diagnosis, and with less time spent chasing records and test results, clinicians will have more time to concentrate on providing quality care for patients.

2.122 The electronic booking service, 'Choose and Book', enables GPs and other primary care staff to make appointments for patients with clinicians or other healthcare professionals at a convenient time and place for the patient. Patients will be able to leave the surgery with a confirmed appointment time and date. If they prefer, they will be able to make their appointment later after consulting with family or work colleagues, either on-line or via a telephone booking management service. Electronic booking will be a key enabler in the Government's Choice initiative under which, by the end of 2005, patients will be offered a choice of four or five hospitals or other appropriate healthcare providers at the time of referral. Development and testing of Choose and Book began in 2004, and the service is now being rolled-out across England in a planned and phased way.

Delivering the National Programme

2.123 From their inception, national programme plans have been subject to rigorous scrutiny by the Office of Government Commerce and HM Treasury. In addition, the National Audit Office is currently carrying out a study into the national programme for IT to examine the procurement processes used for placing the contracts, whether contracts are likely to deliver good value for money, how the Department is implementing the programme and the progress made by the programme so far. The central funding and management of the programme – in response to the recommendations of the 2002 Wanless report, *Securing our Future Health* – is a key mechanism both for ensuring the delivery of the programme and linking the payments to contractors to the realisation of benefits by the NHS.

2.124 The national programme is being implemented incrementally with Phase one – the Choose and Book Service, the electronic transmission of prescriptions, and the NHS Care Record Service – starting to be implemented during 2004-05.

2.125 Phase two, covers implementation to 2008. This will include a richer NHS Care Record Service, with core data and reference links to local electronic patient record (EPR) systems for full record access, all patient appointments, and telemedicine starting to be established.

2.126 Phase three is planned for implementation between 2008 and 2010 to provide ambulance telemonitoring implemented in emergency response vehicles, home telemonitoring in homes requiring it, and a unified health record that includes all appropriate social care information.

2.127 We are already seeing an unprecedented acceleration in the scale of deployment of technology across the service. Increasing numbers of patients are able to book their hospital appointments electronically. The first electronic prescriptions were issued in February 2005, with numbers set to rise dramatically over the coming months. By April 2005 more than 6,000 NHS sites had been connected to the new national network (N3), giving fast and reliable broadband access to over 300,000 users. The network significantly speeds up the transfer of key clinical data between NHS organisations, enabling much faster electronic transmission of visual data, such as video and x-rays. The first NPfIT-delivered picture archiving and communications systems (PACS) have gone live, and over 120,000 users are already registered with Contact, the secure email and directory service for the NHS.

2.128 The national programme has also delivered the Quality Management and Analysis System (QMAS), which supports the Quality and Outcomes Framework of the new General Medical Services Contract for GPs. 100 per cent of GP practices are now using the QMAS system, which provides GP practices with evidence and feedback on the quality of care they deliver. In addition, the delivery of new software to support Payment by Results is on schedule to be implemented in June 2005. The Secondary Uses Service (SUS) that will hold anonymised and pseudonymised patient information for research, trend analysis and public health monitoring will be started by the Payment by Results software, but will be added to in October 2005. All this represents very encouraging progress towards the target of completion of full integration of health and social care systems in England by 2010.

Stakeholder Engagement

2.129 NHS Connecting for Health is working closely with key stakeholders at a number of levels. At a national level, groups have been established to support two-way communications between the national programme and influential stakeholders. Advisory groups of patients and clinicians were consulted on the initial contents of the NHS Care Record and the proposals changed in line with their recommendations. The initial draft technical specification for the patient summary record was shared for consultation with some 260 clinicians.

2.130 A Care Record Development Board has been established. This brings together patients, public, social and healthcare professionals in one body. It will provide clinical and patient input into the development of IT, replacing the national programme's Patient Advisory Board and National Clinical Advisory Board. A very experienced NHS manager and Chief Executive of a Strategic Health Authority has also been appointed as Director of Service Implementation. The Director will take forward and build on existing work and initiatives. National clinical champions have been recruited as part of a structure for service implementation in association with the leaders of the professions. The national clinical champions are clinically credible, experienced people that the professions trust, and will communicate between the programme and the NHS in both directions.

2.131 In the procurement and delivery process, particularly in the development and testing phases, representative stakeholders have been consulted to ensure that concerns are taken into account and that a proper focus on delivering benefits is maintained through all phases of the national programme. It is most important to ensure that the systems implemented enjoy the confidence of the healthcare professionals who will use them. For this reason, NHS Regional Implementation Directors, who have been appointed on the basis of experience and proven track record in implementing NHS information systems, are co-ordinating planning between NHS Connecting for Health, local NHS trusts and the key IT contractors. At a local level, stakeholder consultation will ensure that local implementation planning supports the achievement of local service strategies and the realisation of benefits.

3. Expenditure

3.1 INTRODUCTION
3.4 NHS EXPENDITURE PLANS
3.9 HEALTH AND PERSONAL SOCIAL SERVICES PROGRAMMES
3.19 PROGRAMME BUDGETING
3.31 REGIONAL BREAKDOWN OF SPEND
3.34 SOURCES OF FINANCE
3.38 COMPLEMENTARY SOURCES OF FUNDING
3.49 INVEST TO SAVE BUDGET
3.52 RECOVERY OF NHS COSTS FOLLOWING ROAD TRAFFIC ACCIDENTS
3.55 PERSONAL SOCIAL SERVICES EXPENDITURE

INTRODUCTION

3.1 In 2005-06 the planned total public expenditure for the Department of Health is £87,787 million. This includes the NHS Pensions budget of £8,816 million.

3.2 **Figure 3.1** summarises the resource plans for the Department of Health for the years 1999-2000 to 2007-08. More detailed information is provided in **Annexes A2 and A3**.

Figure 3.1: Department of Health Public Spending

£ million	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 est'd outturn	2005-06 plan	2006-07 plan	2007-08 plan
Consumption of Resources									
NHS	40,755	44,000	51,150	54,601	60,930	66,853	72,797	79,873	87,297
Personal Social Services	539	482	730	1,591	1,626	2,128	2,150	1,844	1,884
NHS pensions[(1) (2)]	3,521	3,782	3,949	4,569	6,328	7,788	8,816	9,610	10,482
Credit Guarantee Finance (AME)[(3)]						6	11		
Total Department of Health Resource Budget	**44,815**	**48,264**	**55,829**	**60,761**	**68,884**	**76,776**	**83,774**	**91,326**	**99,663**
Of which:									
Department of Health Departmental Expenditure Limit (DEL)	41,294	44,481	51,880	56,192	62,556	68,983	74,947	81,716	89,181
Capital Spending									
NHS[(4)]	850	1,173	1,623	1,903	2,451	3,396	4,237	5,163	6,133
Personal Social Services	49	48	93	72	84	85	82	101	121
Credit Guarantee Finance (AME)[(3)]						328	357		
Total Department of Health Capital Budget	**899**	**1,221**	**1,716**	**1,974**	**2,536**	**3,808**	**4,675**	**5,264**	**6,254**
Of which:									
Department of Health Departmental Expenditure Limit (DEL)	899	1,221	1,716	1,974	2,536	3,130	3,818	5,264	6,254
Total Public Spending in Department of Health[(5)]	45,350	49,193	57,241	62,305	71,028	80,029	87,787	95,869	105,121
Of which:									
NHS[(6)(7)]	41,241	44,881	52,469	56,083	63,000	69,708	76,388	84,324	92,643
Personal Social Services[(8)]	588	530	823	1,654	1,699	2,203	2,216	1,935	1,995
NHS Pensions	3,521	3,782	3,949	4,569	6,328	7,788	8,816	9,610	10,482
Credit Guarantee Finance (AME)[(3)]						334	368		
Spending by Local Authorities on functions relevant to the department									
Current	**10,056**	**10,708**	**11,467**	**12,944**	**14,826**				
Of which:									
Funded by grants from the Department of Health	929	913	1,133	1,881	1,816				
Capital	**77**	**89**	**79**	**107**	**161**				
Of which:									
Financed by grants from the Department of Health	49	48	50	72	132				

(1) NHS Pensions is the resource budget of the pension scheme, and it is included in table 3.1 tables because it is part of the Department of Health resource budget. Figures from 1999-2000 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.

(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 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 £365/291/304/430/392/555/662/721/796m.

(6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £365/291/304/421/381/545/646/711/786m.

(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 £0/0/0/9/11/10/16/10/10m.

(9) Figures may not sum due to rounding.

3.3 This chapter provides information on the Government's expenditure plans up until 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 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.**

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

(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).

3.6 The spending plans have been adjusted to reflect the reduction in the discount 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 expenditure figures reported within this chapter, and in Annexes A2 and A3, have been adjusted for this change.

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** below.

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 of Health (such as service specific levies which fund activities in the areas of education and training and research and development).

HCFHS includes all GMS funding. This is because of the introduction of the new GP contract in April 2004 which means that there is no longer any GMS non discretionary funding. All GMS funding is now discretionary and PCTs were informed of their 2004-05 Primary Medical Services (PMedS) Allocation in February 2004. 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** 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 estimated outturn	2005-06 plan	2006-07 plan	2007-08 plan
Departmental Programmes In Departmental Expenditure Limits National Health Service Hospitals and Community Health, Family Health (discretionary) and related services and NHS trusts[1][2]					
Revenue expenditure[4][5][6]					
Gross	59,230	65,340	71,733	79,332	86,553
Charges and receipts	-2,146	-2,572	-2,616	-2,616	-2,616
Net	57,083	62,768	69,117	76,716	83,937
Capital expenditure					
Gross	2,686	3,949	4,406	5,331	6,301
Charges and receipts	-270	-582	-200	-200	-200
Net	2,415	3,367	4,206	5,131	6,101
Total					
Gross	61,915	69,289	76,139	84,664	92,855
Charges and receipts	-2,417	-3,154	-2,816	-2,816	-2,816
Net	59,499	66,135	73,323	81,848	90,039
National Health Service family health services (non-discretionary)[2][3]					
Revenue expenditure					
Gross	3,052	2,953	2,342	1,790	1,844
Charges and receipts	-912	-858	-682	-682	-682
Net	2,141	2,095	1,660	1,108	1,162
Central health and miscellaneous services[6][7]					
Revenue expenditure					
Gross	1,442	1,663	1,544	1,507	1,581
Charges and receipts	-117	-212	-170	-170	-170
Net	1,325	1,451	1,375	1,337	1,412
Capital expenditure					
Gross	36	29	31	32	32
Charges and receipts	0	0	0	0	0
Net	36	29	31	32	32
Total					
Gross	1,478	1,692	1,575	1,538	1,613
Charges and receipts	-117	-213	-170	-170	-170
Net	1,361	1,479	1,405	1,369	1,443
Total National Health Service Revenue expenditure					
Gross	63,724	69,956	75,619	82,629	89,978
Charges and receipts	-3,175	-3,642	-3,468	-3,468	-3,468
Net	60,549	66,314	72,151	79,161	86,510
Net percentage real terms change(%)		7.4	6.1	6.8	6.4
Capital expenditure					
Gross	2,722	3,978	4,437	5,363	6,333
Charges and receipts	-271	-582	-200	-200	-200
Net	2,451	3,396	4,237	5,163	6,133
Net percentage real terms change(%)		35.8	21.7	18.7	15.7
Total					
Gross	66,446	73,934	80,056	87,992	96,311
Charges and receipts	-3,446	-4,224	-3,668	-3,668	-3,668
Net	63,001	69,710	76,388	84,324	92,643
Net percentage real terms change(%)		8.5	6.9	7.5	7.0
GDP as at 16 March 2005	100.0	102.0	104.5	107.4	110.3

(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 Services (PDS) schemes. The scale of transfer will be reassessed in-year as the rate of conversion of PDS and the development of dental services is confirmed.

(4) Includes AME funding available to NHS Foundation Trusts for 2003-04 and 2004-2005.

(5) Excluding HCHS depreciation of (£m): 354 511 611 675 750

(6) With the introduction of a 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 from those reported in last year's Annual report (fig 3.3b), so as to present a consistent run in expenditure.

(7) Excluding CHMS and Dept Admin Depreciation of (£m): 26 29 34 36 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) Figures may not sum due to rounding.

Expenditure in 2004-05

3.11 Figure 3.5 compares estimated outturn expenditure in 2004-05 with planned expenditure published in last year's report.

Figure 3.5: Comparison of Net NHS Net Expenditure for 2004-05 with those in last year's Departmental Report (Cm 6204)

	Departmental Report 2005 Cm 6524 Figure 3.4	Departmental Report 2004 Cm 6204 Figure 3.4b	£ million 2004-05 difference
HCFHS current	62,768	62,641	127
HCFHS capital	3,367	3,262	105
FHS non discretionary	2,095	1,906	189
CHMS Revenue	1,123	1,111	12
CHMS Capital	8	11	-3
Dept Admin Revenue	328	278	49
Dept Admin Capital	20	20	0
NHS Total[(1)]	**69,710**	**69,231**	**479**

(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 2005-06

3.13 NHS Net Expenditure in 2005-06 is planned to be £76.4 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 2005-06, the planned HCFHS revenue expenditure is £69.1 billion. Net HCFHS capital expenditure is planned to be £4.2 billion. Within overall NHS net expenditure, the total for non-discretionary FHS is expected to account for £1.78 billion in 2005-06. The remainder will be spent on Central Health and Miscellaneous Services.

3.16 Figure 3.7 contains the breakdown of NHS Net Expenditure for 2005-06 (Plan).

Figure 3.7: NHS Net Expenditure, 2005-06 (Plan)

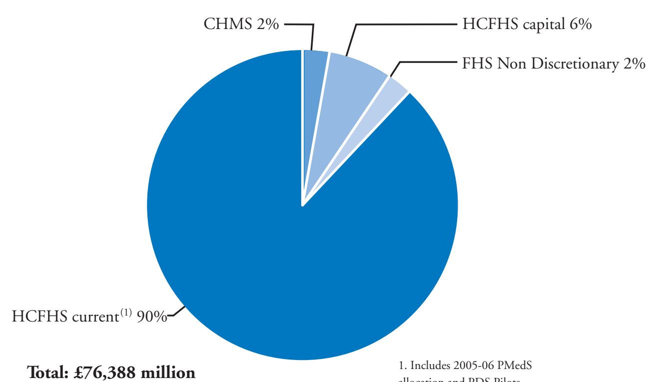


Figure 3.6: Main areas of change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm 6204)

2004-05	Difference[(1)]		
HCFHS current	127 including:	449	Take up of 2003-04 End Year Flexibility (EYF)
		250	Transfer from HCFHS capital
		–189	Transfer to FHS non discretionary
		–58	Net transfers to and from Other Government Departments
		–97	Transfer to CHMS Revenue
		–24	Transfer to DH Admin Revenue
		–200	Forecast underspend
HCFHS capital	105 including:	355	Take up of 2003-04 EYF
		–250	Transfer to HCFHS current
FHS non discretionary	189 including:	189	Transfers to HCFHS Current
CHMS Revenue	12 including:	–100	Transfer to PSS
		97	Transfer from HCFHS
		12	Transfers from other Government Departments
CHMS Capital	–3 including:		No change over £10m
DH Admin Revenue	49 including:	23	Brought forward from 2005-06
		11	Brought forward from 2006-07
		14	Take up of EYF from 2003-04

(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 around 80 per cent of the total NHS budget will be controlled by Primary Care Trusts (PCTs) in 2005-06. Figures are consistent with those shown in Table 1 of Health Service Circular (HSC) 2005/001 announcing two-year PCT revenue allocations.

3.18 They are therefore consistent with the NHS settlement received as part of SR2004. 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.

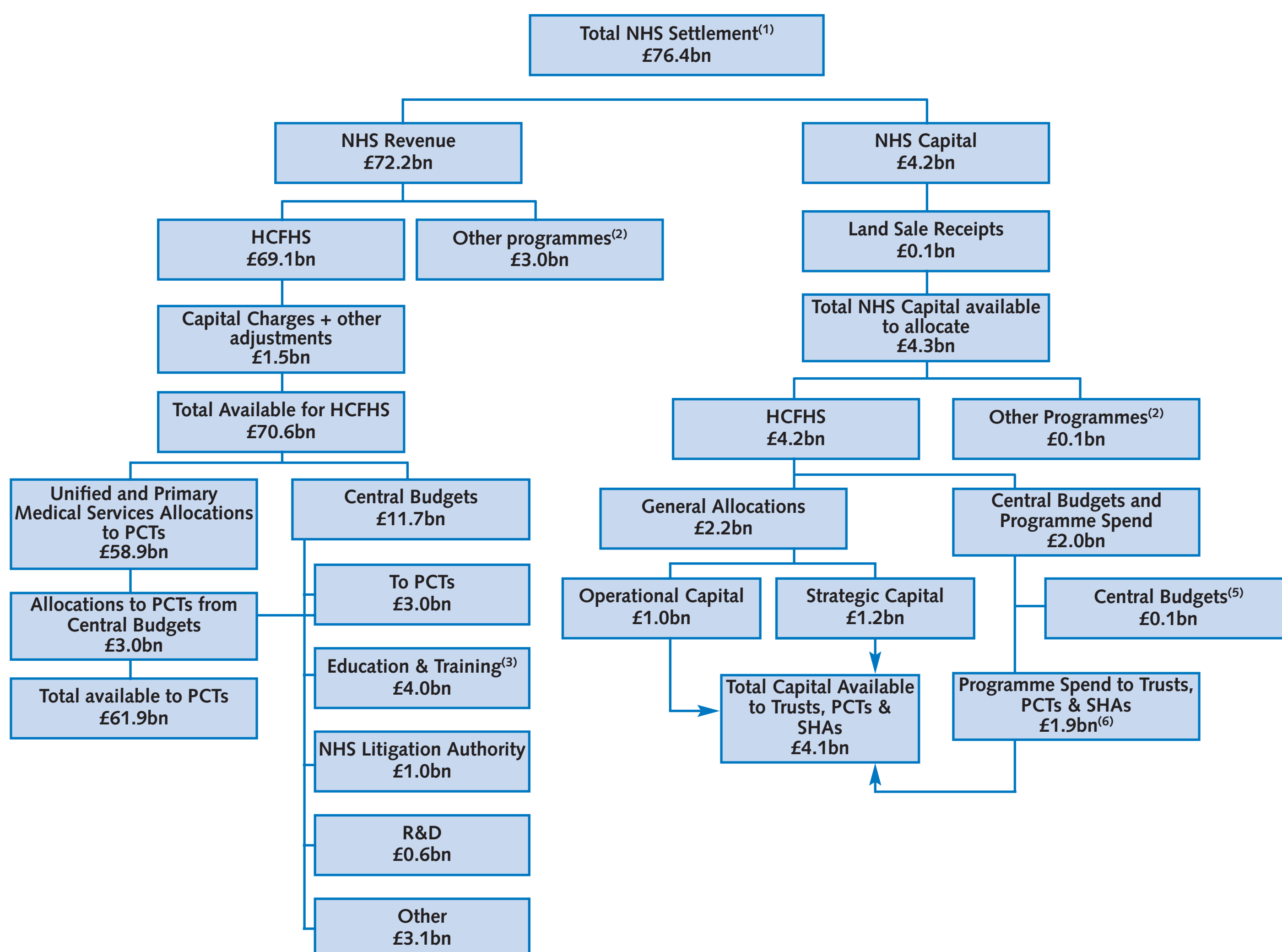
PROGRAMME BUDGETING

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.

Figure 3.8: Disposition of NHS Resources



(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.

3.21 This approach can equally be applied to healthcare. Instead of seeing investment on 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.

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 (PCT) (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 2003-04

3.26 Considerable work has been carried out in preparing for the implementation of Programme Budgeting within the NHS. This has included development work at three pilot sites during 2003 to evaluate and take forward the processes that need to be implemented. From this experience, a methodology has been developed and agreed with organisations including the National Audit Office, HM Treasury and the Audit Commission.

3.27 For the first time, in 2003-04, PCTs and SHAs reported 'bottom up' expenditure figures on each programme budget category. This will provide a range of stakeholders with 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.

3.28 The programme budget figures for 2003-04 are included within Schedule 5 of the resource accounts 2003-04[1], which is shown below in **Figure 3.9**:

Figure 3.9: Department of Health – Resource Accounts 2003-04

Schedule 5

The Key objectives are:
A. To improve service standards.
B. To improve health and social care outcomes for everyone.
C. To improve value for money.

The Department cannot currently make a reliable estimation of the split of overall spend against each of these objectives. The Department is working to ensure that the information presented in Schedule 5 allows a more detailed analysis of expenditure against their objectives. As a result of the first stage of this work the Department is now able to provide a reasonable estimate of the split of overall spend against conditions. This is reproduced below.

Resources by Programme Budget Categories for the year ended 31 March 2004

Programme Budget Categories

The Department of Health's overall aim is to improve the health and wellbeing of the people of England through the resources available to prevent/treat:

	2003-04 Gross £'000	2003-04 Income £'000	2003-04 Net £'000	2002-03 Net £'000
Problems of mental health (including patients with Alzheimer's syndrome)	7,386,096	224,478	7,161,618	6,018,233
Problems relating to the heart, and the circulation of blood in the central and peripheral vessels	5,715,032	193,991	5,521,041	5,614,339
All cancers and tumours, malignant and benign (including those with suspected or at risk of developing cancer)	3,385,750	77,018	3,308,732	3,276,093
Problems due to trauma, and injuries (including burns)	3,186,955	62,926	3,124,029	3,242,800
Problems of gastro intestinal system	3,164,671	77,477	3,087,194	3,445,448
Problems of the musculo skeletal system (excluding trauma)	3,136,752	72,034	3,064,718	3,152,149
Disorders of the genito urinary system (except for those relating to infertility)	2,809,192	59,307	2,749,885	2,625,251
Problems of respiration (including tuberculosis and sleep apnoea)	2,751,908	75,164	2,676,744	2,777,626
Maternity and problems associated with reproduction	2,570,147	37,812	2,532,335	2,934,092
Patients where the primary issue is the problem of learning disability	2,272,971	78,578	2,194,393	1,661,464
Problems due to the teeth (including preventive checks and community surveys)	2,369,407	500,323	1,869,084	1,777,805

(1) The Department's Resource Accounts are a set of statutory accounts that are the subject of NAO audit.

	Gross £'000	2003-04 Income £'000	Net £'000	2002-03 Net £'000
Problems relating to the neurological system	1,569,942	45,590	1,524,352	1,432,980
Disorders of internal metabolism and its regulation	1,515,375	65,917	1,449,458	1,310,426
Problems related to life-management difficulty and problems related to care-provider dependency	1,483,771	50,653	1,433,118	180,678
Problems relating to the eye and vision	1,203,200	20,019	1,183,181	1,264,322
Individuals who have no current problems but who are involved in programmes for prevention of illness and promotion of good health	1,108,418	33,472	1,074,946	798,465
Problems of the skin	1,069,903	31,541	1,038,362	1,046,048
All diseases caused by infectious organisms (excluding Tuberculosis and sexually transmitted disease)	977,350	33,822	943,528	803,462
Disorders of the blood or blood forming systems	827,217	27,744	799,473	696,498
Conditions of babies in the neonatal period	655,015	17,991	637,024	741,255
Poisoning, toxic effects and other adverse events, whether accidental or deliberate	483,360	7,531	475,829	561,756
Problems relating to the ear and hearing and balance	300,721	8,031	292,690	281,809
Other Areas of Spend/Conditions:				
– General Medical Services/Personal Medical Services	5,005,274	124,028	4,881,246	3,280,510
– Strategic Health Authorities (including Workforce Development Confederation)	4,019,965	414,271	3,605,694	3,351,883
– National Insurance Contribution	–	12,777,958	(12,777,958)	(6,396,924)
– Miscellaneous	8,632,925	153,858	8,479,067	4,344,364
Net Operating Cost	**67,601,317**	**15,271,534**	**52,329,783**	**50,222,832**

Notes:

(1) The analysis contained in Schedule 5 is a calculation which uses 2003-04 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. This year, 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.

(2) Figures for 2002-03 are based on an interim "Top Down" analysis (as reqested by HM Treasury and NAO), therefore are not directly comparable to the 2003-04 data.

(3) The 2002-03 Total Net Operating Cost differs from that published in the 2004 Departmental Report. This difference (£529,298,000) is as a result of a prior year adjusted made in respect of transfer of function to Department for Education and Skills.

3.29 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 (2003-04 being the first) will be a best estimate rather than a precise measurement of expenditure.

3.30 Within this context the Department of Health will be looking for year-on-year improvements, in both the process and outcomes of Programme Budgeting, rather than year one being absolutely right.

REGIONAL BREAKDOWN OF SPEND

3.31 The spending data shown in **Figure 3.10a** to **3.10c** is consistent with the country and regional analyses (CRA) published by HM Treasury in Public Expenditure Statistical Analyses (PESA). PESA contains more tables analysed by country and region, and also explains how the analysis was collected and the basis for allocating expenditure between countries and regions.

3.32 The tables include the spending of the Department and its NDPBs on payments to 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.

3.33 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 excluded.

Figure 3.10a: Department of Health Identifiable Expenditure on Services, by country and region

£ million

	1999-2000 outturn	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	2,213.7	2,426.4	2,709.3	3,010.3	3,217.3	3,655.0	3,934.9	4,421.5	4,862.1
North West	5,929.5	6,497.6	7,057.4	7,936.8	8,848.6	9,458.9	10,431.4	11,607.0	12,760.0
Yorkshire and Humberside	4,134.1	4,559.8	4,804.2	5,398.0	5,991.8	6,706.9	7,158.3	8,033.7	8,809.7
East Midlands	3,081.1	3,356.9	3,841.4	3,971.9	4,470.7	5,038.0	5,427.7	6,141.2	6,811.0
West Midlands	4,177.0	4,485.4	5,211.3	5,536.4	6,026.0	6,774.6	7,370.1	8,289.1	9,147.3
South West	3,725.2	4,301.0	4,638.9	4,955.6	5,455.4	6,018.3	6,560.0	7,399.4	8,156.8
Eastern	3,982.9	4,276.9	4,586.5	5,284.9	5,765.1	6,360.2	6,958.8	7,849.4	8,703.9
London	6,734.1	7,543.6	8,311.4	9,241.0	10,258.9	11,449.4	12,012.9	13,303.4	14,522.3
South East	6,008.1	6,521.1	7,282.6	8,028.7	8,717.0	9,648.0	10,462.9	11,725.4	12,892.8
Total England	**39,985.8**	**43,968.7**	**48,443.1**	**53,363.6**	**58,750.9**	**65,109.2**	**70,316.9**	**78,769.9**	**86,665.7**
Scotland	4.8	5.5	-1.0	-0.2	-16.6	-18.2	-19.9	-21.6	-23.6
Wales	32.3	36.8	-8.6	-7.1	-145.2	-158.0	-172.3	-187.8	-204.7
Northern Ireland	1.6	1.9	1.9	0.6	-1.5	-2.0	-2.7	-3.0	-3.2
Total UK identifiable expenditure	**40,024.4**	**44,013.0**	**48,435.3**	**53,356.9**	**58,587.6**	**64,931.0**	**70,122.0**	**78,557.5**	**86,434.2**
Outside UK	13.1	15.3	-4.2	-3.2	-61.3	-66.7	-72.7	-79.3	-86.4
Total identifiable expenditure	**40,037.6**	**44,028.3**	**48,431.1**	**53,353.7**	**58,526.3**	**64,864.2**	**70,049.3**	**78,478.2**	**86,347.9**
Non-identifiable expenditure	0.0	0.0	0.0	0.0	0.0	300.0	700.0	700.0	700.0
Total expenditure on services	**40,037.6**	**44,028.3**	**48,431.1**	**53,353.7**	**58,526.3**	**65,164.2**	**70,749.3**	**79,178.2**	**87,047.9**

(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 2004 and the regional distributions were completed in January 2005. Therefore, the tables may not show the latest position.

(3) Regional attribution of expenditure for the years 1999-2000 to 2003-04 is based on NHS Annual Accounts, and for 2004-05 to 2005-06 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.

Figure 3.10b: Department of Health Identifiable Expenditure on Services, by country and region, per head

£ per head

	1999-2000 outturn	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	868.0	954.0	1,066.6	1,186.1	1,267.0	1,441.6	1,554.1	1,748.3	1,924.3
North West	875.4	959.2	1,042.0	1,170.0	1,300.4	1,388.7	1,529.5	1,699.4	1,865.3
Yorkshire and Humberside	834.1	919.6	965.4	1,081.1	1,196.1	1,335.4	1,421.4	1,590.9	1,739.6
East Midlands	742.0	805.4	916.9	940.5	1,051.4	1,178.5	1,263.0	1,421.5	1,568.2
West Midlands	792.3	851.2	986.9	1,043.8	1,132.7	1,271.0	1,379.7	1,548.2	1,704.4
South West	763.2	874.7	938.4	997.6	1,091.2	1,196.2	1,295.4	1,451.7	1,589.9
Eastern	746.0	795.7	849.3	974.6	1,055.3	1,156.7	1,257.2	1,408.7	1,551.8
London	941.3	1,042.4	1,135.1	1,253.7	1,388.6	1,540.8	1,606.9	1,768.9	1,919.2
South East	755.2	816.1	907.7	998.1	1,078.8	1,187.9	1,281.3	1,428.1	1,561.8
Total England	**815.5**	**893.1**	**979.6**	**1,074.9**	**1,178.4**	**1,300.7**	**1,398.8**	**1,560.3**	**1,709.3**
Scotland	0.9	1.1	-0.2	0.0	-3.3	-3.6	-3.9	-4.3	-4.7
Wales	11.1	12.7	-3.0	-2.4	-49.4	-53.5	-58.0	-63.0	-68.5
Northern Ireland	0.9	1.2	1.1	0.4	-0.9	-1.2	-1.6	-1.7	-1.9
Total UK identifiable expenditure	**682.0**	**747.4**	**819.4**	**899.4**	**983.8**	**1,086.0**	**1,168.2**	**1,303.8**	**1,429.1**

(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 2004 and the regional distributions were completed in January 2005. Therefore, the tables may not show the latest position.

(3) Regional attribution of expenditure for the years 1999-2000 to 2003-04 is based on NHS Annual Accounts, and for 2004-05 to 2005-06 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.

Figure 3.10c: Department of Health Identifiable Expenditure on Services by country and region, 2003-04

£ million

	Health: Central and other health services	Medical services	Total health	Social protection: Personal social services	Public sector occupational pensions	Total social protection	Grand total
North East	67.6	3,238.2	3,305.8	11.1	-99.6	-88.5	3,217.3
North West	183.6	8,906.2	9,089.8	30.3	-271.5	-241.2	8,848.6
Yorkshire and Humberside	125.1	6,032.1	6,157.2	20.6	-185.9	-165.3	5,991.9
East Midlands	92.7	4,506.1	4,598.8	15.3	-143.4	-128.1	4,470.7
West Midlands	122.8	6,061.3	6,184.1	20.2	-178.3	-158.1	6,026.0
South West	115.0	5,546.8	5,661.8	19.0	-225.4	-206.4	5,455.4
Eastern	118.6	5,821.9	5,940.5	19.5	-194.9	-175.4	5,765.1
London	211.5	10,255.4	10,466.9	34.8	-242.9	-208.1	10,258.8
South East	179.0	8,824.8	9,003.8	29.5	-316.3	-286.8	8,717.0
Total England	**1,216.0**	**59,192.8**	**60,408.8**	**200.4**	**-1,858.3**	**-1,657.9**	**58,750.9**
Scotland	0.0	0.1	0.1	0.0	-16.7	-16.7	-16.6
Wales	0.0	0.0	0.0	0.0	-145.2	-145.2	-145.2
Northern Ireland	0.0	0.8	0.8	0.0	-2.3	-2.3	-1.5
UK identifiable expenditure	**1,216.0**	**59,193.7**	**60,409.7**	**200.4**	**-2,022.5**	**-1,822.1**	**58,587.6**
Outside UK	**0.0**	**0.0**	**0.0**	**0.0**	**-61.3**	**-61.3**	**-61.3**
Total identifiable expenditure	**1,216.0**	**59,193.7**	**60,409.7**	**200.4**	**-2,083.8**	**-1,883.4**	**58,526.3**
Not identifiable	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total	**1,216.0**	**59,193.7**	**60,409.7**	**200.4**	**-2,083.8**	**-1,883.4**	**58,526.3**

(1) The functional categories used are the standard United 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

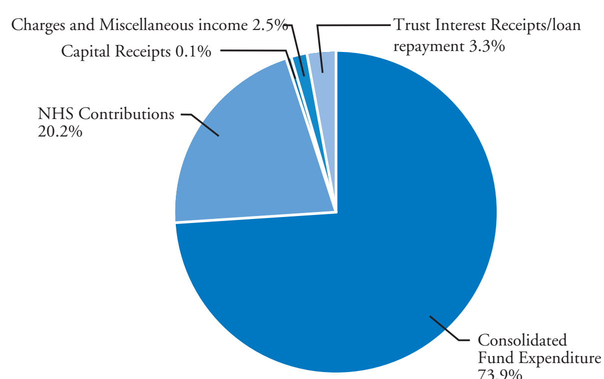
3.34 The NHS is financed mainly through general taxation with an element coming from National Insurance Contributions.

3.35 In 2005-06, it is estimated that 94.1 per cent of financing for the NHS in England will be met from these two sources, 73.9 per cent from the Consolidated Fund, that is, from general taxation and 20.2 per cent from the NHS element of National Insurance Contributions.

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

3.37 **Figure 3.11** represents NHS Sources of Finance for 2005-06.

Figure 3.11: NHS Sources of Finance 2005-06 (Total £78.064m)



3. Expenditure

COMPLEMENTARY SOURCES OF FUNDING

Big Lottery Fund

3.38 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

3.39 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).

3.40 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.

3.41 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.

3.42 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

3.43 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.

Fighting Heart Disease

3.44 The third tranche of £232.5 million was announced in November 2000 with the objectives of boosting the fight against cancer, coronary heart disease (CHD), and stroke. It will also be used to provide palliative care for adults and children.

3.45 £110 million was made available for CHD. Of this, £65 million 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 a total of 89 labs to be installed, which will speed up diagnosis significantly for patients with suspected heart disease. The money is also being used to buy ambulance equipment, defibrillators, to pump prime training officer posts and to improve cardiac rehabilitation and heart failure services.

3.46 £52 million has been deployed to fund nutritional projects to reduce heart disease and cancer. Of this, £10 million is to expand the 5 A Day initiative, and £42 million is to bring forward the targets of the National School Fruit Scheme. There will be 50-60 pilot projects for the School Fruit Scheme, based in Primary Care Trusts with the highest levels of deprivation. The Department will build upon the work delivered by this funding with nutrition being one of the key elements of the recent public health White Paper.

Palliative Care

3.47 £48 million is being used for palliative care for children to improve the quality of life of 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).

3.48 £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, emotional support and in some cases complementary therapies to patients in their homes.

INVEST TO SAVE BUDGET

3.49 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.

3.50 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

3.51 Following the announcement of Round Seven of ISB, over the next 3 years the department will receive £4.244 million, with £1.462 million being received in 2005-06 to support the following projects:

Provision of Therapeutic and emotional support for children

To enable emotional and therapeutic support to be provided to over 100,000 children and their parents annually by 2006-07 through working in partnership with primary schools across the UK and delivering learning services for adults.

Older People Experiencing crisis

Two neighbourhood based, multi-agency teams based in defined areas of deprivation in Bristol to pilot a new approach to preventing crises developing in older people's lives.

The teams will do this through a process of case finding, intensive multi-agency case management and community development.

Day Care facilities for Older People

To recruit and manage volunteers to set up family-based day support in trained volunteer's adapted homes. This will offer respite for carers and meet the needs of older people who are socially and culturally isolated from existing day support provisions.

Smiling More Often

To integrate the physical health gains of the Department of Health's Moving More Often scheme for older people with conditions such as arthritis, stroke etc., with the known mental health gains of exercise for older people as proposed by the National Service Framework for Older People, adding value to the preventative success of a range of local initiatives described in the report 'Smiling More Often', thereby contibuting to reductions in GP consultations, prescription of antidepressants, hospital admission and readmission, and social isolation; and work to further a series of Government priorities by integrating their implementation at neighbourhood level.

New Grounds for play Cross Generational Pilot

To create a cross-generational pilot play scheme on two estates over two years, incorporating older people who are caring for children. The project will: consult groups identified in more detail; install play equipment suitable for all ages; co-ordinate and promote mixed play activities; deliver mixed age play sessions; evaluate the project for mainstreaming; bring together partners who offer a range of skills and services; offer training opportunities to older people.

Crisis Intervention project Lewisham

Through the promotion of neighbourliness and community support and the use of IT; to identify older people at risk of physical or mental crisis by weighting single identified concerns which could warn of crisis. To enable a project manager to facilitate earlier service intervention thus reducing the intervention required.

Brighter Futures for Older People in Kent

This project will pioneer a range of neighbourhood/community-based services delivered by the voluntary and community sector to older people. Preventing inappropriate admissions into hospitals and long-term care by better identification of user needs; providing new types of targeted support services; promoting independence; increasing community participation; delivering efficiency savings.

Priority Care Project Wolverhampton

The Priority Care Project will achieve its objectives through integrating Chronic Disease Management, Electronic Single Assessment Process (eSAP) and preventative community projects focusing particularly on vulnerable older people from Priority Neighbourhoods.

RECOVERY OF NHS COSTS FOLLOWING ROAD TRAFFIC ACCIDENTS

3.52 Since the 1930s, hospitals have been able to recover the cost of treating those injured in 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.

3.53 The system of recovering these costs changed in April 1999 under the provisions contained in the Road Traffic (NHS Charges) Act 1999. The 1999 Act introduced a new, more efficient system of cost recovery with income now being recovered centrally from insurers by the Compensation Recovery Unit (CRU), which is part of the Department for Work and Pensions (DWP).

3.54 CRU recovers around £105 million per year and the money is paid direct to hospitals that have provided treatment. Work is currently underway 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.

PERSONAL SOCIAL SERVICES (PSS) EXPENDITURE

3.55 The Department of Health provides resources for the delivery of high quality social care through local authorities and other agencies. The resources provided for PSS from the Department's public expenditure programme are shown in Chapter 6, section 6.34, which give details on PSS revenue provision.

3.56 **Figure 3.12** shows total local authority current and capital expenditure on PSS. Between 1993-94 and 2003-04 local authority PSS net current expenditure has more than doubled in real terms.

Figure 3.12: Expenditure by Local Authorities on Personal Social Services

£ million

	1993-94 outturn	1998-99 outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn
Current expenditure							
gross[(1)]	6,278	10,847	12,048	12,848	13,598	15,199	16,839
charges[(1)]	621	1,788	1,998	2,152	2,229	2,305	2,077
net							
cash	5,657	9,059	10,050	10,696	11,369	12,894	14,763
real terms[(2)]	7,259	10,210	11,086	11,663	12,089	13,257	14,763
Capital expenditure[(1)]							
gross	185	140	134	156	158	199	260
income	69	53	51	63	70	75	74
net	116	87	83	93	88	124	185
Total local authority expenditure							
gross	6,463	10,987	12,182	13,004	13,756	15,398	17,099
charges/income	690	1,841	2,049	2,215	2,299	2,380	2,151
net	5,773	9,146	10,133	10,789	11,457	13,018	14,948

Source: PSS EX1, RO and RA LAs Returns

(1) Gross current expenditure, income from charges and capital figures are not available for 2004-05.
(2) At 2003-04 prices using the GDP deflator.

4. Investment

4.1 POLICY CONTEXT
4.7 PRIORITIES FOR PUBLIC CAPITAL INVESTMENT IN 2005-06
4.21 VITAL SUPPORTING INVESTMENTS
4.29 DIRECT CAPITAL ALLOCATIONS TO SHAs, NHS TRUSTS AND PCTs
Capital Investment by NHS Foundation Hospitals
Restrictions on Capital to Revenue Transfers
Treasury Capital Modernisation Fund
Prioritisation of Major Capital Schemes
4.42 PUBLIC PRIVATE PARTNERSHIPS AND INNOVATIVE INVESTMENTS
4.50 NHS LIFT
4.54 INVESTMENT TO CONTAIN vCJD
4.56 PROCURE 21
4.59 ASSET DISPOSAL
4.62 POOLED BUDGET ARRANGEMENTS AND INVESTMENT IN SOCIAL CARE

POLICY CONTEXT

4.1 Capital investment will continue to play a pivotal role in the modernisation of the NHS to produce faster, fairer services that deliver better health and tackle health inequalities.

4.2 Key themes for centrally steered capital investment during 2005-06 will include:

- investment in equipment and facilities to improve outcomes in key clinical services, including cancer services and services for cardiovascular disease, mental health;
- further investment to improve access to services and waiting times for treatment;
- modernising primary care; and,
- a major programme of supporting investments that underpin improvements in service standards and efficiency, including the flagship national IT programme.

4.3 2005-06 will also see further significant increases in investment in locally prioritised capital programmes, with NHS Foundation Trusts beginning to make use of their increased capital investment freedoms.

4.4 Further progress will be made with the NHS programme of major hospital redevelopment schemes, mainly through use of the PFI. Fifteen more major projects announced in the summer of 2004 are currently developing their outline business cases with a view to commencing their procurements in either 2005-06 or 2006-07.

4.5 To meet these investment challenges, NHS capital investment is set to rise to over £6 billion in 2005-06, including reinvestment of land sale receipts and private sector capital through the Private Finance Initiative. NHS LIFT will have attracted around £490 million of private capital and £175 million of exchequer funding to support the improvement of primary care premises in 2004-05, a level of investment which is expected to continue in 2005-06 and beyond.

4.6 **Figure 4.1** summarises the Department's capital expenditure plans to 2007-08. **Figure 4.2** shows the disposition of 2005-06 capital resources.

Figure 4.1: NHS Capital Spending 2004-05 to 2007-08 (Resources)

£ million

	2004-05 Forecast Outturn	2005-06 Plan	2006-07 Plan	2007-08 Plan
Government Spending	3,046	3,737	5,163	6,133
Percentage Real Terms Growth[1]		*19.7*	*34.5*	*15.7*
Foundation Trust Capital Expenditure	350	500	0	0
Percentage Real Terms Growth[1]		*39.3*	*n/a*	*n/a*
Receipts from Land Sales	582	200	200	200
Percentage Real Terms Growth[1]		*–66.5*	*–2.6*	*–2.6*
PFI Investment	883	1,650	2,238	1,949
Percentage Real Terms Growth[1]		*82.3*	*32.1*	*–15.2*
Total	4,864	6,087	7,601	8,282
Percentage Real Terms Growth[1]		*22.1*	*21.6*	*6.1*

[1] *Real Terms Growth calculated using GDP deflator of 2.14%/2.53%/2.70%/2.70%.*

Figure 4.2: Disposition of 2005-06 Capital Resources

£ million

Total NHS Capital Investment		6,087
Less: PFI Investment		–1,650
Gross Public Capital available for investment in DH and NHS		4,437
Less:		
Capital funding to support Department of Health operations	20	
Reserved to cover capital expenditure by Foundation Trusts	500	
Costs from the management and disposal of the "retained estate":		
NHS Trust Receipts from asset sales (normally reinvested locally)	10	
Central Capital Programmes	102	
Other NHS capital	11	–643
HCHS capital available for allocation to NHS Organisations:		3,794
To be allocated as follows:		
Central Budgets		1,037
Direct allocations to Strategic Health Authorities, NHS Trusts and Primary Care Trusts		
SHA Strategic Capital	866	
Trust and PCT Operational Capital	1,023	
Access Fund	100	
Total Direct Allocations for local prioritisation		1,989
Programme Capital Budgets		
Equipment in the Cancer Plan	128	
Coronary Heart Disease	144	
CAMHS Specialist Services	20	
Accelerated Discharge Programme	14	
DSPD	15	
DSPD Service Development	11	
Women Only High Support Community Provision	2	
Long Term, Low Secure Accommodation	10	
TILT security improvements	6	
Audiology	26	
Renal Services	14	
Modernising Hospital Manufacturing of Medicines	14	
Improving provision of decontamination services in the NHS	43	
Walk-in Centres	18	
NHS LIFT	14	
Diabetes	12	
Pathology Modernisation	8	
Independent Sector Treatment Centres	226	
Junior Doctor's Working Lives	2	
SIFT - Medical & Dental Undergraduate Support	8	
Dental Modernisation Fund	2	
Expanding Genetics	11	
ODPM Growth Areas Initiative	20	
Total to NHS Trusts/Primary Care Trusts		768
		3,794

PRIORITIES FOR PUBLIC CAPITAL INVESTMENT IN 2005-06

4.7 Programme Capital Budgets exist to ensure that sufficient capital funds are set aside to achieve NHS-wide initiatives. In 2005-06, the massive investment in equipment and facilities to improve outcomes in key clinical services will continue. The most significant of these initiatives are outlined below.

Cancer

4.8 A further £128 million is available in 2005-06 to continue the programme of investment in new and replacement equipment, to improve diagnosis and treatment of cancer. The benefits to patients of this investment include:

- speedier access to diagnostic imaging;
- faster scanning and higher quality images; and,
- improved availability of the latest radiotherapy treatment techniques, including for example 3D conformal therapy and intensity modulated radiation therapy.

4.9 Including investment through the National Lottery's New Opportunities Fund (now known as Big Lottery Fund) over £430 million has already been invested in this programme, with the result that by January 2005, 87 MRI scanners, 184 CT scanners, 90 Linear Accelerators and over 730 items of breast-screening equipment have been delivered since January 2000. This means that 55 per cent of MRI scanners, 58 per cent of Linear Accelerators and 70 per cent of CT scanners in use have been provided new since January 2000.

4.10 The NHS' inventory of scanners is now as modern as any in Europe. Results from the 2002 COCIR survey declared the UK to be the only country in Europe satisfying COCIR's recommendations for the age profile for both CT and MRI scanners. [COCIR is the European Coordination Committee of the Radiological and Electromedical Industries].

4.11 COCIR advise that:

- at least 60 per cent of equipment should be younger than 5 years;
- not more than 30 per cent should be 6-10 years old; and,
- not more than 10 per cent should be older than 10 years.

4.12 Ultimately, access to modern equipment for the diagnosis and treatment of cancer will help the NHS in delivering improved outcomes for patients and the capital funds earmarked for investment in 2005-06 will permit the continued replacement of older equipment.

Coronary Heart Disease

4.13 A further £144 million will be spent in 2005-06 progressing the modernisation and expansion programme for cardiac services. This includes 19 cardiac centres at a cost of £600 million which will expand cardiac services with around 27 additional cardiac theatres and 620 extra beds. To date five schemes have been completed and a further four are expected to be completed in 2005-06.

4.14 This investment will 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 inpatient admissions.

Mental Health

4.15 £78 million of capital is available centrally in 2005-06 for investment in mental health facilities. The funding will be invested in improving security at the three high security psychiatric hospitals and developing facilities for people with Dangerous Severe Personality Disorder (DSPD) and for the transfer of some patients into more appropriate care settings. Capital will also be invested to support the development of specialist facilities for particular client groups, including medium secure facilities for deaf people and dedicated units for women, both secure and in the community, and inpatient accommodation for young people with schizophrenia and other psychoses.

Other Investments in Clinical Services

4.16 Other central capital investments in key clinical services include £12 million to expand the provision of diabetic retinopathy services as prescribed in the National Service Framework for diabetes, which requires 80 per cent of people with diabetes to be offered retinopathy screening by 2006. There will also be a further £14 million of capital investment to increase dialysis capacity in line with rising demand.

Expanding Capacity and Improving Access to Services

4.17 Expansion of capacity will remain an important theme in 2005-06, though this will principally be through Independent Sector Treatment Centres (ISTCs). Through contracts between the NHS and these new private-sector facilities, patients will access this additional capacity free of charge, as they would facilities operated by the NHS. This new capacity will improve access to medical care and contribute to further falls in waiting times.

