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TREASURY MINUTES DATED 25 OCTOBER 2006 ON THE THIRTY-FIFTH, FIFTY-SECOND, FIFTY-FORTH AND THE FIFTY-SIXTH REPORTS FROM THE COMMITTEE OF PUBLIC ACCOUNTS, SESSION 2005-2006

Thirty-fifth Report

Department of Health

The refinancing of the Norfolk and Norwich PFI Hospital

1. In 1998, the Norfolk & Norwich University Hospital NHS Trust (the Trust) let one of the first PFI hospital contracts to a private sector consortium Octagon. In 2003, two years after the new hospital opened, Octagon refinanced the project, increasing its investors' internal rate of return (IRR) from 18.9% (predicted at the time the contract signed) to 60.4%. In accordance with the Treasury's voluntary code – *(Refinancing of Early PFI transactions – Code of Conduct)*, the Trust received 31% of the refinancing gains but took on new risks following the refinancing. On the basis of a report by the Comptroller and Auditor General, *The refinancing of the Norfolk and Norwich PFI Hospital: how the deal can be viewed in the light of the refinancing* (HC 78, Session 2005-06) the Committee took evidence from the Trust and the Department of Health (DH) on how this PFI deal should be viewed in the light of the refinancing and the implications of these refinancing arrangements for other PFI deals.

PAC conclusion (i): Octagon's investors' internal rate of return more than trebled following the refinancing. The total cash, which investors expect to receive from the project reduced from £464 million to £335 million following the refinancing, but they have now got a large part of it much earlier. As a result, their internal rate of return, reflecting the value of getting benefits sooner rather than later, soared from 19% when the contract was let to 60%.

PAC conclusion (ii): This refinancing produced a balance of risks and rewards between the public and private sectors which, even for an early PFI deal, is unacceptable. Octagon was able to optimise its refinancing gain by reducing its interest costs and extending the period of its borrowings. It was then able to increase its debt from £200 million to £306 million, thus accelerating the benefits to its investors.

2. Octagon's successful management of the risks in the construction and early operational phase of the project has allowed them to refinance the deal to accelerate the benefits to its shareholders. It is this acceleration of the benefits that increases the IRR to 60% as the refinancing actually reduced the total cash they could expect by £129m.

3. The sharing of the gains was carried out in accordance with the Treasury's voluntary code *(Refinancing of Early PFI Transactions – Code of Conduct)*. The contract actually entitled the Trust to receive no share at all.

4. The Trust commissioned experienced advisers to assist them in reviewing the private sector's proposals, including assessing the value for money of the refinancing.

PAC conclusion (iii): The Trust secured the right to receive only £34 million (29%) of the resulting £116 million gain. This was despite the gain arising just two years after the hospital opened and the Trust being exposed to significantly increased risks. Contracts are now expected to include provisions to share refinancing gains with the public sector on a 50:50 basis.

5. The share of the gain allocated to the Trust was in accordance with Treasury's Code of Conduct.

PAC conclusion (iv): The possible impact of refinancing gains to the private sector was not considered before the Trust awarded this PFI contract. Although the Department was aware of the potential for refinancing when entering this contract, there was no contractual arrangement to share in refinancing gains and no assessment of the effect of refinancing on the investors' returns. As a result, the Trust's liabilities could now also include all the additional borrowings Octagon took on to accelerate the benefits to its investors.

6. The potential for gains from a refinancing were recognized prior to the contract being signed. The government's policy at the time was that provisions seeking a share for the public sector should not be sought whilst the market was still so volatile. DH introduced such clauses in July 1998 when the Calderdale contract was signed.

PAC conclusion (v): Following the refinancing, the Trust could have to pay up to £257 million more if it needs to end this PFI contract early. It is wholly inappropriate that, in the event of termination, the Trust's liabilities could now include not just the cost of the hospital, but all the additional borrowings Octagon took on to boost its investors' returns. It is unacceptable that, in the event of termination, the Trust could be left with liabilities incurred simply to make it easier for the investors to achieve high returns.

7. The situation facing the department should a PFI hospital become surplus to requirements is similar to that of a publicly funded one. The first step would be an appraisal of the ways to reduce capacity in that locality to see if cheaper solutions, with the same clinical outcomes, can be secured. If no alternatives are available, the NHS will be faced with the prospect of either letting the contractual payments continue until the end of the contract or pay it off early. This again will be subject to a value for money appraisal. If a publicly funded hospital closes early, the same considerations should apply to any outstanding Treasury gilts on the borrowing raised to fund the hospital construction.