4.18 In 'Wave 1' of the ISTC programme, three schemes have already reached Full Service Commencement (FSC) and a number of other schemes are providing interim services in advance of FSC. Seven more schemes are anticipated to reach FSC in 2005.

4.19 In total, £226 million of capital resource cover has been reserved to cover the balance sheet implications of these 'Wave 1' 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.

4.20 Access to services will also be improved by creating additional Walk-in Centres. £18 million has been set aside centrally to support this initiative in 2005-06.

VITAL SUPPORTING INVESTMENTS

4.21 A wide range of perhaps lower profile investments is also essential for the efficient and safe running of the NHS and to support its development. These include: the upgrading of decontamination facilities; creating additional medical school places; and improving facilities for the manufacture of medicines. Some of these initiatives are outlined below.

Decontamination

4.22 In 2005-06, a further £43 million of capital will be invested centrally to continue improving NHS decontamination facilities to lessen the risk of transmitting vCJD and other infectious diseases.

4.23 This will bring to over £250 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. In 2004-05, an additional £21 million was allocated to help improve decontamination in primary care. In the autumn of that year, the Department launched an online decontamination training package aimed at 12,500 NHS hospital staff.

4.24 There remains a need to put in place arrangements to ensure that the redeveloped facilities continue to meet the latest standards – which requires continued investment:

- the NHS is funding some redevelopments from its own resources – and will continue to do so in the long term;
- some sterile supply departments will be redeveloped and maintained as part of a larger PFI/PPP development; and,
- the majority of redevelopments will occur as the result of Joint Ventures between local health economies and commercial interests.

4.25 35 Trusts in eight projects are now in the process of choosing private sector partners to redevelop their sterile services as part of a Joint Venture. The first of these, involving the Bradford, Leeds, and Calderdale and Huddersfield Trusts, is due to award a contract in spring 2005.

Pharmacy facilities and investment in medical school facilities

4.26 In 2005-06, £14 million of capital will be invested in modernising the manufacture of medicines in hospital pharmacies to ensure that NHS patients have access to any medicines they require which are not available from any other source. £35 million will be spent supporting the construction of medical school facilities to house the increase in medical students announced in the NHS Plan.

Information Management and Technology

4.27 In 2005-06, £1,037 million of capital funding has been earmarked for investment in centrally managed capital investment programmes, by far the most significant of which is NHS Connecting for Health's national programme for information technology.

4.28 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 2. 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.

DIRECT CAPITAL ALLOCATIONS TO SHAs, NHS TRUSTS AND PCTs

4.29 2005-06 will be the last year covered by the three years of allocations of capital direct to NHS organisations that were announced in January 2003. These direct allocations were calculated using national needs-based formulae, and will total £1,989 million for 2005-06. Of this, £100 million was allocated to Strategic Health Authorities (SHAs) as Access Funds for use to incentivise trusts and PCTs to improve performance; £1,023 million was allocated to NHS trusts and PCTs as Operational Capital; and £866 million was allocated to SHAs as Strategic Capital.

4.30 Operational capital is allocated unconditionally to NHS trusts and PCTs and is predominantly spent on maintaining buildings and replacing equipment. The £1,023 million allocated for spend in 2005-06 amounts to a 10 per cent increase on 2004-05's figure of £928 million and is 33 per cent higher than the £766 million allocated as Operational Capital in 2002-03.

4.31 The £866 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, this equates to a 13 per cent increase on 2004-05's level of £763 million.

Capital Investment by NHS Foundation Hospitals

4.32 NHS Foundation Trusts 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.

4.33 They are authorised to borrow from commercial banks but the Department has established a Loan Facility to make long-term loans available to NHS Foundation Trusts 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.

4.34 Capital Investment by NHS Foundation Trusts is charged to the Department's capital resource total so funds must be set aside to cover this. £500 million has been set aside in 2005-06 to cover capital investment by the 31 NHS Foundation Trusts that are currently in operation and any other hospitals that begin operating as NHS Foundation Trusts during that year.

Restrictions on Capital to Revenue Transfers

4.35 As in previous years, a limit has been set on capital to revenue transfers to control the amount of capital which can be transferred to support revenue expenditure and thus ensure that capital resources are expended on capital investment as intended.

4.36 In 2005-06, the limit remains £250 million and this has been set aside to provide the flexibility required by NHS Connecting for Health to procure IT facilities and services effectively. This flexibility was granted on the condition that the £250 million of capital-to-revenue virement will be reduced by the extent of any underspending in Health's revenue funding.

Treasury Capital Modernisation Fund

4.37 Historically, health has received generous support from the Treasury's Capital Modernisation Fund. However, the Department's proposals were not prioritised in the last round, which was concluded in 2003.

4.38 There is no funding from this source in the Department's plans for 2005-06, though a small number of projects from earlier rounds are still ongoing.

Prioritisation of Major Capital Schemes

4.39 Since 1997, all proposals for major capital schemes have been subject to national prioritisation to ensure that only the most needed and best prepared schemes use the bidding capacity of contractors.

4.40 The continued success of the Private Finance Initiative (PFI) has meant that private sector interest in health schemes remains strong. As a result, Strategic Outline Cases for another fifteen major new projects, ranging from a £50 million mental health scheme near Sunderland; to a £1 billion investment programme covering all of North Merseyside, were approved in 2004. These schemes are now developing their Outline Business Cases and further refining their specifications and it is expected that three or four of these will be sufficiently advanced to commence their procurements before the end of 2005.

4.41 These fifteen new projects, totalling over £4 billion of investment, bring to 83 the number of major hospital schemes approved to go ahead since 1997. No more formal prioritisation rounds are planned. Instead, we will now be moving to a 'rolling programme' under which the Department will approve a few well worked up and 'deliverable' schemes to go ahead each year matched to market capacity.

PUBLIC PRIVATE PARTNERSHIPS AND INNOVATIVE INVESTMENTS

4.42 The NHS is continuing its major programme of investment through the use of public private partnerships: These include PFI, which continues to deliver most of the hospital building schemes; NHS LIFT, an investment vehicle for modernising primary care premises; and the operation of a private company which collects plasma for treating NHS patients. The partnering principle is also incorporated in the Department's 'ProCure21' initiative.

4.43 Recent progress of these initiatives and their plans for 2005-06 are outlined below:

PFI and delivery of the 100 hospital schemes target

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

4.45 During 2004, a further five PFI schemes with a combined capital value of over £90 million became operational. This means that in total, 50 hospital schemes are now operational against the NHS Plan target. Of these, 42 were delivered under the Private Finance Initiative.

4.46 A further 15 schemes were approved to proceed during 2004 (see 4.40 above). Of these 14 are expected to be funded through PFI.

4.47 In addition to those schemes that became operational in 2004, a further 17 reached financial close and began construction. The schemes under construction continue to vary widely in terms of size, purpose and location; examples are:

- the new £30 million Hadfield wing specialising in Elderly care and Rehabilitation at Sheffield Teaching Hospitals NHS Foundation Trust;
- £47 million general modernisation of acute facilities at Stoke Mandeville Hospital;
- £31 million Mental Health unit at St George's Hospital in Morpeth;
- new Primary Care facilities across Kirklees PCT costing £25 million; and,
- the £420 million scheme in Manchester which involves modernising the Central Manchester site with a linked development of four new hospitals for children's, women's, adult's and specialist eye services.

4.48 All these developments are helping to increase capacity and improve the quality of care for NHS patients across the full range of services that the NHS provides.

4.49 In 2005, seven further schemes are expected to become operational. Around fifteen more schemes ranging in value from £18 million to £1.2 billion are expected to reach financial close, thus maintaining the momentum against the NHS Plan target.

NHS LIFT

4.50 The NHS Local Improvement Finance Trust (NHS LIFT) initiative is contributing to the redevelopment of primary care infrastructure.

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

4.52 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 both a mix of both rural and inner city LIFT schemes, including parts of the country designated by the Office of the Deputy Prime Minister as growth areas.

4.53 There are now 51 LIFT schemes of which 37 have reached financial close. Eight of these now have buildings open to patients. **See Figure 4.3** for a full list of NHS LIFT schemes. By the end of 2005, it is expected that there will be over 50 LIFT buildings open to patients. By the end of 2004-05, NHS LIFT had attracted around £490 million of private capital investment to support the improvement of primary care premises. This level of investment will continue to grow in 2005-06 and beyond. In addition, the Department of Health provided £175 million of public capital up to the end of 2004-05, and will provide another £31 million in 2005-06, to help PCTs with the start-up costs of their LIFT schemes.

INVESTMENT TO CONTAIN vCJD

4.54 The Department has owned a US plasma collection company, DCI Biologicals Inc, since the end of 2002, 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.

4.55 The US company is owned by a UK based company called Plasma Resources UK Ltd, which in turn is 100 per cent owned by the Secretary of State. In 2004-05, the company has paid £3.2 million in interest to the Department of Health in accordance with its contractual obligations.

PROCURE 21

4.56 Procure21 was launched in April 2000 as the NHS response to *Rethinking Construction*[4.1] and HM Treasury's *Achieving Excellence*[4.2]. It provides a standardised approach to the procurement of healthcare facilities, based upon long-term relationships with carefully selected supply chains, which have the ability to work with NHS clients across the whole life cycle of a scheme.

4.57 Procure21 has now become an established method for construction in the NHS, and is already delivering noticeable and measurable improvements. A competitive selection process selected Principal Supply Chain Partners (PSCPs) to sit on a National Framework. Trusts select PSCPs without the requirement for a further tendering exercise. By having a small number of carefully selected PSCPs to work with, the trusts gain considerable benefits. Sharing lessons between organisations is encouraged along with applying new ideas and experience to each new scheme. Better buildings are constructed within budget and on time.

4.58 Since Procure21 was launched, 198 schemes have been registered with an estimated value of around £2 billion. Nineteen schemes are complete, totalling around £74.15 million and another 45 schemes are currently on site.

ASSET DISPOSAL

4.59 The *Sold on Health Report*[4.3] recommendations regarding the disposal of surplus NHS estate continue to be implemented. These require a corporate approach to the disposal of surplus estate to achieve best value. The NHS Estates Agency has taken the lead in the disposal of surplus property owned by the Secretary of State for Health, as well as acting as 'informed client' for all disposals by NHS trusts and PCTs.

4.60 Including the £102 million expected from disposals of land owned by trusts and PCTs (which will be reinvested locally), capital receipts from disposals are expected to contribute £200 million to Health's capital funding envelope in 2005-06.

4.61 During 2004, it was agreed that a substantial package of surplus NHS land would be transferred to the Office of the Deputy Prime Minister, where it will be used to increase the supply of affordable housing. The NHS will receive market value for the land and will use it to fund the replacement of buildings and equipment. The detailed work to implement the transfer is now underway and it is anticipated that the NHS will receive in the region of £400 million.

POOLED BUDGET ARRANGEMENTS AND INVESTMENT IN SOCIAL CARE

4.62 The 1999 Health Act Partnership Arrangements are key powers, which enable: pooled funds; lead commissioning; integrated provision; and money transfer powers. 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.

4.63 Social care capital spend isn't included in the above capital investment tables. Social care investment support through PFI credits will total £90 million in 2005-06, sufficient to enable around 5 to 10 major social care projects to be given the go-ahead. Public capital funding for social care investment will total around £117 million, and will permit further modernisation of information systems, as well as funding investment in areas that find it difficult to attract funding from the local authority main capital pot.

Figure 4.3: NHS LIFT Schemes

Strategic Health Authority	Scheme
LIFT Schemes reached Financial Close with buildings open to patients	
Birmingham and Black Country	Sandwell
Cumbria and Lancashire	East Lancashire
Greater Manchester	Ashton Leigh and Wigan
Norfolk, Suffolk and Cambridgeshire	Norfolk
North East London	East London
North East London	Barking and Havering
Northumberland Tyne and Wear	Newcastle
South Yorkshire	Barnsley
LIFT schemes reached Financial Close with buildings under construction	
Avon, Gloucestershire and Wiltshire	Bristol
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
County Durham and Tees Valley	Tees Valley
Essex	Colchester and Tendring
Greater Manchester	Manchester, Salford and Trafford
Greater Manchester	Oldham
Hampshire and the Isle of Wight	East Hants, Fareham and Gosport
Kent and Medway	Medway
Leicestershire, Northants and Rutland	Leicester
North and East Yorks and North Lincs	Hull
North Central London	Camden and Islington
North Central London	Barnet, Enfield and Haringey
North East London	Redbridge and Waltham Forest
North West London	Brent, Harrow and Hillingdon
North West London	Ealing, Hammersmith and Hounslow
Shropshire and Stafford	North Staffordshire
South East London	Bromley, Bexley and Greenwich
South West London	South West London
South West Peninsula	Cornwall and the Isles of Scilly
South West Peninsula	Plymouth
Thames Valley	Oxford
Trent	Greater Notts (Gedling)
Trent	Southern Derbyshire
West Midlands South	Coventry
West Yorkshire	Bradford
West Yorkshire	Leeds
LIFT schemes announced Preferred Bidder but not reached Financial Close	
Birmingham and Black Country	Dudley South
South East London	Lambeth, Southwark and Lewisham
South Yorkshire	Doncaster
South Yorkshire	Sheffield
Trent	North Notts (Ashfield)
LIFT schemes in early stages of procurement	
Avon, Gloucestershire and Wiltshire	Wiltshire
Bedfordshire and Hertfordshire	South East Midlands
Essex	South East Essex
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
North West London	Kensington and Chelsea

4.64 In social care, new capital investment is primarily funded through revenue funding. Revenue funding allows Local Authorities to commission, or develop services and to launch joint funded partnerships and through increasing revenue payments can procure services delivered in improved facilities.

4.65 There, nevertheless, remains a significant programme of social care led capital investment, the most significant of which is the PFI programme, through which Local Authorities, in conjunction with partner organisations develop facilities for a range of client groups, including respite care, residential care and services for people with learning and other disabilities. In 2005-06, £70 million of PFI credits are available for social care schemes and this will allow roughly the same value in capital investment to take place. This level of investment is equivalent to fully funding the development of six or seven significant projects in the year.

4.66 Social services departments also link closely with their local authorities' overall capital investment strategies and have further projects funded through that route; there will also be investment in specific initiatives such as modernising social care information management.

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

5.1 A BRIEF SUMMARY OF THE NHS PLAN

5.4 THE NHS PLAN – STEP BY STEP REFORM

CARRYING OUT THE PLAN'S REFORMS:

5.7 THE NHS IMPROVEMENT PLAN

5.10 INCREASING DEVOLUTION

- Planning Framework
- Revenue Allocations to PCTs
- NHS Foundation Trusts
- Pay Modernisation in the NHS

5.28 PATIENT CHOICE AT THE HEART OF REFORM

5.47 INCREASING PLURALITY OF PROVISION

- Treatment Centres
- Use of Spare Capacity in the UK Independent Sector
- Overseas Treatment

5.59 CONFIDENCE IN HEALTH SERVICE DELIVERY

- NHS Performance 'star' Ratings
- 2004-05 Performance Ratings Indicators
- Future Assessment System
- NHS Franchising and Register of Expertise
- Legal Powers
- Patient Prospectus
- The Healthcare Commission
- The Commission for Social Care Inspection (CSCI)

5.91 PAYMENT BY RESULTS

5.96 NHS BANK

5.99 PUBLIC HEALTH WHITE PAPER

- Reducing the Numbers of People who Smoke
- Reducing Obesity
- Increasing Exercise
- Encouraging and Supporting Sensible Drinking
- Improving Sexual Health
- Improving Mental Health and Wellbeing
- Promoting Personal Health

5.109 SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS (CHRONIC DISEASE MANAGEMENT)

ACTIONS ACHIEVED TO DATE:

5.118 ACCESS

- Primary Care
- Secondary Care

5.123 MORE STAFF IN THE NHS WORKFORCE

5.130 CAPITAL AND CAPACITY

5.132 HEALTH INEQUALITIES

5.181 CANCER

5.216 CORONARY HEART DISEASE

5.230 PREVENTION OF ILL HEALTH

5.254 OLDER PEOPLE'S SERVICES

5.274 MENTAL HEALTH SERVICES

5.288 CHILDREN

5.299 QUALITY OF CARE

- PALS
- Patient and Public Involvement in Health
- Overview and Scrutiny Committees
- NHS Healthcare Standards
- National Clinical Audit
- Clinical Governance
- Controls Assurance
- Single-sex Accommodation

5.323 IMPROVING PATIENT EXPERIENCE

5.380 NHS DIRECT

5.388 MODERNISING PATHOLOGY SERVICES

5.392 NHS DENTISTRY REFORM PROGRAMME

5.400 A VISION FOR PHARMACY

5.421 AUDIOLOGY MODERNISATION PROJECT

5.423 GENETICS WHITE PAPER

5.427 INDEPENDENT RECONFIGURATION PANEL (IRP)

5.431 MODERNISATION AGENCY

A BRIEF SUMMARY OF THE NHS PLAN

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 full document can be found at **www.nhs.uk/nhsplan**

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, builds on the commitment to a ten-year reform process first set out in *The NHS Plan*.

CARRYING OUT THE PLAN'S REFORMS: THE NHS IMPROVEMENT PLAN

– putting people at the heart of public services

5.7 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.

5.8 *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.

5.9 *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.

INCREASING DEVOLUTION

– driving extra provision locally

Planning Framework

5.10 In July 2004, the Department of Health published the new planning framework, *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08*[5.3]. This new planning framework sets out the national targets for the NHS and social care that will apply from April 2005, and these 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.

5.11 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.

Revenue Allocations to Primary Care Trusts

5.12 In December 2002, revenue allocations for 2003-04 to 2005-06 for Primary Care Trusts (PCTs) were announced. Revenue allocations for 2006-07 and 2007-08 for PCTs were announced in February 2005.

5.13 The revenue allocations to PCTs are based on a weighted capitation formula.

5.14 For the 2006-07 and 2007-08 revenue allocations to PCTs, the pace of change policy has been speeded up, which results in no PCT being 3.5 per cent below their fair share of available resources by 2007-08.

NHS Foundation Trusts

5.15 NHS Foundation Trusts were set up under the powers in the *Health and Social Care (Community Health and Standards) Act 2003*[5.4]. There are now 31 NHS Foundation Trusts in operation and further waves will follow. By 2008, all NHS Trusts will be in a position to apply to become NHS Foundation Trusts.

5.16 NHS Foundation Trusts are independent public benefit corporations, modelled on cooperative and mutual traditions. They symbolise the Government's commitment to community-based public services whilst remaining firmly within the NHS. NHS Foundation Trusts are not for profit organisations that provide NHS services to NHS patients according to NHS principles and standards. They 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 represented too.

5.17 NHS Foundation Trusts have greater freedoms and flexibilities in the way they run their affairs, allowing them to tailor their services to the needs of their local communities, and to promote innovation and enterprise. Greater freedoms are balanced by proper safeguards designed to ensure that NHS Foundation Trusts treat NHS patients according to NHS principles and standards.

5.18 Monitor (the statutory name of which is the Independent Regulator of NHS Foundation Trusts) authorises NHS Trusts to operate as NHS Foundation Trusts through a terms of authorisation ('licence' to operate). Monitor holds responsibility for ensuring compliance with the terms of authorisation conditions and statutory obligations. Independent Regulation is also coupled with freedom from Whitehall interference where NHS Foundation Trusts are freed from central control, notably the Secretary of State for Health does not have the power to direct NHS Foundation Trusts. Instead, accountability for NHS Foundation Trusts is to local people, PCTs, Monitor and Parliament.

5.19 NHS Foundation Trusts have freedom to retain any operating surpluses and to access a wider range of options for capital funding to invest in delivery of new services. They are able to respond much more quickly to the needs of their patients. We are already seeing the benefits. Examples include:

- Countess of Chester – developing a new emergency centre, which will house the traditional A&E service, medical and surgical assessment facilities, and some diagnostic support services;
- Homerton – accelerated building of a new perinatal centre up to two years ahead of schedule (antenatal, delivery suite, neonatal intensive and special care unit);
- Moorfields – increase of at least £6 million in its capital spend, including a £2 million extension to a community outreach centre and £1 million on a new and replacement equipment for clinics and theatres;
- Peterborough – £2 million of extra capital spend on essential equipment upgrades and replacements as well as installation of automatic doors in patient areas and improvement of ward flooring;
- Stockport – investing in new operating theatres and a new cardiology and surgical unit.

5.20 In 2003, the Secretary of State commissioned the Healthcare Commission to undertake a review into the policy to consider the challenges and experiences of first wave NHS Foundation Trusts. The outcome of the review is due to be published in summer 2005.

Pay Modernisation in the NHS

Agenda for Change

5.21 On 23 November 2004, negotiators from the UK Health Departments, NHS employers and staff organisations successfully reached agreement on a new pay system for the NHS covering all staff except for very senior managers and staff within the remit of the Doctors' and Dentists' review body. The agreement reached followed a review of the evidence from the twelve Early Implementer sites. National roll-out began on 1 December 2004, with an effective date of 1 October 2004 for most terms and conditions. It is due to be completed by September 2005.

5.22 The benefits of Agenda for Change for the NHS are:

- an NHS Job Evaluation Scheme that allocates staff to new pay bands by measuring the skills, knowledge, effort and responsibilities they require in post. This ensures fair pay consistent with the principle of equal pay for work of equal value and provides incentives for staff to take on additional duties and responsibilities;
- clearer opportunities for staff to develop into new roles, through effective use of the NHS Knowledge and Skills Framework;
- freedom for NHS organisations to design jobs that offer greater responsiveness to the needs of the patients, improving the quality of patient care; and,
- harmonisation of terms and conditions of employment will result in better team working.

New contracts for hospital doctors

5.23 The new consultant contract has been introduced across the NHS. At 29 October 2004, 76.9 per cent of consultants had

signed up to the new contract and all new consultant appointments are now on the new contract. 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 in January 2005.

5.24 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, with a view to implementation from April 2006.

5.25 Ministers also accepted recommendations from the NHS Confederation that – commissioners should make better use of existing contractual mechanisms to remunerate GPs who provide services in community hospitals, and that these are matters for local negotiation.

New Contracts for GPs

5.26 The new primary medical care contracting arrangements came in to effect on 1 April 2004. They have provided PCTs with flexibilities to contract for primary medical care services in a way that better meets local circumstances. The contracts are delivering improved quality and access to a wider range of services for patients as well as tackling shortfalls in service provision. Practices also have new opportunities and freedoms to develop innovative and improved ways of providing services and we are now seeing new providers enter the market which will increase local capacity.

5.27 The contracts are backed by massive new investment with expenditure in England on primary care being planned to rise from £5 billion in 2002-03 to over £6.8 billion by 2005-06, an increase of 36 per cent. This level of investment is being delivered by a gross investment guarantee mechanism. This means PCTs have the necessary funding to enable them to commission services that will improve primary care provision for patients locally. Increases in investment in primary care will continue beyond 2005-06 and through review of the contracting arrangements ensure that access, quality and the range of services for patients will continue to improve.

PATIENT CHOICE AT THE HEART OF REFORM
– redesigning NHS services around the needs of the patients

5.28 Choice is at the heart of the Government's programme of reform for the NHS.

5.29 Extending choice responds to the public's demand for more choice and control over their healthcare and services and will improve the patient experience by enabling people to choose those services which best meet their individual needs and preferences.

5.30 With 'Payment by Results' – the new financial framework, patient choice also provides new and powerful incentives for providers to improve performance, leading to better local services for all across the whole country.

5.31 The NHS Improvement Plan 2004 sets out our vision for a health service where choice and responsiveness to individual needs are a reality for all, not just the more affluent or the better informed. Our aim is to develop a health service which responds to 21st century public expectations by offering:

- flexible access to services shaped around individuals' needs and preferences, rather than an expectation that people will fit the system;
- greater choice and shared decision-making between patient and clinical team over treatment and care; and,
- better access to the information and support that people need to exercise choice.

5.32 The national choice consultation in 2003 developed our priorities in this area which were presented in *Building on the Best: Choice Responsiveness and Equity in the NHS*[5.5] published on 9 December 2003.

5.33 *Building on the Best* set out ways that people could be offered more choice across the spectrum of healthcare. Over the last year, we have been increasing capacity to provide people with more choice over when, where and how they are treated and increasingly over what treatment they receive. For example, there are now 64 NHS Walk-in Centres with a further 25 sites in the development stages, seven NHS GP led Walk-in Centres within a few minutes walk of mainline stations in London, Leeds and Manchester; and Newcastle will be coming on stream this year and a new community pharmacy contractual framework has been agreed that will give people easier access to medicines. Reforms to the regulatory system will also enable easier access to more pharmacies where people live, work, shop and travel.

Choice of Hospital

5.34 The NHS Improvement Plan set out our commitment to give patients needing planned hospital care the opportunity to choose their hospital for treatment and to book their hospital appointment.

5.35 Considerable progress has already been made and, where we have already introduced choice of hospital, we know it is proving popular with patients. Pilots offering patients, who would otherwise wait six months for surgery, the choice of an alternative provider for faster treatment had high take up rates: 67 per cent of patients participating in the London Patient Choice Project and 50 per cent of those involved in the Patient Choice Initiative in Coronary Heart Disease. Since choice at six months has been rolled out across the NHS from April last year, some 30,000 patients have already accepted a choice offer.

5.36 From December 2005, all eligible patients referred for elective care will be offered the choice of four or five providers at

the point of referral for treatment by their GP and the opportunity to book their hospital appointment for a date and time that suits them. These choices may include NHS Trusts, NHS Foundation Trusts, NHS and Independent Sector Treatment Centres and independent sector hospitals. Choice at referral will mean that some 10 million patients a year will be able to choose the hospital for their treatment which best meets their individual needs and preferences.

5.37 The new service, 'Choose and Book' 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 (a Booking Management Service or BMS). They will also be able to make or change appointments by email and eventually via digital television.

5.38 We know that patients will need easy access to high quality information to help them make informed choices. Nationally, we are enhancing the website **www.nhs.uk** to provide comparative information on waiting times, location and access and hospital performance. PCTs will also provide further local information to support patient choice.

5.39 GPs, other practice staff, patient care advisors and voluntary sector providers will support patients in making their choices. To ensure that everyone can exercise genuine informed choices, PCTs will be providing targeted packages of support to patients and communities the NHS has traditionally found harder to reach.

5.40 From 2008, we will be extending this choice further so that patients will have the right to choose from any health care provider which meets the Healthcare Commission's standards and which can provide the care within the price that the NHS will pay. We will also be developing further information on clinical quality and patient experience factors to support choice and to meet patient and GP expectations.

Choice for CHD patients

5.41 CHD Choice 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.

5.42 From April 2005, patients referred for heart bypass and coronary angioplasty operations will be offered a choice of two hospitals for that treatment, at the time that they are referred for treatment. By December 2005, this will extend to a choice of four or five hospitals

Cataracts and chronic eye conditions

5.43 We have made great progress in cataracts. We have dramatically reduced waiting times, introduced choice at referral and launched a new care pathway to provide faster access and a better patient experience:

- maximum waiting times for cataracts have been reduced from 6 months in March 2004 to a new maximum of 3 months in January 2005;
- a new care pathway for cataracts was launched in April 2004 and this is increasingly being adopted by the NHS following the reduction in waiting times;
- the new care pathway streamlines cataract services by allowing optometrists to refer patients directly to hospital. This means fewer appointments for the patient and more effective use of skills in primary and secondary care; and,
- from January 2005 patients have been offered a choice of at least two providers when they need a referral for cataract surgery. This will increase to a choice of 4 or 5 providers by December 2005.

5.44 We are also investing in chronic eye conditions:

- we launched new care pathways for glaucoma, age related macular degeneration and low vision in April 2004 (together with cataract);
- these new pathways are now being piloted in eight locations across the country; and,
- learning from the pilots will be shared with the NHS on a rolling basis to improve services for all eye care patients.

Better Information, Better Choices, Better Health

5.45 Access to good quality information is fundamental to making informed choices about personal health and healthcare. The need to improve the information available to people was one of the loudest messages from the national choice consultation and confirmed again through the *Choosing Health?*[5.6] consultation on public health. To address this, a new, three-year strategy was launched in December 2004. *Better Information, Better Choices, Better Health*[5.7] strategy is a programme of action, at both national and local level, designed to improve equitable access to the quality information people need and want to exercise choices about their personal health and healthcare.

5.46 The strategy places an emphasis on enhancing the relationship between healthcare professionals and patients 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.

INCREASING PLURALITY OF PROVISION
– patients need a range of different services to exercise choice

Treatment Centres

5.47 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.

5.48 The core objectives of the Treatment Centre programme are to:

- improve access to acute elective care (by contributing an additional 250,000 patients to Treatment Centres and delivering the activity growth needed to achieve maximum six-month waits by 2005). This builds on the NHS Plan aim of 20 Treatment Centres open (of which, 8 would be fully operational) by 2004 treating approximately 200,000 patients a year when all are fully operational; 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.

5.49 32 NHS Treatment Centres are currently open, of which 23 are fully operational, and a further 14 are in development which are expected to be open by December 2005. Over 122,000 patients have been treated in NHS Treatment Centres since the programme was launched in April 2002, 86,000 of whom were treated in the last calendar year, January to December 2004.

5.50 The Independent Sector Treatment Centre (ISTC) programme has closed 10 of 17 contracts to date. Two schemes (Daventry and the Ophthalmic Chain) are fully operational, with interim service also being supplied in Trent, Bradford and Plymouth. In January 2005, the Secretary of State announced that 10,000 patients had been treated in the mobile cataract units. 34 ISTCs will ultimately be deployed in Wave 1 of this procurement.

Use of spare capacity in the UK independent sector

5.51 Building on the Concordat agreed with the private and voluntary healthcare sector in October 2000, the Department is also continuing to encourage the NHS to make use of spare capacity in the existing UK independent sector in a more planned and co-ordinated way.

5.52 In December 2003, the Department launched an additional procurement to use existing independent sector capacity to treat approximately 25,000 extra patients during 2004-05, largely in orthopaedics. The first-year contracts were awarded in May 2004 (Nuffield Hospitals and Capio Healthcare) and have been providing additional capacity throughout England.

5.53 A procurement of diagnostic services, MRI scans, also took place in 2004. A five-year contract was awarded to Alliance Medical for the delivery of over 120,000 additional MRI scans annually. This represents a 15 per cent increase in scanning capacity and was achieved at less than half the equivalent NHS cost.

Overseas treatment

5.54 Overseas treatment offers a means of adding to the physical and human resource capacity of the NHS, by contributing to the reduction of waiting times.

5.55 During 2004, treatment has continued in Belgium through the London Patient Choice Project.

5.56 By March 2005, nearly 890 patients have been treated in total in the European Economic Area (EEA), the majority for orthopaedic conditions, particularly major joint replacements. A small number of patients have also been treated for cataracts during the pilot projects.

5.57 Since December 2004, the NHS overseas commissioners, based at Guys and St Thomas's Hospital are commissioning overseas treatment. Guidance for primary care and acute trusts considering the referral of their NHS patients abroad is available on the Department's website.

5.58 Independently of this initiative, approximately 1,000 patients were authorised last year to receive specific treatment in other EEA states and Switzerland under the longstanding E112 referral arrangements. This is the mechanism which entitles patients to seek treatment in other member states at NHS expense, subject to whatever contributions are required under the national law of the country in which the treatment is being provided and after receiving prior authorisation from the Department of Health.

CONFIDENCE IN HEALTH SERVICE DELIVERY

NHS performance 'star' ratings

5.59 The performance ratings system awards three stars to the highest performing trust, 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.

5.60 The Department of Health published the ratings for 2000-01 and 2001-02, while the independent Commission for Health Improvement published the 2002-03 set. The independent health regulator, the Healthcare Commission, which replaced the Commission for Health Improvement, published the 2003-04 set in July 2004. A total of 590 star ratings were awarded to NHS trusts for their performance in 2003-04. 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.

5.61 The overall results were as follows:

146	★★★
288	★★
121	★
35	0

5.62 For NHS Acute and Specialist Trusts, the results were as follows:

76	★★★
58	★★
29	★
10	0

5.63 For Primary Care Trusts, the results were as follows:

45	★★★
181	★★
63	★
14	0

5.64 For Ambulance Trusts, the results were as follows:

10	★★★
11	★★
6	★
4	0

5.65 For Mental Health Trusts, the results were as follows:

15	★★★
38	★★
23	★
7	0

5.66 Overall 51 Acute and Specialist Trusts received an improved performance rating, 79 were unchanged and 41 received a lower rating. Further details of the ratings published in July 2004 can be viewed at the Healthcare Commission website: **www.healthcarecommission.org.uk**

5.67 The Healthcare Commission is the independent regulator of NHS performance and produced the ratings. The Government is responsible for setting health service priorities, which in turn determine the indicators selected by the Healthcare Commission. Other indicators were selected by the Healthcare Commission with advice from the Department of Health to reflect a wide range of performance issues.

2004-05 Performance ratings indicators

5.68 In March 2004, the Healthcare Commission published the key targets which will be used to measure trust performance in 2004-05. The balanced scorecard indicators were published in December 2004. These indicators are available at the Healthcare Commission website: **www.healthcarecommission.org.uk** The Healthcare Commission will publish the 2004-05 ratings results this summer.

Future assessment system

5.69 The current star rating system will change from 2005-06. On February 2005, the Healthcare Commission completed a three-month consultation on a new system for checking the health of NHS organisations. The new system will measure performance against the new healthcare standards set by the Department of Health. This includes domains on safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health. The Healthcare Commission will also measure against use of resources, national targets, some developmental standards, and also take into account the views of other regulators.

NHS Franchising and Register of Expertise

5.70 NHS franchising is a way of introducing new senior management to poorly performing NHS organisations as a means of improving performance.

5.71 The most likely trigger for franchising – relevant in all instances of franchising to date – is a poor outcome from the annual performance 'star' ratings.

5.72 Franchising has only ever been considered and implemented in zero star trusts who were unable to demonstrate their capacity under existing management for sustainable improvements in performance. It has been a last resort for trusts where less direct forms of assistance, support and/or intervention have already failed or are considered unlikely to succeed.

5.73 Six trusts were franchised following the 2001 star ratings, and one trust was franchised following the 2002 star ratings.

5.74 Strategic Health Authorities (SHAs) as the local headquarters of the NHS are responsible for the performance management and improvement of their local NHS organisations. It is for SHAs to decide whether a Trust/PCT needs support to improve and to agree with that organisation what form of support is appropriate.

5.75 The Department of Health has not received any recommendations from SHAs to franchise the management of a trust or PCT following the 2003 and 2004 star ratings.

Legal Powers

5.76 The legal powers that enable the Department to require individual trusts to change their senior management are contained within Section 13 of the Health and Social Care Act 2001. This states that the Secretary of State may make an intervention order if he is not satisfied that an NHS body is performing one or more of its functions adequately or at all, or that there are significant failings in the way that the body is being run. The intervention order would specify the extent to which changes to senior management would have to be made, which would then be brought about through the franchising process.

5.77 However, in all instances of franchising to date, an intervention order has not been necessary as the relevant senior management posts were already vacant at the start of the process.

Patient Prospectus – *your guide to local health services*

5.78 The concept of local NHS organisations producing *Your Guide to Local Health Services*[5.8] (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.

5.79 Every Primary Care Trust (PCT) annually publishes *Your Guide to Local Health Services* to demonstrate that the NHS is acting on information gained from patients and reporting back to the public about the performance of the healthcare providers in their area.

5.80 It contains information about health services across individual PCTs, ranging from how to access primary care to a hospital's star ratings. Improving the quality of information to patients helps them make the right decisions and choice about their own care.

The Healthcare Commission

5.81 The Healthcare Commission was created under the *Health and Social Care (Community Health and Standards) Act 2003*. It has a range of functions and took over some responsibilities from other commissions. The Healthcare Commission:

- has taken over the work of the Commission for Health Improvement, which ceased to exist on 31 March 2004;
- has taken over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on 31 March 2004; and,
- has picked up elements of the Audit Commission's work which relate to efficiency, effectiveness and economy in healthcare.

5.82 In June 2004, the Healthcare Commission published an agreement between the main healthcare, inspection, review and audit bodies in England (including the Audit Commission, the Health and Safety Executive, and the Mental Health Act Commission) aimed at reducing the burden of inspection on frontline healthcare staff. This Concordat commits each organisation to a set of principles which aim to support improvement in health services while minimising disruption and duplication, ensure that information is shared appropriately and encourage joint inspections. Alongside the Concordat, the Commission published a Strategy for Delivery, which set out a series of initiatives and early progress in co-ordinating inspection in health services.

5.83 In November 2004, the Commission published *Assessment for Improvement – Our Approach*[5.9], a consultation document setting out proposals for a new approach to assessing the performance of organisations that provide healthcare in the NHS and independent sector in England. Central to the proposed new approach is the aim of making assessment less of a burden for those being inspected. Nearly 70,000 copies of the consultation document have been distributed. The consultation period ended on 21 February.

Complaints

5.84 Since the end of July 2004, the Commission has also had a role in the NHS complaints system. Complaints not resolved at local level are referred to the Commission for independent review. The Commission estimates it will receive over 7,000 referrals in the first year.

Funding

5.85 In 2004-05, the Healthcare Commission received a grant in aid of £71.5 million. It also derives income from the registration and inspection fees it charges private and voluntary healthcare providers. Fee income in 2004-05 is expected to be over £4 million. Increased fees for 2005-06 were announced in February 2005; the Commission expects to receive about double its 2004-05 income from this source.

The Commission for Social Care Inspection (CSCI)

5.86 The Commission for Social Care Inspection 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 supports whole systems working focussed on user needs, ensuring 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.

5.87 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;
- keeps registers of social care providers, makes information available to the public about these services, and encourages improvements in the quality of registered services, offering guidance and advice to providers;

- collaborates with other relevant Inspectorates to co-ordinate inspections proportionate to risk and relative performance and to ensure joint approaches to integrated services;
- advises Ministers and policy-makers on the impact of policies in local delivery, on appropriate methods for assessment of performance, and on appropriate intervention where councils are failing to provide adequate services; and,
- takes appropriate enforcement action where service providers do not meet minimum standards.

5.88 The Commission operates in an open and transparent way. It seeks to involve the people who use social care services in its activities. It publishes an annual report [5.10] 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.

5.89 It works closely with other bodies involved in quality. Those bodies include the Commission for Healthcare Audit and Inspection, the Audit Commission and other Inspectorates concerned with local service delivery, the Modernisation Agency, the National Institute for Clinical Excellence, the General Social Care Council and the Social Care Institute for Excellence.

5.90 It acts with integrity, providing independent, robust, knowledge-based assessments of the quality and performance of social care bodies, as well as independent and impartial advice to Government.

PAYMENT BY RESULTS
– providing a fair, transparent and rules-based system for paying for care to NHS patients

5.91 The introduction of Payment by Results (PbR) began in earnest on 1 April 2004 when the first NHS Foundation Trusts became early adopters of the new way in which money will flow around the NHS. For all other NHS trusts, 2004-05 was largely a year of preparation with limited use of the tariff.

5.92 During the year, work continued to refine the tariff, taking into account the results of the consultation exercise *Payment by Results: Preparing for 2005* [5.11]. The revised tariff [5.12], applicable in 2005-06, was published in October 2005 and introduced a number of adjustments, for example, specialist services top-ups and long stay adjustments, which will ensure that providers receive adequate funding pending the release of the revised Healthcare Resource Groups (HRGs) which is due in 2008-09.

5.93 By the end of 2004, the NHS had participated in a large scale exercise to establish the difference between the national and local price of the activity which would fall within the scope of PbR in 2005-06.

5.94 In the light of this exercise, the decision was announced, on 10 January 2005, to restrict the scope of PbR for NHS trusts to elective activity only in 2005-06. NHS Foundation Trusts, including those licensed during the year, will however be able to continue with the full scheme. In addition, a number of Strategic Health Authorities will operate full scope PbR in their entire local health economies.

5.95 The overall timetable for implementation remains unchanged however with all trusts beginning to use the full scope of PbR from 1 April 2006 and around 90 per cent of all hospital activity due to be brought within the scheme by 2008-09.

NHS BANK

5.96 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 and across years.

5.97 Its main functions include:

- administration of the special assistance budget providing support to NHS organisations via SHAs in order to support the management of transitional issues;
- 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;
- coordinate 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 2004-05 this includes advising on the distribution of the nGMS Quality and Outcomes Framework (QoF) achievement allocation; and,
- conclude with the Department the review of cash management and liquidity and cash rebasing exercise.

5.98 It should be noted that the establishment of the NHS Bank as a mutual organisation does not dilute or change the overall responsibilities or accountabilities of SHAs to the Permanent Secretary and Chief Executive of the Department of Health.

PUBLIC HEALTH WHITE PAPER
– Choosing health: Making healthier choices easier

5.99 The NHS improvement plan set out the Government's vision for the NHS for the next five years. Importantly, it emphasised how the NHS will become not just a sickness service but a service that places health and wellbeing at its core. *Choosing health* [5.13] aims to make the same systematic improvement in prevention, and makes the promotion of physical and mental wellbeing, and the prevention of illness, priories for the NHS in the 21st century.

5.100 *Choosing health* marks a step change in the action across government and throughout society to tackle the causes of ill health and reduce inequalities. NHS mainstream expenditure will be supplemented by at least £1 billion to develop new public health services over the next three years.

Core principles

5.101 Three core principles underpin the new public health strategy:

- **informed choice:** Government providing support through credible information to allow people to make their own decision about choices that impact on their health;
- **personalisation:** supporting people to make healthy choices, especially for deprived groups and communities; and,
- **working together:** through effective partnerships across communities.

Overarching Priorities

5.102 The strategy has six main priorities:

1. tackling health inequalities;
2. reducing the numbers of people who smoke;
3. tackling obesity;
4. improving sexual health;
5. improving mental health and wellbeing; and,
6. reducing harm and encouraging sensible drinking.

5.103 In addition, action will be taken across government to:

- help children and young people to lead healthy lives; and,
- promote a healthy and active life amongst older people.

5.104 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.

1. Reducing the numbers of people who smoke

Smoking is a major cause of ill-health and health inequalities. The best way people who smoke can reduce the increased risk of heart disease, stroke, cancer and many other fatal diseases, is to give up smoking.

In 2004, the Department agreed a new Public Service Agreement (PSA) target with the Treasury specifically on smoking 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.*

This target is significantly more demanding than the adult prevalence target in *Smoking Kills*[5.14] of 24 per cent overall adult smoking and extends the inequalities target from the *NHS Cancer Plan*[5.15].

Choosing health promises further action and builds on the Government's six-strand tobacco control strategy. Each strand has a measurable impact on reducing smoking prevalence.

We will see:

- the NHS improving the way it helps people to stop smoking and stay stopped;
- boosted national media and education campaigns with partners, building on the highly effective recent anti-smoking advertising;
- smoke-free environments becoming the norm both at work and at leisure;
- proposals to put hard-hitting picture warnings on cigarette packets;
- further restrictions on tobacco advertising;
- tough action on shops that sell cigarettes to children; and,
- further reductions in tobacco smuggling.

2. Reducing obesity

Obesity, both in children and adults, is increasing and poses a real threat to health which can lead to a number of preventable illnesses such as diabetes, heart diseases and cancer later on in life. As part of the *Choosing Health* consultation, we published a separate consultation document *Choosing Health? Choosing a Better Diet*[5.16]. The White Paper sets out a range of measures to tackle the obesity epidemic and support people in living healthier lives by helping them make healthier choices on what they and their children eat. Effective action on diet, nutrition and exercise (see section below on increasing exercise) will help tackle a range of factors critical to health.

Next steps include:

- a new cross-government campaign to raise awareness of the health risks of obesity and the steps that people can take through diet and physical activity to prevent obesity;
- press in Europe for clear and straightforward mandatory information on packaged food, so that people can easily see what they are buying and what they are eating;
- Department of Health and the Food Standards Agency will work with the food industry to increase the availability of healthier food, sensible portions and targeted reductions in fat, salt and sugar, and increasing access to fruit and vegetables;
- introducing interim and long term targets and indicators for reducing sugar and fat levels in different categories of foods, and introducing compliance through surveys and develop guidance on portion sizes to reduce energy, fat and salt intake;
- the Government will work with the food industry to develop by early 2006 a clear straightforward coding system that is in common use and that will enable people to understand at a glance which foods can make a positive contribution to a healthy diet and which recommended to be eaten only in moderation or sparingly;

- implementation of *Choosing a Better Diet: a Food and Health Action Plan*, which will set out action across government, the food industry and others to improve diet and nutrition. This will be backed up by wider action in the forthcoming FSA Strategic Plan. The action plan will also contribute to the Government's strategy for Sustainable Farming and Food;
- a comprehensive strategy for action to restrict all forms of advertising and promotion to children of foods and drinks high in fat, sugar and salt. The Office of Communications will initiate a consultation process on the advertising to children on TV. On non-broadcast media, we will set up a new industry food and drink advertising and promotion forum to review, supplement, strengthen and bring together existing provisions;
- the new Healthy Start Scheme will provide pregnant women and young children in low income families with vouchers that can be exchanged for fresh fruit and vegetables as well as fresh milk and infant formula. The scheme will be supported by an education and training campaign for healthcare professionals so they can offer high quality advice on diet and nutrition and other health issues;
- half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009;
- publication in early 2005, of a Food in Schools package, to support implementation of the whole-school approach to healthy eating;
- improvements in the nutritional standards of school meals;
- all four to six year old children in Local Education Authority maintained infant primary and special schools are now eligible to receive a free piece of fruit or vegetable every school day;
- nutritional standards for the NHS, Prison Service and Ministry of Defence;
- by 2007, the National Institute of Clinical Effectiveness will prepare definitive guidance on prevention, identification, management and treatment of obesity; and,
- produce a weight loss guide that will set out what is known about regimes for losing weight and help people select the approaches that are healthy and most likely to help them lose weight and maintain a more healthy weight.

3. Increasing exercise

In April 2004, we published a report from the Chief Medical Officer, *At least five a week*[5.17] that sets out evidence on the impact of physical activity and its relationship to health. Strong evidence confirms 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 orders or disorders and will have an important impact on tackling obesity (see above section on reducing obesity).

As part of the *Choosing Health?* consultation, we published a separate consultation we published a separate consultation document *Choosing Health? Choosing an Activity*[5.18], which focused upon exercise. The White Paper therefore places a strong emphasis on increasing physical activity. The details of implementing the White Paper commitments and other physical activity programmes were set out in *Choosing Activity: a physical activity action plan*, published in March 2004. Next steps include:

- improvements to parks and public places through the Safer and Stronger Communities Fund;
- increased cycling through the development of new cycle lanes and tracks, enabling more children to walk or cycle to school by linking the National Cycle Networks to school;
- by 2006, all maintained schools will be in a schools sports partnership, with a target of at least 400 sports specialist schools and academies with a sports focus;
- by 2010, building on existing programmes, all schools in England to have active travel plans, helping more children to walk or cycle safely to school;
- build on Local Exercise Action Pilots, investing over the next three years in initiatives to promote physical activity, supported by guidance to promote best practice for local authorities, PCTs and voluntary bodies with regional Physical Activity Coordinators to coordinate delivery of activity interventions and support planning for use of the Fund.
- build on the *Sustainable Travel Towns* pilots to develop guidance for local authorities, PCTs and others on whole-town approaches to shifting from cars to walking, cycling and public transport;
- work with key interests to develop best practice guidelines on providing free swimming and other sport initiatives, for publication in 2005;
- new initiatives to encourage the use of pedometers to promote awareness of the benefits of physical activity among pupils in school and in clinical practice;
- publish a guide for the local NHS and clubs to encourage and foster links with football clubs on improving the health of their local communities; and,
- establish pilots to develop the evidence base for effectiveness on promoting health and wellbeing through the workplace, including innovative approaches to active living.