8. The net present value of all future contractual payments by the Trust at the time of refinancing over the remaining old contract period was £572.9m. After refinancing (including the five year contract extension) the net present value of all future payments was £572.7m (both numbers are in April 2003 prices).

PAC conclusion (vi): To maximise the refinancing gains, the Trust agreed to extend the minimum period of its PFI contract by five years to 2037. There can be no certainty that a hospital will be needed in its current form in over thirty years time, and the Trust need not have incurred the risks of extending the contract.

9. The Trust considered this an acceptable risk. By extending the contract the Trust are getting the use of a first class state of the art hospital for another five years at a fixed cost in real terms. All PFI schemes must incorporate flexibility and adaptability in their design and variations can be made to the contract – as has already happened at this Trust.

PAC conclusion (vii): The investors took their benefits from the refinancing immediately whereas the Trust is receiving its share over 35 years. On advice from the Department, the Trust is receiving its share of the refinancing gains as a reduction to the annual PFI contract charge it pays to Octagon. If the contract is terminated early, the Trust may find it difficult to recover the outstanding balance of its share of the refinancing gain.

10. Taking the payment over time reflects the economic reality of the transaction. Were the Trust to receive the benefit immediately, as the NAO acknowledges, the maximum termination liabilities would have been higher.

PAC conclusion (viii): This project again shows an authority too readily agreeing with refinancing proposals when more robust negotiations could have produced a better outcome. Staff managing PFI projects should be trained to understand refinancing issues and should appoint experienced advisers to assist in robustly negotiating refinancing.

11. It is important that staff managing PFI projects understand the issues arising from a refinancing and that they should appoint experienced advisers to assist them in negotiating refinancing. The staff and advisers need to apply the terms of extant guidance such as the Code of Conduct and the *Application Note – Value for Money in Refinancing* and consult with the Refinancing Taskforce where necessary as part of the process of approving refinancing. The Trust commissioned experienced advisers to assist them in reviewing the private sector's proposals, including the value for money of the refinancing.

PAC conclusion (ix): The Trust incurred additional financing costs by entering into an early contract in the emerging PFI hospital market. Financing costs were higher on early PFI hospital deals than current deals reflecting the risks of a new market, and the Trust should not be expected to bear the additional cost unaided. The Department argues that the Trust avoided subsequent construction cost inflation, but this is a different issue, which does not relieve the Trust of the higher financial costs.

12. The department agrees that the Trust is paying a higher price for the financial package than later hospitals. It does not follow however that the Trust is prejudiced financially compared to trusts with more recent PFI contracts. Because the costs of construction of later PFI hospital projects were greater, the overall servicing costs of the Norfolk and Norwich PFI project are in fact substantially similar. This analysis was supported by the NAO. There is therefore no case for this Trust to benefit from a centrally funded subsidy because of the circumstances of its contract.

PAC conclusion (x): There is no central data on PFI construction cost inflation or the impact of government building programmes on public sector building costs. In order to manage better the future PFI programme, the Treasury should provide an annual assessment of the effect of construction cost inflation on public building projects, including the effect on PFI projects and a comparison with private sector experience.

13. The Treasury agrees that it is important for procuring authorities to understand the factors underlying cost assumptions made by private sector bidders for PFI. This is important in assessing how construction inflation will impact project affordability from outline business case to preferred bidder selection (a risk borne by the public sector) and from preferred bidder selection/ contract signature until the end of construction (a risk borne by the private sector).

14. However, a number of factors mean that analysis and comparison of PFI construction inflation on a consolidated basis would be not be meaningful. These include:

- the limited number of PFI transactions closing in any one year (e.g. 50-60 deals per annum with 28 over £20m in 2005);
- regional inflation and the geographic spread of PFI transactions;
- sectoral inflation and the sectoral (waste, housing, hospitals, schools, roads, street lightening etc) spread of PFI projects;
- type of PFI capital contracts (e.g. buildings, civil engineering, training equipment, medical equipment, ICT in schools).