4. Encouraging and supporting sensible drinking

Choosing health identified alcohol as a priority, as its misuse is associated with deaths from stroke, cancer, liver disease, injury and suicide. Alcohol misuse has also placed a growing burden on the NHS, particularly in A&E and can cause social harm through domestic violence, violent crime and absenteeism. *Choosing health* builds on the commitments in the *Alcohol Harm Reduction Strategy for England*[5.19], which was published in March 2004.

Next steps include:

- work with the Portman Group and other stakeholders to develop a new and strengthened information campaign to tackle the problems of binge drinking;
- working with industry to develop a voluntary social responsibility scheme for alcohol producers and retailers, to protect young people;
- support to Ofcom to strengthen the rules of broadcast advertising of alcohol, particularly to protect the under-18s;
- reviewing the Sensible Drinking Message, focusing on developing a simpler format and one more relevant to the public's day-to-day experiences;
- develop guidance and training to ensure all health professionals are able to identify alcohol problems early;
- from May 2005, the Department will be piloting a programme of targeted screening and brief interventions. The focus will be on the appropriateness in different health care settings. We will also be looking at similar programmes in the Criminal Justice system; and,
- develop a programme for improvement for alcohol treatment services, based on the findings of an audit for and provision of alcohol treatment in England and the Models of Care framework for alcohol treatment.

5. Improving sexual health

Choosing Health outlined new funding to tackle high rates of Sexually Transmitted Infections (STIs) and improve sexual health in England. This will support modernisation of the whole range of NHS sexual health services, to communicate better with people about the risk, offer more accessible services to provide faster and better prevention and treatment, and deliver these services in a different way.

Next steps include:

- by March 2007, a national screening programme for chlamydia will cover all areas of England;
- by 2008 everyone attending a GUM clinic should be able to have an appointment within 48 hours;
- launching a new national campaign targeted particularly at those at greatest risk of STIs or unintended pregnancies;
- undertaking national reviews of both GUM services and contraceptive service provision, backed up with investment to modernise these services; and,
- strengthening local delivery through the inclusion of sexual health in Primary Care Trust's Local Delivery Plans, and the PSA target *to reduce the under-18 conception rate by 50 per cent by 2010 as part of a broader strategy to improve sexual health.*

6. Improving mental health and wellbeing

Transforming the NHS from a sickness to a health service is not just a matter of promoting physical health. Mental health is crucial to good physical health and making healthy choices. Understanding how everyone in the NHS can promote mental wellbeing is equally important. *Choosing health* set out that a coherent approach to promoting mental health needs to work at three levels:

- **strengthening individuals:** increasing emotional resilience through acting to promote self-esteem, and develop life skills such as communicating, negotiating, relationship and parenting;
- **strengthening communities:** increasing social support, inclusion and participation helps to protect mental wellbeing. Tackling the stigma and discrimination associated with mental health will be critical to promoting this increased participation; and,
- **reducing structural barriers to good mental health:** increased access to opportunities like employment that protect mental wellbeing.

Next steps include:

- extending new models of physical healthcare for people with severe mental ill health in Spearhead PCTs;
- developing new approaches to helping people with mental illness manage their own care and make available information for them on all aspects of health, both mental and physical wellbeing;
- developing a programme to take forward the recommendations in Delivering Race Equality: A Framework for Action, which outlined a whole system approach to tackle inequalities experienced by people from black and minority ethnic communities in the mental health system of care;
- the National Institute for Mental Health in England will work with the Disability Rights Commission to challenge discrimination against people with mental health difficulties, and enable more to gain access to employment;
- developing evidence-based guidelines on occupational health, with measures to follow to ensure a consistent approach;
- working with the NHS Employers' Organisation to help ensure that employees are able to return to work as soon as possible following injury or illness;
- developing with partners guidelines on the management of mild to moderate mental ill health in the workplace to be published in 2005; and,
- incorporating health into the Investors in People UK standard.

7. Promoting personal health

Evidence based approaches to marketing (an independent review will be undertaken in 2005) and communications campaigns and telephone, internet and digital television services (Health Direct to be launched in 2007) will provide people with information they can understand and use to improve their health.

Accredited health trainers (starting in 2005 in the areas of greatest needs, and from 2007 progressively across England) will be trained to provide practical advice and support tailored to

individual needs. They will help people to improve their physical and mental health by developing Personal Health Guides, defining the lifestyle changes people want to make. Health trainers will also provide practical advice, support and motivation (for example, on diet, exercise and smoking), helping to reduce stress and its harmful effects on mental and physical health, linking into other sources of help.

New funding will also be provided to enable every PCT, by 2007, to run at least one local Skilled for Health programme each year, a health literacy programme to help improve people's understanding on health issues. Voluntary codes and pledges from industry and employers will help to create a commercial and work environment which makes healthier choices easier and reduces stress. An independent national centre for media and health will be created to hold regular expert briefings by the Chief Medical Officer on a wide range of health related topics, and support an independent regular forum with regional and national media to discuss major health issues.

Developing the workforce

5.105 All NHS professionals and, increasingly, those working in local government and the wider community will develop the skills and confidence to support people as a part of their normal duties in making positive lifestyle choices and will use information and intelligence to target this support where it is most needed. Government will work closely with professional organisations and employers to embed health improvement competencies in training plans and job specifications and to draw people from disadvantaged and under-represented groups into key roles. The health trainer role will offer a new first entry point for flexible career pathways for public health practitioners.

Building in research and development

5.106 The Department of Health will continue to develop the evidence base for public health interventions and use it to improve policy development and commissioning of services. A new public health research initiative will be established, together with the advisory and consultation structures to support it. A public health research consortium will bring together national policy makers and researchers to focus effort on strengthening the evidence base. In addition, a National Prevention Research Initiative is being set up to encourage collaboration between those currently funding research in the fields of cancer, coronary heart disease and diabetes.

Using information and intelligence

5.107 The development of a comprehensive information system will be overseen by a new Health Information Task Force and used to inform the planning, commissioning and delivery of health improvement services and tackling health inequalities. Standard sets of local and regional health information will be compiled by regional Public Health Observatories so that PCT Directors of Public Health can promote and report on health within their area. Guidelines and reviews of cost-effective interventions will be published by the National Institute for Health and Clinical Excellence (NICE) and an innovation fund will be established to test and develop new and better ways of working and to disseminate best practice quickly.

5.108 In addition, action will be taken across Government on:

- **Children and Young People**

  The *Every Child Matters: Change for Children Programme*[5.20] has established a framework for delivering better outcomes for children and young people, including better health. These outcomes depend on the action taken in local change programmes in 150 local authority areas. Local children's trust arrangements will bring partners together to deliver more integrated services. These will be designed to support good parenting and help children to be fit and healthy, physically and mentally. Frontline services such as Sure Start children's centres, healthy schools and extended schools will play a key role. There will be a drive to boost the role of schools in promoting physical and mental health, new Healthy School standards for food and physical activity programmes will be implemented and at least one full time qualified modern school nurse will support each secondary school and cluster of primaries; and,

- **Older People**

  In order to reduce the risk of falls and fractures in old age, and to promote independence and wellbeing, higher levels of activity and exercise in old age will be promoted through national and local plans.

SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS (Chronic Disease Management)

Improving care for people with long-term conditions

5.109 Some 17.5 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.

5.110 *The NHS Improvement Plan*[5.21] 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. The new PSA target will take this forward by improving outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk, and reducing emergency bed days by 5 per cent by 2008, through improved care in primary and community settings.

An NHS and Social Care Model to support local innovation and integration

5.111 Improving care for people with long-term conditions will demand wholesale change in the way health and social care services deliver care.

5.112 *Supporting People with Long-Term Conditions*[5.22], published in January, outlined a new NHS and Social Care Model for the care of people with long-term conditions. It aims to match support with need, providing personalised, yet systematic health and social care to people with chronic conditions.

5.113 The model categorises patients according to their level of need:

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.

Level 2: Disease-specific care management – is for patients who have a complex single need or multiple conditions which require responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways such as the National Service Frameworks and the Quality Outcomes Framework.

Level 3: Case management – is for the most vulnerable people, who have highly complex, multiple long-term conditions and who will benefit from a case manager, typically a community matron, specifically allocated to help anticipate and co-ordinate their health and social care needs.

5.114 Health and social care communities across the country are already beginning to adopt the new NHS and Social Care Model. These organisations are:

- appointing case managers, typically community matrons, and assigning them to the most vulnerable;
- establishing multi-professional teams; and,
- encouraging and supporting people to manage themselves and their condition more effectively.

National Service Framework for Long-term conditions

5.115 Strong general practice, social services, community nursing and hospital outreach services are at the heart of high quality services for patients 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 patients. The NHS and social care are paving the way towards better care and improved lives for patients with long-term conditions. However, more needs to be done to establish a robust, systematic approach.

5.116 There is common ground between the NSF for *Long-term Conditions*[5.23] (and other disease management related NSFs) and the developing long-term conditions strategy, for example around patient centred care planning, information and support, self care and improving the management of specific conditions.

5.117 The NSF for *Long-term Conditions*, published in March 2005, focuses on the significant detail of how to improve services for people with neurological conditions whilst also drawing out some lessons that could be applied to other long-term conditions. The long-term conditions strategy is broader than this and aims to set out the key principles for changing the way services are delivered to people with long-term conditions. In many ways, the NSF trail-blazes the fundamental shift in services that we are aiming to deliver through the broader long-term conditions agenda. However, it is important that the NSF preserves its neurological focus during implementation and maintains its own discrete identity under the umbrella of this broader agenda.

ACTIONS ACHIEVED TO DATE:

ACCESS

Primary Care

5.118 At April 2005 nationally:

- 99.9 per cent of patients were able to be offered a GP appointment within 48 hours or one with a primary care professional appointment within 24 hours.

5.119 These results represent a major improvement over 2003-04. Further details on Access can be found in Chapter 7.

Walk-in Centres

5.120 NHS Walk-in Centres are now an established service providing an alternative means of access to growing numbers of people and complementing general practice and A&E. 64 centres are now established. A further 25 sites are being developed – including seven centres focused on providing a service for commuters. These new centres will bring the total number of NHS Walk-in Centres in England to 89.

Secondary Care

5.121 Figures published for the end of March 2005 show the total number of patients waiting for a hospital operation has fallen by over 84,000 since March 2004. The number waiting over six months has fallen by over 39,300 over the same period. The NHS is on course to deliver the target of no-one waiting more than six months for inpatient treatment by the end of December 2005.

5.122 At the end of March 2005, only 148 patients, for whom English commissioners were responsible, were waiting over 17 weeks for an outpatient appointment, a fall of around 31,000 compared with September 2003.

MORE STAFF IN THE NHS WORKFORCE

– Increase numbers of staff within the service and modernise jobs

Nurses, Scientific, Therapeutic and Technical Staff

5.123 Figures for September 2004 show that since September 1999 there has been an increase of 67,880 nurses and since 1997, there has been an increase of 78,660. Within this increase, the number of nurses working in the community and general practice, delivering more treatment, advice and support to patients either in their homes or as close to them as possible, has increased by 19,780 since 1999 and by 25,115 since 1997. These extra community and general practice nurses are helping to put patient needs at the centre of the NHS. Also within this nursing increase, the number of midwives employed in the NHS has increased by 2,045 since 1999 and 2,460 since 1997.

5.124 Figures for September 2004 show that since September 1999 there has been an increase of 26,490 qualified scientific, therapeutic and technical staff, and 32,585 since 1997.

GPs and Consultants

5.125 Figures for December 2004 show that since September 1999, the number of consultants has increased by 7,540, GPs (excluding retainers, registrars and locums) by 3,330, and GP Registrars by 865. Since September 1997, the number of consultants has increased by 9,390, GPs (excluding retainers, registrars and locums) by 3,750, and GP Registrars by 1,045. Figures for September 2004 show that the number of Registrar Group doctors has increased by 4,140 since 1999 and 4,915 since 1997.

Social Workers

5.126 Figures for September 2004 show that since September 1999 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 15 per cent in the number of full time equivalent social workers for local councils.

Affordable housing for healthcare staff

5.127 Appropriate and affordable housing is a major factor in the recruitment and retention of NHS staff.

5.128 The first dedicated home ownership programme for key workers – the Starter Home Initiative – started in September 2001 and, by the end of October 2004, had helped 3,895 healthcare workers on to the property ladder. That scheme has now finished.

5.129 A new £690 million 'Key Worker Living' programme started on 1 April 2004. It focuses on those delivering frontline public services, such as health workers and teachers, where there are significant recruitment and retention issues. It builds on the foundations of the Starter Home Initiative and extends housing assistance to key workers at different life-stages, not just first time buyers. Within health, staff groups have been prioritised for assistance, with clear emphasis on clinical grades. The response from key workers to the Key Worker Living scheme has been very good. By the end of April 2005, 1,359 health workers had completed or exchanged contracts under Market Purchase Homebuy and a further 461 were at an advanced stage of home purchase. In addition, a further 546 health staff had completed on lettings or sales under the new build element of the programme.

CAPITAL AND CAPACITY

– increase and improve capital and infrastructure within the system

Primary Care

5.130 By 2004, up to £1 billion in total will have been invested to modernise the primary care estate.

5.131 Some 2,850 premises have already been modernised (through substantial refurbishment or replacement with new buildings), helping GPs to provide highest quality services in the highest quality settings. At December 2004:

- some 510 one-stop primary care centres have already brought primary and community services and, where possible, social services and other primary care providers together on one site to make access more convenient for patients;
- 42 areas have started establishing NHS local improvement finance trusts (LIFTs) to use public and private partnership (PPP) principles to support wholesale refurbishment or replacement of primary and community care estate to support delivery of modernised primary care services;
- £35 million of public capital has been targeted on investment in the most under-doctored areas to develop training practices in deprived and most needy communities. This should lead to almost 500 premises being improved to provide accommodation for an extra 550 GP Registrars; and,
- £165 million has been invested in areas where there are no LIFT schemes underway to support investment through traditional capital and general medical/personal medical services funding arrangements as well as joint ventures with the private sector.

HEALTH INEQUALITIES

– improve public health services and reduce level of inequalities in health status

5.132 The Public Service Agreement national health inequalities target is:

By 2010, reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

5.133 Following the publication of the Public Health White Paper *Choosing Health*[5.24], *Tackling Health Inequalities: A Programme for Action*[5.25] remains extant. They both stress the need to ensure that the most marginalised and excluded groups and areas in society see faster improvements in health, through effective prevention and treatment services.

Prevention

5.134 The burden of disease falls most heavily upon the most disadvantaged: death rates from coronary heart disease are nearly twice as high among unskilled and semi-skilled male manual workers than among men in professional and managerial occupations. These premature deaths, and the inequalities that underpin them, can be prevented through action on smoking, diet and physical activity.

Primary Care

5.135 An important element of the Programme for Action is improving access to, and the quality of, primary care services for disadvantaged areas and groups. Action includes:

- enabling 99% of patients (January 2005 figures) 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 Primary Care Trusts (PCTs) (to raise the quality of service), 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, which are at the forefront of new primary care estates development for the first time. Of the five health facilities provided under LIFT that have already opened their doors to patients, one is in East London, three are in Barnsley and one is in Wigan. LIFT allows GPs and other healthcare professionals to relocate from wholly unsuitable premises to modern purpose built ones.

Local Improvement Finance Trusts (LIFT)

5.136 LIFT projects often involve the re-planning of services. GP surgeries may well be provided in the same building as other community health services (e.g. dentistry), hospital outpatient clinics, social services and local authority housing offices. This will enable each of these agencies to work out of modern premises that are conveniently located for patients and clients.

5.137 There are currently 51 LIFT schemes, each providing a series of modern health facilities. As noted, eight health facilities have already opened their doors to patients, and this number is expected to rise to over 50 by the end of 2005.

Contracting Routes

5.138 Since April 2004, four contracting routes have been available to enable PCTs to commission or provide primary medical services. These routes are General Medical Services (nGMS); Personal Medical Services (PMS); which includes, Specialist PMS, Trust-led Medical Services (PCTMS) and Alternative Provider Medical Services (APMS).

5.139 Collectively, these routes give PCTs considerable flexibility to develop services that offer greater patient choice, improved capacity, improved access, and greater responsiveness to the specific needs of the community. All four routes can be used to provide essential, additional, enhanced, and Out of Hours (OOH) services, or a combination of any of these.

5.140 At present about 60 per cent of primary medical services are provided by contracts between PCTs and nGMS practices, and about 40 per cent 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, and with NHS providers through an APMS contract.

CHD & Cancer

5.141 There are marked health inequalities in the incidence of CHD and cancer, and in the survival rates for those who develop these conditions. To address these inequalities, prevention and treatment services must better reflect need.

5.142 One of the purposes of the National Service Framework for Coronary Heart Disease was to establish the same high standards of care across the country, in every healthcare setting, replacing the expectation that quality would vary from place to place.

5.143 In 2004, the national target for reducing premature mortality from heart disease and stroke and related diseases was amended to include a reduction of 40 per cent in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole. Inequalities in the death rate in this area have been narrowing for the last six years and with the new impetus of the Public Health White Paper. We are currently on track to meet our target for 2010. The trend shows a 22 per cent reduction in the absolute gap.

5.144 The systematic care described in the NSF has contributed to this progress, reducing waiting times for treatment by redesigning services and investing in staff, buildings and equipment. As a result there has been a dramatic reduction in waiting times for both diagnosis and treatment, saving patients months of unnecessary worry.

5.145 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 54 per cent compared to about 24 per cent before the NSF.

5.146 More treatment is now being given by paramedics in a pre-hospital setting. In December 2004, 24 out of 31 ambulance trusts had paramedics trained to give thrombolysis. Paramedic thrombolysis now accounts for about 5 per cent of thrombolytic treatments and is increasing rapidly.

5.147 We also know that the increase in the number of coronary revascularisation procedures being carried out is properly targeted. Evidence suggests that the reallocation of revenue within a community can improve equity of access to revascularisation.

5.148 *The NHS Cancer Plan*[5.26] made a commitment to tackle health inequalities. The Department's overall target to reduce cancer mortality was amended in 2004 to include a reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole. We are continuing to invest record amounts of money in new cancer equipment. This is providing faster and more accurate imaging and treatment particularly to patients in areas which have historically had poor access to these services. By implementing NICE guidance the NHS should be able to provide cancer patients with the highest standard of care and treatment regardless of where they live. The section on Cancer at **[paragraph 5.181]** gives more detail on how we are trying to achieve this.

Stopping smoking

5.149 Smoking accounts for most of the variation in life expectancy between areas and population groups. Reducing smoking in manual groups will have a major impact on cancer, CHD and respiratory disease.

5.150 The Department of Health's commitment is to reduce smoking among manual groups from 32 per cent in 1998 to 26 per cent by 2010 to help narrow the health gap between manual and non-manual groups.

5.151 In 2004 the Department agreed a new Public Service Agreement (PSA) target with the Treasury specifically on smoking 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.

5.152 This target is significantly more demanding than the adult prevalence target in 'Smoking Kills' of 24 per cent, overall adult smoking and extends the inequalities target from the NHS Cancer Plan.

5.153 There are strong indications that the NHS Stop Smoking Services (formerly known as the Smoking Cessation Services) are being successful in reaching manual socio-economic groups.

5.154 An important intervention to narrow the gap in infant mortality is to reduce smoking in pregnancy. In the first six months of 2004, 6,746 pregnant women set a quit date through the stop smoking services and 3,312 (49%) had successfully quit based on self-report at the four week follow-up stage.

Teenage Pregnancy/Supporting Teenage Mothers

5.155 Teenage pregnancy is strongly associated with social class and areas of deprivation. Teenage mothers are more likely to have a low birth weight baby and the infant mortality rate for babies of teenage mothers is 60 per cent higher than for babies of older mothers. Teenage mothers are also more likely to suffer post-natal depression, are least likely to breastfeed and are the group most likely to smoke during pregnancy.

5.156 The Teenage Pregnancy Strategy is making progress towards achieving the joint Department of Health (DH)/Department for Education and Skills (DfES) public service agreement target to reduce under-18 conceptions rates by 50 per cent by 2010, within a broader strategy to improve sexual health. Data for 2002, show a reduction in the under-18 conception rate of 9.8 per cent since the 1998 baseline year.

5.157 The new focus of the teenage pregnancy strategy will be on supporting all partners in local areas to intensify delivery of their local strategies in neighbourhoods with the highest under-18 conception rates. Fifty per cent of conceptions occur in the twenty per cent of wards with the highest rates. Areas will also be provided with analysis, such as school attainment and attendance data to help them identify the most vulnerable young people (low attainment/poor attendance are identified as risk factors for early pregnancy, over and above deprivation factors).

5.158 In July 2004, updated guidance was issued to health professionals by the Department on the provision of confidential advice on contraceptive and sexual health services to under-16s, a key action point from the Teenage Pregnancy Strategy Action Plan. The Teenage Pregnancy Unit is also working closely with DH officials on the implementation of the service standards contained in the National Service Framework (NSF) for children, young people and maternity services, and on the commitments relating to young people's sexual health contained in the recently published Public Health White Paper.

Helping 13-15 year-olds to address risk

5.159 The Young People's Development Programme, launched by DH and DfES in February 2004, aims to address risk-taking behaviour especially in relation to reducing teenage pregnancy and substance misuse and improving sexual health amongst 13-15 year olds through 27 pilot schemes in some of the country's most deprived areas. This groundbreaking programme, with £6 million funding over a three-year period, is based on a similar approach in the United States where it has contributed to reductions in teenage pregnancy and builds on existing programmes in England. The programme, which has a structured, developmental, broad-based approach, will be thoroughly evaluated by the University of London Institute of Education's Social Science Research Unit to inform a potential rollout, if it proves successful. The initial findings from the evaluation will be available in spring 2005.

Sexual Health and HIV

5.160 The Public Health White Paper, Choosing Health, has established a new £300 million programme over three years, to modernise and transform sexual health services. Specific commitments include a major new sexual health media campaign; national reviews of both contraceptive service provision and genito-urinary medicine, backed by additional investment to improve services; and the roll-out across the country of a chlamydia screening programme by March 2007.

5.161 To help ensure the necessary action is taken at local level, a requirement has been introduced for sexual health to feature in local delivery plans for the first time. Monitoring of genito-urinary medicine clinic waiting times is now in place, so that we can work towards the goal of all patients being offered an appointment within 48 hours, by 2008.

Screening

5.162 Significant progress has been made in developing screening programmes in England. For example, the Down's syndrome screening programme aims to ensure equitable access around the country and screening is now offered in approximately 95 per cent of maternity units to women of all ages. The Newborn Hearing Screening Programme is now screening 70 per cent of newborns and nearly 750 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.

5.163 A newborn screening programme for sickle cell disorder is being implemented across England. The aim of this programme is to achieve the lowest possible childhood mortality rates and to minimise morbidity from sickle cell disease in childhood. It is estimated that by the end of 2004-05 newborn screening for sickle cell will cover at least 90 per cent of affected births. In the first seven months of screening alone, 103,000 babies have been screened for sickle cell, and 125 babies with the condition have been identified. Antenatal screening for sickle cell disease and thalassaemia is currently being rolled out in high prevalence areas. Low prevalence areas will have developed and implemented antenatal screening by 2006. The aim of the antenatal screening programme is to provide informed choice to couples at risk of an affected pregnancy.

Nutrition

5.164 Establishing healthy eating patterns as early in life as possible, especially among families on low incomes and with reduced access to healthier options, is a high priority for the Department.

5.165 Breastfeeding is the best form of nutrition for infants, as it provides all the nutrients a baby needs for the first six months of life and protects against common childhood infections and diseases. The initiation and duration of breastfeeding by new mothers is particularly low amongst disadvantaged groups, and they are therefore less likely to benefit from positive health benefits.

5.166 Action by the Department of Health to increase breastfeeding rates has included:

- the Priorities and Planning Framework target to increase breastfeeding initiation by 2 per cent a year between 2003 and 2006, focusing on disadvantaged groups;
- new weaning advice; and,
- an Infant and Child Nutrition resource pack that provides advice on diet and nutrition, which was distributed in November 2004 to midwives and health visitors.

5.167 The first of the reforms to the Welfare Food Scheme was introduced in October 2004, with a new application form for eligible pregnant women that has to be signed by a healthcare professional. This provides closer links with the NHS and gives an opportunity for the provision of advice on diet and nutrition, as well as other health issues such as smoking and drinking during pregnancy.

5.168 Further reforms to be implemented from mid-2005 include the phased introduction of the new Healthy Start Scheme that will:

- ensure equal benefits for breastfeeding mothers, compared with mothers using formula feeds; and,
- provide vouchers for pregnant women and young children in low income families that can be exchanged for fresh fruit and vegetables, as well as fresh milk and infant formula.

5.169 We will also be expanding the 5 A Day programme, which has provided better access to, and availability of, fresh fruit and vegetables within 66 disadvantaged communities and to nearly 2 million 4-6 year olds through the School Fruit and Vegetable Scheme (SFVS). In addition to producing resources to support PCTs to deliver the 5 A Day message, we will be expanding the number of schemes and PCTs taking part. We will also consider extending the SFVS to stand-alone LEA maintained nurseries, following the national evaluation of the SFVS which is due to be completed in mid 2005, and will extend the use of the 5 A Day logo to composite fruit and vegetable products and foods targeted at children.

Oral Health

5.170 In June 2004, the first results from the 2003 *National Survey of Child Dental Health*[5.27] were published by the Office for National Statistics. These demonstrated further improvements in the oral health of older children compared with 1993. Twelve-year old children in England now have the best oral health in Europe. There have also been significant improvements in fifteen-year olds as well. Oral health improvement in younger children has, however, slowed down with no significant changes in the levels of dental disease over the last ten years.

5.171 Inequalities in oral health still exist across England. Socially deprived areas in the north of England have twice as much dental decay as compared to the more affluent areas of the north.

5.172 *The Water Act 2003*[5.28] now gives the NHS the power to commission water fluoridation schemes to improve oral health where the local population is in favour. Children from deprived areas where the water is fluoridated have dental health equal to, or better than, children from more affluent areas where there is no fluoridation.

5.173 In areas that do not have fluoridated water supplies, the 'Brushing for Life' scheme encourages young children to use fluoride toothpaste. The scheme was extended in 2003 to all Sure Start areas because of the strong association between tooth decay and economic and social deprivation.

5.174 Mouth cancer is a disease whose incidence is increasing. The Department of Health will be developing a programme to raise the awareness of this disease, which has a high mortality rate if not diagnosed early.

5.175 As part of the delivery plan for the Public Health White Paper 'Choosing Health', an Oral Health Plan will be published in summer 2005. This will support PCTs and dental practices on the most appropriate delivery of local oral health programmes and ways in which dental teams can contribute to other aspects of public health.

Drug Misuse

5.176 The Department remains committed to providing substance misuse services that will ensure all vulnerable young people are protected from harm, enjoy good mental and physical health, and a healthy lifestyle. Action includes:

- working in partnership with the Home Office and the Department for Education and Skills, and others to integrate substance misuse issues among children and young people into government programmes; For instance:
  - implementation of the cross-government young people drug delivery plan *Every Child Matters: Change for Children, Young People and Drugs* which is designed to lead to a systematic shift within children and young people's services towards better integration, early intervention and prevention and improved accountability. It is a coherent package of universal services and high quality targeted interventions to help prevent today's vulnerable young person becoming tomorrow's adult drug misuser and help integrate them fully into society. The joint approach is being implemented nationally with more rapid and sustained progress in 30 high focus areas;
  - the existence of the Young People's Substance Misuse Partnership Grant agreed in April 2004 with the aim of developing appropriate and effective drug intervention programmes for children and young people. The grant total for 2005-06 is approximately £63 million of which the Department of Health will contribute approximately £37 million; and
  - the FRANK campaign, which plays a vital role in delivering the young people's PSA delivery plan, through extra activity in targeted areas and by linking vulnerable young people to support and treatment when they contact the service. Assessment to date indicates that the campaign is already making a significant contribution to all areas of the Government's Drug Strategy, and in particular to the delivery of specific PSA targets.
- continuing to fund community engagement programmes on drug prevention, education and treatment as a means of improving the quality and responsiveness of those services and reducing health inequalities;
- working with the National Institute for Health and Clinical Excellence (NICE) to build and disseminate the evidence base on effective preventive and targeted interventions for substance misuse among young people and children with particular emphasis on those deemed to be vulnerable; and,
- there is also an expansion of the National Healthy School Programme, which sets standards for drug education and provides schools with support on becoming healthier places to work and learn, and developing the evidence base for what works in educating young people about drugs.

Preventing accidental injury

5.177 The Public Health White Paper *Choosing Health – Making Healthy Choices Easier* in its summary of intelligence on accidents, identified the inequalities which exist in accidents:

- there is a strong association between childhood injury and social deprivation, particularly for pedestrian injuries; and,
- men are more likely to die from accidental injury than women. In England, the accidental injury death rate for men is double that for women. For young men (aged 15 to 24), the accidental injury death rate is over 3.5 times that for women in the same age group.

5.178 Secretary of State, has directed that public health resources should initially be focused towards reducing health inequalities. The Public Health White Paper states we are now going to:

- help children and young people start on the right path by working with the charity Smartrisk to assess the effectiveness of their 'Heroes' programme in changing behaviour and what lessons might be applied elsewhere. The programme warns adolescents about the risks of accidental injury and explains how they can avoid such risks; and,
- help local communities lead for health by commissioning 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.

Health Services for Prisoners

5.179 Responsibility for health services delivered within prisons is transferring over to PCTs from April 2006. Health

Partnerships are working closely with the Prison Service to ensure that the transfer of responsibility is seamless from April 2006.

5.180 The establishment of the National Offender Management Service (NOMS) in the Home Office offers opportunities for broadening the scope of the work programme beyond prisons to address the wider health interfaces with the criminal justice system. These range from working to reduce potential offending to the rehabilitation of existing offenders and the reduction of their rates of re-offending. A new joint unit has been set up between the Department of Health and NOMS to develop this work, including:

- improvements in mental illness, substance misuse and communicable disease services;
- diversion in the courts;
- the policy and systems oversight for high security hospital services; and,
- development of services for people with dangerous and severe personality disorder.

CANCER

– Improve care of patients with cancer and reduce mortality and morbidity from cancer.

5.181 *The NHS Cancer Plan* was published on 27 September 2000. It is a long term, national strategy to prevent, diagnose and treat cancer; to reform the way cancer services are delivered; to standardise care and improve patient experience; to co-ordinate research and to invest in equipment and the cancer workforce.

5.182 The Department published *The NHS Cancer Plan and the New NHS*[5.29] in October 2004. This sets out progress made since the Cancer Plan was published, as well as showing how cancer fits in the changing NHS.

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

- a 12 per cent reduction in cancer mortality in the under-75s since 1997;
- survival rates for the major cancers are improving across the board;
- over 99 per cent of patients urgently referred by their GP with suspected cancer, are seen by a specialist within two weeks;
- nearly 98 per cent of women with breast cancer received their first treatment within one month of the diagnosis being made, and over 96 per cent received their first treatment within two months of being urgently referred by their GP;
- the establishment of specialist cancer multidisciplinary teams, an important element in delivering improved patient centred treatment and better patient outcomes;
- integrated cancer care pilots have commenced to improve co-ordination between primary and secondary care;
- the appointment of an additional 1,060 cancer consultants since 1999, as well as an extra 2,368 consultants in specialties, that spend a lot of time looking after cancer patients; and,
- the proportion of people entering clinical trials for the latest cancer treatments and drugs continues to rise, and the National Cancer Research Institute has announced major new initiatives on research into prevention and supportive and palliative care.

Prevention

5.184 Smoking is the leading single cause of avoidable ill health and death. It kills 106,000 every year – one in five of all deaths – 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 linked to physical inactivity. The section on *Prevention of Ill Health* at paragraph 5.230 gives details of how the Department's work in these areas contributes to reducing the incidence of cancer.

Breast Screening

5.185 By December 2004, 77 per cent of breast screening units had started inviting women aged 65-70 as part of the expansion NHS Breast Screening Programme. Since the age extension began in April 2001, over 300,000 more women have been invited for breast screening. We expect all units to have implemented the age extension by April 2005. In addition, over 95 per cent of units had started taking two-view mammography images. These two changes to the programme represent a 40 per cent increase in the workload of the programme.

5.186 Statistics published in February 2005 showed that 14 per cent more cancers were detected between 2002-03 and 2003-04 (a 31 per cent increase in the two years since 2001-02). This has been attributed largely to the introduction of two-view mammography and the emerging effects of the age extension.

Cervical Screening

5.187 The Department is investing £7.2 million in the national roll out of Liquid Based Cytology (LBC) as part of the modernisation of the NHS Cervical Screening Programme. LBC 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.

5.188 The retraining of staff and installation of new equipment is a major undertaking, and we expect full implementation will take five years. We are starting by converting the nine regional cytology training schools in England, which will then be able to train the rest of the programme.

NHS Bowel Cancer Programme

5.189 Bowel cancer is the second largest cancer killer in England, accounting for over 13,000 deaths per annum. There is strong evidence that some of these deaths could be prevented by earlier diagnoses and treatment of patients who present with symptoms.

5.190 Secretary of State announced, in October 2004, that a national screening programme for bowel cancer will be rolled out across England from April 2006. This will be the first cancer screening programme for both men and women in the UK, and the first of its kind in Europe. The screening programme is expected to reduce the death rate in those screened by around 15 per cent.

5.191 A planning framework has been developed to address issues of call/recall, laboratory provision, screening centres, endoscopy capacity, quality assurance and links to the national programme for IT.

5.192 The Department of Health is continuing with the assistance of key stakeholders from the voluntary sector, patient groups and the NHS to address issues around speeding up the diagnosis of bowel cancer, improving treatment, better patient information and the development and expansion of the bowel cancer endoscopy workforce.

NHS Prostate Cancer Programme

5.193 The Department, on behalf of the Prostate Cancer Advisory Group, published *Making Progress on Prostate Cancer*[5.30] in November 2004. The report details progress made since the NHS Prostate Cancer Programme was launched in September 2000. It also sets out the challenges ahead for the most commonly diagnosed cancer in men in England and the second biggest killer of men. The report details progress on:

- the Prostate Cancer Risk Management Programme – helping men make an informed choice about being tested for prostate cancer;
- public awareness – improving knowledge of prostate cancer in the general public, including key messages on prostate cancer now agreed by 20 key stakeholder organisations;
- information for prostate cancer patients, empowering men to make the right decision for them on treatment for prostate cancer;
- improving access to services – over 99 per cent of people with suspected urological cancers (including prostate) are seen within two weeks of being urgently referred by their GP;
- building capacity – 30 per cent more urologists since 1999; and,
- continued investment in research such as ProtecT, which is a major programme looking at prostate cancer screening and treatment, and the PROCESS study, which is looking at the disease in men from ethnic minority groups.

Cancer Waiting Times

5.194 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 achieved by 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.

5.195 Achieving these targets will be a major challenge, for PCTs and acute trusts. To help them meet this challenge, a National Cancer Waits Project has been established. Building on the successful approach adopted to reduce waits in Accident and Emergency departments and waits for elective orthopaedic surgery, this approach has four key strands:

- increased focus on the issue in the NHS and engaging the support of Royal Colleges and relevant professional bodies;
- implementing best practice, e.g. lessons learnt through the Cancer Services Collaborative Improvement Partnership;
- robust performance management; and,
- targeted support for the NHS, e.g. for patients with bowel and urological cancers where waits tend to be longest.

Cancer treatment

5.196 Improving Outcomes guidance is now available on eight tumour groups (breast, colorectal, lung, gynaecological, upper gastrointestinal, urological, haematological cancers, and head and neck cancers) as well as adult supportive and palliative care. Guidance addressing four further groups of cancers (sarcoma, skin and brain cancers as well as cancers affecting children and young people) will be published by NICE during 2005 and 2006.

5.197 Each of the NICE guidance reports emphasises that Multi Disciplinary Team (MDT) working is vital if we are to continue improving the overall experience of cancer patients. MDTs lead to improved communication between professionals involved, and patients are, therefore, more likely to receive better continuity and co-ordination of care through all stages of their disease and better advice on appropriate treatment. A survey by Dr Foster to inform their *Good Hospital Guide 2004*[5.31] indicated that 100 per cent of breast cancer patients, 97 per cent of lung cancer patients, 94 per cent of upper GI cancer patients and 99 per cent of bowel cancer patients are now being cared for by MDTs.

5.198 Sixteen cancer drugs have been appraised by NICE and a further eleven appraisals are in progress or planned. These will address treatments for early breast cancer, lung cancer, gastrointestinal stomal tumours, colorectal cancer, head and neck cancers, mesothelioma, ovarian cancer, prostate cancer and cancer treatment-induced anaemia.

5.199 The National Cancer Director published a report [5.32] in June 2004 that 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, including:

- development of a capacity planning model for chemotherapy to support the NHS in assessing the local impact of implementing NICE guidance; and,
- improving data collection on the take up of NICE approved drugs by bringing forward the electronic prescribing module of the National Programme for Information Technology.

5.200 The Department issued a revised Manual for Cancer Services to the NHS in July 2004. It sets out the characteristics of a good cancer service based on the recommendations of NICE and other guidance. The intention is to help those planning, commissioning and organising cancer services to ensure the quality and appropriateness of existing services, and identify gaps through a process of self-assessment and peer review. A new three-year rolling programme of cancer peer review started in November 2004.

Lung Cancer

5.201 The Lung Cancer Advisory Group, established in November 2003, has identified three key strands of work for the coming year: Awareness and Early Diagnosis of Lung Cancer; the Lung Cancer Workforce; and Mesothelioma (a cancer of the lining of the lung, often associated with asbestos exposure). Three subgroups are considering how best to take these issues forward.

Supportive and Palliative Care Strategy

5.202 The Health Select Committee inquiry into palliative care during 2004 reviewed palliative care services and helped raise the profile of this important area of health care. Although more remains to be done, Government action in the past few years has been unprecedented.

5.203 *Building on the Best: Choice Responsiveness and Equity in the NHS*[5.33] firmly commits the Department to tackle inequalities in palliative care provision. This was one of the key objectives underlying the £12 million End of Life Care programme. This will take forward training for staff working in general practices, care homes and on hospital wards so that all adult patients nearing the end of life, regardless of their diagnosis, will have access to high quality palliative care and so be able to choose where they are cared for.

5.204 Tackling inequalities was also one of the key objectives underlying the NHS Cancer Plan commitment to invest an additional £50 million per annum in specialist palliative care by 2004. This commitment has been met. Analysis shows that over half of the £45.8 million reported on so far has gone to voluntary sector organisations, mostly to hospices. The extra money has so far funded 28 additional consultants in palliative medicine, 133 new clinical nurse specialists and 38 new specialist palliative care beds. The £50 million is a significant boost to NHS funding for specialist palliative care for adults with cancer, an increase of almost 40 per cent above 2000 levels.

5.205 Other important developments during 2004 included:

- the publication of the National Institute for Clinical Excellence's Supportive and Palliative Care Guidance. Cancer networks are developing action plans to ensure this is implemented. The guidance will also benefit non-cancer patients;
- the conclusion of the successful £6 million, three-year programme to train 10,000 district and community nurses in the principles and practice of palliative care, training which will benefit patients with cancer and also non-cancer; and,
- the investment of £6 million over two years in a series of Integrated Cancer Care Pilots, which will develop and deliver a model to help patients get the best quality of care possible and to find out the most effective ways to use resources. The principles of patient choice will be applied so that people can make positive decisions to suit their personal circumstances.

Cancer Workforce and Training

5.206 Underpinning all the work in cancer is having the right amounts of trained staff in place. A cancer care group workforce team has been established to oversee specific programmes to address workforce shortages. A number of projects within endoscopy, histopathology, radiology and improved treatment are already well underway.

5.207 A new national training programme for colorectal cancer has been designed as part of the NHS Bowel Cancer Programme. This training is not just for surgeons dealing with colorectal cancer patients, but also for radiologists, pathologists, oncologists and nurse specialists. Together, members of the team will 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.

5.208 Also as part of the NHS Bowel Cancer Programme, more than £6 million over three years was committed in 2003 to expand endoscopy training capacity further. As a result, three national and seven regional training centres 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, reduce waiting times and make services more convenient, and will facilitate the introduction of a national bowel cancer screening programme.

5.209 Funding has also been made available for the development of a national training programme 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.

5.210 The Care Group has also commissioned Skills for Health to develop competency frameworks 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.

Cancer Equipment

5.211 The Department of Health has provided major investment to increase machine capacity and replace ageing equipment to ensure that patients have better access to diagnostic scanning and radiotherapy services. The equipment is being provided where it is needed most. For example:

- two out of every three linear accelerators have been allocated to cancer centres in the north of England to continue to redress the historic north/south divide; and,
- additional CT and MRI scanners have been provided to local populations which have had poorer access.

5.212 As a result of this investment, capacity has increased as follows:

- new and replacement cancer equipment delivered through central programmes includes, as at 14 April 2005, 193 CT scanners, 102 MRI scanners, 101 linear accelerators and over 700 items of breast screening equipment, all delivered since April 2000. This means that 72 per cent of CT, 60 per cent of MRI and 62 per cent of linear accelerators now in use in the NHS are new since January 2000. A further 18 CT and 10 MRI scanners, and 7 linear accelerators are due to be installed later in 2005;
- the NHS has a stock of CT and MRI scanners as modern as any country in Europe;
- the new diagnostic scanning equipment provides higher quality images and faster scanning for patients; and,
- the new linear accelerators provide the latest treatment techniques, for example 3D conformal therapy and intensity modulated radiation therapy.

5.213 The table below shows numbers of pieces of equipment available in the NHS in 1997, January 2000 and January 2005:

Equipment Type	Installed base in 1997	Installed base as at Jan 2000	Installed base as at Jan 2005
CT	200	285	345
LINACS	140	152	198
MRI	110	182	247

Positron Emission Tomography

5.214 A draft consultation document setting out the introduction and development of Positron Emission Tomography (PET) scanning in the NHS was issued in July 2004. This gives advice to commissioners on the benefits of PET scanning; number of scanners likely to be needed; workforce and training issues; capital and revenue costs and further research and evaluation.

5.215 We have considered the responses to the public consultation, and a revised framework will be issued later in 2005.

ON THE GROUND – EXAMPLES OF SERVICE IMPROVEMENT

Due to poor room utilisation and scheduling of appointments, patients attending Plymouth's ultrasound department were waiting up to 64 weeks for their scans.

However, through implementing a booking system, a reminder service to reduce the amount of patients that didn't attend appointments, and arranging ultrasound scanning appointment slots from 30 to 20 minutes, waiting times dropped significantly to a two week wait for most ultrasounds.

The outpatient process at The Royal Bournemouth NHS Acute Trust for patients with Haematuria has been redesigned to provide patients with suspected cancer, a fully co-ordinated One-Stop Haematuria Clinic appointment. Before redesign, patients had to visit the clinic up to four times and had to wait up to sixteen weeks for definitive treatment to commence. Now the patient's GP can fax referrals to Royal Bournemouth and the patient is contacted within 48 hours to mutually agree a date to attend the clinic. The patient attends the One-Stop Clinic for one appointment only. Ultrasound and Cystoscopy are performed and results are given on same day. This redesign has reduced the pathway to diagnosis from 112 days to 14 days. This affects approximately 750 patients per annum.

The lead lung consultant at West Sussex Health Care NHS Trust has piloted and implemented a one-stop clinic for suspected lung cancer patients. Previously, suspected lung cancer patients made a separate visit to the hospital, on average nine days after their first appointment for bronchoscopy, and often had a further wait if CT was needed. Now patients are given the option to have bronchoscopy and/or CT at this first outpatient appointment with a follow-up appointment usually within a week. This new clinic has reduced the waiting times from nine days down to zero days.

Patients attending the Nurse Led Haematuria clinics at Stockport NHS Trust can now receive an ultrasound scan on the day of their first appointment with the specialist team. Through reducing the number of steps and visits the patient has to make to the hospital by implementing same day investigations, the trust has reduced their waiting times in this area from five weeks to one day.

CORONARY HEART DISEASE

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

Prevention

5.216 The section on Prevention of Ill Health at paragraph 5.230 gives details of how the Department's work will contribute to reducing the incidence of CHD.

In Primary Care

5.217 Primary care has a major role to play in both primary and secondary prevention of heart disease and in the management of CHD and heart failure as long-term conditions. Systematic care can help patients to manage their own conditions, to keep them out of hospital and to improve their health outcomes.

5.218 All of these aspects are addressed in the new GMS contract. The Quality and Outcomes Framework includes a range of Quality Indicators (QIs) for CHD and heart failure, totalling 121 potential points, and reflecting the Planning and Priorities Framework targets for these conditions. Underpinned by disease

registers, these QIs emphasise the importance of regular review and control of key risks such as cholesterol and blood pressure.

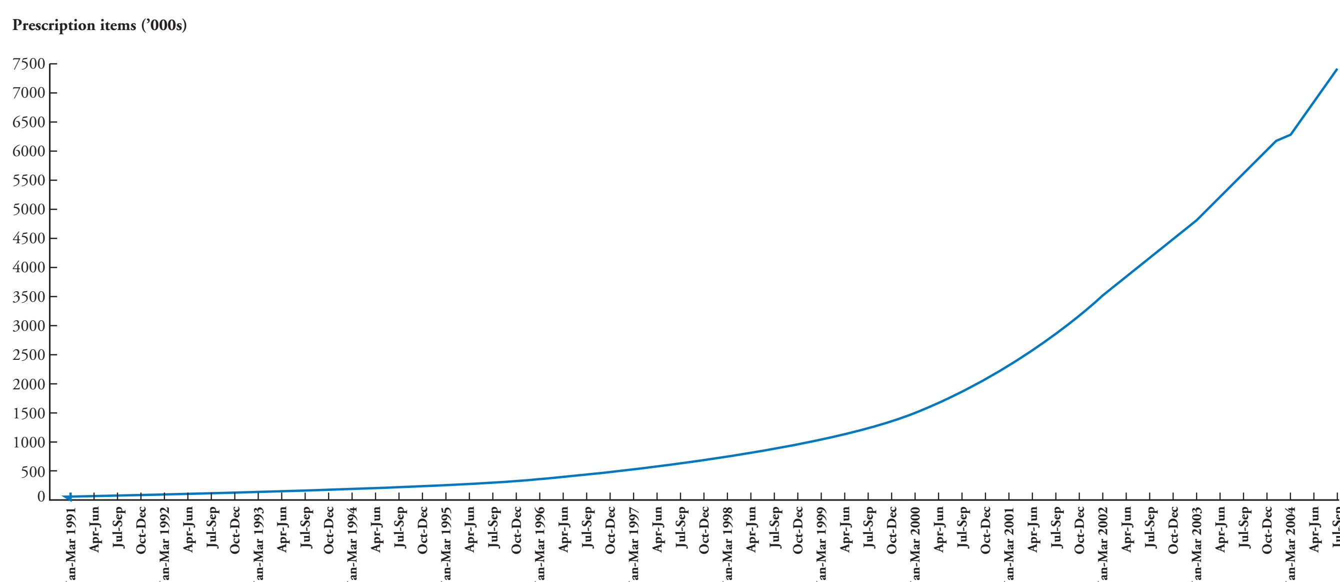
5.219 Quality Management and Analysis System (QMAS) and Quality, Prevalence and Indicator Database (QPID) data will provide the detail of the impact at practice level. In the meantime prescribing data show that, for example, prescribing on statins, which lowers cholesterol levels, continues to rise at 30 per cent per year. We estimate that the NHS will spend about three-quarters of a billion pounds on statins in 2004, benefiting approximately two and a half million patients, saving an estimated 9,000 lives and preventing heart attacks.

Clot-busting drugs

5.222 The National Service Framework goal is that eligible heart attack patients should receive clot-busting drug treatment (thrombolysis) within 60 minutes of calling for help. There has been consistent and sustained improvement in the faster delivery of clot-busting drugs to heart attack patients since the NSF was published in 2000.

5.223 In 2004, over 80 per cent of heart attack victims received thrombolysis within 30 minutes of arriving at hospital, compared to only 38 per cent in March 2000. At the end of 2004, the proportion of patients receiving treatment within 60 minutes of calling for professional help was 54 per cent, compared to 24 per cent in 2000. An increasing number of patients are receiving thrombolysis before they arrive in hospital. 1,659 patients to date have received clot-busting drugs administered by ambulance service paramedics.

Figure 5.1: Total Number of Statins Prescription Items Prescribed and Dispensed in the Community, in England, since January 1991



In Emergency Care

5.220 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 re-training) of volunteers and for maintaining the equipment in the sites where the AEDs have been installed. Up to May 2005, evidence suggests that 58 lives have been saved through the work of this programme.

5.221 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 of Health is responsible for delivering the programme in light of experience gained to date.

Rapid Access Chest Pain Clinics

5.224 The roll out of Rapid Access Chest Pain Clinics (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. Most recent data showed 92.6 per cent of patients were seen within 14 days of referral.

Angiograms

5.225 In 2003-04, over 124,000 angiograms were carried out in the NHS compared to only 74,000 in 1995-96. Currently, over 95 per cent of patients waiting for an angiogram are seen within six months. The NHS is set to increase this to 100 per cent by the end of 2005.

Heart Operations

5.226 In 2003-04, the NHS performed nearly 62,000 coronary revascularisations (a collective term for coronary bypass operations and angioplasty procedures), over 21,000 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 time of diagnosis.

Figure 5.2: Trend in Number of Heart Procedures

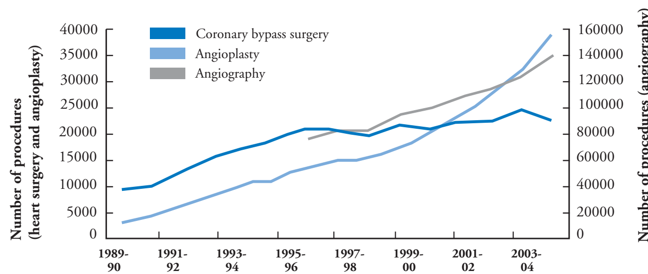


Figure 5.3: Trend in Number of People Waiting More Than 6 Months for Heart Treatment

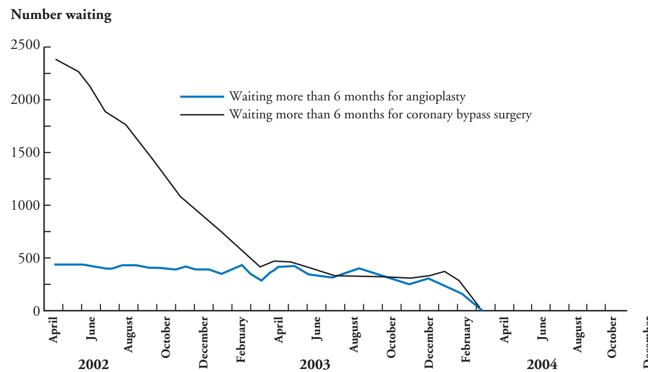


Figure 5.4: Trend in Number of People Waiting for Heart Treatment

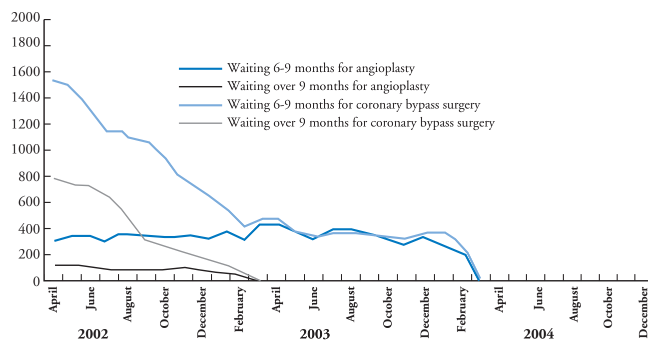
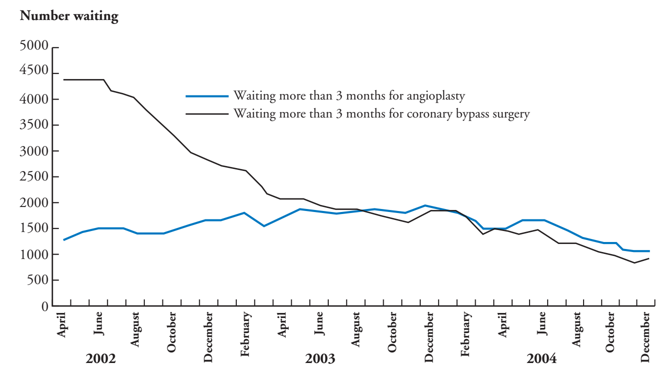


Figure 5.5: Trend in Number of People Waiting More Than 3 Months for Heart Treatment



Recruitment and retention of staff

5.227 The Department of Health 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 is under development. The first part of the competency framework covering prevention, heart failure and rehabilitation was launched on 11 November 2003.

Long-term investment

5.228 There has been continued long-term investment in the capital infrastructure needed to support further expansion of 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 and Somerset and Newcastle were announced in March 2004. The total cost of these developments is £600 million.

5.229 In 2002, the New Opportunities Fund announced £110 million funding for coronary heart disease, of which £65 million 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 89 labs to be installed, which will speed up diagnosis significantly for patients with suspected heart disease.

PREVENTION OF ILL HEALTH

Physical Activity

5.230 The Chief Medical Officer's report on the impact of physical activity and its relationship to health, published in June 2004[5.34], presents strong evidence for the many potential health benefits from being active, including a lower risk of coronary heart disease, stroke, type 2 diabetes and certain types of cancer.

5.231 The details of implementing the White Paper commitments and other physical activity programmes were set out in *Choosing Activity: a physical activity action plan*[5.35], published in March. Next steps include:

- improvements to parks and public places through the Safer and Stronger Communities Fund;
- increased cycling through the development of new cycle lanes and tracks, enabling more children to walk or cycle to school by linking the National Cycle Networks to school;
- by 2006, all maintained schools will be in a schools sports partnership, with a target of at least 400 sports specialist schools and academies with a sports focus;
- by 2010, building on existing programmes, all schools in England to have active travel plans, helping more children to walk or cycle safely to school;
- build on Local Exercise Active Pilots, investing over the next three years in initiatives to promote physical activity, supported by guidance to promote best practice for local authorities, PCTs and voluntary bodies with regional Physical Activity Coordinators to coordinate delivery of activity interventions and support planning for use of the Fund;
- build on the *Sustainable Travel Towns* pilots to develop guidance for local authorities, PCTs and others on whole-town approaches to shifting from cars to walking, cycling and public transport;
- work with key interests to develop best practice guidelines on providing free swimming and other sport intiatives, for publication in 2005;
- new initiatives to encourage the use of pedometers to promote awareness of the benefits of physical activity among pupils in school and in clinical practice;
- publish a guide for the local NHS and clubs to encourage and foster links with football clubs on improving the health of their local communities; and,
- establish pilots to develop the evidence base for effectiveness on promoting health and wellbeing through the workplace, including innovative approaches to active living.

Smoking

5.232 During the period April 2004 to December 2004, around 313,100 people set a quit date through the NHS Stop Smoking Services, and around 170,600 (54 per cent) were successful at the four-week follow-up. This compares with 116,200 in the same period in 2002-03 an increase of 47 per cent.

5.233 During the same period, 10,239 pregnant women set a quit date through the Services and 5,100 (50 per cent) had successfully quit at the four-week follow-up.

5.234 The NHS Stop Smoking Services are part of a comprehensive six-strand tobacco control strategy, each strand has a measurable impact on reducing smoking prevalence. The Department of Health has substantially increased its media and education campaigns with an all year-round presence on TV. In addition, the Department of Health has supported both Cancer Research UK and the British Heart Foundation on new, hard-hitting anti-smoking campaigns. These campaigns have now become the main reason why smokers said they tried to quit in 2004.

5.235 *The Tobacco Advertising and Promotion Act 2002*[5.36] came into force on 14 February 2003, bringing to an end newspaper, billboard and magazine advertising, in-pack promotions, direct marketing and almost all tobacco sponsorship. Regulations greatly restricting point of sale advertising came into force on 21 December 2004. Regulations prohibiting tobacco brand sharing will come into force in July 2005, as will prohibitions on sponsorship. Since September 2003, misleading terms like 'light', 'mild' and 'low tar' were removed from cigarette packs and from other tobacco products from September 2004. Bigger and more direct health warnings, such as 'smokers die younger', have been compulsory on cigarette packs from September 2003 and on all tobacco products from September 2004.

5.236 In 2005, The Department of Health will consult on introducing hard-hitting picture warnings on tobacco products.

5.237 On 16 December 2004, the Government ratified the WHO Framework Convention on Tobacco Control (FCTC), which is the first ever global health treaty. It provides the basic tools for countries to enact comprehensive tobacco control legislation. The FCTC came into force on 27 February 2005.

5.238 On 16 November 2004, the Government published the White Paper *Choosing Health: Making Healthier Choices Easier*, proposing radical action to tackle tobacco:

- the NHS improving the way it helps people to stop smoking and stay stopped;
- smoke-free environments becoming the norm both at work and at leisure;
- proposals to put hard-hitting picture warnings on cigarette packets;
- further restrictions on tobacco advertising;
- tough action on shops that sell cigarettes to children; and,
- further reductions in tobacco smuggling.

5.239 *Choosing Health* also sets out proposals for legislation, in England, to shift the balance significantly in favour of smoke-free environments. The timetable is:

- all Government departments and the NHS will be smoke-free by end 2006;

- enclosed public places and workplaces smoke-free by end 2007, other than licensed premises (and those specifically exempted); and,
- for licensed premises, arrangements in place by end 2008 making those that prepare and serve food smoke-free.

Obesity

5.240 *The NHS Improvement Plan: Putting People at the Heart of Public Services* (2004)[5.37] shows how the NHS will, in partnership with other organisations, make further in-roads into levels of obesity and other major causes of disease.

5.241 Reducing obesity is one of the six overarching priorities of the *Choosing Health* White Paper published in November 2004. In March 2005, we published *Delivering Choosing Health: Making Healthier Choices Easier, Choosing a Better Diet: a Food and Health Action Plan and Choosing Activity: a Physical Activity Action Plan*. These set out how the commitments will be delivered and how they will contribute to the delivery of the PSA target announced in July 2004 (jointly owned by DH, DfES and DCMS):
"halting the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole".

5.242 The development of the public health workforce is a key long-term issue. As a first step, £3 million has been allocated to PCTs over 2004-06 to fund training for healthcare professionals in obesity prevention and management.

Nutrition

Choosing a Better Diet: a food and health action plan

5.243 In *Choosing Health*, published in November 2004, the Government set out its programme of work to improve nutrition and health in England, with a focus on tackling obesity, particularly among children. *Choosing a Better Diet: a Food and Health Action Plan,* published in March 2005, will summarise how we will deliver that programme and also contribute to the Government's Sustainable Farming and Food Strategy, in which the commitment to a food and health action plan was first made. *Choosing a Better Diet: a Food and Health Action Plan* presents the action that the Government will take across a wide range of areas, including:

– **healthy eating in a consumer society** and how information can be improved to enable healthier choices;

– encouraging healthy eating behaviours in **children and young people**, including improving diet and nutrition in schools;

– promoting opportunities for **healthy eating in the communities** where we live;

– ensuring that the **NHS promotes healthy eating** in all aspects of its work;

– promoting opportunities for **healthy eating in the workplace** and ensuring that the public sector leads by example; and,

– **working with the food industry** to increase the availability of, and access to, healthier foods.

Healthy start and breastfeeding promotion

5.244 Government proposals for the new Healthy Start scheme, which will replace the current Welfare Food Scheme, were published in February 2004. The first stage of reform of the Welfare Food Scheme was the introduction of a new application form for pregnant women, introduced in October 2004. Consultation on the draft Regulations for Phase 1 of Healthy Start began in February 2005. Phase 1 is due to begin mid-2005, with national rollout in Spring 2006. The new scheme will allow beneficiaries to exchange their vouchers for fresh fruit and vegetables, as well as fresh milk and infant formula, and will equalise benefits for breastfeeding and non-breastfeeding women. A communications and training programme for beneficiaries and health professionals will be introduced in parallel to the scheme.

5.245 To support the new scheme, an Infant and Child Nutrition Resource Pack was published in November 2004 and distributed to all midwives and health visitors. This is part of an overall communications strategy to meet the NHS Plan and White Paper commitments to support breastfeeding. The Department is reviewing the Infant Formula and Follow-on Formula Regulations with a view to further restricting the promotion of follow-on formula and will be pressing for amendments to the EU Directive on infant formula and follow-on formula.

5 A Day including school fruit and vegetable scheme

5.246 The New Opportunities Fund (now the Big Lottery Fund) made £10 million available to support the establishment of 66 local 5 A Day community initiatives, led by Primary Care Trusts, to increase access to, and availability of, fruit and vegetables within disadvantaged communities (reaching over six million people). *Choosing Health* made a commitment to extend the number of schemes and PCTs involved from April 2006, following evaluation of the 66 community initiatives, due to be completed in December 2005. We will also be launching new resources for those working in PCTs to deliver the 5 A Day message.

5.247 The 5 A Day logo is now licensed with over 450 organisations. We will extend the use of the 5 A Day logo to composite fruit and vegetable products, and foods targeted at children. The nutritional criteria to be used is due to be completed in autumn 2005. We are also considering ways to simplify the 5 A Day messages for children and adults – for example, 'using a handful'

5.248 The national roll out of the School Fruit and Vegetable Scheme was completed in November 2004. Nearly two million 4-6 year olds, in over 16,100 schools, are now receiving a free piece of fruit or vegetable every day. The Department of Health committed £77 million for the period April 2004-March 2006 to roll out and maintain the scheme. We will consider extending the scheme to stand-alone LEA maintained nurseries, following completion of the national evaluation of the scheme, due to be

completed in mid 2005. A survey of the School Fruit and Vegetable Scheme in October 2004 found that over a quarter of children and their families reported that they were eating more fruit at home after joining the scheme, rising to nearly a third for social class C2DE.

Food in schools and school meals

5.249 Following successful pilots carried out in over 300 schools in 2004, a comprehensive Food in Schools Toolkit is now available from local healthy schools coordinators or at **www.foodinschools.org**. The Toolkit provides guidance and resources for helping schools become healthy schools by promoting good practice through the day in breakfast clubs, tuck shops, vending machines, lunch boxes and cookery clubs, as well as through water provision, growing clubs and the dining room environment. This resource is being fully integrated into the joint DH / DfES Healthy Schools Programme.

5.250 An evaluation of secondary school meals, carried out in late 2004, found that although in most cases healthy food was on offer, children frequently selected options high in fat, salt and sugar. The DH is now working alongside DfES and FSA to make improvements to the nutrition of school meals, by revising school meals standards, and is strongly considering the introduction of nutrient-based standards. We will also consider extending the new standards, subject to legislation, to cover food across the school day.

Food promotion/advertising to children

5.251 *Choosing Health* set out our commitment to having in place a comprehensive approach to restrict further the advertising and promotion to children of those foods and drinks high in fat, salt and sugar. We will look to Ofcom to consult on proposals to tighten rules on broadcast advertising, sponsorship and promotion of food and drink. We will work with industry, advertisers, consumer groups and other stakeholders to encourage new measures to strengthen existing voluntary codes in non-broadcast areas and will establish a new Food and Drink Advertising Promotion Forum to review, supplement, strengthen and bring together existing provisions. The Government will 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 early 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.

Salt

5.252 We are working with the Food Standards Agency and industry to reduce the salt content in prepared and processed foods. We asked all stakeholders to produce action plans in November 2003 and commitments to salt reduction have now been obtained from 65 organisations. An action plan has been developed to take forward the work on salt, which includes the formation of a small stakeholder group to discuss the establishment of interim targets for key categories and a five-year framework for self reporting. In keeping with the White Paper commitment to work with the food industry to increase the range of healthier foods, this work will now be extended to include reformulating processed foods to reduce fat and sugar.

Public procurement

5.253 Building on the work of DEfRA's sustainable procurement initiative and best practice, the Department will work with stakeholders on a new working group to develop and implement nutritional standards for all foods procured by the National Health Service, the Armed Forces and HM Prisons. Government will promote the agreed procurement standards to the private sector.

OLDER PEOPLE'S SERVICES

– improve the care provided to older people

5.254 The Older People's Public Service Agreement for 2003-2006 is to: *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.* This target was reached in March 2004, when the number of households receiving intensive home care was 30.1 per cent of the total number of older people being supported at home and in care homes. There was an increase of 5,700 homes receiving intensive home care, compared to March 2003, and the target was reached two years before the target date.

5.255 The new PSA target, agreed as part of the Spending Review 2004, takes this further by including a target not just to shift the emphasis of where support is provided, but also to increase the total numbers of those supported to live at home. The target is to 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 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 at home or in residential care.

The National Service Framework (NSF) for Older People

5.256 Most of the infrastructure and organisational requirements for local delivery of the NSF are in place.

5.257 All general hospitals that care for people with stroke have a specialised stroke service as described in the stroke service model.

5.258 Intermediate care services, which bridge the gap between hospital and home, are supporting more than 331,271 people a year, with 80 per cent of these being older people.

5.259 Major progress has been made in promoting health. There has been increased uptake of:

- flu vaccination, rising from 65 per cent of over-65s in 2000 to 71 per cent in 2004;
- breast cancer screening, rising from 103,000 women over 65 in 2000 to 148,700 in 2004; and,
- smoking cessation, rising from 12,900 people over 60 per year in 2000-01 to 42,900 in 2003-04.

Assessment and Access

5.260 The milestone of April 2004 for implementation of the Single Assessment Process, which places older people at the heart of the assessment of their needs and subsequent service planning and delivery, was met, and practice continues to develop and improve.

5.261 An estimated two million contacts from new clients were made to councils with social services responsibilities in England in 2003-04. An estimated 1.74 million clients received services during the year, a rise of three per cent from 2002-03.

5.262 In 2003-04, 70 per cent of new older clients had received all services specified in their care plan within two weeks of their completed assessment.

Community equipment services

5.263 70 per cent of England had community equipment services integrated between NHS and social care in 2004, compared to 400 separate NHS and social care services in 2000.

5.264 The Local Government finance settlement announced £80 million over two years 2006-07 and 2007-08, for a 'Preventive Technologies Fund' which will help councils and their health service partners introduce electronic technology into people's homes to help keep them independent and help prevent them going into care or hospital.

Financial help

5.265 The carers' grant has increased each year and has provided an extra £325 million for carers' services over the past five years. It is worth £125 million in 2004-05 and will rise to £185 million in 2005-06. In the Local Government finance settlement at the end of 2004, the Department confirmed its commitment to continue the Carers' Grant until at least the end of the 2007-08 financial year.

5.266 *The Carers (Equal Opportunities) Act*[5.38] received Royal Assent in July 2004. The Act will ensure that carers are able to take up opportunities that those without caring responsibilities take for granted and will be implemented from April 2005. A new carers' performance indicator will be published in autumn 2005, to ensure that councils recognise that support for carers continues to be a priority for the Government.

5.267 More people continue to enjoy the control and flexibility that a direct payment can offer. In 2003-04, 17,300 adults aged 18 and over received direct payments during the year, increasing from 9,600 in 2002-03, a rise of 80 per cent. Of these, 11,300 were aged between 18-64 (an increase of 61 per cent) and 6,000 were aged 65 and over (an increase of 122 per cent).

Delayed Discharge

5.268 Since the implementation of the *Community Care (Delayed Discharges etc) Act 2003*[5.39], the levels of delayed discharge have continued to fall considerably, from 4,267 in September 2003 (the start of the shadow operation period) to 2,619 by June 2004. Compared with September 2001, almost 4,500 fewer people are experiencing a delayed discharge on any one day. The reduction in delays has not focused on any particular age, the number of over-75s experiencing a delay on any one day has fallen by over 3,700 since September 2001. Only 4.43 per cent of patients aged over 75 are experiencing a delayed discharge compared to 12 per cent in September 2001.

Extra care housing for older people

5.269 Housing has a central role to play in enabling older people to remain involved in their community and to live their lives in the way they wish. It has to be allied with care and support, and a wide range of other services such as transport and community safety.

5.270 Extra care housing can provide a supportive living environment, sometimes with the added benefit of assistive technology. It should offer:

- flexible care;
- 24 hour support from social care and health teams;
- access to meals;
- domestic support;
- leisure and recreation facilities; and,
- 24 hour/7days a week security to create a genuinely safe environment.

5.271 The Extra Care Housing Fund, run in partnership by the Department of Health and the Housing Corporation, has the support of the Office of the Deputy Prime Minister and aims to develop innovative housing with care options.

5.272 The Department of Health made £87 million available for 2004-06. In total, 46 projects have been supported, providing 3,076 new units of extra care housing. The majority of the successful projects involve new build provision, with some remodelling of existing sheltered housing schemes and upgrades to communal facilities. The Government's original target was to produce 1,500 extra care housing places with this fund in 2004-06. Schemes funded include some retirement care villages as well as schemes in general supporting provision for older people with dementia, older people with learning disabilities and intermediate care facilities. £2.3 million within the fund has been set aside to fund schemes for adults with learning disabilities. A further £60 million for extra care housing in 2006-08 was announced in the Spending Review 2004.

Ending Nightingale wards

5.273 The elimination of Nightingale wards for older people is one of the key aims of the NSF. To date, over 260 Nightingale wards for older people, plus another 350 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.

MENTAL HEALTH SERVICES

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

5.274 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, and reduce the mortality rate from suicide and undetermined injury by at least 20 per cent by 2010.

Suicide rate

5.275 The suicide rate is at its lowest recorded figure and current data indicates we are on track to achieve the target by 2010. The target requires a reduction from the 1995-97 baseline of 9.2 deaths per 100,000 population to 7.4 deaths per 100,000 in 2009/2010/2011. The latest suicide monitoring data for the three-year period 2001-03 shows a reduction of 6 per cent to 8.6 deaths per 100,000. Significant progress has also been made in reducing inpatient deaths and in reducing the suicide rate for young men which was particularly high.

5.276 Implementation of the National Service Framework for Mental Health (MHNSF) contributes to the above target. The provision of mental health services in the community is being strengthened. Mental health services have taken 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, 261 assertive outreach and 109 early intervention teams established in England. 17,500 people are now being seen by assertive outreach teams and around 69,000 people benefited from crisis resolution services in 2004-05.

5.277 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 600 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.

5.278 A new programme to modernise inpatient care by eradicating all unsuitable wards through increased capital investment in the mental health estate is underway. This will focus on improving local and general psychiatric intensive care units. £30 million has been allocated for capital spend in 2005-06.

5.279 A programme of work to reduce inequalities and to make services more responsive and appropriate to Black and minority ethnic communities in mental health is a priority. In January 2005, we published 'Delivering Race Equality in Mental Health Care', an action plan for reform of services. Implementation is now underway. A framework for the introduction of Community Development Workers (CDWs) has also been published. CDWs will link with local Black and minority ethnic communities to build capacity within the community and bridge gaps with local services. A national steering group to oversee progress is chaired jointly by Rosie Winterton, Minister of State and Lord Victor Adebowale Chief Executive of Turning Point.

Strengthening the workforce

5.280 There have been significant increases in the numbers of consultant psychiatrists (49%), mental health nurses (21%) clinical psychologists (74%), non-medical psychotherapists (125%), and art/music/drama therapists (23%) working in the NHS. A programme of action to improve recruitment and retention of consultant psychiatrists was published in 2004 and its implementation is underway. Work which aims to maximise the skills of the mental health workforce under the *New Ways of Working* programme continues. In the light of policy changes, a review of mental health nursing is taking place in 2005 in order to ensure that we maximise the skills of mental health nurses.

Future developments

5.281 A national programme to reduce stigma and discrimination, SHIFT, is underway following the launch of *From Here to Equality* [5.40] (June 2004). A five-year strategic plan, which includes action to address the issues in this area highlighted in the 'Social Exclusion Unit report on mental health' was also published in June 2004.

5.282 Work to develop mental health services within the context of key national initiatives such as Choice, and the Public Health White Paper, *Choosing Health* [5.41] is also underway. Within these programmes there will be a focus on improving information to support self-help, access to services, including psychological therapies, improving care for those with long-term conditions and reducing health inequalities.

Child and Adolescent Mental Health Services

5.283 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* [5.42] published in September 2004.

5.284 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 second exercise results were published in 2004. They indicated increased levels of CAMHS provision. The number of CAMHS teams increased by 23 per cent, staff by 15 per cent and cases seen by 12 per cent compared to the previous year.

Prison mental health

5.285 Suicide rates in prison remain higher than in the general population and a primary objective of the National Prison Mental Health Programme is to reduce suicides and self-harm in prison. A new multi-disciplinary framework for the management of suicide and self-harm has been developed through 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 Partnerships directorate of the National Offender Management Service) and the Prison Service. This framework is currently being rolled out, supported by comprehensive training for staff, across the prison estate. Prison mental health forums have been established in each of the NIMHE regional development centres.

5.286 360 prison in-reach workers are now providing 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 commenced in April of this year. Best practice guidance for commissioners and frontline staff has been published. This provides a framework for evidence-based mental health services from the point of arrest, through prisons to release into the community. The implementation of this guidance is being supported by each of the NIMHE regional development centres.

5.287 A programme of mental health awareness training for Prison Service officers has been developed, the delivery of which is being coordinated via the NIMHE regional development centres. Part of this well received package includes a multi-award winning mental health awareness training video, designed specifically for prison officers.

CHILDREN

– improve children's health and social care services

National Service Framework for Children, Young People and Maternity Services

5.288 *The NSF for Children, Young People and Maternity Services* was published jointly by the Department and DfES, in September 2004. This followed publication of the hospital standard in April 2003. The NSF sets standards across health and social care and some education services. The NSF forms an integral part of the Government's strategy for children and young people, *Every Child Matters: Change for Children*[5.43].

5.289 Five standards have been set which apply to all children. These cover promoting health and wellbeing; supporting parenting; child-centred care; growing-up into adulthood, and safeguarding and promoting the welfare of children and young people. The other standards cover children who: are ill; disabled children and those with complex health needs; the mental health and psychological wellbeing of children; and medicines and maternity services.

5.290 Alongside the standards, exemplars were published which illustrate what the standards mean for children with specific conditions and are presented as a child's journey through services. Those published so far include autistic spectrum disorder; asthma; chronic fatigue syndrome/ME and acquired brain injury. Further exemplars will be published covering a child with mental health difficulties, the care pathway for a pregnant woman and a child with complex needs.

5.291 *The NSF Information Strategy*[5.44] was published at the same time and included the national and the local actions that will be needed to deliver the NSF standards. Particular projects will be the development of datasets for child health, maternity and child and adolescent mental health, and the development of a methodology to map child health and maternity services (**www.childhealthmapping.org.uk**) comparable to the work that has already been done to map child and adolescent mental health services (**www.camhsmapping.org.uk**).

5.292 The NSF Delivery Strategy, *Supporting Local Delivery*[5.45], was published in December 2004. It places the health agenda for children in the context of Every Child Matters: Change for Children, and also sets out the action which the Government will take to support implementation of the NSF.

www.everychildmatters.gov.uk/content/documents/ECM%20Health%20and%20LocalDelivery.pdf.

Every Child Matters: Change for Children

An outcomes driven programme

5.293 Following the publication of the *Every Child Matters* Green Paper, Government Departments, including the Department of Health, have been working together to support local organisations to improve the five key outcomes for children identified by the Green Paper:

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

Children Act 2004

5.294 These outcomes were set in statutory form by the *Children Act 2004*[5.46], and local bodies, including PCTs, were placed under a duty by the Act to co-operate with each other to improve the outcomes. The *Children Act 2004* included the following key reforms:

- a Children's Commissioner to champion the views and interests of children and young people;
- a duty on key agencies to safeguard and promote the welfare of children;

- establishment of statutory Local Safeguarding Children's Boards to replace the current Area Child Protection Committees; and,
- creation of an integrated inspection framework and the conduct of Joint Area Reviews to assess local areas' progress in improving outcomes.

Chief Nursing Officer's review

5.295 In response to a recommendation in *Every Child Matters*, the Chief Nursing Officer published a review of the nursing, midwifery and health visiting contribution to the health and wellbeing of vulnerable children and young people in August 2004[5.47]. The review included recommendations on: service planning and integration; workforce issues; health visiting; general practice; school nursing; secondary care; midwifery; child protection; information technology; and professional practice.

Development of Children's Trusts

5.296 Thirty-five 'pathfinder' children's trusts have been integrating health, social care, education and other services for children and young people. The Children Act provides a legislative basis for the extension of children's trust arrangements across all 150 local authority areas.

Regional Change Advisors

5.297 The Department of Health and the Department for Education and Skills have appointed 12 'Regional Change Advisors' to work across health, social care and education to ensure that the *Every Child Matters: Change for Children* agenda, and the five outcomes it is built around, are delivered effectively in partnership.

Joint Inspection Arrangements

5.298 The Healthcare Commission has joined 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 outcomes.

QUALITY OF CARE

– improve the quality of clinical care and ensure a more patient-centred service

Patient Advice and Liaison Services (PALS)

5.299 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.

5.300 In 2005, funding is being 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.

5.301 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.

Patient and Public Involvement in Health

5.302 Patients' Forums (also known as Patient and Public Involvement Forums) have been in place for NHS trusts and Primary Care Trusts since December 2003 and for NHS Foundation Trusts since April 2004 – there are around 5,000 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 to improve patients' experiences of the NHS.

5.303 The Commission for Patient and Public Involvement in Health (CPPIH) is responsible for ensuring Patients' Forums have staff support, training and guidance to enable them to carry out their functions. The CPPIH will be abolished as part of the review of the Department of Health's arm's length bodies – Patients' Forums will, however, continue. In future, the NHS Appointments Commission will be responsible for making appointments to Patients' Forums, a new "centre" will be established to provide information and guidance for Patients' Forums and the NHS about patient and public involvement, and new arrangements will be put in place to provide staff support to Patients' Forums.

5.304 Work is also taking place with the Healthcare Commission and the CPPIH to strengthen the relationship between the role of Patients' Forums and the Healthcare Commission. A consultation exercise to seek views about the detail of these new arrangements ended on 30 January 2005, and the response setting out further details about the future arrangements was published in March 2005[5.48]. The Government's response to the consultation included the following proposals:

- NHS Appointments Commission will be fully responsible for forum appointments from the abolition of CPPIH in August 2006;
- In the future all forums will be required to have chairs who will be appointed by the NHS Appointments Commissions – forum members will be involved in this process;
- The proposed 'ppi resource centre' will become a resource for both forums and the NHS from December 2005;
- Staff support will be provided under a limited number of contracts, focused on the nine existing regions;
- Forums will be combined within PCT areas but retain a focus on every NHS trust in that PCT area;

- The number of forum members across England will remain at least at the same level;
- We will consider the development of regional and national networks for forums; and,
- Forums will continue to be involved in the development of the work needed to make these recommendations happen.

5.305 The NHS is continuing to deliver its duty to involve and consult the public. This means consulting and involoving:

- in ongoing service planning, not just when a major change is proposed;
- in the development of that proposal, not just in the consideration of a proposal; and,
- in decisions about general service delivery, not just major changes.

5.306 Best practice guidance showing examples of how involving and consulting has changed patients' experiences was launched in October 2004 entitled *Getting Over the Wall: How the NHS is Improving the Patient's Experience*[5.49].

Overview and Scrutiny Committees

5.307 A grant of £2.25 million has been awarded to the Centre for Public Scrutiny (CfPS) to support, facilitate and evaluate health scrutiny. The CfPS has set up two groups to assist its work – a Stakeholder Management Group, comprising the Local Government Association, NHS Confederation, Healthcare Commission, CPPIH, Audit Commission, Social Care Commission, Social Care Institute for Excellence, Office of the Deputy Prime Minister, and the Department – to oversee the strategic direction of the work. In addition, a 'Practitioners' Forum' comprising officers from local government and the NHS, is bringing expertise to this project.

NHS Healthcare Standards

5.308 *The Health and Social Care (Community Health and Standards) Act 2003*[5.50] gives power to the Secretary of State for Health to publish a statement of standards to improve the quality of care.

5.309 *Standards for Better Health* was issued for a twelve-week public consultation on 10 February 2004. Over 500 responses were received and a summary of these can be found on the DH website. The final version of *Standards for Better Health*[5.51] was published on 21 July 2004.

5.310 The standards are wide ranging and cover the full spectrum of NHS provision, including primary care and public health, and apply to all organisations providing services to or for the NHS, including foundation trusts and treatment centres.

5.311 There are 24 core standards and 13 developmental standards. The core standards draw the key requirements on the health service into one place and give patients an assurance of what they can expect from the NHS. The developmental standards are designed to provide a dynamic force for continuous improvement over time, as well as to enable health care organisations and the public to see progress being made year-on-year.

5.312 There is a direct relationship between the standards set out in the national service frameworks and the healthcare standards, which they support. The NSF frameworks should be seen as elaborating the healthcare standards to tailor them specifically to the needs of the relevant condition or client group.

5.313 The Healthcare Commission will determine the degree to which standards are met. It is currently holding a public consultation on the criteria it will use to assess performance related to each of the core standards, which will contribute to performance ratings for 2005-06.

National Clinical Audit

5.314 The Healthcare Commission has developed a programme of national clinical audits. This builds on the clinical audit programmes transferred to Commission for Health Improvement from the National Institute for Clinical Excellence and from the National Clinical Audit Support Programme (NCASP) funded by the Department. Full details of the Healthcare Commission's programme can be found at **www.healthcarecommission.org.uk**. Mr Graham Copeland, a Warrington-based surgeon, has been appointed Clinical Audit Development Director. Based within the Clinical Governance Support Team, he is leading on work to support local clinical audit programmes.

Clinical Governance

5.315 In September 2003, the National Audit Office report, *Achieving Improvements through Clinical Governance: a Progress Report on the Implementation in NHS Trusts*[5.52], found that about three-quarters of trusts had identified improvements in the healthcare they provided as a result of implementing the clinical governance strategy. The report highlights the beneficial impact clinical governance has already had and cites the importance of the Clinical Governance Support Team, recommending that the support and advice it provides to organisations should continue to be developed and enhanced.

5.316 Following the publication of the Cabinet Office report *Reducing Burdens in Healthcare Inspection and Monitoring*[5.53], Strategic Health Authorities (SHA) are no longer expected to submit their development plans and end of year reports to the DH. Deadlines for completing reports and plans are now set locally by each SHA, not by the Department, as set out previously in guidance issued in 2002.

5.317 In his report, *Making Amends*[5.54], Professor Sir Liam Donaldson, Chief Medical Officer for England, proposed reform of the way the NHS clinical negligence system currently works. The proposals included establishing an NHS Redress Scheme to offer an alternative to litigation when things go wrong.

5.318 Work is moving forward after consultation with a broad range of stakeholders, including clinicians, health service

managers, the legal profession and patients. Discussions have been wide-ranging and included how the proposed NHS Redress Scheme might work in practice, and how it could link to other reforms such as the NHS Complaints Procedure and the work of the National Patient Safety Agency. The Department intends to make an announcement shortly.

Controls Assurance

5.319 The controls assurance standards process were abolished in August 2004.

Single-sex accommodation

5.320 The Department of Health has given a strong public commitment to protecting patients' privacy and dignity, and to ensure the provision of single-sex accommodation in all NHS hospitals.

5.321 Clear objectives have been set for the NHS, designed to deliver separate sleeping areas for men and women, separate toilet and washing facilities and, for those trusts delivering mental health services, safe facilities for people who are mentally ill. The NHS is continuing to build upon the 95 per cent compliance achieved by the target date of December 2002. By December 2004:

- 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.

5.322 Over 99 per cent of general inpatient wards meet the standards that we have set. The remainder will achieve those standards on completion of Private Finance Initiative developments and other building projects currently underway.

IMPROVING PATIENT EXPERIENCE

5.323 Following Parliamentary approval of the *Health and Social Care (Community Health and Standards) Act 2003*[5.55], the *National Health Service (Complaints) Regulations 2004*[5.56] came into force on 30 July 2004. These regulations transferred responsibility for the independent review of NHS complaints to the Healthcare Commission.

5.324 Introduction of a revised, wider statutory framework for NHS complaints, due to be introduced in spring 2004, was put on hold pending publication of the Shipman Inquiry's fifth report. The local resolution stage of the complaints procedure remained largely unchanged.

5.325 The Department is carefully considering all the recommendations in the Shipman fifth report, which covers the NHS complaints process. We will discuss the recommendations with stakeholders before making a decision on how to proceed. Nonetheless, the Department now aims to introduce a revised NHS complaints procedure in 2005.

Independent Complaint Advocacy Services (ICAS)

5.326 The Independent Complaints Advocacy Service (ICAS), launched on 1 September 2003, provides trained advocates to support people in England wishing to complain about the treatment or care they received under the NHS. During its first year of operation, ICAS concentrated resources on frontline delivery with 88 per cent of staff being client facing. One of the priorities for 2005-06 will be to agree good practice for ICAS delivery. We will also consult stakeholders about the future direction of ICAS in response to changes in the NHS Complaints Procedure.

Director for Patients and the Public

5.327 Harry Cayton, the Director for Patients and the Public, has made a significant contribution to ensuring the patient-centred vision for the NHS, set out in the *NHS Plan*[5.57], becomes a reality. Harry ensures that the views and experiences of service users inform and engage with policy development and service delivery to improve patient experience. During 2004-05, he chaired the Working Group on patient charges for NHS dentistry; directed the national consultation on choice, which led to *Building on the Best*; and chaired the Expert Group on the regulation of cosmetic surgery, whose report was published in January 2005.

5.328 Future work also includes publishing guidance on:

- payment and reimbursement for service users involved in patient and public activities;
- ethics and patient and public involvement; and,
- patient and staff consent for filming in NHS premises.

5.329 Harry Cayton took over the strategic leadership of the Expert Patient Programme, chairing the programme's Strategic Management Board which has a significant proportion of patient and voluntary sector organisations on its membership. This group will ensure the successful implementation of the EPP and that quality standards are applied effectively. He has also been appointed chair of Connecting for Health (formerly the National Programme for IT) Development Board, the role of which is to ensure the engagement and representation of patients and NHS staff in Connecting for Health.

Patient feedback surveys

5.330 Listening to the views of patients is essential for delivering a patient-centred service, and all NHS trusts and PCTs take part in a rolling programme of patient surveys administered by the Healthcare Commission.

5.331 To date, nearly 1 million patients have given their views about local services across a range of healthcare settings. The results are used to form part of the assessment of NHS service providers for the ratings system. Survey results will also be used to assess against the new framework *Standards for Better Health*[5.58].

5.332 During 2004-05, the Healthcare Commission will carry out four national surveys asking patients across England about their experiences of emergency departments, outpatients, mental health and primary care services. Findings from the first two of the 2004-05 surveys were published on the Healthcare Commission website in February. Results showed that, nationally, around seven in ten or more users of A&E and outpatients services rate the quality of care they received as *excellent* or *very good* (70 per cent and 78 per cent respectively), while a further one in six (18 per cent and 16 per cent) rate their care as *good*. Two in three or more also say that they were *completely satisfied* (68 per cent and 72 per cent) with how the main reason for their visit was dealt with. A similarly high proportion of patients are positive about most of the different aspects of care and treatment covered in both surveys.

5.333 Detailed reports for the most recent surveys are available on the Healthcare Commission website **www.healthcarecommission.org.uk**. Results for the 2004-05 primary care and mental health service survey will be published in summer 2005.

The Voluntary and Community Sector (VCS)

5.334 The 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 are fully committed to the recommendations in the 2002 Treasury cross-cutting review of the VCS in public service delivery. We are working with the Home Office to implement its recommendations as well as exploring what more can be done in the specific health and social care context to make the Reviews conclusions a reality. We have also been actively engaged in the Treasury's VCS Review as part of the Spending Review 2004. Older Peoples Services was the focus for the Health element of the review, which will be taken forward in *Independence, Wellbeing and Choice*[5.59] the Green Paper on the future of adult social care in England.

5.335 The 31 recommendations from the Section 64 grant scheme review, published in September 2003 [5.60], were accepted in principle and are being put into practice incrementally. Our implementation of the S64 Review recommendations and a determination to strengthen support for volunteering in health and social care, is part of a wider strategy to build a progressive, dynamic and innovative partnership with the VCS.

5.336 Launched in September 2004, *Making Partnerships Work for Patients, Carers and Service Users – Strategic Agreement*[5.61] 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. It is a key milestone in strengthening partnerships between the NHS and social care, independent and voluntary sectors in order to improve the quality and range of service planning and provision. Informed by the response of the VCS to the *Making Partnerships Work* consultation, this jointly developed Strategic Agreement provides a framework for a new strategic partnership with the VCS. A National Strategic Partnership Forum has been formed 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 will draw up an action plan to support the development of local partnership working. As well as identifying and addressing the main barriers to partnership, the Forum will be a focal point for good practice and innovation.

Self-care

5.337 Self-care is one of the five building blocks in the NHS Plan vision for a health service designed around the patient. *The Wanless Report*[5.62] emphasised the potential benefits from enhanced support for self-care. There is growing evidence to show that supporting self-care improves health. For example, emerging findings from the Expert Patients Programme indicates improvement in health outcomes for people and reduction in the use of services.

5.338 Self-care has become integral to major policies in the NHS and social care and in the voluntary sector. The NHS Direct family of services, the Expert Patients programme, the Model for Supporting People with Long-Term Conditions, *Choosing Health*[5.63] and the National Service Frameworks now have self-care as a key component. This is also in keeping with public expectations – a Mori survey commissioned by us has found that patients and the public want more support for self-care.

5.339 The main driver for this work is improved health and the more appropriate use of services through the development of a culture in which self-care is accepted as part of the integrated care solution. We published a guidance document *Self Care – A Real Choice: Self Care Support – A Practical Option*[5.64] which describes the benefits of self-care and how NHS and social care practitioners, professionals and managers can provide self-care support in their routine business. Over the coming year we plan to increase the evidence base on self-care and local good practice examples of successful self care support initiatives. We will also support the Working in Partnership Programme (established in the new GMS Contract) to develop and implement three innovative projects for setting up integrated self-care support initiatives in several PCT economies.

A Safe, Clean, Comfortable, Friendly Place to be

5.340 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, a pleasanter hospital environment where services are provided by staff who are attentive to patients' needs and proactive about improving standards.

Clean Hospitals

5.341 A clean, comfortable and safe environment is of paramount importance to patients and the public. It is a visible manifestation of the health of the NHS. It is also a source of reassurance at a time when there is considerable public concern over healthcare associated infections.

5.342 The 2004 PEAT programme was significantly revised and strengthened, particularly through the introduction of a more robust 'weighting' process. The changes included the expansion from 18 to 24 the number of areas assessed, and the sub-division of the form into 130 separate 'elements'.

5.343 As a result of the revised assessment, over 97 per cent of hospitals were assessed as 'acceptable' or better, with 49 per cent being rated as good or excellent. Out of 1,184 hospitals assessed, just 27 failed to meet acceptable levels, and each of these subsequently produced an action plan detailing the steps to be taken to effect improvements.

5.344 For 2005, the system has been further enhanced with the introduction of a new area relating to infection control procedures.

5.345 In December 2004, a new guidance document for the NHS – *A Guide to Contracting for Cleaning*[5.65] was published to assist the NHS in ensuring that all contracts for cleaning deliver the appropriate mix of quality and value for money, rather than being based on cost alone. Included in this document are revised cleaning standards, recommended minimum cleaning frequencies and a guide to 'Best Value' selection processes. During 2005, a Ward Cleaning Management System will be introduced to assist in the process of placing more responsibility for what gets cleaned, how often and by whom, into the hands of matrons and senior nursing staff.

Engineering and Science

5.346 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 safest and efficient healthcare buildings for patients, staff and visitors. Since 2002, the Centre for Healthcare Engineering has been the recognised centre of excellence for healthcare engineering, providing leading-edge expertise and evidence-based strategic advice to the NHS.

5.347 Continuing work also encompasses issues surrounding infection control and the built environment. This includes developing new engineering ventilation models for use in isolation, setting up working groups to develop features that will reduce reservoirs of infection, supporting the work to improve standards in clinical practice and funding research around reducing HCAI rates.

5.348 For 2005, a new core suite of technical healthcare specific guidance will be developed. This major restructuring exercise, the first for over 30 years, will ensure that Health Technical Memorandums will continue to support the NHS in delivering a world class environment for care for patients, visitors and staff.

Environment and Sustainability

5.349 The environment in which people live and work has a key influence on their health. Government policy states that environmental considerations in areas such as energy, waste and transport must be properly taken into account in the activities and services of the NHS.

5.350 In accepting that many resources are limited, progress towards achieving environmental aims, goals and aspirations has to take into account economical considerations. The NHS already has considerable experience in looking after its estate and facilities to provide essential services from within set resources and budgets. DH Estates and Facilities continues to work with other Government departments on new and forthcoming EU Directives, legislation and regulation as it affects the NHS and provision of healthcare services overall. This will include supporting the Department of Health during the UK's EU Presidency in 2005.

The Matron's Charter

5.351 *The Matron's Charter: An Action Plan for Cleaner Hospitals*[5.66] was launched in October 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.

5.352 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. To keep cleanliness at the forefront of everyone's mind and encourage ward teams to work together towards a common goal, the 28 February became 'Think Clean Day'.

ON THE GROUND

Kings College Hospital have set up a Patient Environment Forum, in response to rising infection rates and complaints about cleaning. The forum has input from the Environment Office, Infection Control Nurse, Contract Services Manager, Domestic Supervisors, ward staff and patients. The key achievements of the group have been a decrease in MRSA rates, increased screening for MRSA and changes in infection control practice.

Better Hospital Food

5.353 Ensuring patients can get enough food and nutrition is a vital component in effective overall healthcare.

5.354 Since its launch in 2001, the Better Hospital Food programme has been addressing issues of access, availability and quality through a range of initiatives such as 24-hour catering, new recipes, improved menus and additional snacks. There has been significant progress across all areas, and the Patient Environment Action Team (PEAT) process in 2004 found that in 93 per cent of hospitals food quality is acceptable or better.

5.355 Over the coming year, the BHF programme will continue to address issues raised in the Council of Europe report relating to the prevention of under-nutrition in hospitals.

5.356 In addition, work will be taken forward to explore the practicalities of, and issues around, extending the range of choice available to patients each day. Guidance on identifying the causes of and managing food waste will also be issued, and work will continue to be taken forward with the NHS to build on issues surrounding Sustainable Development in food procurement/provision.

Ward Housekeeping

5.357 Ward housekeepers are key members of the ward team. Their role is centred firmly upon the patient and the fulfilment of their basic care needs. Ward housekeepers ensure that wards are cleaned to agreed standards and kept clean, that patients receive food that they can eat and enjoy, and by making certain that ward equipment is available and working. Ward housekeepers have become, for many patients, the person to turn to for their non-clinical needs.

5.358 Over £14 million has been invested to support the introduction of ward housekeepers across the NHS. This investment has released staff and organisational energy to make rapid progress – so much so that the target to introduce ward housekeepers into half of all NHS hospitals was met ahead of schedule.

5.359 Ward housekeepers are now working in over 53 per cent of all hospitals and in larger hospitals, where the majority of patients receive treatment, 70 per cent have established housekeepers. This means that the majority of trusts, (66 per cent) with hospitals, have introduced housekeepers and are seeing tangible benefits for patients and staff.

5.360 Many trusts are so pleased with the success of their ward housekeepers that have begun to introduce them in areas other than wards. For example, many trusts now employ ward housekeepers in A&E departments.

5.361 Basic Care Networks continue to operate in each Strategic Health Authority to help and encourage trusts in sharing best practice, problem solving and learning from each other. The Networks, open to all trusts within the SHA area, are chaired jointly by nursing and regularly discuss local and national issues such as Think Clean Day and the NPSA's '*clean your hands*' campaign.

ON THE GROUND

At Sandwell Hospital in Birmingham, housekeepers check and clean the underneath of equipment (particularly commodes) on a daily basis. They also check items such as drip stands, chairs, flower vases, staff fridges and other equipment. They receive copies of the monthly PEAT inspections, which Matrons undertake with support services, and follow up on the actions identified. In the spirit of improving services by working in different ways, housekeepers have completed training to carry out a daily check of the oxygen and suction equipment.

Bedside Televisions and Telephones

5.362 Working with the private sector, the NHS has benefited from over £115 million in private investment, and services are delivered at no cost to the NHS. Entertainment plays an important part in our everyday lives, but before this investment patients in major hospitals had little in the way of bedside entertainment and communication with friends and relatives.

5.363 By the end of December 2004, 155 hospitals provided integrated TV and telephone services at the patient's bedside, giving around 75,000 patients access to the service. Another 64 hospitals were having the system installed or had signed a contract to do so.

A healing environment

5.364 The Department of Health continues to support the highly successful King's Fund *Enhancing the Healing Environment* initiative. Our vision is to create a future where healthcare Architecture and Design positively contributes to healing and promotes wellbeing 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, functional buildings of which we can all be proud.

5.365 A national 'Design and Costing' function within the Department will provide multi-faceted, professional expertise to the NHS and industry addressing strategic healthcare design and capital investment, promoting quality environments, which are value for money and fit for purpose. This function will continue the work of the former NHS Estates Centre for Healthcare Architecture and Design to maintain, develop and deliver the SofS's major design programme and support the NHS to deliver up-to-date, fit for purpose, patient focused healthcare buildings.

5.366 The partnership with bodies such as the Commission for Architecture and Building Environment (CABE) and the Prince's Foundation will continue. Working with CABE to raise the profile of design with schemes being procured through Local Improvement Finance Trust (LIFT); and partnering the Prince's Foundation to carry out the Enquiry by Design process with NHS trusts which invites stakeholders of a proposed development to collaborate in producing a strategic development framework plan.

5.367 The NHS Design Reviews of major capital schemes at two key stages, from initial concept and prior to financial close, is progressing alongside the NHS Design Champions agenda. There are approximately 350 NHS design champions raising the profile of design at trust board level.

5.368 A new website-based collective memory for design, OnDesign, was launched in 2004, providing a portal to demonstrate design innovation. It is a visually led repository of information, providing a valuable resource to the NHS

front line, allowing staff to take virtual tours of inspirational projects across the country, sharing best practice and lessons learnt, on-line.

5.369 The Environment for Care programme is providing the NHS with the information and support it needs to create patient and staff spaces that support the healing process. The *Environment for Care Club*, of which HRH the Prince of Wales is a founding member, is ensuring that the message about the therapeutic benefits to patients and staff of well-designed healthcare environments is reaching a wide audience. The Environment for Care Club now has more than 150 members from the NHS, private, public, academic and voluntary sector.

Patient Safety

5.370 Ensuring the safety of patients has become a high visibility 'quality of care' issue for those delivering health care, not just here but worldwide. In this country, we are helping to lead an international initiative championing patient safety and putting it right at the centre of all health care being delivered today.

5.371 The National Patient Safety Agency (NPSA) has a major role in helping the Department of Health and the NHS to take this agenda forward. Established in England as a special health authority on 2 July 2001, the NPSA has since extended its services to Wales. Its core function is to improve the safety of NHS patient care by promoting a culture of reporting and learning from adverse events.

5.372 The NPSA has already begun to have an impact on patient safety and has introduced the National Reporting and Learning System (NRLS) for patient safety incidents, and has linked NHS Trusts in England and Wales to the system, as well as issuing practical solutions to help make care safer for NHS patients in a range of areas, including:

- safer storage and handling of strong potassium solutions;
- solutions to help prevent deaths linked to methotrexate;
- improving infusion device safety; and,
- using alcohol-based hand rubs to reduce hospital infections.

5.373 Over time, the agency will begin to give us a real handle on the scale of the problem – allowing us to understand the real extent and nature of patient safety incidents, and the ability to act on that knowledge.

5.374 Following the 2004 review of the Department of Health's arm's length bodies, the National Clinical Assessment Authority (NCAA) will be brought into the National Patient Safety Agency (NPSA). The NCAA has made a major impact on the handling of poor practitioner performance and shortening long suspensions of doctors. The Authority has received 1,500 referrals from local NHS organisations and provided expert support and back up to help with problems arising in a doctor's practice. The NPSA will also support high quality, independent ethical review of all research that could affect patients. The NPSA will take on the lead national perspective on hospital food, cleanliness and safe hospital design. NPSA will also take over responsibility for the national confidential enquiries from NICE.

5.375 Further information about the Agency's work is available on its website at **www.npsa.nhs.uk**.

5.376 Safety is the first area within the new NHS standards that, from 2005, all organisations providing NHS care in England will be expected to meet.

5.377 DH Estates and Facilities are committed to providing a safe environment and reducing risks for both patients and staff in the NHS. The Defect and Failure Reporting System exists to manage reported risks relating to non-medical equipment, engineering plant, installed services and building fabric in the NHS. The system, which holds over 12,000 records, provides a risk management resource for discrete areas of risk within the NHS, which in turn protects and maintains public health and safety.

5.378 In addition, a concordat exists with the Health and Safety Executive to work in collaboration on safety and security, concentrating on areas where patients are most vulnerable i.e. theatres, wards, outpatient areas.

5.379 DH Estates and Facilities will work together in partnership with other Government departments as well as Fire and Emergency Planning Divisions throughout England to meet the shared objective of improving fire safety measures to safeguard the welfare of patients, visitors, staff and premises throughout the NHS property portfolio.

NHS DIRECT

5.380 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, 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.

5.381 *The NHS Plan*[5.68] 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;
- Since March 2002, access to out-of-hours care through NHS Direct has been available to 10 million patients. Technical and operational links are now in place to allow NHS Direct to transfer calls to any out-of-hours provider in the country; and,

- 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.

5.382 NHS Direct has also been involved in contributing to a responsible and coherent response to public health. NHS Direct has worked with the Department of Health 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.

5.383 NHS Direct has responded to the growing appetite for high quality health information, which makes health one of the most important reasons for using the internet. Over the next couple of years, a number of exciting possibilities exist to develop this multi-channel approach further in particular in terms of increased interactivity.

5.384 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.

5.385 The NHS Direct Interactive service was launched on digital satellite in December 2004 and will provide health information via digital TV. 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.

5.386 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.

5.387 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.

MODERNISING PATHOLOGY SERVICES

5.388 In February 2004, the Department of Health published good practice advice for the NHS, *Modernising Pathology Services*[5.69]. This set out a vision for the NHS of pathology services, which:

- are built around the needs of patients and their clinicians, seeing services from their perspective;
- enable and empower staff to work across traditional boundaries to deliver the highest quality care to all;
- offer patients greater choice in where, when and how they access pathology services; and,
- are integrated into wider service developments and improvements.

5.389 In April 2004, Dr Ian Barnes was appointed as the Government's first National Pathology Adviser, to champion pathology modernisation across the country and to help drive forward change. Ian is supported by the National Pathology Oversight Group (set up in August last year), which he chairs.

5.390 *The NHS Improvement Plan's*[5.70] focus on speeding up access to treatment, making diagnostic services, including pathology, more flexible and responsive to patients' needs, and increasing plurality of providers sets the framework for the next stage of the Modernising Pathology Programme.

5.391 Specific funding to support pathology modernisation has also been made available: £9 million revenue and over £53 million capital over the period 2003-06.

NHS DENTISTRY – REFORM PROGRAMME

5.392 In July 2004, the Chief Dental Officer published a report *NHS Dentistry: Delivering Change*[5.71] which focused on the reforms to NHS dentistry that were to be implemented.

5.393 The future vision for NHS dentistry is to:

- offer access to high quality treatment;
- focus on disease prevention; and,
- give a fair deal to dentists and their teams.

5.394 The Government has pledged a series of investments worth £368 million in total to support both immediate and longer-term developments that contribute to the most ambitious reform and expansion of NHS dentistry since 1948. The Government's expected spend on dentistry in 2005-06 will be over £1.6 billion (net of patient charge income) and will represent an increase of over 19 per cent compared to the equivalent spend in 2003-04. By October 2005, there will be the equivalent of an extra 1,000 dentists providing care for a further two million people.

5.395 In 2004-05, £50 million was delegated to PCTs to support local schemes aimed at improving access to NHS dental care and improvements in facilities.

5.396 An NHS Dentistry Support Team is working with the PCTs that are the hardest pressed in terms of dental access. Starting in 2003, the Support Team has now worked with over 30 PCTs, which is about 10 per cent of all PCTs in England. Each PCT is supported in developing an action plan that shows clearly what it is doing to improve NHS dentistry and makes sure that it has the capacity to implement the plan.

5.397 Training places for dentists will be increased by at least 170 places from October 2005, an increase of 25 per cent and £80 million capital over four years will be provided in support.

5.398 PCTs will be playing a major role in delivering system change for NHS dentistry and ensuring that appropriate local services are available to meet the oral health needs of the local population. In order to provide the NHS and dental practices with time for change, it is intended that full implementation of the new contractual arrangements for NHS dentistry will take place by April 2006. A further £9 million has been provided to support and build collaborative working arrangements between dental practices and PCTs. By April 2005, 25 per cent of dental practices had already moved to working in new ways as Personal Dental Service (PDS) practices.

5.399 As part of the delivery of the national programme for IT, NHS Connecting for Health has begun to determine the functional requirements for dental IT. A dedicated Programme Director and Programme Team has been recruited. Alongside establishing the wider functional requirements for dental IT, planning is underway to provide some early support to dentistry through the New National Network (N3) together with developing the specification of an NPfIT compliant clinical system for use in England's dental hospitals.

A VISION FOR PHARMACY

5.400 *A Vision for Pharmacy in the new NHS*[5.72], published in July 2003, welcomed the excellent progress achieved in implementing the challenging programme *Pharmacy in the Future* and outlined plans to build on that success. It also highlighted the role of pharmacy as being an integral part of the NHS and its contribution in delivering high quality NHS services to all patients wherever they live and wherever they are treated.

5.401 The proposals within *A Vision for Pharmacy* were generally well received and a summary of the responses was published in March 2004.

New contractual framework for community pharmacy

5.402 The new contractual framework for community pharmacy, which contractors voted overwhelmingly to accept, was agreed in November 2004. It applies to England and Wales, and was negotiated between the Department of Health, the Pharmaceutical Services Negotiating Committee (PSNC) and the NHS Confederation. It completes a long-held ambition to modernise and shape NHS community pharmacy services for the future. The new arrangements went live from 1 April 2005.

The OFT report on pharmacies

5.403 On 18 August 2004, the Department of Health announced its plans to implement the balanced package of reforms to the control of entry system for NHS community pharmacies.

5.404 The balanced package will continue 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. There are three main changes:

- 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.

5.405 The Department published the full report of the expert multidisciplinary Advisory Group established to advise on how best to carry out the changes, when the Regulations were laid in March this year. The changes are being implemented in tandem with the new contractual framework.

Repeat dispensing

5.406 Further progress was made on the repeat dispensing of prescriptions, an important element of improving access to medicines highlighted in *Building on the Best*[5.73]. By April 2004, over 80 PCT Pathfinder sites had gone live. Repeat dispensing is being rolled out nationally from 1 April 2005 as part of the new contractual framework for community pharmacy. 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

5.407 The medicines' management collaborative continues to help people make better use of their medicines with nearly half of PCTs supported to develop local schemes. The Department funded a PSNC co-ordinated trial in which people with coronary heart disease received advice on their medicines from their community pharmacist. The report was published in January 2005 and contains many valuable lessons for the provision of medicine management services of this type.

5.408 Following the success of last year's event, the second *Ask about medicines* week was held in November 2004, as part of the initiative to promote medicines partnership and shared decision making, between patients and health professionals to support effective medicine taking.

5.409 Local Pharmaceutical Services (LPS) pilot schemes, which provide opportunities for existing pharmacy contractors and others to get involved in innovative local PCT pharmacy contracts, continued to develop, with forty-nine pilots approved to date. A national evaluation of LPS has been commissioned and will report in 2005.

Pharmacists as prescribers

5.410 There are now over 500 pharmacist supplementary prescribers across the United Kingdom. Of those, over 350 are in England.

5.411 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.

5.412 A formal consultation on options for the introduction of independent prescribing by pharmacists has been completed.

Pharmacy public health

5.413 The Department published *Choosing Health Through Pharmacy, A Programme for Pharmaceutical Public Health*[5.74] on 1 April 2005, which is in line with *Choosing Health – Making Healthier Choices Easier*[5.75]. The strategy aims to maximise the contribution of pharmacists working in all sectors of the profession to improve health and reduce health inequalities.

Modernising hospital pharmacy services

5.414 Investment in hospital pharmacy has continued. The modernisation of manufacturing of medicines in hospitals is being overseen by a national Implementation Board, which is now led by the NHS. Building on the £4 million capital funding already invested in the modernisation, £42 million is being allocated for 2004-2006. To build on pharmacists' involvement in improving the prescribing of antimicrobial medicines, £12 million is being allocated over the period 2003 to 2006.

5.415 Following the revised Medicines Management Framework, which was launched in September 2003, the way in which hospitals use medicines has continued to be improved. The Department's funding for the Hospital Medicines Management Collaborative continues. Lessons learned from the first 20 trusts participating in the Collaborative are helping to inform how best practice can be shared more widely.

Better use of the talents of pharmacists and their staff

5.416 The Department continues to strive to make better use of the talents of pharmacists and their staff, through improved skill mix and information technology. *A Vision for Pharmacy in the New NHS* promised further consultation on proposals that, in some circumstances, pharmacists should not have to supervise personally the sale and dispensing of medicines, though they would retain overall responsibility for the conduct of business within the pharmacy. Consultation on more detailed proposals ended in March 2005.

5.417 Work was progressed to develop the consultant pharmacist's role. Guidance was issued on 1 April 2005 including a national definition for the role of consultant pharmacists and an approval process for consultant pharmacist posts.

Pharmacy and IT

5.418 NHS Connecting for Health will roll out the electronic transmission of prescriptions (ETP) service in phases, throughout 2005. The first phase, which involves a small number of sites operating a basic system, is already underway. ETP is included as an essential service in the new contractual framework for community pharmacy. However, the roll out of ETP is logistically demanding and so the transition period to allow pharmacies to prepare for ETP will be longer than the six months allowed for other essential services.

5.419 The Department, with the NHS Connecting for Health agency, is working to achieve community pharmacy IT requirements, to support pharmacists' expanding role, such as e-mail, access to on-line information and appropriate community pharmacist access to patient records. To this end, the Department is looking to issue a consultation document on pharmacist access to patient records and patient confidentiality in 2005.

Modernising the home oxygen service

5.420 The Department announced plans to modernise the home oxygen service in July 2003. Currently, community pharmacies deliver the oxygen cylinder service, with specialist companies delivering and maintaining the oxygen concentrator service – for patients with long-term needs. Under the terms of a new service contract, a single supplier, for each of ten regions, will meet all home oxygen needs, including ambulatory oxygen, which becomes available to patients at home for the first time. The four successful companies have been announced and the new service is expected to come into operation later in the year.

AUDIOLOGY MODERNISATION PROJECT

5.421 Between September 2000 and March 2005, the Department will have invested around £125 million in the Modernisation of Hearing Aids Services (MHAS) project. Modernisation includes offering digital hearing aids to all patients that will benefit from them, and improving service facilities and audiologists' training. All 164 NHS audiology departments in England have participated and from 1 April 2005 all departments are now routinely fitting digital hearing aids.

5.422 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

5.423 The Department of Health published the genetics White Paper *Our Inheritance, Our Future – Realising the Potential of Genetics in the NHS*[5.76] in June 2003. This set out the Government's vision for bringing the benefits of developments in the knowledge and understanding of the role of genetics in disease to improved healthcare for patients. Building on earlier investment, it committed £50 million to a number of initiatives to build capacity and skills, and extend the role of genetics.

5.424 This has included developing and modernising the capacity of specialist genetic services through increased training places for counsellors and laboratory scientists and £18 million investment in new laboratory equipment to modernise and expand laboratory capacity and support reduced waiting times for test results.

5.425 Another major focus of the White Paper is developing the skills and knowledge of non-specialist healthcare professionals, and we have established a NHS Genetics Education and Development Centre to provide a focal point for genetics education and training in the NHS. The Department is also funding a number of pilot projects testing out ways of integrating genetics into other clinical areas; this includes coronary heart disease prevention and a collaborative project with Macmillan Cancer Relief to develop services for patients with a family history that puts them at increased risk of developing cancer.

5.426 Under the White Paper, the Department is also supporting research to generate new knowledge, including £4 million funding for research into pharmacogenetics for existing common drugs and £6.5 million for gene therapy for single gene disorders such as cystic fibrosis, haemophilia and muscular dystrophy.

INDEPENDENT RECONFIGURATION PANEL (IRP)

5.427 The Independent Reconfiguration 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 for a final decision. It also offers support and generic advice to NHS, local authorities and other interested bodies involved in NHS service reconfiguration.

5.428 The programme to modernise and improve the NHS is now well advanced. Nevertheless, for many people charged with the task at local level, reconfiguration may be a '*once in a lifetime*' event. Appropriate support and advice for these people is essential. In the last year, the Panel has worked with a variety of NHS bodies and local authority overview and scrutiny committees, sharing experience and disseminating good practice. Involvement has ranged from areas planning major service reconfigurations, such as Bristol and Manchester, to assisting scrutiny committees in Essex and Hampshire in taking on new responsibilities for health overview and scrutiny.

5.429 The Panel has also been pleased to offer advice on reconfiguration to organisations from abroad including an expert group undertaking a review of the system for healthcare provision in France and the Irish Department of Health and Children on proposals for future healthcare provision in the Republic of Ireland.

5.430 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**.

MODERNISATION AGENCY

5.431 When the NHS Modernisation Agency was established in April 2001, its mission – as set out in *The NHS Plan*[5.77] – was 'to help local clinicians and managers redesign local services around the needs and convenience of patients'.

5.432 By the end of 2004, the Agency had several thousand improvement projects, covering every part of England and every aspect of healthcare. Champions of modernisation are now found in all frontline services and include every profession and sector of the service. Over the last four years, at least 150,000 staff within the NHS have been engaged in the Agency's work.

5.433 The Agency has worked successfully to make improvement a core discipline in the NHS. Excellence in leadership at all levels is a key element in the successful adoption and spread of modernisation: therefore, the Modernisation Agency prioritised the development of clinical and management leaders for the front line. To date, more than 45,000 nurses, allied health professionals, healthcare scientists, doctors and managers have completed development and training programmes run by the Agency's Leadership Centre.

5.434 The Agency can point to substantial and widespread benefits from its work. Its National Booking Team: Access, Booking and Choice, for instance, helped to achieve the target that two thirds of all patient appointments should be booked, and to achieve it five months ahead of time. Over 40 per cent of diagnosed cancer patients are benefiting from services redesigned through the Agency's Cancer Services Collaborative. Helped by the Emergency Services Collaborative, all 24-hour Accident and Emergency departments have ensured that 96 per cent of patients are seen, treated or discharged within 4 hours – on course to achieve the NHS Plan target of 100 per cent. At the heart of many modernisation initiatives has been new ways of working, often involving the redefining the scope and function of individual jobs. The Agency has helped redesign over 150 work roles across the NHS, aligning the focus, the talents and the skills of staff with the realities of delivering care to patients.

5.435 In September 2004, the Agency published *10 High Impact Changes for Service Improvement and Delivery – A guide for NHS leaders*[5.78]. The ten high impact changes are based on the principles of clinical services improvement which is recognised as one of the most significant emergent directions in healthcare improvement in recent years. There has been significant interest in the approach from around the world. With 30,000 copies already distributed across the NHS and over a million 'hits' on the website this document now underpins every local delivery plan across England and is seen as an integral part of evidence based innovation which will support the concerted efforts underway led by local communities to transform NHS services for the benefit of patients.

5.436 In July 2005, the NHS Modernisation Agency will be dissolved and a new NHS Institute for Learning, Skills and Innovation will be established. This will promote excellence and innovation across the healthcare system, assuming a leadership role in the implementation and delivery of change in the NHS. It will also incorporate the new National Innovation Centre, recommended in the Healthcare Industries Taskforce Report.

6. Breakdown of Spending Programme

6.1 HOSPITAL AND COMMUNITY HEALTH SERVICES

- -HCHS Resources by Sector
- -HCHS Current Resources by Age Group
- -Resource Allocation

6.26 CENTRALLY FUNDED INITIATIVES AND SERVICES AND SPECIAL ALLOCATIONS

6.27 FAMILY HEALTH SERVICES

- -FHS Gross Expenditure
- -Family Health and Personal Medical and Dental Services Resources

6.33 DRUGS BILL

6.44 CENTRAL HEALTH AND MISCELLANEOUS SERVICES

6.46 PERSONAL SOCIAL SERVICES

- -PSS Revenue Provision
- -PSS Capital Resources
- -How the Resources are Used

HOSPITAL AND COMMUNITY HEALTH SERVICES

HCHS Resources by Sector

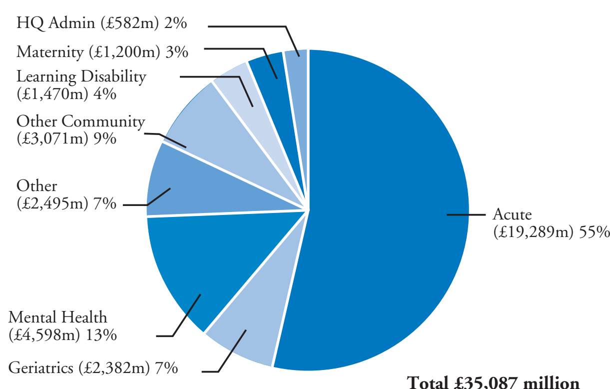
6.1 **Figure 6.1** shows the breakdown by service sector of health authority gross current expenditure on the Hospital and Community Health Services (HCHS) in 2002-03, the latest year for which disaggregated data are available. (The figure includes capital charges, but does not include spending on General 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 3.3a**

6.2 The proportion of HCHS expenditure by programme of care is as follows:

- Acute services 55 per cent;
- Mental health 13 per cent;
- Other Community 9 per cent;
- Geriatrics 7 per cent;
- Learning disabilities 4 per cent;
- Maternity 3 per cent;
- HQ Administration 2 per cent; and,
- Other 7 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, 2002-03

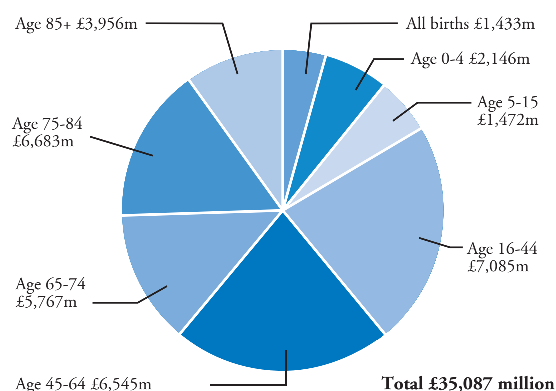


6.4 Of the total HCHS spend, i.e. £35.1 billion, £0.6 billion (1.7%) is spent on administration, leaving £34.5 billion (98.3%) for patient services. From this, hospital expenditure accounts for £27.9 billion (80.9%), community services £5.6 billion (16.4%) and £0.9 billion (2.7%) for ambulance services.

HCHS Current Resources by Age Group

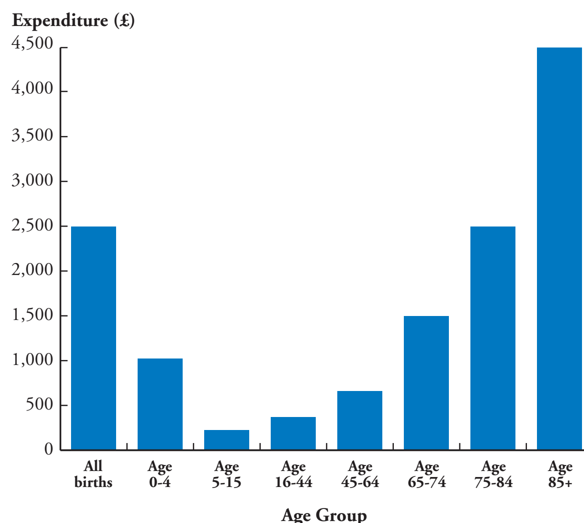
6.5 **Figure 6.2** shows that in 2002-03 people aged 65 and over accounted for approximately 47 per cent of total expenditure, a group however, that comprises around 16 per cent of the population. This is primarily because approximately 55 per cent of acute expenditure and significant proportions of expenditure on services for mentally ill people and other community services are for people aged 65 and over.

Figure 6.2: Hospital and Community Health Services Gross Current Expenditure by Age, 2002-03



6.6 **Figure 6.3** shows the estimated expenditure in 2002-03 on HCHS for each age group, expressed as a cost per head of the population. High costs are associated with each birth, but costs per head then falls steeply, remaining low through young and middle age groups, before rising sharply from age 65. This reflects the greater use of health services by elderly people.

Figure 6.3: Hospital and Community Health Services Gross Current Expenditure Per Head, 2002-03



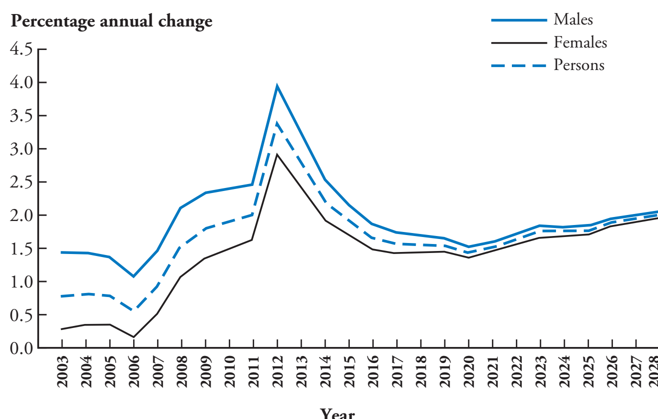
6.7 The changing demographic make up of the population affects the demand for NHS care. The elderly, in particular, have an impact. **Figure 6.4** shows that over the next ten years the increase in the population, aged 65 and over, is expected to average 1.6 per cent per year.

6.8 Over the next twenty years, the growth rate becomes slightly more pronounced at 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. However, the pattern of service delivery may need to change in the future.

6.9 The current trend is for reductions in the growth rate of people aged 65 and over, but this will end in two years 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 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 2003-04 to 2005-06

6.10 Revenue allocations to Primary Care Trusts (PCTs) for 2003-04 to 2005-06 were announced in December 2002. The distribution of resources for the 2003-04 to 2005-06 revenue allocations is shown in **Figure 6.5** below. More details of these allocations can be found in *2003-04, 2004-05 and 2005-06 Primary Care Trust Revenue Resource Limits Exposition Book*[(6.1)].

Figure 6.5: Distribution of Resources for 2003-06

	2003-04		2004-05		2005-06	
	£m	% increase	£m	% increase	£m	% increase
HCHS	51,950		56,998		62,391	
Capital charges and other funding adjustments	1,722		1,799		1,899	
Total available	53,672		58,797		64,290	
CFISSA[1]	8,645		9,469		10,365	
Total for PCTs	45,027	9.24	49,328	9.55	53,925	9.32

1 *Centrally funded initiatives and services and special allocations.*

Primary Medical Services Allocations

6.11 Primary Medical Services (PMedS) allocations to PCTs for 2004-05 were announced in February 2004. The total PMedS allocation for PCTs in 2004-05 was £4.3 billion. This was a non-recurrent allocation.

6.12 This was the first time PCTs received a resource limited allocation for the commissioning of General Medical Services and Personal Medical Services. As a result of this allocation, the General Medical Services non-discretionary arrangements ceased to exist.

6.13 On 22 November 2004, the 2005-06 PMedS allocation to PCTs was announced. The total PMedS allocation to PCTs for 2005-06 was £4.5 billion. This was a recurrent allocation.

6.14 For future allocations, the PMedS allocation has been made recurrent and forms part of the 2006-08 revenue allocations to PCTs – see paragraph later in this section on baseline changes.

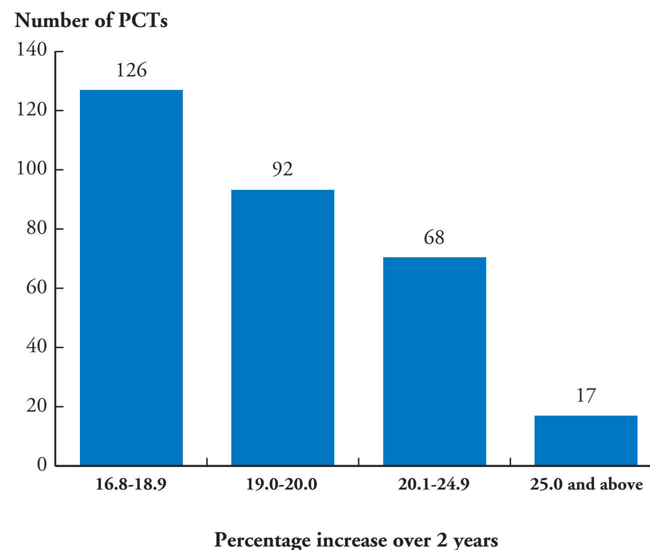
Revenue Allocations to Primary Care Trusts for 2006-07 and 2007-08

6.15 Revenue allocations to PCTs for 2006-07 and 2007-08 were announced on 9 February 2005. These allocations represent £135 billion investment in the NHS, £64 billion to PCTs in 2006-07, and £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.

6.16 For 2006-07 revenue allocations, the range of PCT cash increases is between 16.8 per cent and 32.3 per cent over the two years, with an average of 19.5 per cent.

6.17 **Figure 6.6** shows the distribution of increases over the period 2006-07 and 2007-08 by Primary Care Trust.

Figure 6.6: Revenue Allocations 2006-07 and 2007-08 distribution of increases



6.18 The distribution of resources for the 2006-07 to 2007-08 revenue allocations is shown in **Figure 6.7**. Further information on the 2006-07 and 2007-08 allocations is available at: **www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/Allocations/fs/en**

Figure 6.7: Distribution of Resources for 2006-07 and 2007-08

	2006-07 £m	2006-07 % increase	2007-08 £m	2007-08 % increase
HCHS	74,119		80,960	
Capital charges and other funding adjustments	1,635		1,784	
Total available	75,754		82,744	
CFIS[1]	11,444		12,389	
Total for PCT recurrent revenue allocations	64,310	9.2	70,355	9.4

1 Centrally funded initiatives and services

6.19 It is not possible to compare the 2003-06 revenue allocation figures to the 2006-08 revenue allocation figures. This is because of the changes to the funding included in PCT allocations. These changes are known as baseline changes – see paragraph later in this section on baseline changes.

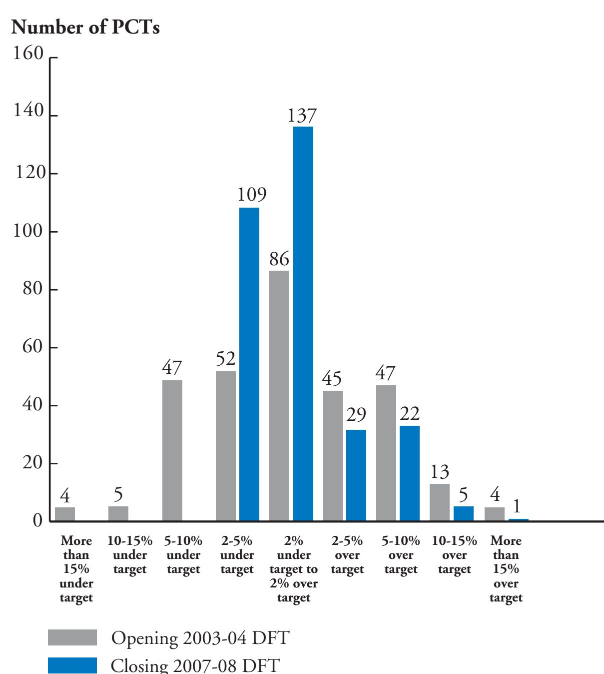
Revenue Allocations – pace of change policy

6.20 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.

6.21 **Figure 6.8** shows PCTs:

- opening 2003-04 distances from target; and,
- closing 2007-08 distances from target.

Figure 6.8: Primary Care Trusts' Distances from Target – 2003-04 to 2007-08



Revenue allocations 2006-07 and 2007-08 – changes

Baseline changes

6.22 In relation to the 2006-07 and 2007-08 revenue allocations, there has been a number of baseline changes, the most significant of which are:

- 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; and,
- devolution of funding from central budgets. For example, the devolution of almost £600 million for NHS funded Nursing Care and the PMedS allocation referred to in paragraph 6.13.

Weighted Capitation – formula changes

6.23 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 care component was incorporated into the allocations, which 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, 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.

Choosing Health White Paper – funding

6.24 The revenue allocation separately identifies £211 million in 2006-07 and a total of £342 million in 2007-08. This funding represents around half of the £1 billion promised in November 2004 by Secretary of State to support the *Choosing Health White Paper*[6.2]. The funding has been targeted to the most deprived areas, including the PCTs in Spearhead areas. It will enable local delivery of interventions to help to meet new PSA targets on obesity, smoking, sexual health and inequalities.

Advisory Committee on Resource Allocation

6.25 Equity in resource allocation is an important issue. The Advisory Committee on Resource Allocation (ACRA) oversees the weighted capitation formula, which is used to inform the revenue allocations to PCTs. ACRA's membership comprises, National Health Service management, GPs and Academics.

CENTRALLY FUNDED INITIATIVES AND SERVICES AND SPECIAL ALLOCATIONS (CFISSA)

6.26 The CFISSA programme provides central revenue funding to implement the NHS Plan and other initiatives. **Figure 6.9** provides details of the CFISSA programme for 2004-05 and 2005-06 budget levels. The figures for these years 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 (CFISSA), 2004-05 to 2005-06

Budgets	2004-05	£000s 2005-06
Improving Access to all Services:		
• Better emergency care	137,901	181,080
• Waiting, booking and choice	188,373	222,642
Improving Services & Outcomes in:		
• Cancer	113,636	72,362
• Coronary Heart Disease	27,322	31,699
• Mental Health	112,178	82,996
• Older People	585,084	2,850
• Children	21,040	481
Improving Patient Experience	69,041	65,557
Reducing Health Inequalities	158,473	343,582
Contributing to a Reduction in Drug Misuse	263,287	306,714
Building Capacity		
• Workforce	4,215,488	4,411,157
• IM&T	649,311	698,253
Other CFISSA budgets:		
R&D	602,561	609,649
Statutory Bodies	312,904	333,780
Specialist Health Services (e.g. Audiology Services, Dentistry, Ophthalmic)	500,921	309,418
Modernisation Agency	96,222	149,193
Primary Care	4,171,517	55,666
Public Health	79,752	250,570
Central Payments made on behalf of the DH (e.g. Injury Allowances)	30,767	55,151
Residual CFISSA budgets (e.g. SHA Running Costs, NHS Bank)	3,181,793	866,754
CFISSA budgets issued with PCT allocations	262,230	1,444,226
Cost of Living Supplement	108,765	108,765
Non Cash CFISSA budgets (including Capital Charges, Provisions etc)	861,128	698,210
TOTAL	16,749,694	11,300,755

FAMILY HEALTH SERVICES (FHS)

6.27 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 of Health following consultation with representatives of the relevant professions, and administered locally by Primary Care Trusts (PCTs).

6.28 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 onwards, the GMS non-discretionary element will cease to exist and GMS funding will become part of the overall PCT allocation as part of the new GP contract.

FHS Gross Expenditure

6.29 **Figure 6.10** shows the gross cash FHS expenditure by services in England, the real terms increase and the year-on-year growth of discretionary and non-discretionary expenditure. Gross expenditure means that figures are **not** net of PPRS receipts and dental and prescription charge income.

Figure 6.10: Family Health Services Gross Expenditure (Cash & Resource), 1993-94 to 2003-04, England

£ million

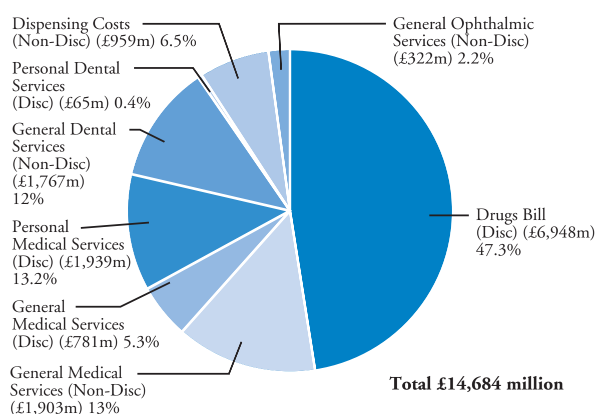
	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2000-01	2001-02	2002-03	2003-04	% real terms growth 1993-94 to 2003-04[9][11]	% growth 2002-03 to 2003-04
	Cash								Resource[10]					
Total Drugs[1][2]	**2,980**	**3,252**	**3,506**	**3,808**	**4,107**	**4,356**	**4,852**	**5,168**	**5,160**	**5,714**	**6,345**	**6,948**	**81.7%**	**9.5%**
GMS Non-Discretionary[5]	1,840	1,902	1,965	2,073	2,198	2,243	2,451	2,510	2,507	2,271	2,068	1,903	-19.4%	-8.0%
GMS Discretionary	715	723	754	800	835	878	885	940	1,024	959	864	781	-14.9%	-9.6%
PMS (discretionary)[3][4]	n/a	n/a	n/a	n/a	n/a	37	84	174	203	689	1,152	1,939	n/a	68.3%
Total GMS & PMS	**2,555**	**2,625**	**2,719**	**2,873**	**3,033**	**3,158**	**3,420**	**3,623**	**3,734**	**3,919**	**4,084**	**4,623**	**41.0%**	**13.2%**
GDS[6]	1,223	1,281	1,292	1,325	1,349	1,439	1,479	1,556	1,561	1,638	1,709	1,767	12.6%	3.4%
PDS (discretionary)[3]	n/a	n/a	n/a	n/a	n/a	4	12	21	21	36	41	65	n/a	58.5%
GOS[7]	192	213	223	237	241	240	281	292	290	302	304	322	30.7%	5.9%
Dispensing Costs[8]	677	679	706	746	768	781	808	856	857	879	919	959	10.4%	4.4%
Total FHS	**7,627**	**8,050**	**8,446**	**8,989**	**9,498**	**9,978**	**10,852**	**11,516**	**11,623**	**12,488**	**13,402**	**14,684**	**50.0%**	**9.6%**

1 Since 1999-2000 the Drugs budget has been part of the Unified Allocation. Figures reported are gross and do not include PPRS savings.
2 Drugs bill cash figures include amounts paid from April to March to contractors for drugs, medicines and appliances which have been prescribed by a GP/Nurses (relates to February to January prescriptions).
3 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. PMS and PDS expenditure figures are drawn from HAs' income and expenditure accounts.
4 PMS cash expenditure totals are intended to cover all PMS contract costs for waves 1, 2a, 2b, 3a, 3b, 4a and 4b only.
5 GMS non-discretionary figures are taken from the FIMS (FIS) returns up to 2000-01. Resource totals for 2000-01 are from the ASF06/HAA05 and HAA09 accounts returns.
6 The Gross GDS costs include the cost of refunds to patients who incorrectly paid dental charges.
7 Expenditure on GOS increased in 1999-00 as a result of the Government's decision to extend eligibility for free NHS sight tests to everyone aged 60 and over from April 1999.
8 Dispensing costs is the remuneration paid to contractors for dispensing prescriptions written by GPs. This includes payments to pharmacists and appliance contractors, dispensing doctors and non dispensing doctors in respect of personally administered items.
9 Figures have been converted into real terms using the March 2004 GDP deflator.
10 Figures from 1992-93 to 2000-01are in Cash terms and the figures from 2000-01 to 2003-04 are in Resource terms. This is to reflect the change in Department of Health Accountancy practices.
11 Growth in Dispensing Costs is affected by the inclusion of an increasing element (around £18m in 2002-03) in PMS discretionary expenditure.

Family Health and Personal Medical and Dental Services Resources

6.30 **Figure 6.10a** shows the distribution of gross resource expenditure for FHS of £14,684 million in 2003-04 among the constituent Family Health Services, England.

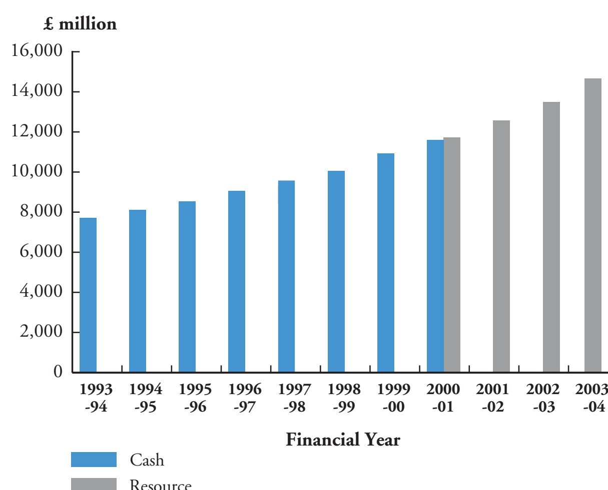
Figure 6.10a: Family Health and Personal Medical and Dental Services Gross Expenditure, 2003-04, England



6.31 In 2002-03, 8.6 per cent of the gross FHS spend was attributed to PMS discretionary. In 2003-04, this has increased to 13.2 per cent. The GMS distribution proportions have decreased from 2002-03 to 2003-04 by 8.0 per cent and 9.6 per cent for non-discretionary and discretionary respectively. These decreases are caused by the significant transfer of GMS GPs into PMS.

6.32 **Figure 6.10b** charts the total FHS gross expenditure for 1993-94 to 2003-04.

Figure 10b: Total FHS Gross Expenditure 1993-94 to 2003-04, England



- The real term growth between 1993-94 and 2003-04 is 50 per cent.

**Please see Chapter 7 for more information on General and Personal Medical Services, General and Personal Dental Services, General Ophthalmic Services and Pharmaceutical Services.*

DRUGS BILL

6.33 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 NHS practitioners. Net drugs bill expenditure is total gross expenditure minus Pharmaceutical Price Regulation Scheme (PPRS) receipts.

6.34 The gross 2003-04 FHS drugs bill outturn for England was £6,802 million in cash terms; this represents a 9.4 per cent increase on the previous year. The average increase in the drugs bill over the previous five years was 9.3 per cent per annum.

6.35 In resource terms, the growth in the 2003-04 FHS drugs bill in England over the preceding year was 9.5 per cent and largely reflects the implementation of Government priorities set out in National Service Frameworks (NSFs) and NICE appraisals. In 2003-04 prescribing volume showed a contrast between the growth in the total number of items dispensed at 5.6 per cent, and a higher rise in some areas linked to NSFs – such as diabetes – 10 per cent, and National Institute for Clinical Excellence (NICE) guidance – such as on drugs for psychoses – 7 per cent. Of the 2003-04 growth in the drugs bill about 60 per cent was due to volume increases and 40 per cent to cost increases.

6.36 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 a GP/nurse 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/nurse in the period April to March.

Figure 6.11: Gross Family Health Services Drugs Bill, 1993-94 to 2003-04, England

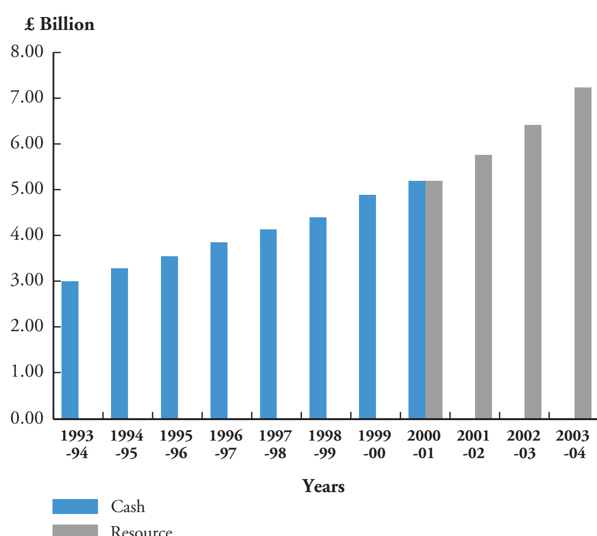
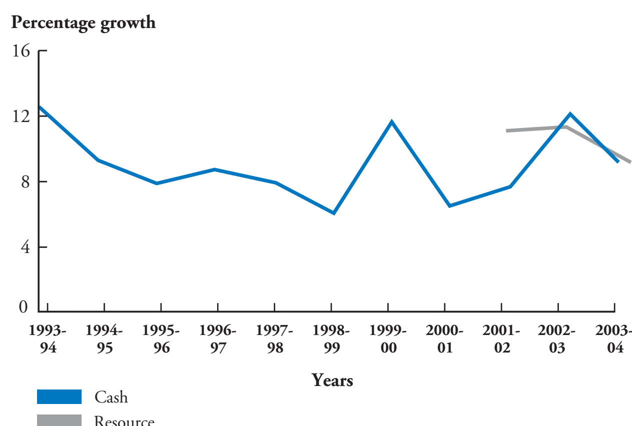


Figure 6.12: Gross Family Health Services Drugs Bill – Percentage Growth, 1993-94 to 2003-04, England



Branded Medicines

6.37 A new voluntary five-year agreement, negotiated with the Association of the British Pharmaceutical Industry (ABPI), replaced the 1999 Pharmaceutical Price Regulation Scheme (PPRS) from 1 January 2005. It indirectly controls the prices of branded prescription medicines to the National Health Service (NHS) by regulating the profits that companies can make on these sales.

6.38 The 2005 PPRS includes a seven 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 cut achieved as part of the 1999 PPRS has produced estimated savings to the NHS of £1.1 billion during the fifty-one months ended 31 December 2003.

6.39 The new agreement, announced on 3 November 2004, is a package of measures which reward innovation and research, but also keep public expenditure under control.

6.40 The 2005 PPRS states that, subject to public consultation, 'standard' branded generics will no longer be covered by the PPRS and will be transferred to the new arrangements for the reimbursement of generic medicines. This consultation exercise has started and is seeking comments by mid-April 2005.

Generic Medicines

6.41 The Maximum Price Scheme introduced in August 2000 continues to secure annual savings in the order of £330 million when compared with expenditure that would have been incurred if prices had remained at March 2000 levels.

6.42 In 2003, the Department identified significant differences between reimbursement prices and procurement prices of four new generic medicines and reduced the reimbursement prices of these medicines to align them more closely with widely available market prices, thereby creating annual savings of about £200 million. In September 2004, the Department further reduced reimbursement prices of these medicines to realign them with market prices, thereby generating additional savings of £100 million per annum.

6.43 Revised long-term arrangements for the reimbursement of generic medicines will be introduced in April 2005 leading to annual savings in the order of £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 6.13** provides details of the CHMS programme 2004-05 and 2005-06 budget levels. The figures for these years take into account all changes made to the programmes since the original announcement in 2003.

Figure 6.13: Central Health and Miscellaneous Services (CHMS) Gross Expenditure, 2004-05 to 2005-06

Budgets	2004-05	£000s 2005-06
Improving Services and Outcome in:		
• Cancer	39,692	54,000
• Children	3,187	3,150
Reducing Health Inequalities	29,056	37,791
Contributing to a reduction in Drug Misuse	1,364	3,150
Other CHMS budgets:		
Central Payments made on behalf of DH (e.g. EEA Medical Costs)	471,551	496,608
Public Health (e.g. Welfare Foods)	177,577	176,437
Statutory Bodies (e.g. Health Protection Agency)	126,283	128,901
R&D	37,226	35,586
Residual CHMS budgets (e.g. Communications, grants to voluntary organisations)	185,099	174,659
TOTAL	1,071,035	1,110,282

PERSONAL SOCIAL SERVICES

Personal Social Services Revenue Provision

6.46 In 2005-06, revenue funding of £11,448 million will be available for Adults' social services and the Child and Adolescent Mental Health Services element of Children's PSS. This is 8 per cent more than was available in 2004-05. The vast majority of this will be distributed to authorities through the Formula Spending Share, whilst the remainder will be distributed as specific grants.

Figure 6.14 below sets out all revenue and capital resources that will be made available for social services in 2005-06.

Figure 6.14: Personal Social Services Provision for Adults, 2005-06

	£ million
Formula Spending Shares (FSS)	9,552.0
Specific Revenue Grants:	
Preserved Rights	348.2
Residential Allowance	214.4
Access and Systems Capacity	642.0
Delayed Discharges	100.0
Carers	185.0
Mental Health	133.0
AIDS Support	16.5
National Training Strategy	94.9
Human Resources Development Strategy	62.8
Child and Adolescent Mental Health Services	90.5
DH funded. Allocated by other Government Depts.	*8.5*
Total Revenue Grants	1,895.8
Total Revenue Provision	11,447.8
Capital Resources	
Single Capital Pot SCE(R)	27.7
Ringfenced SCE(R) for mental health	22.6
Ringfenced SCE(R) for AIDS/HIV	3.1
Improving Information Management Grant	25
Total Capital Resources	78.4
Total PSS Provision	11,526.2

Figures may not sum due to rounding.

Personal Social Services Capital Resources

6.47 In 2005-06, the Department of Health will make available a total of £27.7 million for the Adults' PSS Single Capital Pot. Total capital funding in this category is allocated using the Department's own distribution formula.

6.48 In addition, a total of £25.7 million will be available to local authorities from DH in the form of two ring fenced Capital programmes, these being for Mental Health (£22.6 million) and AIDS/HIV services (£3.1 million). A further £25 million will be issued as a specific capital grant as part of the Improving Information Management programme.

6.49 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

6.50 Local authorities choose how much to spend on social services, what services they provide, and how to allocate the resources provided by central government between services. The figures provided show the actual expenditure by local authorities on personal social services in 2003-04. **Figure 6.15** shows gross expenditure by client group in 2003-04. **Figure 6.16** displays the breakdown by type of provision.

6.51 In 2003-04, gross expenditure in England on personal social services was £16.8 billion. The largest items of expenditure were for residential care (43 per cent) and day care (42 per cent). Within spending on residential care, most was spent on residential and nursing home care provided by the independent sector.

Figure 6.15: Local Authority Personal Social Services Gross Expenditure by Client Group, 2003-04

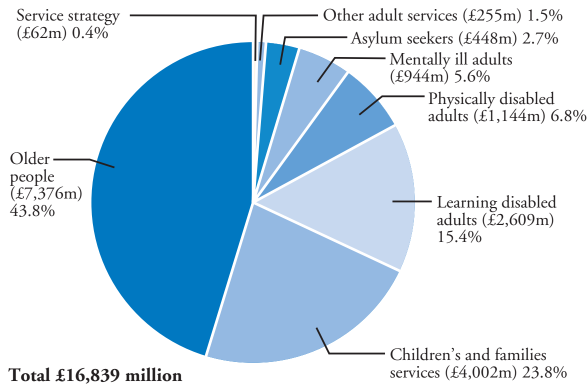
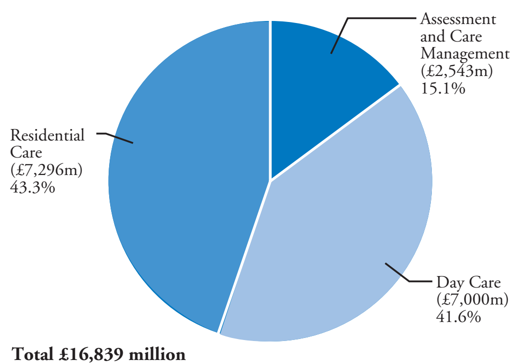


Figure 6.16: Local Authority Personal Social Services Gross Expenditure by Type of Service, 2003-04



7. Activity, Performance and Efficiency

7.1 NHS HOSPITAL ACTIVITY TRENDS

7.2 INPATIENT AND OUTPATIENT WAITING

7.6 EMERGENCY CARE

7.14 COMMUNITY NURSING, DENTAL AND CROSS SECTOR THERAPY SERVICES ACTIVITY

7.19 ACCESS TO PRIMARY CARE

7.31 FAMILY HEALTH SERVICES (PRIMARY CARE)

- -General and Personal Medical Services
- -Pharmaceutical Services
- -General and Personal Dental Services
- -General Ophthalmic Services

7.36 PERFORMANCE

- -Management Costs
- -Reducing Bureaucracy

7.39 FINANCIAL PERFORMANCE

7.54 EFFICIENCY

- -Reference Costs
- -Unit Costs

7.76 PERSONAL SOCIAL SERVICES

- -Adult's Services Activity

7.77 PSS PERFORMANCE AND PERFORMANCE ASSESSMENT

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	5,446	3.5%	0.0%
Emergency and other admissions (non-elective admissions)[1]	3,526	3,729	3,849	3,887	3,943	3,961	4,007	4,274	4,474	6.7%	4.7%
Total admissions (first finished consultant episodes)[1]	7,557	8,141	8,676	8,778	8,944	8,997	9,269	9,719	9,920	4.8%	2.1%
Geriatrics (thousands of episodes)											
Total admissions (first finished consultant episodes)[2]	459	401	399	383	359	347	359	359	n/a	0.1%	n/a
Maternity (thousands of episodes)											
Total admissions (first finished consultant episodes)[2]	905	827	880	884	896	877	906	970	n/a	7.1%	n/a
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	n/a	4.7%	n/a
- of which, Geriatrics[3]	77	107	108	113	114	115	115	125	n/a	8.7%	n/a
Maternity[3]	612	590	565	554	537	504	522	505	n/a	-3.3%	n/a
Mental Illness[3]	238	290	287	282	285	263	271	267	n/a	-1.5%	n/a
Learning Disabilities[3]	4	6	6	7	7	8	7	8	n/a	14.3%	n/a
All Specialties[3]	9,342	11,529	11,778	12,136	12,466	12,613	12,879	13,431	n/a	4.3%	n/a
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	n/a	-3.7%	n/a
- of which, Geriatrics[2]	26.9	22.7	22.2	21.8	23.3	23.4	23.1	19.7	n/a	-5.4%	n/a

(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. 2004/05 data are subject to revision once final outturn figures are received. Data are presented for financial years and are not adjusted for the differing number of working days per year. There were 3 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. 2004/05 data not yet available.

(3) Source KH09 and QMOP. Figures for 2001/2 and onwards are sourced from QMOP. 2004/05 data not yet available.

(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 2002-03 and 2003-04 for first outpatient attendances was 4.7 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,
- there was no increase between 2003-04 and 2004-05 for general and acute elective hospital admissions.

INPATIENT AND OUTPATIENT WAITING

7.2 In line with the *NHS Plan*[7.1], maximum inpatient waiting times will fall to six months by the end of 2005. The maximum waiting time for a first outpatient appointment will fall to three months (13 weeks) by the end of 2005.

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 Since 1 April 2004, the standard maximum waiting time for an inpatient appointment has been nine months and the standard maximum waiting time for a first outpatient appointment has been 17 weeks. Latest figures (December 2004) show that around seven out of ten inpatients are admitted within three months of decision to refer. The average wait to be seen for an outpatient appointment is around six 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 inpatient waiting times of over nine months and outpatient waiting times of over 17 weeks. PCTs and trusts are now concentrating on eliminating waits to meet the December 2005 targets.

EMERGENCY CARE

7.6 Improving access to emergency care is one of the Department's top priorities. The dramatic improvements made over the last two years are delivering a system of fast, responsive and effective emergency care services for the benefit of NHS patients and NHS staff.

7.7 The NHS Plan set a target of reducing the maximum time spent in A&E, from arrival to admission, discharge or transfer, to four hours. This was subsequently translated into the operational standard that at least 98 per cent of patients should be admitted, discharged or transferred within four hours to allow for the minority of patients who clinically need more than four hours in A&E.

7.8 This became a live operational standard at the beginning of January 2005. The latest monthly management information shows a figure of 98.1 per cent for April 2005 and in January to March 2005 97.3 per cent of patients were seen within four hours. In January to March 2004 just 92.7 per cent of patients were seen within four hours. This improvement is a substantial achievement. It has been delivered through the hard work of people across the NHS and its partner organisations.

7.9 Quarterly statistics on A&E performance can be seen at: **www.performance.doh.gov.uk/hospitalactivity/data_requests/**.

Delivering improvement

7.10 The National Audit Office's report on A&E services in October 2004 described "significant and sustained improvement in waiting times and also improvements in the environment for patients and staff". The October 2004 progress report, *Transforming Emergency Care in England*[7.3] by Sir George Alberti, the national clinical director for emergency care, set out the key factors contributing to this unprecedented improvement in emergency care. These included the ambitious, ground-breaking nature of the four-hour target, the ten-year strategy *Reforming Emergency Care*[7.4], changes to models for providing primary care out-of-hours services, the Emergency Services Collaborative, and a delivery plan that reflected the need for whole-system co-ordination.

7.11 Sir George's report also set out the successful approaches that local health communities had taken, supported by the Department of Health, to transform emergency care:

- **identifying local problems:** the Department has supported Trusts in diagnosing the specific local factors causing delays in A&E (e.g. waits for beds, waits for specialists, waits for diagnostic tests);
- **improvements across the hospital:** the Department and the Emergency Services Collaborative have worked with the NHS to transform ways of assessing and treating patients with minor complaints using the innovative 'See and Treat', to improve bed management across elective and emergency care, to ensure availability of specialist doctors, and to re-design processes for diagnostic interventions;
- **improvements across the whole system:** the development of Minor Injury Units and Walk-in Centres, changes to primary care out-of-hours provision, improvements in ambulance services, and the development of staff roles such as emergency care practitioners; and,
- **improvements for specific patient groups:** including children, older people, patients with mental ill health, and patients with coronary heart disease.

Improving the patient experience in A&E

7.12 Surveys confirm that waiting times are a top priority for patients in A&E. That is why the Government introduced the NHS Plan target outlined above. However, patients are also concerned with cleanliness and being treated in a more pleasant environment, having access to information, and having better facilities for children. Jonathan Asbridge, clinical director for patient experience in emergency care, is leading a programme to improve the overall experience of patients who are seen and treated in A&E. Work to date has included developing the role of modern matrons and nurse consultants and improving the experience of particular groups of patients. For example, a checklist to help improve the care of patients with mental ill health who access emergency care services was issued last year and a children's checklist will be issued shortly.

Not everyone wants or needs to go to A&E

7.13 A&E is just one part of a much wider system of urgent care. Nowadays, in addition to A&E, patients are able to access Minor Injury Units, primary care out-of-hours services (where a GP or a nurse may treat them) and Walk-in Centres. Alternatively, they may prefer to receive self-care advice from a pharmacist or NHS Direct. To build on the successes achieved in reducing time spent in A&E and improving access to primary care professionals, the Department is developing a programme of work to join up urgent care services so that patient health and social care needs and preferences are addressed in a timely and consistent way.

COMMUNITY NURSING, DENTAL AND CROSS SECTOR THERAPY SERVICES ACTIVITY

7.14 Statistics on community nursing services and on cross sector therapy services over the period 1998-99 to 2003-04 are shown in **Figure 7.2.**

7.15 Overall, contacts with therapy services professionals and with community nursing services rose slightly in 2003-04. The highest increase in 2003-04 was for specialist care nursing services with 6 per cent more new episodes of care commenced in the year; only for chiropody was the number of new episodes of care lower in 2003-04 (showing a fall of 3 per cent compared with 2002-03).

Chiropody

7.16 About 56 per cent of initial contacts were with patients aged 65 and over.

Speech and language therapy

7.17 About 39 per cent of the new episodes were with school and pre-school children in the age range 3-15.

Occupational therapy and physiotherapy

7.18 About 76 per cent of the new episodes of care for occupational therapy and 64 per cent for physiotherapy were referrals from hospital (as opposed to GP or other referrals).

7.23 These results represent a major improvement for which practices (and PCTs) deserve great credit

7.24 The strategy has three components:

Effective management by PCTs

A managed approach through PCTs that requires them to ensure that the target is delivered and sustained across their area. PCTs have been asked to ensure that all patients not only have 24/48 hour access but can also book an appointment for a future date. 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

Figure 7.2: Community nursing, dental and cross sector therapy services activity

Thousands

Number of episodes [1] [2]	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04
Health visiting	3,600	3,400	3,300	3,200	3,000	3,000
Community nursing services (total)	2,900	2,900	2,700	2,700	2,600	2,600
District nursing	2,200	2,200	2,000	2,000	1,900	2,000
Community mental health nursing	360	340	330	330	320	330
Community learning disability nursing	26	24	24	23	24	24
Specialist care nursing	300	310	310	310	320	330
Chiropody services	880	850	830	820	820	790
Occupational therapy	1,160	1,180	1,190	1,190	1,250	1,270
Physiotherapy	4,200	4,200	4,200	4,200	4,200	4,300
Speech and language therapy	330	330	330	330	340	340
Community dental services [3]	967	869	747	609	544	n/a

(1) Number of new episodes commenced in the year except health visiting (number of different persons seen at least once in a year) and community dental services (number of episodes of care commenced in year).

(2) Estimated national totals based on those NHS trusts supplying data.

(3) Includes a small number of discontinued episodes of care.

ACCESS TO PRIMARY CARE

7.19 Primary care is the shop window of the NHS. There are some 300 million consultations with general practice each year. Alongside consistently high levels of satisfaction with the services provided in primary care, patients have expressed some dissatisfaction about access to those services.

7.20 The NHS Plan sets a target for: *guaranteed access to a primary care professional within 24 hours and to a GP within 48 hours, to be achieved nationally by 2004.*

7.21 Almost all patients can now get quick access to a GP or Primary Care Professional (PCP) within the NHS Plan target time frames.

7.22 The most recent primary care access survey in January 2005 showed that:

- 99.9 per cent of patients were able to be offered a GP appointment within 2 working days; and,
- 99.9 per cent were able to be offered a primary care professional appointment within one working day.

and pre-bookable appointments that meet the needs of their patients.

Modernisation at practice level

The National Primary Care Collaborative now works with over 5,000 practices responsible for over 32 million patients promoting primary care modernisation with individual practices. Through this Advanced Access Programme, GPs' peers provide working examples that help persuade doctors that quick and convenient patient access can be delivered largely within existing resources through changed working practices. It also shows that this approach is a proven strategy towards improving the working lives of GPs and practice staff.

Incentives at PCT and practice level

Both the above approaches are supported by incentive schemes in the new GMS and PMS contracts.

7.25 Improving access is embedded in the new GMS contract as a *Directed Enhanced Service*[7.5], requiring PCTs to offer practices incentive payments for improving access (with local discretion on

what each practice is expected to deliver). An average sized practice receives £5,000 over 2005-06.

7.26 *The Quality and Outcomes Framework*[7.6] rewards practices who deliver 24/48 hour access with 50 bonus points, worth typically £3,750 for 2004-05, increasing to £6,000 from 2005-06.

7.27 PCTs are incentivised through star ratings where 24/48 access represents two out of the nine key target indicators. Access to Primary Care will also feature in the 2005 Performance ratings.

NHS Walk-in Centres

7.28 64 NHS Walk-in Centres are now open and operating a service. They provide an alternative means of access to growing numbers of people and complement both general practice and A&E.

7.29 Since opening in 2000, the centres have seen around 6 million people. On average, each centre sees around 115 patients a day, i.e. 42,000 patients a year.

7.30 The Department is also developing an initial seven commuter-focused NHS Walk-in Centres, through independent procurement, as part of the Government's commitment to give commuters access to primary care services near to their workplace. Four will be in London at Victoria, Kings Cross, Canary Wharf and Liverpool Street, with a further three in Newcastle, Manchester and Leeds coming on stream from spring 2005. Each will be open to local residents too.

FAMILY HEALTH SERVICES (PRIMARY CARE)

7.31 See glossary for definitions of the FHS areas.

General and Personal Medical Services (GMS and PMS)

7.32 **Figure 7.3** provides key information on General and Personal Medical Services in England.

Key Points:

- the total number of GMP (GMS and PMS combined) Unrestricted Principals and Equivalents (UPEs) rose by 7.0 per cent in 2003-04;
- the numbers of GPs transferring over from GMS into PMS continue to reflect year-on-year decreases in overall GMS spend. In total, GMS non-discretionary and discretionary spend in 2003-04 has reduced overall by 7.7 per cent and is less than the same period in 2002-03, whilst PMS continues to increase across all waves, 1 to 5b, to 68.3 per cent in the same period;
- real terms GMS non-discretionary and discretionary expenditure per GMS GPs are now expressed from 2000-01 in resource terms in line with Government accounting arrangements;
- figures on the total number of consultations for 2003-04 are 215 million and the total number of consultations per GMP (UPE) is 7,500;
- PMS Pilots are a key element in the modernisation programme of the NHS, improving patient access to the NHS by opening up new, more flexible ways of offering Primary Care services;
- up to 2003-04, 3,834 PMS pilots have been established since the introduction of PMS in April 1998 (i.e. waves 1 to 5b); and,
- PMS Pilots at 2003-04 account for some 39.5 per cent of GMS GPs having transferred into PMS. The intended NHS Plan targets of 33 per cent coverage by 2004 has now been achieved a year earlier than anticipated.

Figure 7.3: Key Statistics on General & Personal Medical Services (GPMS), England

	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	% Change 1995-96 to 2003-04	% Change 2002-03 to 2003-04
Staffing											
Number of General Medical Practitioners (UPEs)[1]	26,702	26,855	27,099	27,392	27,591	27,704	27,843	28,031	28,568	7.0%	1.9%
of which GMS UPs	26,702	26,855	27,099	27,031	26,710	26,436	24,039	21,547	18,470	-30.8%	-14.3%
Number of GP Practice Staff (WTE)[1]	59,255	59,318	60,579	61,331	63,087	62,583	64,998	67,107	69,140	16.7%	3.0%
Number of practice nurses(WTE)[1] (included in practice staff)	9,745	9,821	10,082	10,358	10,689	10,711	11,163	11,998	12,967	33.1%	8.1%
Organisation											
Number of practices[1]	9,062	8,999	9,003	8,994	8,944	8,878	8,817	8,748	8,757	-3.4%	0.1%
Average List size[1][2]	1,887	1,885	1,878	1,866	1,845	1,853	1,841	1,838	1,845	-2.2%	0.4%
Consultations											
Total number of consultations (millions)[3][4]	237	256	*	220	*	224	217	241	215	-9.3%	-10.8%
Total number of consultations per GMP (UPEs)[3][4]	8,900	9,500	*	8,000	*	8,100	7,800	8,600	7,500	-15.7%	-12.8%

Figure 7.3: Key Statistics on General & Personal Medical Services (GPMS), England

	Cash [5]						Resource [6]					
	1995-96	1996-97	1997-98	1998-99	1999 -2000	2000-01	2000-01	2001-02	2002-03	2003-04	% Change 1995-96 to 2002-03	% Change 2002-03 to 2003-04
Expenditure												
Total General Medical Services (£m)	2,719	2,873	3,033	3,121	3,336	3,449	3,531	3,230	2,908	2,684	-1.3%	-7.7%
GMS Discretionary (Cash limited) (£m)	754	800	835	878	885	940	1,024	959	840	781	3.6%	-7.0%
GMS Non Discretionary (Non-cash limited) (£m)	1,965	2,073	2,198	2,243	2,451	2,510	2,507	2,271	2,068	1,903	-3.2%	-8.0%
Total Personal Medical Services (Discretionary)[6] (£m)	n/a	n/a	n/a	37	84	174	203	689	1,152	1,939	n/a	68.3%
Total GMS expenditure per GMS UP (£)	101,828	106,982	111,923	115,460	124,897	130,474	133,568	134,365	134,961	145,317	42.7%	7.7%
Total GMS expenditure per GMS UP at real terms 2002-03 prices[7] (£)	125,146	127,202	129,719	146,865	137,761	142,347	n/a	142,830	138,740	149,386	19.4%	7.7%
GMS Discretionary expenditure per GMS UP (£)	28,238	29,790	30,813	32,481	33,134	35,543	n/a	39,894	38,985	42,285	49.7%	8.5%
GMS Discretionary expenditure per GMS UP at real terms 2003-04 prices[7] (£)	34,704	35,420	35,712	41,316	36,546	38,778	n/a	42,407	40,076	43,469	25.3%	8.5%
Real terms total GMS and PMS expenditure per consultation (2003-04 prices)[7] (£)	14.10	13.34	n/a	18.26	n/a	17.65	n/a	19.20	17.32	22.10	56.8%	27.6%
Dec 04 GDP	1.23	1.19	1.16	1.27	1.10	1.09	n/a	1.06	1.03	1.03		

(1) Source GMS Census as at 1 October 1995-1999 and 30 September 2000-2003. Data refers to Unrestricted Principals & Equivalents- UPEs (Unrestricted Principals, PMS Contracted and PMS Salaried GPs).
(2) Average list size is calculated per UPE whether full, three quarter, half-time or job share.
(3) Source General Household Survey. Data for 1997 and 1999 are unavailable as there was no General Household Survey for these years.
(4) The method of calculating estimates of GP consultations is subject to revision in future. Historic figures may be changed in light of this and of ONS work on amending previous population estimates.
(5) All cash information taken from Appropriation Accounts up to 2000-01 and from FIMS FHS 4 returns up to 2001-02. All resource figures from 2000-01 to 2003-04 are taken from the ASF audited accounts returns.
(6) In line with government accounting arrangements from 2000-01 following the introduction of resource accounting, all expenditure will be in resource terms only.
(7) PMS expenditure totals are intended to cover all PMS contract costs for waves 1, 2a, 2b, 3a, 3b, 4a, 4b, 5a and 5b only.
(8) Figures have been converted into real terms using the latest December 2004 GDP deflator.

Pharmaceutical Services (PHS)

7.33 **Figure 7.4** provides key information on Pharmaceutical Services in England.

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 2003-04 was 5.1 per cent, the same as the previous year;
- the gross cost per prescription increased by 0.4 per cent in 2003-04;
- the drugs bill continues to rise – see chapter 6 for more information; and,
- the percentage of prescriptions that attract a charge has remained fairly constant at between 13.7 per cent to 14.9 per cent over the past five years.

General and Personal Dental Services (GDS and PDS)

7.34 **Figure 7.5** provides key information on General and Personal Dental Services in England.

Key Points:

- the overall volume of activity was broadly stable in 2003-04;
- the number of general and personal dental practitioners continues to increase, by 1 per cent in the year to September 2003 and by 23 per cent in the last ten years but dentists on average are doing less GDS work;
- patient registrations have decreased slightly between 2002-03 and 2003-04 but in general have been stable since 1998, following the reduction caused by the shortening of the registration period to 15 months from September 1996;
- there were over 26 million courses of treatment for adults during 2003-04, similar to the number in 2002-03 and 6 per cent higher than in 1993-94;
- the average cost of an adult course of treatment was £43 in 2003-04, 1 per cent lower in real terms than in the previous year. The reduction of 8 per cent since 1993-94 reflects a reduction in the amount of complex or advanced treatments;
- the introduction of the Personal Dental Service in October 1998 has replaced some GDS activity; and,
- at 30 September 2003, 1,190 dentists were working in the PDS, 802 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 7.4: Family Health Services – Key Statistics on Pharmaceutical Services, England

		1993-94	1999 -2000	2000-01	2000-01	2001-02	2002-03	2003-04	% change 1993-94 to 2003-04	% change 2002-03 to 2003-04
		Cash			Resource					
Pharmaceutical Services[1]										
Prescriptions (millions)[2]		455.3	542.6	570.2		603.5	633.4	666.0	46.3	5.1
Number of contracting pharmacies[3] [4]		9,766	9,767	9,765		9,756	9,748	9,759	-0.1	0.1
Average number of prescriptions dispensed by pharmacy and appliance contractors		41,290	49,641	52,066		55,238	58,047	60,998	47.7	5.1
Cost of pharmaceutical services per prescription in real terms (2002-03 prices) (£)[2] [5]	*Gross*	10.3	11.51	11.52	11.51	11.62	11.84	11.89	15.4	0.4
	Drug	8.4	9.86	9.88	9.87	10.07	10.34	10.45	24.4	1.1
	Remuneration	1.90	1.65	1.64	1.64	1.55	1.50	1.44	-22.6	-4.0
Net cost of drugs and appliances in real terms (2002-03 prices) (£m)[2] [6] [8]		3,787	5,331	5,628	5,625	6,069	6,549	6,960	83.8	6.3
Percentage of all prescription items which attracted a charge[7]		17.9	14.9	14.9		14.6	14.3	13.7		

(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 (eg 2003-04 relates to the period Feb 2003 to Jan 2004) 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 (eg. 2003-04 is number as at 31 March 2004).
(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 1 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 December 2004 GDP deflator.
(9) Costs are shown in cash from 1993-94 to 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.

Figure 7.5: Family Health Services – Key Statistics on General and Personal Dental Services, England

	1993-94	1999 -2000[2]	2000-01[2]	2001-02[2]	2002-03[2]	2003-04[2]	% Change 1993-94 to 2003-04	% Change 2002-03 to 2003-04
General Dental Services[1][2]								
Number of general dental practitioners[3]	15,773	17,721	18,049	18,354	18,400	18,537	18	1
Adult courses of treatment (thousands)	24,848	25,915	26,353	26,318	26,284	26,394	6	0
Adults registered into continuing care (thousands)[4][5]	21,530	16,649	16,813	16,793	16,739	16,650	-23	-1
Children registered into capitation (thousands)[4][5]	7,396	6,821	6,845	6,784	6,733	6,671	-10	-1
Average gross cost of an adult course of treatment (2003-04 prices) (£)[6][7]	46	43	44	44	43	43	-8	-1
Personal Dental Services[2]								
Number of personal dental practitioners[8]	n/a	148	326	707	997	1,190	n/a	19
Number of personal dental practitioners not working in the general dental service[8]	n/a	89	192	467	656	802	n/a	22
Courses of Treatment (thousands)	n/a	217	312	480	659	762	n/a	16
Total Dental Services								
Number of general and personal dental practitioners	15,773	17,810	18,241	18,821	19,056	19,339	23	1

(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 has affected some 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 onwards.
(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 2003-04 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 7.6** provides key information on General Ophthalmic Services in England.

Key Points:

- the number of NHS sight tests has risen substantially by some 66 per cent over the ten years from 1993-04 to 2003-04, 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 then the underlying trend has been for an average annual increase of about 1 per cent in the volume of tests;
- the volume of NHS optical vouchers has fluctuated over the past ten years, reflecting changes from year to year 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), but is relatively stable over the longer period. The volume of vouchers in 2003-04 was about 1 per cent higher than the totals in both the previous year and the equivalent figure for 1993-94;
- 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 2003-04 total of 8,331 represented an increase of 3 per cent over the previous year's figure, and an increase of 26 per cent over the numbers in 1993-94.

PERFORMANCE

Management Costs

7.36 Management costs continue to be reported within end of year accounts for all NHS organisations and figures show a downward trend in the total amount of money being spent on management as a proportion of the total NHS budget. In 1998-99, 4.7 per cent of the NHS budget was spent on management; by 2003-04 that had fallen to 3.8 per cent.

Reducing Bureaucracy

7.37 The Department has recently undergone an 18-month programme of change, so that it provides more effective strategic leadership to the NHS and social care and a better service to the public. The first and largest of its type in Whitehall, it has led to a 38 per cent reduction in staff in the Department. The reduction of central DH staff reflects the continuation of shifting the balance of power from Whitehall to frontline NHS staff and organisations.

7.38 DH has made significant progress in delivering the Prime Minister's Six Point Strategy to reduce bureaucracy in public services, for example:

- the Department has exceeded its own target of a 20 per cent reduction in data collection by March 2005;
- we have cut the volume of communications to the NHS and Social Care by 50 per cent;
- the number of central DH staff has reduced by 38 per cent;
- the Department's review of arm's length bodies (ALBs) is on course to deliver a 50 per cent reduction in the number of ALBs, generate savings in expenditure of £0.5 billion, and a reduction in staffing levels by 25 per cent by 2007-08;
- we are also implementing the principles of the Gershon and Lyons Reviews; improved efficiency, reduced bureaucracy, better value for money and the location of ALBs, whenever possible, outside London and the South East;
- there are 31 NHS Foundation Trusts currently in operation and by 2008 all NHS trusts will be in a position to apply to become NHS Foundation Trusts;

Figure 7.6: Family Health Services – Key Statistics on General Ophthalmic Services

General Ophthalmic Services	1993-94[4]	1999 -2000	2000-01	2001-02	2002-03	2003-04	% Change 1993-94 to 2003-04	% Change 2002-03 to 2003-04
NHS sight tests (thousands)[1]	5,930	9,399	9,567	9,807	9,662	9,845	66%	2%
Optical vouchers (thousands)[2]	3,480	3,662	3,575	3,607	3,472	3,520	1%	1%
Number of opticians[3]	6,619	7,517	7,824	8,103	8,096	8,331	26%	3%

(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.
(4) 1993-94 NHS sight tests and optical voucher figures are rounded to the nearest 10,000.

- ministers have been engaging with frontline staff through a series of front line visits and seminars to improve communications and ensure that resources are best placed to tackle significant burdens;
- we have reduced the number of national targets for the NHS and social care from 62 in the 2002-03–2004-05 planning round, to only 20 for the next three years (from April 2005); a reduction of over two-thirds;
- the Department of Health scrapped the requirement for NHS trusts to report on Controls Assurance in August 2004; and,
- the Healthcare Commission and the Department have jointly launched a Healthcare Inspection Concordat. This will mean fewer and less burdensome inspections, less data collections and more joined up action planning.

FINANCIAL PERFORMANCE

Overall NHS Performance

7.39 In 2003-04, primary care trusts, NHS trusts and strategic health authorities achieved an overall revenue resource underspend of £73 million and a capital resource underspend of £161 million.

Strategic Health Authorities

7.40 Strategic health authorities 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 of Health. This includes the performance management of NHS trusts and primary care trusts.

7.41 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 without the need of unplanned financial support – this is not a statutory duty but a performance management measure.

7.42 In 2003-04, all SHAs achieved their statutory financial duty to remain within revenue resource, capital resource and cash limits. They also all achieved the financial balance performance measure.

Primary Care Trusts

7.43 Primary care trusts 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 2003-04.

7.44 In the same way as strategic health authorities, PCTs are subject to revenue and capital resource limit and cash limit control. PCTs are also required to achieve financial balance without the need of unplanned financial support – this is not a statutory duty but a performance management measure.

7.45 In 2003-04, there were 262 PCTs that achieved their statutory financial duty to remain within their revenue resource limit, and 41 which reported an overspend. On capital, 301 PCTs contained spending within their capital resource limit, and two breached the limit, one by more than the de minimus limit of £50,000. No PCTs breached their cash limit in 2003-04.

NHS Trusts

7.46 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.

7.47 There were 269 operational NHS trusts in 2003-04. NHS trusts have five main financial duties, which are:

- to breakeven on an income and expenditure basis. NHS trusts have a statutory duty to breakeven, 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 breakeven duty, but in exceptional cases the Department of Health may agree to a five-year timetable;
- 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 breakeven 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.

7.48 In aggregate, NHS trusts reported an income and expenditure deficit, on an accruals basis, of £138 million in 2003-04, compared to a £94 million deficit in 2002-03. There were 204 NHS trusts that achieved financial balance or better and 65 that made a deficit. No NHS trusts breached their statutory financial duty to breakeven 'taking one financial year with another'.

7.49 In 2003-04, after adjustment for immaterial results, 261 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 eight absorbed less than the required return.

7.50 There were 259 NHS trusts that contained capital expenditure within the capital resource limit after taking account of de minimus overshoots.

7.51 Also, 262 NHS trusts remained within their external financing limit, after taking account of de minimus overshoots.

Payment of Bills by NHS

7.52 All health bodies are expected to conform to Government Accounting Regulations and the Better Practice Code. 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.

7.53 NHS performance in paying its bills has improved over the years, and a large number of NHS trusts, PCTs and health authorities are prompt payers. The national average is around 84 per cent of bills paid on time. However, improvement is required before the current target of 95 per cent is attained.

EFFICIENCY

7.54 The NHS, social services and Department of Health are to make very significant efficiency gains over the next three years. These will maximise benefit for patient care from the additional investment we are making.

7.55 The Department of Health agreed an efficiency target as part of SR2004 to achieve savings of £6.5 billion by 2007-08, equivalent to 2.7 per cent per year. This is 30 per cent of the total projected savings across government.

7.56 A significant proportion of savings will come from improving the productive time of frontline staff through:

- new pay contracts for consultants, GPs and other health staff;
- the modernisation of services in the NHS; and,
- the implementation of a modern ICT infrastructure in the NHS.

7.57 The other main areas where we are expecting to achieve savings are:

- the procurement of goods and services in the NHS through national contracts and regional procurement hubs;
- improving the procurement of adult social care by carrying out a supply chain review similar to the one that has already identified savings of at least £500 million in the NHS;
- use of shared service centres in the NHS to reduce the cost of the central finance function; and,
- reduction in the size of the Department of Health and a reduction in the number and size of the arm's length bodies.

7.58 There have already been a number of early gains. We have made progress in reducing the cost of policy, funding and regulation of the system:

- Department of Health (head office) staff numbers have been reduced by 38 per cent;
- the completion of a review of the Department's arm's length bodies (ALBs) confirmed a reduction in ALBs from 38 to 20 generating a saving of £500 million by 2007-08 and a 25 per cent reduction in posts by the same date; and,
- following on from the ALB review it has been announced that the Healthcare Commission and Commission for Social Care Inspection will merge to form a single organisation by 2008, helping to reduce the burden that regulation can place on the front line.

7.59 Gains made in improving procurement in 2004-05 include:

- agreement with the pharmaceutical companies that will save the NHS over £300 million per year;
- negotiated savings in the price of generic drugs that will save around £300 million per year;
- annual savings of £160 million on renegotiation of national procurement contracts; and,
- through NHS Connecting for Health eleven enterprise software agreements were signed for the NHS, including a contract with Microsoft and Oracle.

7.60 Improvements have been made in reducing the costs of corporate services such as finance and human resources. NHS Shared Business came into being on 1 April this year. This is a joint venture between the private sector firm Xansa and the Department and is the first of its kind. It will deliver savings of more than £220 million of NHS funding over the next ten years by offering NHS organisations the benefits of guaranteed cost savings, reduced capital expenditure and high quality services.

7.61 To measure progress against our 2002 Spending Review value for money PSA targets, the Department of Health has developed an interim value for money measure, which measures value for money in terms of improvements in cost efficiency. In 2003-04, this measure suggests that value for money through cost efficiency increased by 2.1 per cent.

7.62 Cost efficiency is measured as the inverse of NHS unit cost growth after adjustment for:

- changes in the mix of NHS services provided;
- input cost inflation; and,
- expenditure on improving NHS quality.

7.63 Service effectiveness is measured by valuing:

- changes in post hospital mortality rates; and,
- changes in waiting times.

7.64 One of the principal recommendations of the Atkinson Review of the Measurement of Government Output and Productivity was that quality of care should be included in the measurement of NHS output and productivity measures. The Department of Health will, therefore, be working closely with the Office for National Statistics (ONS) to improve further the NHS output and productivity measures and, in particular, measures of quality improvements.

7.65 The Department has submitted to the Atkinson Review Team and Office for National Statistics draft proposals for a revised output measure for social services for adults, for use in the National

Accounts. This takes the form of a cost-weighted activity index, which covers around 90 per cent of social services activities (in expenditure terms). It takes account of changes in the quantities of services but not of changes in the quality of care or the need/dependency of service users.

7.66 The Department has commissioned the Personal Social Services Research Unit (PSSRU) at the University of Kent and London School of Economics to produce a further revised measure of social care output that will take account of changing quality of care and changing client dependency. A report of this research is expected in autumn 2005.

Reference Costs

7.67 *Reference Costs 2004*[7.7] details the national average unit costs across the NHS for a range of treatments and procedures for the 2003-04 financial year.

7.68 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.

7.69 The publication covers over £33 billion of NHS expenditure, compared with approximately £29 billion in 2002-03. This accounts for over 90 per cent of hospital and community health services expenditure.

7.70 The unit costs cover services ranging from:

- straightforward x-rays to complex treatments such as transplant surgery; and,
- a midwife's visit to a new baby, to the cost of physiotherapy treatments.

7.71 The range of coverage allows reference costs to be used as the basis of a number of other initiatives. These include efficiency targets, and the setting of guidelines for a national tariff for NHS services, as part of the new Payment by Results initiative.

Unit Costs

7.72 With the exception of services intended primarily for the elderly, overall unit costs in the hospital sector have tended to rise in real terms in the last ten years to 2003-04, most markedly in Learning Disabilities. However, the position varies depending on the category of care being delivered.

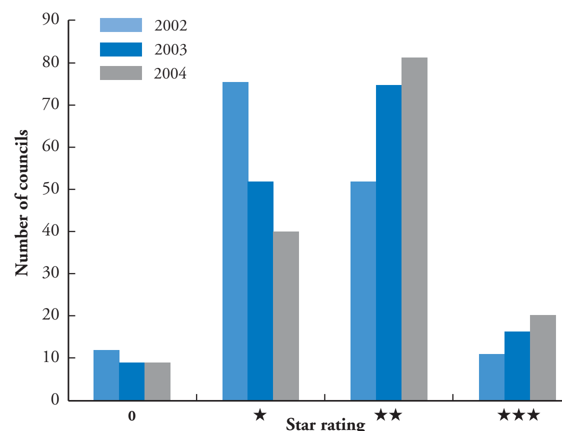
The Learning Disabilities Sector

7.73 In the Learning Disabilities sector, unit costs of inpatient care rose since the early 1990s, due to the changing use of NHS facilities. Although the NHS does still provide some social care for people with learning disabilities, the specialist NHS services are increasingly concerned with those with complex needs such as multiple disabilities, mental health problems or challenging behaviour. Increasingly, people with learning disabilities rely on generic health services for their day-to-day health needs and use specialist services for assessment and treatment of needs that can only be met by the specialist learning disability services.

7.74 Due to estimations used to produce the 1999-2000 HCHS Programme Budget, the figures shown for 1999-2000 should not be used in comparison with other years.

7.75 **Figure 7.7** shows how unit costs have moved in real terms across the five major categories of hospital inpatient care.

Figure 7.7: Average unit costs by category of care 1992-93 to 2002-03 (Index 1991-92 = 100)



PERSONAL SOCIAL SERVICES

Adults' Services Activity

7.76 **Figure 7.8** gives a summary of Personal Social Services provided to adults. Adults' services include all services provided to those who have just reached adulthood to the most elderly of the population.

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;
- whilst 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. There is also evidence that in 2003-04 there were more people helped to live at home by means of community-based services that are wider than home care. The number of older people (aged 65 or over) helped to live at home in 2003-04 was 662,100. The number of younger adults (aged 18-64) helped to live at home was 319,200 in 2003-04;
- around 87,100 households (24 per cent of households receiving home care) received intensive home help/home care in 2003 (defined as more than 10 contact hours and six or more visits during the week). This represents a 7 per cent increase from the 2002 figure of 81,400;
- the number of people supported by councils in residential or nursing care has decreased slightly by 2 per cent in 2003-04,

following a steady increase 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. The number of residents supported in local authority homes continues to fall whilst those supported in independent homes has risen; and,

- the PSA target – to increase by March 2006 the number of those supported intensively to live at home to 30 per cent of all those being supported by social services at home or in residential care – has risen to 30.1 per cent in 2003-04, therefore meeting the target two years early.

PSS PERFORMANCE AND PERFORMANCE ASSESSMENT

Performance Ratings for Social Services

7.77 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.

7.78 The information below represents the performance ratings for councils responsible for social services in England at November 2004. The star ratings summarise the CSCI's independent judgements of performance across all social services, on a scale of zero to three stars.

Figure 7.8: 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[4]	2001-02[4]	2002-03[4]	2003-04[4]
All adults aged 18 or over											
Households receiving fairly intensive home care[1]	61,800	86,800	107,900	107,100	117,600	133,800	143,500	151,700	156,800	160,800	163,900
Households receiving intensive home care[1a]	..	..	..	..	..	60,700	68,700	72,300	77,400	81,400	87,100
People supported in residential care[6,7]	119,200	137,500	153,200	170,300	176,500	181,200	185,800	184,400	186,600	200,500	196,500
People supported in nursing care[6,7]	25,200	43,200	57,200	66,100	72,900	73,500	73,900	71,800	72,600	78,400	75,800
People aged 18-64											
with physical/sensory disabilities											
helped to live at home per 1000 pop[2]	..	..	..	2.2	2.3	2.0	..	..	..		
helped to live at home per 1000 pop[3,5]	..	..	..	..	..	3.6[R]	3.8[R]	3.8	3.8	4.1	4.2
supported in residential care[6,7]	6,300	7,100	6,700	7,200	5,900	5,900	6,300	6,100	6,000	6,900	6,500
supported in nursing care[6,7]	1,500	2,300	2,700	3,200	2,800	3,200	3,400	3,400	3,700	4,500	4,400
with mental health problems											
helped to live at home per 1000 pop[2]	..	..	..	1.2	1.2	1.2	..	..	..		
helped to live at home per 1000 pop[3,5]	..	..	..	..	..	1.8[R]	2.2	2.7	3.1[R]	3.3	3.4
supported in residential care[6,7]	4,200	5,200	6,500	6,800	7,900	8,700	8,900	9,300	9,500	10,300	9,900
supported in nursing care[6,7]	270	600	850	1,130	1,370	1,500	1,600	1,700	1,800	2,500	2,400
with learning disabilities											
helped to live at home per 1000 pop[2]	..	..	..	2.3	2.2	2.2	..	..	..		
helped to live at home per 1000 pop[3,5]	..	..	..	..	..	2.5[R]	2.4[R]	2.5	2.6	2.6[R]	2.7
supported in residential care[6,7]	17,500	20,300	22,200	24,800	25,100	26,900	28,500	28,700	29,200	33,400	32,600
supported in nursing care[6,7]	190	300	640	690	930	930	1,010	990	1,090	1,860	1,860
in other groups											
supported in residential care[6,7]	1,400	1,800	1,700	2,100	2,300	2,000	1,800	1,700	1,500	1,500	1,500
supported in nursing care[6,7]	140	190	230	280	340	300	260	270	200	240	170
People aged 65 or over											
helped to live at home per 1000 pop[2]	..	..	..	83	81	71	..	..	..		
helped to live at home per 1000 pop[3,5]	..	..	..	..	..	82	86[R]	84[R]	84	84[R]	84
number helped to live at home[5,8]	..	..	..	..	729,600	637,600	662,000	649,700	660,200	660,700[R]	662,100
supported in residential care[6,7]	89,800	103,100	116,100	129,400	135,300	137,800	140,400	138,600	140,400	148,400	146,100
supported in nursing care[6,7]	23,100	39,900	52,800	60,800	67,500	67,500	67,600	65,500	65,800[R]	69,300	67,000

Care in own homes comes from a survey week in September, care in residential/nursing homes is at 31 March.
(1) Intensive is defined here as receiving more than 5 hours of home care and 6 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 6 or more visits during a survey week in September/October.
(2) 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.
(3) 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.
(4) The total number of households is calculated differently for 2000-01 and onwards than in previous years.
(5) Data as at March each year.
(6) Data from 2002-03 includes clients formerly in receipt of preserved rights.
(7) Data in 2003-04 includes Boyd loophole residents.
(8) Some of the increase over the years may reflect improvements in data quality.
R - Figure has been revised

Why are ratings being published?

7.79 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 taxpayer. Central government needs to know how well each council is meeting the aims and objectives it has set to improve social services.

Who produces the ratings?

7.80 The CSCI works independently of the councils to assess their performance, drawing on evidence from inspections, monitoring and performance indicator data. The ratings summarise this evidence in a way that is both accessible to all and soundly based on all the available information.

What do the ratings mean for councils?

7.81 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 planning information. Councils with zero stars receive additional support, return fuller information, and are subject to more frequent monitoring.

Additional Information about local performance

7.82 In addition to the judgements and star ratings, a report of CSCI's annual review of each council's improvement and performance is published on the CSCI website. These reports are sent by CSCI to the council following an annual review meeting, 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

7.83 Star Ratings are a product of a wider performance assessment process, bringing CSCI and the councils into continuous contact throughout the year. Assessment includes 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 assessment culminates in an annual review meeting with each council, normally during the summer. The purpose of this meeting is to review past performance and consider the priorities for further improvement. Following the annual review, 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.

Criteria used in reaching performance judgements

7.84 The standards and criteria for judgements are published each year. These 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 2003-04 are set out for each council in a performance report sent after the annual review meeting.

The role of *Key Thresholds*

7.85 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. This year the set included a progress check on the implementation of the Race Relations (Amendment) Act 2000.

Proportionate approach to inspection

7.86 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. 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

7.87 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.

7.88 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 feed directly into the local government CPA. The social services star rating also appears in the CPA report card, alongside assessments of other council services. A council must receive a good star rating for their social services in order to receive the highest comprehensive performance assessment rating.

The Results

How well are councils performing overall?

7.89 The performance ratings were first published in 2002, and since then the national trend for all councils shows a year-on-year improvement, with an overall average star score this year of 1.76, up from 1.65 in 2003 and 1.41 in 2002. Ten of the twelve councils that were on zero stars in 2003 have improved sufficiently to be awarded a star. There are, however, 24 councils (16 per cent) with one star in 2002 that have remained at this level, suggesting the need for a stronger improvement drive in those areas.

7.90 Since last year, the star rating has changed for 25 per cent of councils. Of these, 71 per cent have improved and 29 per cent have decreased. In population terms, this means that, in the last year, social care performance has improved for councils containing fourteen per cent of the population. For councils serving nearly eighty per cent of the population, performance ratings have stayed the same, and for councils serving eight per cent of the population, performance has deteriorated.

Figure 7.9: Distribution of Star Ratings between 2002 and 2004

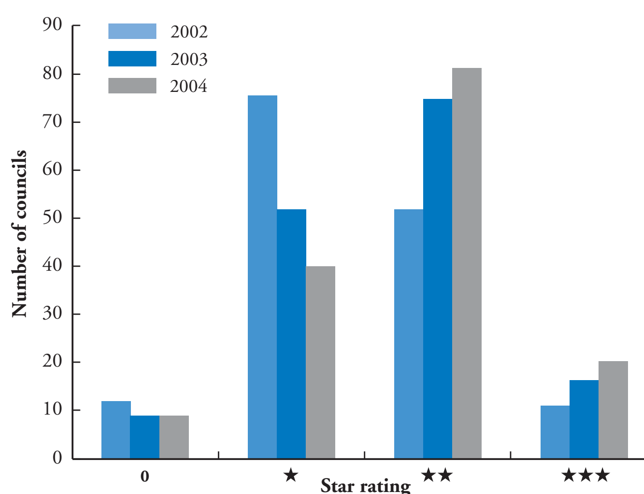


Figure 7.10: Changes in Rating from 2003 to 2004

2003				2004
16	↑ 5	★★★	↓ 1	20
74	↑ 20	★★	↓ 8	82
52		★		40
8	↑ 2	zero	↓ 2	8

Capacity to improve

7.91 The councils are judged to have an increasingly clear vision and are better organized in the way they plan and commission services for both children and adults. There is evidence of sound, high-level linkages with other local service partners, such as health and education services, where a high degree of cooperation and coordination is essential to good outcomes and to the delivery of convenient and effective services. A typical example would be in the coordination of child protection services, where it is crucial that agencies work to an agreed policy and process to identify children at risk, communicate effectively, and to act promptly and effectively to safeguard children's interests.

7.92 There is evidence, too, that social services managers have become increasingly skilled in monitoring and managing the performance of social services, making improvements to the processes and systems needed to ensure the quality of the services they commission or provide directly. (Examples of this might include checking systematically that home care services supporting older people at home arrive on time, or that those people awaiting discharge from hospital are unnecessarily delayed due to poor coordination between hospital and social services staff.)

7.93 Progress towards a better-trained and racially and culturally diverse workforce continues to be the least well achieved aspect of capacity. Whilst national and local initiatives to improve training and diversity have been underway during the period to which this assessment refers, the impact on delivery cannot yet be observed.

What progress has been made amongst the councils performing least well last year?

7.94 Of the eight councils that were rated at zero stars in November 2003, two improved sufficiently to gain one star. However, this has been matched by the movement of two councils from one star to zero stars, leaving the overall number of zero star rated councils unchanged from 2003.

Changes to performance ratings in-year

7.95 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.

8. Managing the Department of Health

8.1 ADMINISTRATION COSTS AND STAFFING TABLES
8.7 THE DEPARTMENT OF HEALTH CHANGE PROGRAMME
8.12 NON-DEPARTMENTAL PUBLIC BODIES (NDPBs), SPECIAL HEALTH AUTHORITIES AND EXECUTIVE AGENCIES
8.19 PUBLIC APPOINTMENTS
8.27 RECRUITMENT
8.30 SENIOR CIVIL SERVICE SALARIES
8.31 A HEALTHIER WORKPLACE
8.37 ACCOMMODATION AND ICT (Information and Communication Technology)
8.44 THE ENVIRONMENT

ADMINISTRATION COSTS AND STAFFING TABLES

8.1 The Department comprises three groups, dealing with various aspects of the organisation's work (Standards and Quality of Public Health and Care Services, Delivery and Performance in the NHS, and Promotion of the Strategy Objectives and Business Development of the Department). Group Directors report to the Chief Executive/Permanent Secretary. There are also two Executive Agencies.

8.2 Detailed information on Departmental administration costs is given in **Figure 8.1**. Information on staffing levels is provided in **Figure 8.2**.

8.3 The administration costs agreed in the 2004 Spending Review reflect the reduction in size and shape of the Department consequent on the major change programme commenced in 2003 and continuing into 2005 and beyond. The changes support the ongoing transformation of the whole NHS and social care system and the drive for decentralisation within a framework of national standards.

8.4 As a result, the Department is on target to reduce its staffing numbers by a third by April 2005.

8.5 Whilst the cost of the change programme (including reducing staff numbers by a third) has been met from within the Department's overall resources, it has involved re-profiling the administration spending review figures for 2004-05, 2005-06 and 2006-07. A total of £23 million has been brought forward from 2005-06 (£12m) and 2006-07 (£11m) to 2004-05 to meet the upfront costs of the changes. These changes are reflected in **Figure 8.1.**

8.6 No maladministration payments were made in 2003.

Figure 8.1: Department of Health Administration Costs

£ million

	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 Estimated outturn	2005-06 Plans	2006-07 Plans	2007-08 Plans
Administration Expenditure									
Paybill	131	141	151	142	140	119	99	101	103
Other	142	122	135	162	155	177	162	138	134
Total Administration Expenditure	**273**	**263**	**286**	**304**	**295**	**296**	**261**	**239**	**237**
Administration Income	-5	-4	-8	-8	-13	-15	-12	-12	-12
Total Administration Budget	**268**	**259**	**278**	**296**	**283**	**281**	**249**	**227**	**225**
Analysis by activity:									
Central Department	264	254	278	296	283	281	249	227	225
Youth Treatment Service	4	5	-	-	-	-	-	-	-
Total Administration Budget	**268**	**259**	**278**	**296**	**283**	**281**	**249**	**227**	**225**

Figure 8.2: Staff Numbers

Staff-years

	2000-01 Actual	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Plans	2004-05 Actual	2005-06 Plans	2006-07 Plans	2007-08 Plans
Department of Health (Gross Control Area)									
CORE DH (Full Time Equivalents)	3,632	3,809	3,390	2,964	2,245	2,050	2,245	2,245	2,245
Designated to transfer from DH (Full Time Equivalents)						139	119		
NHS Pensions Agency (Full Time Equivalents) [1]	452	466	268	258	nil[1]	nil[1]	nil[1]	nil[1]	nil[1]
MHRA (Full Time Equivalents) [2]	nil[2]	nil[2]	nil[2]	747[2]	750[2]	782[2]	863[2]	874[2]	n/a
Medical Devices Agency[2]	141	149	156	nil[2]	nil[2]	nil[2]	nil[2]	nil[2]	nil[2]
Medicines Control Agency[2]	436	574	519	nil[2]	nil[2]	nil[2]	nil[2]	nil[2]	nil[2]
NHS Purchasing and Supplies Agency (Full Time Equivalents)	285	291	309	328	328	324	328	328	341
NHS Estates[3]	326	435	390	375	375	314	nil[4]	nil[4]	nil[4]
TOTAL DEPARTMENT OF HEALTH	**5,272**	**5,724**	**5,032**	**4,672**	**3,698**	**3,609**	**3,555**	**3,447**	**2,586**

(1) The NHS Pensions Agency became a Special Health Authority (part of the NHS) in April 2004
(2) The MCA and MDA merged with effect from 1 April 2003 to become the Medicines and Healthcare Products Regulatory Agency.
(3) NHS Estates became a Trading Fund on 1 April 1999. Figures from 2003-04 include staff in Inventures.
(4) NHS Estates abolished 31 March 2005 – remaining staff transferred or redeployed by September 2005.

THE DEPARTMENT OF HEALTH CHANGE PROGRAMME

8.7 The health and social care system is being reformed to deliver more choice and a faster, more modern and responsive service.

8.8 The purpose of the Change Programme is to enable the Department to provide leadership that is more effective to the NHS and Social Care, and a better service to Ministers and the public.

8.9 Over the past 18 months the Department has been reshaped, reduced by 1,400 posts and created a smaller more strategic organisation with operational responsibility devolved throughout the system.

8.10 The Department's ambition is to transform the organisation to enable it to respond to this wider modernisation of the health and social care system. It is a transformation that aims to create a Department that is:

- **more strategic** – focused on the strategy, while managing short-term demands efficiently;
- **more joined-up at the top** – with closer working and joint understanding between Ministers, the Board and the wider leadership;
- **far-sighted** – making best use of knowledge and external contacts to pick up and act on issues before they hit;
- **part of a network** – overseeing the health and social care system, rather than running it, and forging stronger links with a range of stakeholders;
- **focused** – with a clear system for identifying which policy work should be pursued within a smaller department; and,
- **responsive and flexible** – with the ability to quickly resource new policy work.

8.11 The Board initiated the first stage of the Programme in April 2003. This focused on reshaping the Department's structure and reducing posts. This was completed in October 2004 and the focus is now on transforming how the Department does business. Work is currently on four key areas:

- redesigning our core business processes to improve our efficiency and enhance delivery;
- redesigning our planning and governance processes to enable smarter working and ensure better alignment of our resources to our strategic priorities;
- improving the way we work with all our stakeholders to ensure delivery; and,
- creating and sustaining a leadership and workforce which has the energy, capacity and capability to deliver the Department's ambitious agenda.

NON-DEPARTMENTAL PUBLIC BODIES (NDPBs), SPECIAL HEALTH AUTHORITIES AND EXECUTIVE AGENCIES

8.12 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 [8.1]. 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.

8.13 Last year we reported that the Department was to review its arm's length bodies. The Secretary of State published the outcome of the review in July 2004 and proposals for implementation in November 2004. The ALB Review implementation programme is 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 frontline 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.

8.14 The ALB Review change programme itself will deliver a redistribution to the front line of at least £0.5 billion a year by the end of 2007-08. The number of bodies will be reduced to 20 from the base year of 2003-04, despite the sector assuming new functions under statutes approved by Parliament. Even with these new functions, which bring new costs, we will be setting the 2005-06 budget for the ALB sector so that it will cost about £100 million a year less to run than in 2003-04. A further £200 million a year will become available for redistribution to the front line by the end of 2006-07 and again in 2007-08. This will inevitably mean significant changes in the organisation, staffing, financing and governance of the ALB sector. These changes are set out in more detail in the November 2004 implementation framework document [8.2]. A programme is now under way to deliver them.

8.15 In 2005-06, the NHS will benefit from a minimum of £140 million in savings from more efficient procurement being driven by the Commercial Directorate of the Department of Health through the Supply Chain Excellence Programme; the NHS Purchasing and Supply Agency (PASA) is closely involved in this programme. By the time we get to 2007-08, we expect these procurement activities, together with other supply chain initiatives such as the recently negotiated Pharmaceutical Price Regulation Scheme, to be delivering at least £870 million savings annually for use by the NHS front line. This £870 million saving is made up of £370 million from the Pharmaceutical Price Regulation Scheme and £500 million from the Supply Chain Excellence Programme.

8.16 The Government's Better Regulation Task Force has shown the way forward in reducing the burden of regulation. Linked to this is the need to systematise more effectively the work of inspectors and reduce the burden they impose on the NHS front line. The Government has already merged some inspectorates. The ALB review will continue this process and build on the work of the new Health Inspection Concordat. This concordat will reduce the number of inspection days in the NHS, cut the information demands, especially through the new Health and Social Care Information centre, using more self-assessment and providing 'inspection holidays' for high performing organisations. The budgets of the inspection sector will be 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.

8.17 'Local' is where the NHS action is and will continue to be. Eight Regional Offices and 100 Health Authorities have been replaced by 28 Strategic Health Authorities. The Department of Health's change programme has reduced the size of the centre by 38 per cent. The ALB Review programme will reduce the staffing of the ALB sector by 25 per cent. The ALB Review will help us to keep management costs under control across the whole health sector by ensuring that the local NHS gets efficient, better value-for-money response from central services, a contained regulatory and inspection system, and fewer demands made on it from the centre.

8.18 Ministers are determined to secure the changes set out in the ALB Review within the timescales it proposes. They will be fully supported in that purpose by Sir Nigel Crisp as the Accounting Officer, the Departmental Management Board and by Christine Outram, the programme director.

PUBLIC APPOINTMENTS

8.19 The Department is responsible for public appointments to 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 2005

Type of Body	Chairs	Members	Total
Strategic Health Authorities	28	180	208
NHS Trusts	246	1,198	1,444
Primary Care Trusts	266	1,723	1,989
Special Health Authorities	21	300	321
Advisory Non-Departmental Public Bodies	24	464	488
Executive Non-Departmental Public Bodies	9	148	157
Other Bodies	0	19	19
Total	**593**	**4,032**	**4,625**

8.20 More comprehensive information on Department of Health appointments can be found in the Cabinet Office publication *Public Bodies*, which can be found at: **www.publicbodies.gov.uk/publications**

8.21 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

8.22 All appointments to local NHS bodies, Special Health Authorities, Executive Non-Departmental Public Bodies (ENDPBs) and Advisory Non-Departmental Public Bodies (ANDPBs), which are sponsored by the Department of Health, 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 assessors.

NHS Appointments Commission

8.23 The NHS Appointments Commission now undertakes all appointments to the boards of NHS Trusts, Health Authorities and Primary Care Trusts, as are the majority of national appointments to Special Health Authorities and NDPBs.

8.24 The Commission was established as a Special Health Authority on 1 April 2001. It is chaired by Sir William Wells, who is supported by eight Regional Commissioners.

8.25 The Secretary of State determines the criteria against which all candidates are judged by the Commission, as well as setting equal opportunities goals and objectives to ensure that NHS boards are representative of the communities they serve. This apart, the Secretary of State no longer has any direct role in the appointments process to local NHS boards or to the majority of national public bodies sponsored by the Department.

Gender and ethnic balance

8.26 As at 1 January 2005 the gender and ethnic balance and the proportion of non-executive board members, who were 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

	NHS Trusts, Health Authorities and Primary Care Trusts	Special Health Authorities and Non-Departmental Public Bodies
% board members who are women	46.2	36.9
% chairs who are women	39.6	47.1
% board members from black and ethnic minorities	9.8	12.7
% board members who are disabled	4.6	1.2

RECRUITMENT

8.27 The strengthened recruitment controls, introduced in 2003, remained in place throughout the year in order to support the redeployment of colleagues whose posts were displaced by the Change Programme. This meant that a major focus was on filling posts in the new Departmental structure with internal candidates with the right skills.

8.28 A limited amount of external recruitment continued where it was not possible to identify displaced colleagues with the right skills. This was carried out on the basis of fair and open competition in accordance with the provisions of the *Civil Service Commissioners Recruitment Code*[8.3].

8.29 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:

- Three 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;
- 28 secondments;
- One re-appointment of a former civil servant; and,
- One appointment of a disabled candidate under modified selection arrangements.

SENIOR CIVIL SERVICE SALARIES

8.30 Details of Senior Civil Service salaries for the Department of Health are given in **Figure 8.6**.

Figure 8.6: Salaries in the Department of Health for Senior Civil Service staff in post at 1 April 2004

Payband (per annum)	Number of Staff
£55,000 – £59,999	19
£60,000 – £64,999	40
£65,000 – £69,999	65
£70,000 – £74,999	59
£75,000 – £79,999	33
£80,000 – £84,999	23
£85,000 – £89,999	22
£90,000 – £94,999	9
£95,000 – £99,999	18
£100,000 - £104,999	8
£105,000 - £109,999	10
£110,000 - £114,999	9
Over £115,000	29
Total	**344**

A HEALTHIER WORKPLACE

8.31 The Department remains committed to meeting Cabinet Office and Treasury targets for reducing levels of sickness absence.

8.32 The Department continues to meet its legal obligations to safeguard the health and safety of its staff.

Health and Safety Policy

8.33 Our Health and Safety Policy has been revised in line with current regulations and good practice.

8.34 Training activities have been actively promoted and delivered and a number of health and safety promotion events are being planned.

8.35 A system of regular inspection and meetings involving managers, staff representatives and the Health and Safety Unit continues to operate with success in the Department's buildings.

Figure 8.5: Recruitment into the Department of Health 2004

	Total	Male	Female
Permanent Staff joining who are still employed by the Department of Health			
Senior Civil Service	16	8	8
Fast Stream	7	4	3
Posts at former UG6 and below	85	18	67
Total	**108**	**30**	**78**
Permanent Staff joining who are no longer employed by the Department			
Total	**5**	**3**	**2**
All Permanent Staff joining the Department			
Senior Civil Service	16	8	8
Fast Stream	7	4	3
Posts at former UG6 and below	90	21	69
Total	**113**	**33**	**80**

8.36 An electronic accident reporting system is being trialled.

Statistics for 2004

Reported accidents

	2004	2003
Not resulting in absence	99	83
Resulting in absence	0	14
Resulting in absence and RIDDOR	1	5
Total	**100**	**102**
Reported near misses	0	5

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. During the year, planning has continued to vacate sub-standard accommodation at Elephant and Castle and co-locate more staff at Government premises at New King's Beam House in Blackfriars. When completed, the London HQ estate will have been reduced to four buildings.

Relocation

8.38 The Department has committed to relocate 1,100 posts by 2010, in response to the Lyons Review. The majority of these posts are in our arm's length bodies, although it is planned to relocate the Customer Service Centre from central London to Leeds during 2006.

Information Technology

8.39 The Department contracted in 2002 with CSC (Computer Sciences Corporation) for the supply and operation of its ICT (Information and Communication Technology) infrastructure for a period of seven years.

8.40 Work is now complete on a major transformation programme to upgrade all desktop, network and portable products which has improved services to mobile workers, and supports collaboration within the Department and across the Departmental boundary with the NHS and external stakeholders. The CSC contract will deliver significant year-on-year cost savings.

Knowledge Management

8.41 Enhanced knowledge management has been recognised as a key project within the Departmental Change Programme and there is a strategy and implementation plan to improve the control of key information sources and create a 'one stop shop' for information access via an enterprise portal.

8.42 Our strategy recognises that behavioural change is also required, and a knowledge management awareness and training programme is being rolled out to all staff.

8.43 The Department's electronic record system met the cross-Government target in 2004 and we have achieved 100 per cent rollout. Our focus is now on benefits realisation and ensuring that everyone is using the system effectively to meet business requirements.

THE ENVIRONMENT

8.44 The Department continues to develop its operational response to the *Framework for Sustainable Development on the Government Estate*[8.4]. The remaining *Framework* targets were published during the course of 2004, and now cover travel, water, waste, energy, estates management, procurement, biodiversity and social impacts.

8.45 Details of the Department's progress against these targets are maintained on the Department's Sustainable Development webpage at: **www.dh.gov.uk/AboutUs/HowDHWorks/ServiceStandardsAndCommitments/SustainableDevelopment/fs/en**

8.46 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 10.12 m^3 in 2001-02 to 6.85 m^3 in 2003-04. This considerably exceeds the Framework target of 7.7 m^3 per person by March 2004;
- re-tendering our cleaning and waste management contract. The new contract has a strong emphasis on continuous environmental improvement with a commitment to increasing the Department's recycling/recovery rate from the current 60 per cent to more than 90 per cent; this will be achieved by a combination of staff awareness/education, revised waste management processes, and use of modern waste segregation facilities. Currently all paper, cans, glass, plastic and fluorescent tubes discarded from our London buildings is recycled. We also have in place arrangements for recycling printer and toner cartridges and redundant IT equipment;
- continuing to pursue the purchase of renewable energy for consumption on the London estate. In a highly competitive market we have succeeded in purchasing 26 per cent 'green' electricity for our London estate; this exceeds the *Framework* target of 5 per cent; and,
- reviewing the stationery catalogue to promote environmentally friendly products.

8.47 We are also working with NHS Purchasing and Supplies Agency to encourage manufacturers, suppliers and contractors – through tighter specifications – to provide environmentally preferable goods and services at competitive prices.

8.48 The Department's official operational environmental contacts are:

- Martin Chaplin, Head of Business Services Unit; and,
- Julia Armstrong, Sustainable Development Manager.

List of Annexes

A1 Total Capital Employed by the Department

A2 Department of Health – Resource Budget

A3 Department of Health – Capital Budget

B List of Executive Agencies of the Department of Health

C Other Bodies (including Executive Non-Departmental Public Bodies and Special Health Authorities)

D Public Accounts Committee – Reports Published in 2004

E Spending on Publicity, Advertising and Income from Sponsorship in 2004-05 (estimate)

F Departmental Public Service Agreements (PSAs) – CSR 1998 (targets already achieved)

ANNEX A1

DEPARTMENT OF HEALTH – TOTAL CAPITAL EMPLOYED

£ million

	1998-99 outturn	1999 -2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 Projected	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	11,613	11,842	12,139	12,466	12,803
Investment outside Accounting Boundary (3) (4) (5) (6) (7)	15,853	22,529	23,011	23,112	24,849	27,458	28,002	28,702	29,477	30,273
Total Capital Employed	33,749	38,342	38,157	35,686	37,139	39,071	39,844	40,840	41,943	43,076

(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 2004-05 and beyond, figures are uplifted in line with GDP deflator of 16 March 2004.

(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) Source: NHS Trusts summarisation schedules, and accounts of other organisations. For 2003-04 and beyond, figures are uplifted in line with forecast GDP deflator of 16 March 2004.

(7) 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

	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 estimated outturn	2005-06 Plan	2006-07 Plan	2007-08 Plan
Consumption of Resources by activity									
National Health Service (NHS)	**40,755**	**44,000**	**51,150**	**54,601**	**60,930**	**66,853**	**72,797**	**79,873**	**87,297**
of which									
National Health Service Hospitals, Community Health, Family Health (discretionary) and related Services and NHS Trusts (1) (2)	**38,182**	**41,308**	**48,236**	**51,641**	**57,438**	**63,280**	**69,728**	**77,392**	**84,688**
of which									
Health Authorities unified budget and central allocations and grants to local authorities	38,182	41,308	48,236	51,641	57,438	63,280	69,728	77,392	84,688
Family Health Services	**1,796**	**1,875**	**1,951**	**2,024**	**2,141**	**2,095**	**1,660**	**1,108**	**1,162**
of which:									
General dental services(1) (2)	1,071	1,109	1,166	1,221	1,283	1,215	658	0	0
General ophthalmic services	288	290	302	304	322	337	354	361	375
Pharmaceutical services	808	869	893	919	962	971	1,099	1,198	1,238
Prescription charges income	-371	-393	-411	-421	-426	-428	-452	-452	-452
Central Health and Miscellaneous Services	**507**	**526**	**649**	**600**	**1,024**	**1,140**	**1,109**	**1,092**	**1,169**
of which									
Welfare Foods DEL	101	102	101	102	137	109	119	120	120
EEA Medical Costs	146	192	207	251	417	454	475	512	588
Other Central Health and Miscellaneous Services	260	232	341	246	470	576	515	461	461
Departmental Administration including agencies	**270**	**291**	**314**	**336**	**328**	**339**	**300**	**281**	**279**
Personal Social Services (PSS)	**539**	**482**	**730**	**1,591**	**1,626**	**2,128**	**2,150**	**1,844**	**1,884**
of which									
Personal Social Services	13	11	46	159	201	228	259	269	291
Local Authority personal social services grants	526	470	684	1,432	1,425	1,900	1,892	1,575	1,593
of which									
Training Support programme for social services staff	39	43	47	58	57	53			
Grants for adults	436	425	540	1,130	1,203	1,758	1,734	1,419	1,437
Grants for children	51	1	95	194	60	65	95	94	94
Human resources development strategy					10	24	63	63	63
Grants funded from the invest to save fund		2	1	2					
Performance fund				48	96				
NHS – Superannuations – England & Wales	**3,521**	**3,782**	**3,949**	**4,569**	**6,328**	**7,788**	**8,816**	**9,610**	**10,482**
Credit Guarantee Finance(3)						**6**	**11**		
Total Department of Health Resource Budget	44,815	48,264	55,829	60,761	68,884	76,776	83,774	91,326	99,663

(1) Funding for primary dental services (PDS) 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.

(2) 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.

(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) Figures may not sum due to rounding.

ANNEX A3

DEPARTMENT OF HEALTH – CAPITAL BUDGET

£ million

	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 estimated outturn	2005-06 Plan	2006-07 Plan	2007-08 Plan
National Health Service (NHS)	**850**	**1,173**	**1,623**	**1,903**	**2,451**	**3,396**	**4,237**	**5,163**	**6,133**
of which									
Hospital and Community Health Services[1]	**820**	**1,155**	**1,596**	**1,873**	**2,415**	**3,367**	**4,206**	**5,131**	**6,101**
of which									
Health Authorities unified budget and central allocations and grants to local authorities	820	1,155	1,596	1,873	2,415	3,367	4,206	5,131	6,101
Central Health and Miscellaneous Services	**15**	**9**	**13**	**20**	**13**	**8**	**11**	**11**	**11**
Departmental Administration including agencies	**15**	**9**	**13**	**9**	**23**	**20**	**20**	**21**	**21**
Personal Social Services (PSS)	**49**	**48**	**93**	**72**	**84**	**85**	**82**	**101**	**121**
of which									
Personal Social Services (including Credit Approvals)	49	47	90	47	60	60	57	56	56
Local Authority Personal Social Services Grants		1	3	25	25	25	25	45	65
of which									
Grants for Adults								20	40
Grants funded from the Invest to Save Fund		1	#						
Improving Information Management			3	25	25	25	25	25	25
Credit Guarantee Finance (AME)[2]						**328**	**357**		
Total Department of Health Capital Budget	**899**	**1,221**	**1,716**	**1,974**	**2,536**	**3,808**	**4,675**	**5,264**	**6,254**

(1) Includes funding available to Foundation Trusts for 2004-05 and 2005-06.

(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) Amounts below £0.5 million are not shown but indicated by a #.

ANNEX B

EXECUTIVE AGENCIES OF THE DEPARTMENT OF HEALTH

NHS Estates

NHS Estates' mission is to advise on and enable a modern environment of care for NHS services. We fulfil this mission by providing a corporate overview managing the public sector estate and facilities management (*efm*) services – from the strategic dimensions of estate strategy and the planning of buildings to meet the modernisation of clinical services, through to the concept of the well-serviced hospital – creating an environment that provides front line support to patient needs.

The Agency focuses on strategic estate deployment, developing and delivering solutions to *efm* challenges and problems, using new or existing technologies, through innovation, creativity and change. We develop and apply new technologies, promote advanced designs and design methods, introduce new and more efficient production techniques, marketing and construction concepts, pioneer new *efm* services and management methods.

The Agency acts as a central hub of expertise in a diverse range of estates and facilities management issues. It is uniquely positioned to support and facilitate modernisation programmes by:

- translating professional and technical information on *efm* issues into forms which the NHS can use to deliver a better healthcare environment;
- adding value to building spaces by promoting and supporting trusts in providing a warm, safe, comfortable patient environment;
- providing know-how and support on the fundamentals of hospital care, engineering, decontamination and the planning, design, procurement and eventual disposal of healthcare buildings;
- developing and delivering world class products and strategic services, on which the NHS can draw to improve the quality of the environment where patients receive care; and,
- providing a unique link between estates and facilities management and clinical policy.

NHS Estates sets clear national standards for strategic stewardship of the estate, procurement and construction, engineering, design quality and hospitality services. Within the new NHS landscape, the Agency is working closely with SHAs and supporting the development of new models for regulation and inspection, looking to work closely with bodies such as the Office of the Independent Regulator for NHS Foundation Trusts and the new Healthcare Commission.

The Agency is to be abolished in 2005-06 as a result of the Department's review of its arm's length bodies with its functions transferred to core DH, other ALB's, SHA's and other Government bodies.

More information on the Agency's activities, progress towards its objectives and associated key tasks and targets can be found on the web site at **www.nhsestates.gov.uk** or by calling 0113 254 7000.

NHS Purchasing and Supply Agency

The NHS Purchasing and Supply Agency 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. The Agency is an advisory and co-ordinating body and also an active participant in the ongoing modernisation of purchasing and supply in the health service. The Agency ensures that purchasing and supply issues are taken into account when determining national healthcare policies.

The Agency also provides advice to individual NHS bodies and negotiates contracts for goods and services on behalf of the NHS. The Agency employs over 300 people and its gross running costs from 1 April 2004 to 31 March 2005, were £21.5 million.

2004-05 update:

A review of the Supply Chain for the Department and the NHS, including NHS PASA, was conducted during late 2003 and the findings fed into the Department's review of its arm's length bodies. The review concluded that a number of changes need to be effected in the structure and management of the Supply Chain.

The initial stages of this implementation involved:

- enhanced sourcing activity in selected categories of spend handled by the Agency;
- changes in the organisation and roles of the Agency consistent with changes in the Department and those identified by the ALB review;
- a renewed emphasis on the development of regional procurement; and,
- a review of NHS Logistics Authority and related procurement functions.

In each of these areas, there has been significant progress.

- a national contracts sourcing project has been implemented with the initial phase covering eleven categories and delivering £96m of savings by December 2004;
- a re-organisation of NHS PASA is currently underway – it is envisaged that there will be some work transferred to the Agency from other ALBs;
- the majority of NHS procurement work is now covered by supply management confederations – with a collaborative hub concept now being tested through pilot organisations; and,
- a review of NHS Logistics, and related procurement activity, has been undertaken and a market testing exercise is currently underway.

The Agency is closely involved with the implementation of the Supply Chain Excellence Programme. It is anticipated that the Agency will be assuming a revised role in the future as the operating arm of the Commercial Directorate and will be leading subsequent phases of SCEP.

The Agency will be responsible for delivering enhanced savings to the NHS following the above review. It will continue to support raising the level of purchasing and supply professionalism within the NHS, and will seek to maximise the volume of Agency business delivered through e-systems.

Medicines and Healthcare Products Regulatory Agency

The Medicines and Healthcare products Regulatory Agency (MHRA) was created on 1 April 2003 as an executive agency of the Department of Health. It was created from a merger of the existing Medicines Control Agency and the Medical Devices Agency.

The aim of the Medicines and Healthcare products Regulatory Agency is to protect and promote public health and wellbeing by ensuring that medicines and healthcare products meet set standards of safety, quality, performance and effectiveness, and are used safely.

The MHRA has some 700 staff and a total budget of around £50 million, and operates as a trading fund. The Agency's main sources of funding are from fees and charges from the pharmaceutical industry, and funding from the Department of Health for its operations on regulating medical devices.

The main tasks carried out by the MHRA are to license pharmaceuticals, ensure compliance in the UK with statutory obligations relating to the manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices, operate systems for recording, monitoring and investigating adverse reports and incidents, and taking enforcement action to safeguard public health. The Agency also provides advice and support to Department of Health Ministers on policy issues and represents the UK in European and other international discussions concerning the regulation of medicines and healthcare products.

ANNEX C

OTHER BODIES (INCLUDING EXECUTIVE NON-DEPARTMENTAL PUBLIC BODIES AND SPECIAL HEALTH AUTHORITIES)

Human Fertilisation and Embryology Authority (HFEA)

The Authority was established by the Human Fertilisation and Embryology Act 1990 and began its work in August 1991. Its main responsibilities are to license and monitor those clinics which carry out IVF and donor insemination, and to license research projects involving the creation of embryos in vitro, or the keeping or use of embryos. It also regulates the storage of gametes and embryos. It has 17 members (including the Chairman and Deputy Chairman) and has approximately 100 staff.

The Authority's total expenditure in 2003-04 was £7,444,580. Approximately 45 per cent of the Authority's income was raised from licensing and other income, with the remaining 55 per cent from the Department of Health. Particular issues considered by the Authority were the use of sex selection, the use of preimplantation genetic diagnosis with tissue typing, safe cryopreservation and donor anonymity. Further information about the work of the Authority and its accounts can be found in its Annual Report and Accounts, which is available on the HFEA's website: **www.hfea.gov.uk**. Otherwise, information can be obtained form Mr Ted Webb at the Department of Health, Room 654C, Skipton House, 80 London Road, London SE1 6LH; (020 7972 5863).

Commission for Patient and Public Involvement in Health (CPPIH)

The Commission for Patient and Public Involvement in Health was set up on 1 January 2003. The chair of the CPPIH is Sharon Grant and the chief executive is Steve Lowden – there are 10 commissioners. The main functions of the CPPIH are to set up and maintain Patients' Forums and to ensure that they have staff support available to them so that they can carry out their functions. 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.

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). NBSB collaborates with the World Health Organisation (WHO), the European Commission and other related 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 batch 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 review of its arm's length bodies proposed abolishing the NBSB and transferring the NIBSC to the Health Protection Agency. Subject to the passage of legislation, this is expected to be implemented by April 2007. The Board's gross expenditure in 2003-04 was £18.8 million, of which the Government funded £14.2million. It employed 305 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.

For more information about the NBSB contact Mr Victor Knight, National Institute for Biological Standards and Control, Blanche Lane, South Mimms, Herts EN6 3QG; 01707 6411000 or see the NIBSC's website at: **www.nibsc.ac.uk**.

National Radiological Protection Board (NRPB)

The NRPB was set up in 1970. It conducts research into, and provides advice on the effects and risks of radiation (including non-ionising radiation such as ultra-violet, mobile phones and power lines etc), radiation measurement and dose assessment, monitoring radon in homes, the environmental impact of nuclear discharges and waste disposal, emergency planning and the consequences of nuclear accidents. The Board also provides advice to international organisations and provides services to industrial and other radiation users. Gross expenditure in 2003-04 was £16.348 million of which the Government (including £0.33 million by the Scottish Executive) provides £6.385 million. NRPB employs 315 staff.

NRPB's corporate aims and strategy, together with performance against key targets, can be found in their Annual Report and Accounts.

As part of the Department's review of its arm's length bodies and, subject to legislation, it is intended that the functions of the National Radiological Protection Board should transfer to the Health Protection Agency when that agency is established as a non-departmental public body. It is envisaged that this will take place on 1 April 2005

For more information about the NRPB, contact Dr Hilary Walker, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5122, or NRPB's website at: **www.nrpb.org**

Public Health Laboratory Service (PHLS)

Most of the functions of the PHLS were transferred to the Health Protection Agency (HPA) or to the NHS in April 2003. After that date, it retained the function of providing microbiological culture media to the HPA and the NHS. The decision to sell the PHLS media services business to Oxoid Ltd was announced in August 2004. The sale will be completed on 31 March 2005, at which time the PHLS will be abolished. The PHLS gross expenditure was approximately £4.4 million during 2003-04, of which DH provided £931,000. PHLS media services employed 69 staff over this period.

For more information about the PHLS, see their website at: **www.phls.co.uk** or contact Brian Bradley, Department of Health, Skipton House, 80 London Road, London SE1 6LH; Tel 020 7972 5304.

General Social Care Council

The Care Standards Act 2000 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.

The GSCC has a registration function based on the completion of approved training. Before a person may be registered with the GSCC he/she will need to show that they are:

- of good character;
- physically and mentally fit to undertake the work;
- properly qualified and trained; and,
- satisfies any requirements of practice, conduct and competence the Council imposes.

The GSCC opened the Social Care Register on 1 April 2003 with the aim of registering all qualified Social Workers by 1 April 2005. The registration of other social care workers will then be rolled out.

The GSCC published Codes of Practice for social care workers and employers on 23 September 2002. These are the first codes of practice governing social care and are UK wide. They were developed in consultation with a wide range of stakeholders, including service users. They are a critical part of regulating the profession and helping to improve standards and public protection.

All staff and employers are required to adopt these. The Code for employers includes the need to have rigorous and thorough recruitment and selection processes, making sure that only people who have the appropriate knowledge and skills enter the workforce. It is also necessary to undertake checks on relevant registers and indexes and assess whether people are capable of carrying out the job they have been selected for prior to appointment. The NCSC and SSI will take the Code of Practice for Social Care Employers into account in their enforcement of care standards.

The Department of Health funded the GSCC's operating costs of £11.3m in the year to 31 March 2004. The GSCC employs 161 staff.

Part of the Government's commitment to raising the status of the whole social care workforce is the introduction of protection of title for the professional title of social worker, which will restrict the use of the title Social Worker to registered, qualified Social Workers.

This was implemented on 1 April 2005. After this date, it became an offence for a person in England and Wales to, with intent, deceive another:

a) take or use the title social worker; or

b) take or use any title that implies s/he is a registered social worker; or

c) take or use any description that implies s/he is a registered social worker; or

d) in any way hold him/herself out as a registered social worker;

unless s/he is registered as such by one of the four Councils. A person who is convicted of an offence under S61 shall be liable to pay a fine of up to (at the present time) £5,000.

The benefits of this new regulation will be seen most strongly in two of the main objectives of our work in social care: the raising of standards and greater protection for the service user. On the first of these, being registered as a Social Worker with a Care Council acknowledges that an individual has reached a level of training and professionalism that allows them to use that title. For the second, the user can feel confident that, when they have contact with anyone using the title, not only is the individual qualified but an independent body that has service user protection as a guiding principle also regulates them.

For further information, contact the GSCC on 0207 397 5100 or refer to their website at: **www.gscc.org.uk**. The Department of Health and Social Care contact is Tim Lund on 0113 2546900.

SPECIAL HEALTH AUTHORITIES

NHS University (NHSU)

NHSU was established as a Special Health Authority on 1 December 2003. NHSU was designed to help to focus education, training and development within the NHS, giving more people more opportunities to improve patient care.

Following the Department's review of its arm's length bodies, Ministers announced in November 2004 that the NHSU would be dissolved by July 2005. At the same time, a new NHS Institute will be established covering innovation, learning, skills and improvement.

Work is progressing to define the functions and remit of the new organisation.

For further information about NHSU, contact Hannah Dornin, NHSU, Floor 15, 88 Wood Street, London, EC2V 7RS; 0208 528 1434 or the NHSU website at: **www.nhsu.nhs.uk**

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 strategic documents *Countering Fraud in the NHS*[C1] and *A Professional Approach to Managing Security in the NHS*[C2] set out the detail of development of these areas of work and the ways in which progress towards objectives are measured.

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;
- 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.

From their creation in 1998 to the end of 2003-04, the CFSMS and its predecessor achieved the following in countering fraud:

- more than 460 professionally trained and accredited counter fraud specialists put in place across the NHS, backed up by counter fraud training provided, so far, to over 500 Directors of Finance and over 200 Human Resources Directors;
- over 940,000 NHS staff and professionals covered by Counter Fraud Charter agreements to work with the NHS Counter Fraud Service to counter fraud and corruption;
- more than 1,100 fraud awareness presentations delivered to key NHS staff;
- overall, losses in the area of patient fraud have been cut by 49 per cent from £171m to £87m; and,
- in some areas, claims by NHS professionals have fallen by 31 per cent for attendance claims and 46 per cent for domiciliary visits after processes were fraud-proofed.

All of this has been achieved with a 13:1 return on the investment in counter fraud work through an overall positive financial impact of £478 million, a very cost-effective basis.

In the two years since CFSMS took over responsibility for security management it has made an impact including:

- developing high-quality and professional Accredited Security Management Specialist (ASMS) training that has been accredited by the University of Portsmouth;
- ensuring, through Secretary of State Directions, that every health body has a Local Security Management Specialist who has successfully completed the ASMS Specialist training;
- guidance on physical assaults and non-physical assaults;
- a new Lone Worker policy for NHS staff and the Lone Worker protection device to better protect NHS staff;
- conflict Resolution Training available to all frontline NHS staff;
- a national reporting system for physical assaults against NHS staff has been put in place and will be fully operational by summer 2005;
- guidance on the security of radioactive materials was issued in July 2004; and,
- forming a legal protection unit to tackle individuals who pose a serious risk to NHS staff and others. Its results have included the first national Anti-Social Behaviour Order for an individual who assaulted NHS staff over the past 15 years and who, subsequently, received a three-year prison sentence.

As a result of the Department's review of its arm's length bodies, from 1 October 2005 the CFSMS, together with the Dental Practice Board, NHS Pensions Agency and the Prescription Pricing Authority, will be merged into a new organisation called the NHS Business Services Authority (BSA). CFSMS has acted expediently to comply with the staff and budget reductions that are requirements of the review.

For further information on the CFSMS contact the Department of Health at FID-CFSM, 207 Hannibal House, 7th Floor, Elephant & Castle, London SE1 6TE, 020 797 22501; 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**

Dental Vocational Training Authority

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 transferred to the Postgraduate Medical Education and Training Board. Discussions are underway on the timing of the transfer.

The DVTA's gross expenditure in 2003-04 was £265,000. The Authority is funded entirely by Government. From April 2003 to March 2004, the DVTA issued 1,285 vocational training numbers. 101 applications for a vocational training number were rejected in the same period. The Authority has four staff. For further information, contact Patrick Kavannagh or Trevor Homewood, Dental Vocational Training Authority, Master's House, Temple Grove, Compton Place, Eastbourne, East Sussex BN20 8AD; 01323 431189

NHS Appointments Commission

The NHS Appointments Commission was established in April 2001, with power delegated by the Secretary of State to appoint the chair and non-executive directors of NHS Strategic Health Authorities, Primary Care Trusts and NHS Trusts. It is also responsible for ensuring that those it appoints have access to appropriate training and support and have regular appraisals. In 2003, the Commission's remit was extended to cover the appointment process for the Department's national bodies, and now provides a valuable service to the Department in ensuring the highest standards in public appointment processes, and that the best possible people are appointed. The Commission makes approximately 1,500 appointments and provides 4,000 training places a year, and is now offering its expert services to other Government departments. The Commission currently comprises the Chair, eight Regional Commissioners and the Chief Executive. It employs 58 staff and has offices in Leeds and London.

As part of the Department's review of its arm's length bodies and, subject to legislation, the Commission will become an ENDPB by 1 April 2006.

For appointments in the South and South West, contact:

NHS Appointments Commission
138 Cheapside
London
EC2V 6BB
Tel 0207 615 9300

For appointments in the Midlands and North and to National bodies, contact:

NHS Appointments Commission
Blenheim House
Duncombe Street
West One
Leeds
LS2 7UE
Tel 0113 394 2950

Health Protection Agency

The Health Protection Agency was established as a Special Health Authority (SHA) in England and Wales on 1 April 2003. It has responsibility for a range of health protection functions provided under the NHS Act and previously carried out by other bodies. In England, the SHA is responsible for the functions that were performed previously by:

- the Public Health Laboratory Service (but not its general clinical diagnostic microbiology services which have transferred to the NHS);
- the Microbiological Research Authority;
- the National Focus for Chemical Incidents, Regional Service Provider Units and the National Poisons Information Service;
- the health protection functions provided by consultants in communicable disease control and other health protection staff; and,
- the advice and other functions provided by regional health emergency planning advisers and their staff.

The core functions as summarised in the HPA's Corporate Plan for 2004-09 are to:

- identify and respond to health hazards and emergencies;
- anticipate and prepare for emerging and future threats;
- alert and advise the public and Government on health protection;
- provide specialist health protection services; and,
- support others in their health protection roles.

Its estimated income for 2004-05 is £198m, of which £124m is provided directly by DH. The HPA employed 2,518 staff on 31 March 2004. In addition to this, approximately 200 staff were engaged on various agency, secondment and similar arrangements during the previous 12 months.

The HPA Act, which received Royal Assent on 22 July 2004, establishes the HPA as a new UK-wide non-departmental public body (NDPB) on 1 April 2005. The HPA NDPB will be an authoritative source of advice and support in health protection matters. The UK Government and each of the devolved administrations will look to the Agency to provide all the functions currently carried out by the National Radiological Protection Board (NRPB), which will be wound up.

Contact: Brian Bradley, Department of Health, room 604a, Skipton House, 80 London Road, London, SE1 6LH, 020 7972 5304; Mr Michael Harker, Health Protection Agency; Central Office, 1-11 John Adam St, London WC2N 6HT, 020 7339 1321; or see the HPA's website at: **www.hpa.org.uk**

National Clinical Assessment Authority (NCAA)

The NCAA is a Special Health Authority which provides a support service to NHS Trusts, the Prison Health and Defence Medical Services when faced with concerns over the performance of an individual doctor or dentist. The NCAA's role is to support employers and clinicians and to boost patient confidence in the NHS.

In order to help doctors and dentists in difficulty, the NCAA will provide advice, take referrals and carry out targeted assessments where it is deemed necessary. Many cases are resolved locally, following NCAA advice; however a small proportion of referrals progress to the assessment stage. Once an objective assessment has been carried out, the NCAA will advise on the appropriate course of action. The Authority was established as an advisory body and the employer organisations remain responsible for resolving the problem once the NCAA has produced its assessment.

The NCAA employs around 120 people. Progress made at the NCAA since it was established in 2001 includes:

- providing a full advice service which has managed well over 1,000 cases, which represents over one per cent of the medical workforce;
- providing a robust assessment service;
- further strengthening relations with stakeholders, including the medical profession, NHS managers, patients' groups and other bodies leading the health service quality agenda;
- widening its service coverage to include health services in Wales and Northern Ireland, plus the Prison Health and Defence Medical Services;
- working with the Chief Medical Officer to reduce the number of long-term clinical suspensions. The NCAA now monitors exclusion of hospital doctors and dentists which exceed six months;
- the NCAA was also the first Special Health Authority to sign up the Department of Health's Positively Diverse programme;
- taking forward its important education and research and development strategies;
- launched a web-based toolkit to share good practice throughout the NHS;
- helped to reduce the amount of inappropriate suspension/exclusion from work. In 85 per cent of cases referred to it where suspension had been considered, the NCAA has been able to recommend a safe alternative to suspension; and,
- supports the new exclusions framework for hospital doctors and dentists.

The NCAA's revenue expenditure was £5.9 million in the year to 31 March 2004. This was funded primarily by the Department of Health, with additional income provided by the Welsh Assembly and the Prison Service.

From 1 April 2005, the NCAA will become a division of the National Patient Safety Agency under the name of the National Clinical Assessment Service.

For further information contact the NCAA on 0207 273 0850 or refer to their website at: **www.ncaa.nhs.uk** at: The Department of Health and Social Care contact is Tim Lund on 0113 2546900.

National Blood Authority (NBA)

The National Blood Authority is responsible for the management of the National Blood Service in England and North Wales including:

- the collection of blood from voluntary donors, its processing, testing and supply to hospitals through its network of blood centres; and,
- the International Blood Group Reference Laboratory (IBGRL), which provides a reference service and issues diagnostic materials, and the Bio Products Laboratory (BPL), which makes therapeutic products from blood plasma and makes and issues diagnostic materials.

The Authority's gross expenditure in 2003-04 was £392 million, which was recouped largely through blood handling charges to hospitals and through sales of BPL products. It employs around 5,599 staff.

As a result of the Department's review of its arm's length bodies, the Authority will merge with UKT by 1 October 2005 to form NHS Blood and Transplant.

Further information, including summary financial statements, are included in the NBA's 2004 Annual Report which is available from the National Blood Authority, Oak House, Reeds Crescent, Watford WD1 1QA; 01923 486800. Website **www.blood.co.uk**

National Treatment Agency (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. DATs are local planning bodies responsible for commissioning drug services from a pooled national treatment budget. This stood at £260.1 million in 2004-05. This budget has increased significantly over the past two years and is matched locally by expenditure by PCTs, local authorities and criminal justice agencies. As a result of the Spending Review announcement in September 2004 all Drug Action Teams will receive a 55 per cent increase in their allocations between 2006-08.

The NTA has already made significant progress in improving both access to and the quality of drug treatment services. In 2003-04, the methodology used for counting the number of drug users in treatment was revised to reflect numbers in treatment more accurately. The definition of structured drug treatment has also been tightened with the implementation of Models of Care for the treatment of adult drug misusers, which was published in 2002. Based on the new methodology the figure for the numbers in treatment at any point in the year was 126,000. However, to ensure that the numbers in treatment could be compared with previous years an estimate was made of the numbers in treatment based, as far as possible, on the methodology used in previous years.

Based as much as possible on the previous methodology it is estimated that in 2003-04 there were around 154,000 problem drug misusers in treatment at drug treatment agencies and general practitioners in England, compared to around 140,900 in 2002-03 (an increase of almost 10 per cent)

It is estimated that in 2003-04 the total number of individuals successfully completing treatment in 2003-04, or retained in treatment on 31 March 2004 was 90,511. This is an increase from the 80,600 problem drug misusers who successfully completed treatment in 2002-03.

In December 2001, the NTA working with the NHS Modernisation Agency set maximum waiting time targets. Although there is some way to go, with delays in accessing treatment still unacceptably long in some parts of the country, the overall trend is positive. There is currently an average waiting time of between two to four weeks. In those areas where waiting times are particularly long the NTA are working with DATs to reduce them.

The NTA is also implementing a workforce strategy to encourage professionals to work in the field of drug treatment. The number of people working in drug treatment services rose from 6,794 in March 2002 to 9,619 in September 2004, well ahead of expectations.

The NTA employs 81 staff, with the annual wage bill for 2004-05 projected to be almost £4 million. The Chief Executive, Mr Paul Hayes, may be contacted at 5th Floor Hannibal House, Elephant and Castle SE1 8UG, tel 020 7972 2226. Further information can be obtained from NTA's website at: **www.nta-nhs.org.uk**

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 660 million prescription items were processed in 2003-04);
- 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;
- 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 2003-04 was £67.662 million of which the Department funded £66.196 million. During 2003-04, the average number of employees was 2,919 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. For further information on the Authority contact Mr John Roberts, PPA Business Manager, Room 621, Eileen House, 80-94 Newington Causeway, London SE1 6EF; john.roberts@dh.gsi.gov.uk 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 by October 2005.

The Mental Health Act Commission (MHAC)

The Commission was set up in 1983 as an SHA with responsibility under the Mental Health Act 1983 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 all detained patients and will often attend inquests as an interested party. The Commission has collated its finding in relation to such deaths over recent years and published a report *Deaths of Detained Patients in England and Wales*[C3] in February 2001.

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 8,500 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 has provided training to mental health practitioners on the revised Code of Practice and on Good Practice and the Mental Health Act.

The Commission is required to publish an Annual Report (September 2003) 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 Tenth Biennial Report covered the period 2001-03 and was published on 10th December 2003 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 2003-04 was £4.1 million. The Commission employs 35 staff. For further information, contact Mat Kinton (Communications Manager), Mental Health Act Commission, Maid Marion House, 56 Hounds Gate, Nottingham NG1 6BG; 0115 9437106. The Commission's email address is chief.executive@mhac.trent.nhs.uk and its website address is **www.mhac.org.uk**.

Family Health Services Appeal Authority (Special Health Authority) (FHSAA(SHA))

The Family Health Services Appeal Authority (Special Health Authority) was established on 1 April 1995. In the year to 31 March 2004, the Authority received £870,000 in Government funding and its total gross expenditure was £955,000. The Authority employs 13 staff. Its role 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 issues arising under the General Medical Services Regulations, General Dental Services Regulations, General Ophthalmic Services Regulations, the Pharmaceutical Regulations, family health services practitioners' terms of service with the NHS, and the NHS (Service Committee and Tribunal) Regulations. The Special Health Authority also provides support to the Family Health Services Appeal Authority, which was introduced by the Health and Social Care Act 2001.

As a result of the Department's review of its arm's length bodies, the FHSAA(SHA) will be dissolved and its functions will form part of the NHS Litigation Authority from 1 April 2005.

For further information, contact the FHSAA(SHA) on 01423 535 415 or refer to their website at: **www.fhsaa.nhs.uk**. The Department of Health and Social Care contact is Tim Lund on 0113 2546900.

Health Development Agency (HDA)

The Health Development Agency was established as an SHA in January 2000 and became fully operational from 1 April 2000. The HDA's remit is to establish and maintain an evidence base of what works in public health practice; provide advice on developing and setting standards; and develop the capacity and capability of the public health workforce.

The Agency's gross expenditure in 2003-04 was £13,304k of which £11,680k was from the Department of Health. The Agency employed 132 staff in 2003-04.

As a result of the Department's review of its arm's length bodies, by 1 April 2005 the Health Development Agency will be dissolved and its functions transferred to the National Institute for Health and Clinical Excellence (NICE).

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 **www.nice.org.uk**.

NHS Information Authority (NHSIA)

The NHS Information Authority was established as a Special Health Authority on 1 April 1999. The Authority, working in partnership with NHS professionals, suppliers, academics and others, is responsible for the provision of national products, standards and services to support the sharing and best possible use of information throughout the health service.

The Board of the NHSIA consists of a Chair, Chief Executive, three executive officers and four non-executive members. The Authority had 784 WTE staff as at 31 October 2004. Its gross operating cost in 2003-04 was £257 million, of which the Department of Health funded £253 million.

As a result of the Department's review of its arm's length bodies, the NHSIA will be dissolved by 1 April 2005. Responsibility for the IT elements of the Authority's work will transfer to the NHS Connecting for Health agency and information management to the Health and Social Care Information Centre.

Details of the Authority's key achievements are contained in its 2003-04 Annual Report. This report, together with more information about the Authority's activities, is available from the Authority's website at: **www.nhsia.nhs.uk** or by contacting Steven Harrison, Head of Corporate Affairs, NHS Information Authority, Aqueous II, Waterlinks, Aston Cross, Rocky Lane, Birmingham B6 5RQ. Telephone 0121 333 0120, fax 0121 333 0150 or e-mail: steven.harrison@nhsia.nhs.uk.

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. 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.

The Authority has taken firmer control of the litigation process by establishing, by tender, a panel of legal advisers to be instructed on all future CNST claims. From the 100 firms dealing with cases in 1996, there are now only 13 specialist panel teams now appointed to act for the Authority on clinical negligence cases and nine specialist panel teams working on non-clinical cases. In April 2001 the Authority took over the handling and financial management of all cases under the ELS and from April 2002 the CNST.

As a result of the Department's review of its arm's length bodies, the Authority will absorb the functions of the FHSAA by 1 April 2005.

The Authority's administration costs for 2003-04 amounted to £14.4 million. At December 2004, it employed 167 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.

The organisational purpose is achieved through three main activity areas:

- provides the main supply channel for consumable healthcare products to the English NHS;
- provides a range of modern supply chain services to support the delivery of quality health care; and,
- supports the development of a world class supply chain across the NHS.

With an annual turnover of over £677 million in 2003-04, NHS Logistics' current catalogue service offering 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 out of six Distribution Centres and employs around 1,340 staff.

The highlights of 2004-05 included:

- record customer demand at £729 million, an increase of 7.7 per cent;
- lowest service on-cost at 9.96 per cent;
- additional in year benefits of £10.4 million delivered to NHS front line;
- special cash return to Department of Health of £3.0 million; and,
- highest level of customer satisfaction at 88 per cent.

Professional recognition through five national and international awards:

- UK Supply Chain Team of the Year;
- UK Supply Chain Technology Award;
- HSJ Award 'Improving Patient Care with E-Technology;
- European Service Industries, Utilities and Public Sector Award; and,
- European Supply Chain Team of the Year.

The Department's review of its arm's length bodies, confirmed:

- that NHS Logistics provides considerable value to the NHS and the policy is to grow the activity to generate further benefits;
- that the activities of NHS Logistics would be market tested and the results of this process will be known by September 2005;
- that the market testing process would assess whether the NHS Logistics' function should be outsourced to the private sector;

- that should the market test show that outsourcing is not the best option, that there will be a merger between NHS Logistics and the NHS Purchasing and Supply Agency; and,
- that NHS Logistics would be dissolved on 1 April 2006.

Details of NHS Logistics' other 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, Corporate Communications Manager, NHS LogisticsAuthority, West Way, Cotes Park Industrial Estate, Alfreton, DE55 4QJ; telephone 01773 724261, or by email to carole.appleby@logistics.nhs.uk.

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 2003-04 the DPB employed an average of 332 full time staff and during the year approved fees of over £1.7 billion to 20,653 dentists at a gross administration cost of £24.2 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 October 2005.

For further information contact the Chief Executive, Dental Practice Board, Compton Place Road, Eastbourne BN20 8AD; 01323 417000 or **www.dpb.nhs.uk**

Council for HealthCare Regulatory Excellence (CHRE)

CHRE was established as a key part of the drive for greater co-ordination and accountability in professional self-regulation. CHRE was established in law in June 2002 (as the Council for the Regulation of Health Care Professionals) by the NHS Reform and Health Care Professions Act, 2002, and 2003-04 was its first year of activity. (Its name has changed but not its functions or purpose.)

Since April 2003, CHRE has:

- set up the organisation and systems to support its work. CHRE aimed to be collaborative, supportive, sensitive and independent;
- carried out a first performance review of the work that the regulators do;
- considered the disciplinary decisions of the nine regulators for healthcare professionals and referred certain decisions to the High Court when they considered that the regulators' decision was 'unduly lenient' and that a referral was necessary to protect the public;
- promoted good practice by enhancing communication between the regulators, consulted on its powers to change regulators' rules and to review regulators' disciplinary decisions, and developed principles of good practice;
- published a study of the nine regulators' work and developed relationships with stakeholders; and,
- identified some of the challenges facing the regulation of healthcare professionals.

Professional self-regulation in health care provides independent standards of training, conduct and competence for each profession to protect the public and to guide workers and employers.

CHRE was proposed in the NHS Plan and its functions have been shaped by the Kennedy report into Children's Heart Surgery at the Bristol Royal infirmary. The Council oversees the nine regulatory bodies who regulate all health care professionals. They are the:

- General Medical Council;
- General Dental Council;
- General Optical Council;
- Nursing and Midwifery Council;
- Health Professions Council;
- General Chiropractic Council;
- General Osteopathic Council;
- Royal Pharmaceutical Society of Great Britain; and
- The Pharmaceutical Society of Northern Ireland.

CHRE's role is to promote the interests of patients and the public in the way that these regulators do their work. Its main functions include formulating principles of good regulation and helping the regulators conform to them in a consistent manner. It will publish an annual report on the performance of the professional regulation system.

CHRE received £1,450,000 in grant in aid from the Department of Health in the year to 31 March 2004 to cover its running costs, and it employs 10 staff.

For further information on CHRE email: i**nfo@chre.org.uk** or telephone 0207 389 8030, or refer to their website at: **www.chre.org.uk**. The Department of Health and Social Care contact is Tim Lund on 0113 2546900.

The National Patient Safety Agency (NPSA)

The National Patient Safety Agency (NPSA) was established in England as a special health authority on 2 July 2001, and has since extended its services to Wales. Its core function is to improve the safety of NHS patient care by promoting a culture of reporting and learning from adverse events. The NPSA will manage a new national reporting and learning system to record adverse incidents and 'near misses' in health care and ensure that lessons learnt in one part of the NHS are properly shared with the whole of the health service.

The NPSA is funded by a grant from the Department and receives a proportional contribution from the National Assembly for Wales. Sue Osborn and Susan Williams are the Joint Chief Executive of the Agency and may be contacted at 4-6 Maple Street, London, W1T 5HD, telephone 020 7927 9500. Further information about the Agency's work to develop safety solutions for the NHS and to implement the new national reporting system during 2004 is available on its website at **www.npsa.nhs.uk**

As a result of the Department's review of arm's length bodies, the NPSA will continue its work in co-ordinating system wide efforts to improve the safety of care and to reduce the number of mistakes that result in injury to patients.

It will also take on additional responsibilities from 1 April 2005. These include responsibilities currently undertaken by the National Clinical Assessment Authority (NCAA), those for hospital food, cleanliness and safe hospital design currently undertaken by NHS Estates, responsibilities for National Confidential Enquiries currently undertaken by NICE and responsibility for the Central Office for Research Ethics Committees (COREC).

United Kingdom Transplant (UKT)

UKT leads organ donation transplantation throughout the UK and the Republic of Ireland. Its main objective is to increase the availability of organs for transplant and facilitate their effective and equitable distribution. The Department of Health funds UKT through a centrally held budget in Vote 1. Other UK countries contribute on the basis of agreed proportions. The operational budget for UK Transplant for 2003-04 was £11,022 million and £13,855 million in 2004-05. The Authority also operates and maintains the NHS Organ Donor Register, which is a computerised record of people who have registered their wish to be an organ donor in the event of their death

As a result of the Department's review of arm's length bodies, the NHS Blood and Transplant Authority will be formed from October 2005 by combining the functions of the National Blood Authority and UK Transplant. The new organisation will be responsible for the collection processing, testing and supply of blood across England and transplanted organs across the UK.

For further information on the work of UK Transplant e-mail: enquiries@uktransplant.nhs.uk or visit their website: **www.uktransplant.org.uk**.

National Institute for Clinical Excellence (NICE)

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. The NICE work programme is set by the Department of Health.

Broadly NICE develops three forms of guidance:

- 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.

The NICE executive board consists of three executive members (Chief Executive, Director of Resources and Planning, and Clinical Director). There are nine non-executive members, including the Chair and Vice Chair.

In addition, a Partners' Council of around 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 seven collaborating centres: 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. There are also three Appraisal Committees.

NICE has published 86 technology appraisals and 23 Clinical Guidelines from its inception to January 2005.

As a result of the Department's review of its arm's length bodies, NICE will merge with HDA (Health Development Agency) in April 2005 and will be known as the National Institute for Health and Clinical Excellence (NICE).

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: **www.nice.org.uk**.

Healthcare Commission (Commission for Healthcare Audit and Inspection – CHAI)

The Healthcare Commission was established by the Health and Social Care (Community Health and Standards) Act 2003 and commenced its functions on 1 April 2004 as an Executive Non-Departmental Public Body. It took on functions previously carried out by the Commission for Health Improvement (CHI) and the National Care Standards Commission (NCSC). The Healthcare Commission also took over some responsibilities from the Audit Commission, and subject to legislative changes, it is proposed that it will also take on work currently undertaken by the Mental Health Act Commission.

In 2004-05 the Healthcare Commission operated with 670 staff (headcount as at 31 January 2005) and operating costs of £67million (as at 31 January 2005). 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.

Its 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 perfomance of those who provide services. Its responsibilities cover health care providers in both the NHS and independent sectors.

The main goals of the Healthcare Commission are to assess healthcare performance across the NHS and independent sector and undertake annual ratings for NHS providers; deal with complaints, concerns and significant failings in health care swiftly and appropriately; provide authoritative, independent, relevant and accessible information about what is going on in health care; promote action to reduce inequalities in people's health and their experiences of health care; take a lead in co-ordinating and improving the value for money of assessment, inspection and regulation in health care; create an efficient, flexible and highly skilled organisation delivering world class inspection.

For further information about the Healthcare Commission please see **www.healthcarecommission.org.uk**

The 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.

NHS Direct

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.

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 been previously been available through the NHS;

Since March 2002, access to out-of-hours care through NHS Direct has been available to 10 million patients. By December 2004, technical and operational links will be in place to allow NHS Direct to transfer calls to any out-of-hours provider in the country, and further clinical integration of services will follow. Experience from existing schemes shows that NHS Direct can reduce workload for OOH providers by between 25 and 40 per cent;

NHS Direct has been able to directly refer 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 or pharmacists and helps relieve some pressure on GPs.

NHS Direct has also been involved in contributing to a responsible and coherent response to public health. NHS Direct has worked with the Department of Health 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.

Since December 2004, NHS Direct health information has been available via digital TV as well as via the telephone and internet.

The strategy document for developing NHS Direct, published in April 2003, sets out the continued commitment to this popular and innovative service. The impact of new financial investment will further support plans to use technology and new ways of working to boost productivity and increase capacity. In total, NHS Direct will aim to expand its call taking capacity three fold in the next three years, whilst at the same time, developing the various channels through which patients can access the service

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 trusts 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.

Temporary nursing staff alone costs the NHS more than £0.5 billion each year – it is critical that NHS Professionals leads a national approach to the management of temporary staff for the NHS in England.

NHS Professionals provides a service that:

- 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 priced at an appropriate level;
- 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 staff suitably qualified for the role and professionally managed.

NHS Professionals also offers savings to the NHS by managing demand and by controlling costs through managing the Agency Framework Agreements.

NHS Professionals has an independent Board and Chief Executive, reporting directly to the Department of Health. For further information, contact:

NHS Professionals
1st Floor, Regent's Place,
338 Euston Square,
London NW1 3BT
Tel: 0207 887 7171

NHS Professionals expects to move to new premises during in 2006 to:

Riverside House
Southwark Bridge Road
London SE1

NHS Pensions Agency

On the 1 April 2004 the NHS Pensions Agency (NHSPA), an Executive Agency of the Department of Health since November 1992, was established as a Special Health Authority within the NHS.

The Authority 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, not less than five and no more than seven non-executive members and up to five executive members, one of whom must be the Chief Executive of the Authority, and one the Director of Finance.

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 by 1 October 2005.

The Authority maintains financial information on the annual accounts of their expenditure, including administration costs. The Chief Executive, Alan Stuttard, 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, the NHS Pension Scheme and NHS Bursary 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.

OTHER NHS BODIES

Tribunal Non-Departmental Public Bodies

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. 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, Room 610, Eileen House, 80-94 Newington Causeway, London SE1 6EF.

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. There are two operational tribunal offices and one business support office based in London. The MHRT employs a total of 70 Department of Health staff who arrange hearings for patients detained in hospitals and units throughout England. In 2003-04, there were 22,038 applications and 11,815 hearings. Administrative running costs, including salaries were £2.5 million. The costs for the membership were £11.8 million. For more information about MHRT, contact Jack Fargher, Head of the MHRT, Wellington House, 135-155 Waterloo Road, London SE1 8UG; 020 7972 4577.

The 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, the functions of the tribunal provided under that Act were extended by other legislation. This includes the Care Standards Act 2000, the Children Act 1989 (as amended by the Care Standards Act and the Education Act 2002); the Criminal Justice and Court Services Act 2000 and; the Education Act 2002.

The Care Standards Tribunal hears appeals in relation to:

- decisions made by the National Care Standards Commission, 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 Chief Inspector of Schools in England in relation to the registration of Early Years Child Care Inspectors and Nursery Education Inspectors; 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. No such applications are expected until January 2006 at the earliest.

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 2002 to 31 March 2003, the Tribunal received 138 appeals, 53 of which were withdrawn by the appellant. The Tribunal heard 89 appeals (including preliminary and costs hearings) in this period. The budget for 2002-03 was £1.2 million. Outturn costs for the year were £649k. The outturn figure reflects the less than originally anticipated number of appeal hearings. 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. Tel: 0207 960 0664.

ANNEX D

PUBLIC ACCOUNTS COMMITTEE – REPORTS PUBLISHED IN 2004

Four PAC reports were published in the calendar year of 2004. 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. Procurement of vaccines by the Department of Health – **27 April 2004**
2. Hip replacements: an update – **5 May 2004**
3. Increased resources to improve public services: a progress report in departments' preparations – **19 October 2004**
4. The management of suspensions of clinical staff in NHS hospitals and ambulance trusts in England – **16 November 2004**

1. Procurement of vaccines by the Department of Health

The Committee concluded that there was no evidence of any link between political donations and the award of a smallpox vaccine contract to PowderJect. It recommended that the Department should encourage suppliers to stay in the market and to demonstrate it was getting good value for money in its procurement process.

Action taken on PAC conclusions and recommendations includes:

- the Department welcomed the Committee's findings that there had been no evidence of impropriety in the awarding of a smallpox contact;
- the Department has strengthened its procurement system by requiring all medium and high risk procurement projects to be subject to the Office of Government Commerce 'gateway' review procedures;
- the Department already holds regular meetings with vaccine manufactures to discuss their plans for new and existing vaccine products. Where practicable, vaccine contracts are awarded to more than one supplier, in order to encourage suppliers to stay in the UK market and to reduce the risk of shortages; and,
- in August 2003, the Department appointed a commercial director to upgrade the commercial capability of the Department and the NHS. An action plan is now in place to secure enhanced savings. Specific targets were incorporated into the Gershon Efficiency Review.

2. Hip replacements: an update

The Committee concluded that since it last reported there had been a number of key developments including the launch of the National Joint Registry (NJR) and the publication of guidelines by NICE on the evidence of effectiveness required for hip prostheses used in the NHS. It recommended comprehensive participation in the new NJR by NHS trusts. There should be strict safeguards for new prostheses which had little or no track record, that the Department should gain a good understanding of the relationship between the number of operations carried out by individual surgeons and outcomes, and that standards should be set for follow up action after surgery.

Action taken on PAC conclusions and recommendations includes:

- data on individual NHS trusts' reports to the NJR will be published on its website, shortly, and regularly updated;
- NHS Purchasing and Supply Agency has set up the Orthopaedic Data Evaluation Panel to give an independent view of manufacturers' claims regarding their products in relation to NICE benchmarks;
- as part of the National Orthopaedic Project, the Department commissioned research to determine whether surgeons who carry out hip operations should be set a minimum number for a given timescale. DH is currently reviewing the data; and,
- the British Orthopaedic Association has published guidance on the issue of follow up action following surgery and the Department expects compliance.

3. Increased resources to improve public services: a progress report in departments' preparations

The Committee concluded that there were a number of key issues that departments needed to manage if they were to convert successfully their increased resources into better public services. It recommended that departments gain assurance that their delivery partners have sufficient capability and capacity to deliver services effectively; that they simplify complex delivery chains and financing mechanisms, and establish a direct link between funding and specific expected improvements in service; and that departments should identify and tackle unacceptable disparities in service quality.

Action taken on PAC conclusions and recommendations includes:

- the Department considers it essential that its delivery partners can deliver services effectively and that performance is monitored regularly. For example: for IT contracts, DH has established a contestable framework for delivery of the National Programme for IT, organised through five regionally based 'clusters', to ensure there is no dependence on any one supplier organisation; and for the provision of Treatment Centres by the independent sector, contracts are monitored regularly throughout the procurement process;

- for 2004-05, the Department directly allocated to primary care trusts (PCTs) around 80 per cent of the NHS budget, to ensure that resources are spent in the most efficient and effective way depending on local circumstances; and,
- the Department uses various levers to incentivise good performance and identify and deal with poor performance. These include: the need for medical practitioners to participate in an appraisal system approved by the PCT; encouraging clinical audit; ensuring contractors have an effective system of clinical governance; and performance management by Strategic Health Authorities.

4. The management of suspensions of clinical staff in NHS hospitals and ambulance trusts in England

The Committee concluded that money was being wasted, as the NHS did not have a grip on staff suspensions and, whatever the reason for excluding staff, the process should be fair, open and transparent. It recommended the Department should repeat the National Audit Office's (NAO) survey to determine the extent and costs of exclusions. It should complete negotiations with the British Medical Association (BMA) and issue further guidance, should make clear confidentiality clauses are not used to prevent disclosure of settlements, and the National Clinical Assessment Authority (NCAA) should achieve its targets for advising trusts and completing assessments.

Action taken on PAC conclusions and recommendations includes:

- responsibility for monitoring long-term suspensions is now with the NCAA, but the Department will liaise with NHS Employers and the NCAA to undertake a repeat of the NAO's survey;
- the Department has completed negotiations with the BMA, and a new mandatory framework on disciplinary procedures should come into effect from April 2005 to cover doctors and dentists employed in the NHS. It includes principles of good practice for agreeing terms of settlement on termination of employment; and,
- the Department continues to monitor the performance of the NCAA in achieving its targets. The functions of the NCAA will be transferred to the National Patient Safety Agency from 1 April 2005.

ANNEX E

SPENDING ON PUBLICITY AND ADVERTISING AND INCOME FROM SPONSORSHIP 2004-05 (ESTIMATE)

The Department runs a number of publicity campaigns each year and the forecast outturn for 2004-05 is estimated to be £53 million. The main components included in this total are given below.

New activities in 2004-05 were:

This year has seen a continuation of high profile activity on the Tobacco Control Programme.

International evidence from smoking cessation campaigns has suggested that successful campaigns, delivering prevalence reductions, are comprehensive and maintain a strong media presence for extended periods. A key feature of these campaigns is that they feature:

- a continuous presence which reminds people of the health risks of smoking, offers them help and raises awareness of the dangers of second hand smoke;
- an increased media weight. This enables the campaign to surround the target audience with messages and run in a wide range of high-audience media;
- a multi-layered approach, including a range of approaches and messages, which could include cessation ads, with smokers talking to smokers, second hand smoke, support and charity campaigns; and,
- it is also beneficial to include third party voices.

To that end, an increased level of funding has allowed the Department of Health to continue an expanded mass media campaign.

We have been able to introduce new messages and use a number of motivations to encourage cessation. These included the 'emotional consequences' of serious, smoking-related illness on self and family. The Department has also produced TV advertisements featuring testimonials from successful quitters, and run these to help support awareness and use of local stop smoking services.

The Department of Health, in conjunction with the Home Office, has continued to run the *Frank* drugs misuse information campaign.

National TV and press advertising ran again in January 2005 to recruit social care workers.

Sponsorship

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' i.e. the provision of goods or services to support a campaign or other activity. In 2004-05, all the sponsorship received by the Department was 'in-kind'.

Sponsorship Received by DH from Other Organisations 2004-05

Sponsor	Amount received	Support received
BT	£793,000	Promotion of FRANK drugs helpline and website in kiosks.
Club 18-30	£100,000	Promotion of FRANK drugs information helpline and website in resorts
Pearl & Dean Advertising	£52,000	12 months' promotion of FRANK via cinema advertising
Mykindaplace.com	£5,000	FRANK online promotion
Addictive Interactive	£38,000	FRANK online promotion
Habbohotel.com	£25,000	FRANK online promotion
Westminster City Council	£10,000	Use of Leicester Square for 2 days for Hepatitis C awareness promotion
BBC Radio 1	£28,000	Promotion of Adult Sexual Health Campaign
Durex	£410,000	Provision of free condoms to support Adult Sexual Health campaign
Trojan	£150,000	Provision of free condoms to support Adult Sexual Health campaign
Pasante	£75,000	Provision of free condoms to support Adult Sexual Health campaign
Club 18-30	£75,000	Promotion of Adult Sexual Health campaign
Escapades	£58,000	Promotion of Adult Sexual Health campaign at events

Sponsor	Amount received	Support received
2twentys	£59,000	Promotion of Adult Sexual Health campaign at events
Luminar Leisure	£444,000	Promotion of Adult Sexual Health campaign at events
Revolution	£126,000	Promotion of Adult Sexual Health campaign at events
Sintillate	£90,000	Promotion of Adult Sexual Health campaign at events
Ministry of Sound	£17,000	Promotion of Adult Sexual Health campaign at events
Jumpin Jaks	£25,000	Promotion of Adult Sexual Health campaign at events
C-Side	£9,000	Promotion of Adult Sexual Health campaign at events
Glastonbury Festival	£11,000	Promotion of Adult Sexual Health campaign at events
Reading & Leeds Festivals	£9,000	Promotion of Adult Sexual Health campaign at events
TheSite.org	£46,000	Promotion of Adult Sexual Health campaign online
Yates bars	£45,000	Promotion of Adult Sexual Health campaign on 115 plasma screens in bars
Itbox	£75,000	Promotion of Adult Sexual Health campaign on 4,500 games machines
NHS Live	£1.2m	Sponsorship of Conference

Sponsorship Paid by DH to Other Organisations 2004-05

Recipient	Amount sponsored	Support donated
Association of Healthcare Communicators	£30,000	Sponsorship of conference
National Association for Primary Care	£16,000	Sponsorship of events
Ask About Medicines Week	£111,000	Sponsorship of week
Royal College of Physicians	£230,000	Funding of Information Library
Health Service Journal	£12,000	Sponsorship of emergency care award at HSJ Awards
Tongues of Fire	£30,000	Sponsorship of Asian Women's Film Festival
Trained Nursing Association of India	£6,000	Sponsorship of workshops on 'Nursing Management of Patients with Trauma and Accidents'
Nicola Lester (recipient of Nursing Standard Nurse of the Year 2004 award)	£8,000	Sponsorship to provide support to South African healthcare project. Joint sponsorship with the Open University.
British Medical Association	£20,000	Sponsorship of the Humanitarian Fund to support projects in developing countries.

Figure E1: Departmental Spending on Publicity and Advertising and Sponsorship 2004-05

Campaigns run by the Department	£ million
Smoking (Tobacco Information)	30
Workforce	9
Social Workers Recruitment	3
Teenage Pregnancy	0.77
Child Immunisation	1.2
Drugs	1.5
Older People (inc. Keep Warm, Keep Well)	0.45
Sexual Health	2
Health Care Abroad (inc. E111 and EHIC marketing)	1.3
Children's Services	0.53
Flu immunisation	2.25
Get the right treatment and Ask About Medicines Day	0.96
Total	**52.96**

ANNEX F

DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS – CSR 1998 (TARGETS ALREADY ACHIEVED – CURRENT POSITION WHERE APPROPRIATE)

PSA Target	Measure	Progress
Target 6: Achieve the Government's commitment to reduce NHS inpatient 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 822,000, at the end of March 2005. 336,000 below the inherited level,
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. 1.65 million calls received in 1999-2000, rising to over 6.4 million in 2003-04.
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% whole-time-equivalent GPs in 1997 over 1996, there will be progress towards a national average annual increase of 1% 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%) and between September 2003 and September 2004 the increase was 985 (fte) (3.3%).
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 December 2004.
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% 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 3 pieces of cancer service guidance and eight clinical guidelines. In 2004, NICE published 13 technology appraisals (including one review), 15 clinical guidelines and 3 pieces of cancer service guidance. A further 22 technology appraisals, 9 clinical guidelines and 4 pieces of cancer service guidance are due to be published in 2005.

Departmental Public Service Agreement Targets Analysis – CSR 1998 (targets already achieved)

PSA Target	Measure	Progress
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 3 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 targets and progress on value for money is reported in Chapter 2 under PSA (SR2000)Target 12.
Target 15: The Department to ensure that all NHS trusts set a target of at least 3 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 (SR2000) 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% to above that level by the end of March 2002, from a baseline of 598 practices < 40% 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%, December 2000 data. 34 practices < 40%, April 2002 to January 2003 data. The Department no longer monitors this target.
Target 18: A 50% 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% 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.
Target 22: Achieve efficiency and other value for money gains in Personal Social Services expenditure equivalent of 2% in 1999-2000 and 2000-01, and 3% in 2001-02.	Value of efficiency and other value for money savings.	**Met:** The estimated efficiency gains for the three years were 2.1%, 2.3% and 2.5%, totalling 7.1% against a three-year target of 7.2%. For 2002-03 there was no target as such, but the Service Delivery Agreement included an expectation of 2.5% efficiency gains. Estimated gains of 2.0% were made, meaning that the four year total was 9.2%, just short of the cumulative target/expectation of 9.8%.
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 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% of children on the Child Protection Register being re-registered (i.e. target of 17.2% 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 – CSR 1998 (targets already achieved)

PSA Target	Measure	Progress
Target 28: Achieve efficiency and other value for money gains in Departmental operations equivalent of 2.5% 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 (SR2000) 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% of services by March 2003.	Percentage of services reviewed.	**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 ongoing 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% 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% (a total of 21 services) are able to be delivered electronically as at 2 February 2005. A further 9 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 timescale.	**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 Analysis – CSR 2000 (Targets already achieved – current position where appropriate)

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 March 2004 and March 2005, the proportion of 'acute' beds occupied by patients aged over 75, for which the patient's transfer was delayed decreased 0.3 percentage points from 2.0% to 1.7%. Between March 2004 and March 2005, the proportion of 'acute' beds occupied by patients of all ages, for which the patient's transfer was delayed, decreased 0.5 percentage points from 2.7% to 2.2% (rounded). The rate of Emergency Re-admissions within 28 days, for patients of all ages for January to March 2005 was 6.3%.

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See 2.7

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See 0.4

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See 2.4

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See 5.15

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See 2.10

5.34
See 5.17

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See 0.4

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See 2.7

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See 2.8

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See 1.5

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See 1.5

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See 5.51

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See 2.4

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See 0.1

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See 0.4

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See 5.5

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See 2.4

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See 2.4

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See 0.1

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See 0.4

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Deaths of detained patients in England and Wales
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List of Figures

Figure 3.1: Department of Health public spending

Figure 3.2: England net NHS expenditure plans (Stage 2 Resource Budgeting) 2004-05 to 2007-08, as per the Spending Review 2004

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

Figure 3.4: National Health Service, England – by area of expenditure (Stage 2 Resource Budgeting)

Figure 3.5: Comparison of NHS net expenditure for 2004-05 with those in last year's Departmental Report (Cm 6204)

Figure 3.6: Main areas of change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm 6204)

Figure 3.7: NHS net expenditure, 2005-06 (Plan)

Figure 3.8: Disposition of NHS resources

Figure 3.9: Department of Health - Resource Accounts 2003-04

Figure 3.10a: Department of Health identifiable expenditure on services, by country and region

Figure 3.10b: Department of Health identifiable expenditure on services, by country and region, per head

Figure 3.10c: Department of Health identifiable expenditure on services, by country and region, 2003-04

Figure 3.11: NHS sources of finance 2005-06

Figure 3.12: Expenditure by local authorities on Personal Social Services

Figure 4.1: NHS capital spending 2004-05 to 2007-08 (resources)

Figure 4.2: Disposition of 2005-06 capital resources

Figure 4.3: NHS LIFT schemes

Figure 5.1: Total number of statins prescription items prescribed and dispensed in the community, in England, since January 1991

Figure 5.2: Trend in number of heart procedures

Figure 5.3: Trend in number of people waiting more than 6 months for heart treatment

Figure 5.4: Trend in number of people waiting for heart treatment

Figure 5.5: Trend in number of people waiting more than 3 months for heart treatment

Figure 6.1: Hospital and Community Health Services gross current expenditure by sector, 2002-03

Figure 6.2: Hospital and Community Health Services gross current expenditure by age, 2002-03

Figure 6.3: Hospital and Community Health Services gross current expenditure per head, 2002-03

Figure 6.4: Estimated growth in people aged 65 and over: year-on-year percentage increases

Figure 6.5: Distribution of resources for 2003-06

Figure 6.6: Revenue allocations 2006-07 and 2007-08: distribution of increases

Figure 6.7: Distribution of resources for 2006-07 and 2007-08

Figure 6.8: Primary Care Trusts' distances from target (DFT) 2003-04 to 2007-08

Figure 6.9: Centrally funded initiatives and services and special allocations (CFISSA), 2004-05 and 2005-06

Figure 6.10: Family Health Services gross expenditure (cash and resource), 1993-94 to 2003-04, England

Figure 6.10a: Family Health and Personal Medical and Dental Services gross expenditure, 2003-04, England

Figure 6.10b: Total FHS gross expenditure 1993-94 to 2003-04, England

Figure 6.11: Gross Family Health Services drugs bill, 1993-94 to 2003-04, England

Figure 6.12: Gross Family Health Services drugs bill – percentage growth, 1993-94 to 2003-04, England

Figure 6.13: Central Health and Miscellaneous Services (CHMS) gross expenditure, 2004-05 to 2005-06

Figure 6.14: Personal Social Services provision for adults, 2005-06

Figure 6.15: Local authority Personal Social Services gross expenditure by client group, 2003-04

Figure 6.16: Local authority Personal Social Services gross expenditure by type of service, 2003-04

Figure 7.1: Hospital activity trends, 1992-93 to 2004-05

Figure 7.2: Community nursing, dental and cross sector therapy services activity

Figure 7.3: Key statistics on General & Personal Medical Services (GPMS), England

Figure 7.4: Family Health Services – key statistics on Pharmaceutical Services, England

Figure 7.5: Family Health Services – key statistics on General and Personal Dental Services, England

Figure 7.6:	Family Health Services – key statistics on General Ophthalmic Services
Figure 7.7:	Average unit costs by category of care 1992-93 to 2002-03 (Index 1991-92 = 100)
Figure 7.8:	Adults receiving Personal Social Services – a summary
Figure 7.9:	Distribution of star ratings between 2002 and 2004
Figure 7.10:	Changes in rating from 2003 to 2004
Figure 8.1:	Department of Health administration costs
Figure 8.2:	Staff numbers
Figure 8.3:	Public appointments sponsored by the Department (members in post) at 1 January 2005
Figure 8.4:	Public appointments - progress by gender and ethnic balance
Figure 8.5:	Recruitment into the Department of Health 2004
Figure 8.6:	Salaries in the Department of Health for senior civil service staff in post as at 1 April 2004
Annex A1:	Total capital employed by the Department
Annex A2:	Department of Health – resource budget
Annex A3:	Department of Health – capital budget
Annex E1:	Departmental Spending on Publicity and Advertising and Sponsorship 2004 – 05

Glossary

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.

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).

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.

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 following consultation with representatives of the relevant professions, and administered locally by Primary Care Trusts (PCTs). Funding of the FHS is demand led and not subject to in year cash limits at Primary Care Trust 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 Primary Care Trusts' (HCHS) 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.

Non-discretionary GMS expenditure includes all demand led item of service payments such as capitation payments, health promotion and basic practice allowance.

Funding for this is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation. Discretionary GMS expenditure includes reimbursement of GMS GPs' practice staff, premises, out of hours and IM&T expenses. Funding for this is subject to local resource limits and forms part of PCTs' discretionary allocations.

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.

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.

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.

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 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.

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 as 'block capital' and since 2003-04, has 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.

Outturn

The actual year end position in cash terms.

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 Group (PCG)

Primary Care Groups are fundamentally about improving the health of the population they serve by bringing together GPs, community nurses, managers, social services, local communities, PCTs, trusts and other health professionals in effective partnership to deliver three main aims:

- improve the health of their community;
- develop primary and community services; and,
- commission secondary services.

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.

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 & 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.

Real Terms

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

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.

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 its behalf.

Specific Grants

Grants (usually for current expenditure) allocated by Central Government to local authorities for expenditure on specified services, reflecting Ministerial priorities.

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 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.

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.

Full Contents List

Page

Foreword by the Secretary of State 1

Ministerial Responsibilities 3

Structure of the Department of Health 5

Contents Summary 6

Chapter 1: Introduction

1.1 Introduction 7
1.5 Department of Health 7
1.10 National Health Service (NHS) 7
1.12 Personal Social Services (PSS) 7
1.15 Delivering the NHS Plan 8
1.23 NHS Foundation Trusts 9
1.26 Department of Health Change Programme 9
1.28 Arm's Length Body Review 9
1.30 Efficiency Programme 9
1.33 Public Health White Paper 9

Chapter 2: Delivering Better Public Services – Progress

2.1 Introduction 12
2.4 The Department of Health Aims and Objectives 12
Table – Departmental Public Service Agreement Targets Analysis (1998) 13
Table – Departmental Public Service Agreement Targets Analysis (2000) 15
Table – Departmental Public Service Agreement Targets Analysis (2002) 18
2.11 Departmental Public Service Agreement Targets (2004) 24
Targets from Cross-Departmental Reviews:
2.14 Health Inequalities 25
2.19 Action Against Illegal Drugs 25
Cross-Government Initiatives:
2.22 Sure Start 26
2.37 National Service Framework for Children, Young People and Maternity Services 26
2.42 Every Child Matters: Change for Children 27
An Outcomes Driven Programme 27
Children Act 2004 27
Chief Nursing Officer's Review 27
Development of Children's Trusts 27
Regional Change Advisors 27
Joint Inspection Arrangements 27
2.48 Social Exclusion and Neighbourhood Renewal 27
2.52 Sustainable Development 28
Modernising Government Action Plans:
2.56 The Policy Hub 28
2.59 The Policy Collaborative 28

2.62 Equality and Human Rights 28
2.63 Race Relations (Amendment) Act 2000 29
Background 29
The Department's New Race Equality Scheme 29
NHS Compliance Race Relations Legislation 29
Raising Awareness of the Contribution of Black and Minority Ethnic and Other Minority Groups to the Health Sector 29
Communication/Information for 'hard to reach' Groups 30
Improving Ethnic Origin Information 30
Black and Minority Ethnic Mental Health 30
Disability 30
Employment and Ethnicity Data 30
2.92 Rural Proofing 31
2.99 Better Regulation and Regulatory Impact Assessments (RIAs) 32
Legislation 32
Regulatory Impact Assessments (RIAs) 32
Helping Discussions in Europe 32
Alternatives to Prescriptive Regulation 32
The Regulation Reform Action Plan 32
Consolidation of NHS Law 33
Regulatory Reform Orders (RROs) 33
Public Consultations 33
Avoiding Regulatory Creep 33
Reviews of Regulations 33
Better regulation Task Force (BRTF) Reports 33
2.117 e-Government and IT in the NHS 33
Funding IT Development 33
Benefits for Patients 34
Delivering the National Programme 34
Stakeholder Engagement 34

Chapter 3: Expenditure

3.1 Introduction 37
3.4 NHS Expenditure Plans 38
Spending Review 2004 Settlement 38
Personal Social Services 39
3.9 Health and Personal Social Services Programmes 40
NHS HCHS and Discretionary FHS 40
NHS Non-Discretionary FHS 40
Central Health and Miscellaneous Services 40
Administration of the Department of Health 40
NHS by Area of Expenditure 40
Expenditure in 2004-05 42
NHS Expenditure Plans in 2005-06 42
NHS Resources 43
3.19 Programme Budgeting 43
Background to Programme Budgeting 43

Department of Health – background 44
Financial Year 2003-04 44
3.31 Regional Breakdown of Spend 45
3.34 Sources of Finance 47
3.38 Complementary Sources of Funding 48
Big Lottery Fund 48
Healthy Living Centres 48
Living with Cancer 48
Fighting Heart Disease 48
Palliative Care 48
3.49 Invest to Save Budget 48
3.52 Recovery of NHS Costs following Road Traffic Accidents 49
3.55 Personal Social Services Expenditure 49

Chapter 4: Investment

4.1 Policy Context 51
4.7 Priorities for Public Capital Investment in 2005-06 53
Cancer 53
Coronary Heart Disease 53
Mental Health 53
Other Investments in Clinical Services 53
Expanding Capacity and Improving Access to Services 53
4.21 Vital Supporting Investments 54
Decontamination 54
Pharmacy Facilities and Investment in Medical School Facilities 54
Information Management and Technology 54
4.29 Direct Capital Allocations 54
Capital Investment by NHS Foundation Hospitals 54
Restrictions on Capital to Revenue Transfers 55
Treasury Capital Modernisation Fund 55
Prioritisation of Major Capital Schemes 55
4.42 Public Private Partnerships and Innovative Investments 55
PFI and Delivery of the 100 Hospital Schemes 55
4.50 NHS LIFT 56
4.54 Investment to Contain vCJD 56
4.56 ProCure 21 56
4.59 Asset Disposal 56
4.62 Pooled Budget Arrangements and Investment in Social Care 56

Chapter 5: The NHS Plan – A Plan for Investment; A Plan for Reform

5.1 A Brief Summary of the NHS Plan 60
5.4 The NHS Plan – Step by Step Reform 60
Carrying out the Plan's Reforms:
5.7 The NHS Improvement Plan 60
5.10 Increasing Devolution 60
Planning Framework 60
Revenue Allocations to PCTs 60

NHS Foundation Trusts ... 61
Pay Modernisation in the NHS ... 61
5.28 Patient Choice at the Heart of Reform ... 62
Choice of Hospital ... 62
Choice for CHD Patients ... 63
Cataracts and Chronic Eye Conditions ... 63
Better Information, Better Choices, Better Health ... 63
5.47 Increasing Plurality of Provision ... 63
Treatment Centres ... 63
Use of Spare Capacity in the UK Independent Sector. ... 64
Overseas Treatment ... 64
5.59 Confidence in Health Service Delivery ... 64
NHS Performance "star" Ratings ... 64
NHS Franchising and Register of Expertise ... 65
Patient Prospectus ... 66
The Healthcare Commission ... 66
The Commission for Social Care Inspection (CSCI) ... 66
5.91 Payment by Results ... 67
5.96 NHS Bank ... 67
5.99 Public Health White Paper ... 67
5.109 Support for People with Long-Term Conditions ... 71
Actions Achieved to Date:
5.118 Access ... 72
Primary Care ... 72
Secondary Care ... 72
5.123 More Staff in the NHS Workforce ... 73
5.130 Capital and Capacity ... 73
5.132 Health Inequalities ... 73
Prevention ... 74
Primary Care ... 74
Local Improvement Finance Trusts (LIFT) ... 74
Contracting Routes ... 74
CHD and Cancer ... 74
Stopping Smoking ... 75
Teenage Pregnancy/Supporting Teenage Mothers ... 75
Helping 13-15 Year-Olds to Address Risk ... 75
Sexual Health and HIV ... 76
Screening ... 76
Nutrition ... 76
Oral Health ... 76
Drug Misuse ... 77
Preventing Accidental Injury ... 77
Health Services for Prisoners ... 77
5.181 Cancer ... 78
Prevention ... 78
Breast Screening ... 78

Cervical Screening ... 78
NHS Bowel Cancer Programme ... 78
NHS Prostate Cancer Programme ... 79
Cancer Waiting Times ... 79
Cancer Treatment ... 79
Lung Cancer ... 80
Supportive and Palliative Care Strategy ... 80
Cancer Workforce and Training ... 80
Cancer Equipment ... 81
Positron Emission Tomography ... 81
5.216 Coronary Heart Disease ... 81
In Primary Care ... 81
In Emergency Care ... 82
Clot-Busting Drugs ... 82
Rapid Access Chest Pain Clinics ... 82
Angiograms ... 82
Heart Operations ... 83
Recruitment and Retention of Staff ... 83
Long-term Investment ... 83
5.230 Prevention of Ill Health ... 84
Physical Activity ... 84
Smoking ... 84
Obesity ... 85
Nutrition ... 85
5.254 Older People's Services ... 86
The National Framework for Older People ... 86
Assessment and Access ... 87
Community Equipment Services ... 87
Financial Help ... 87
Delayed Discharge ... 87
Extra Care Housing for Older People ... 87
Ending Nightingale Wards ... 87
5.274 Mental Health Services ... 88
Suicide Rate ... 88
Strengthening the Workforce ... 88
Future Developments ... 88
Child and Adolescent Mental Health Services (CAMHS) ... 88
Prison Mental Health ... 89
5.288 Children ... 89
National Service Framework for Children, Young People and Maternity Services ... 89
An Outcomes Driven Programme ... 89
Children Act 2004 ... 89
Chief Nursing Officer's Review ... 90
Development of Children's Trusts ... 90
Regional Change Advisors ... 90
Joint Inspection Arrangements ... 90

5.299 Quality of Care 90
PALS 90
CPPIH 90
Overview and Scrutiny Committees 91
NHS Healthcare Standards 91
National Clinical Audit 91
Clinical Governance 91
Controls Assurance 92
Single-sex Accommodation 92
5.323 Improving Patient Experience 92
Independent Complaint Advocacy Service 92
Director for Patients and the Public 92
Patient Feedback Surveys 92
The Voluntary and Community Sector (VCS) 93
Self Care 93
A Safe, Clean, Comfortable, Friendly Place to Be 93
Clean Hospitals 94
Engineering and Science 94
Environment and Sustainability 94
The Matron's Charter 94
Better Hospital Food 94
Ward Housekeeping 95
Bedside TVs and Telephones 95
A Healing Environment 95
Patient Safety 96
5.380 NHS Direct 96
5.388 Modernising Pathology Services 97
5.392 NHS Dentistry – Reform Programme 97
5.400 A Vision for Pharmacy 98
5.421 Audiology Modernisation Project 99
5.423 Genetics White Paper 99
5.427 Independent Reconfiguration Panel (IRP) 100
5.431 Modernisation Agency 100

Chapter 6: Breakdown of Spending Programme

6.1 Hospital and Community Health Services 102
HCHS Resources by Sector 102
HCHS Current Resources by Age Group 102
Resource Allocation 103
6.26 Centrally Funded Initiatives and Services and Special Allocations 105
6.27 Family Health Services 105
FHS Gross Expenditure 105
Family Health and Personal Medical and Dental Services Resources 106
6.33 Drugs Bill 107
6.44 Central Health and Miscellaneous Services 108
6.46 Personal Social Services 108
PSS Revenue Provision 108

PSS Capital Resources 109
How the Resources are Used 109

Chapter 7: Activity, Performance and Efficiency

7.1 NHS Hospital Activity Trends 112
7.2 Inpatient and Outpatient Waiting 112
7.6 Emergency Care 113
Delivering Improvement 113
Improving the Patient Experience in A&E 113
Not Everyone Wants or Needs To Go To A&E 113
7.14 Community Nursing, Dental and Cross Sector Therapy Services Activity 113
7.19 Access to Primary Care 114
7.31 Family Health Services (Primary Care) 115
General and Personal Medical Services 115
Pharmaceutical Services 116
General and Personal Dental Services 116
General Ophthalmic Services 118
7.36 Performance 118
Management Costs 118
Reducing Bureaucracy 118
7.39 Financial Performance 119
7.54 Efficiency 120
Reference Costs 121
Unit Costs 121
The Learning Disabilities Sector 121
7.76 Personal Social Services 121
7.77 PSS Performance and Performance Assessment 122

Chapter 8: Managing the Department of Health

8.1 Administration Costs and Staffing Tables 125
8.7 Department of Health Change Programme 127
8.12 Non-Departmental Public Bodies (NDPBs), Special Health Authorities and Executive Agencies 127
8.19 Public Appointments 128
8.27 Recruitment 129
8.30 Senior Civil Service Salaries 129
8.31 A Healthier Workplace 129
8.37 Accommodation and ICT (Information and Communication Technology) 130
8.44 The Environment 130

List of Annexes 131

Bibliography 158

List of Figures 165

Glossary of Terms 167

Full Contents List 172

NOTES

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