15. The Treasury does believe that oversight of construction costs is important. OGC and departments' private finance units (PFUs) are best placed to support procuring authorities in assessing the impact of inflation. The Treasury will remind PFUs of the importance of actively monitoring construction inflation in their sectors. Several resources are already available to aid departments in this:

- Departments can access construction inflation data that is collected and analysed by the Department for Trade and Industry (DTI). The data includes sectoral breakdowns, and also PFI contracts but the latter is not disaggregated from other procurement routes.
- the Public Sector Construction Client's forum (PSCCF), which was set up by the OGC in 2005 in response to the Kelly report on 'Competition and Capacity planning', has produced a commissioned study on *2005-2015 Construction demand/Capacity*. This examines the industry's ability to deliver significant capital development programmes and any potential impact on inflation. The work is informed in part by the OGC's Public Sector Construction Demand Database, which is also available for Departments' use.

Fifty-second Report

Department of Health

Reducing brain damage: faster access to better stroke care

1. Stroke, the brain equivalent of heart attack, is one of the top three causes of death in England, and the leading cause of adult disability. There are around 110,000 strokes each year in England, a quarter of which occur in people under the age of 65. Some 300,000 people in England are living with moderate to severe disabilities as a result of stroke. However many strokes are preventable; and developments over the last decade have shown that fast and effective acute treatment of stroke, and high quality rehabilitation, can significantly reduce death and disability. On the basis of a Report by the Comptroller and Auditor General, *Reducing brain damage: faster access to better stroke care* (HC 452, Session 2005-06), the Committee took evidence from the Department of Health (DH) on the provision of stroke care in England.

PAC conclusion (i): Stroke is the third biggest cause of death in England, after heart disease and cancer. It is also the leading cause of adult disability. Although historically stroke has been seen as an inevitable risk of growing old, with little to be done for stroke patients other than trying to make them comfortable, a quarter of strokes occur in people under the age of 65. Fast and effective acute treatment, and high quality rehabilitation, can significantly reduce death and disability.

2. The Department of Health agrees with this conclusion. Recent evidence has shown that a number of interventions can have a significant impact on the number of people who die or are seriously disabled as a result of a stroke. These include clot-dissolving treatment (thrombolysis) following a computerised tomography (CT) scan to determine the type of stroke suffered; admission to a stroke unit; and early supported discharge.

3. DH has responded to this emerging evidence base by developing Action on Stroke Services: an Evaluation Toolkit (ASSET)[1]. ASSET is designed to help health providers understand how they can improve stroke services by reviewing performance compared with other providers, and identifying the positive impact on patient outcomes and efficiency from four specific service interventions. Those interventions are thrombolysis, admission to a stroke unit, early supported discharge and rapid referral to carotid surgery via a one-stop Transient Ischaemic Attack (TIA) clinic.

[1] *www.dh.gov.uk/stroke*

4. Building on these recent developments DH is developing a national stroke strategy to be published in Autumn 2007. This will cover prevention of strokes as well as fast and effective acute treatment and high quality rehabilitation.

PAC conclusion (ii): Stroke costs the economy £7 billion a year, including £2.8 billion in direct care costs to the NHS. Stroke costs the NHS more than heart disease, and should receive the priority warranted by its impact and cost. To raise the profile of stroke with commissioners and clinicians, the Department of Health should work with the Healthcare Commission and the Royal College of Physicians to develop benchmarks for stroke care – for example the proportion of suspected stroke patients receiving a brain scan within three hours, or the proportion of stroke patients being treated on a stroke unit.

5. The Department accepts that the high cost and impact of stroke, together with the more robust evidence base now available, warrant action to ensure that resources are used efficiently to improve outcomes for stroke patients. The *National Service Framework for Older People*[2] has driven forward significant improvements in stroke services and set a standard that has ensured that there is an infrastructure in place in all hospitals. In light of recent evidence, Ministers have asked Professor Roger Boyle, National Director for Stroke, who implemented the National Service Framework for Coronary Heart Disease, to develop a new national stroke strategy to improve stroke services. Professor Boyle will draw on the experience of addressing similar issues in redesigning the acute care pathway for coronary heart disease to accelerate access to treatment.

6. The Healthcare Commission funds the Royal College of Physicians (RCP) National Sentinel Stroke Audit, which takes place every two years. This audit includes key performance indicators, including proportion of stroke patients being treated on a stroke unit, which enables Trusts, and others, to benchmark performance against the national average. The audit continues to evolve and DH will be working with the RCP and the Healthcare Commission, as part of the work to develop the national stroke strategy, to consider any future changes.

7. The stroke toolkit, ASSET, enables Trusts to benchmark themselves against other Trusts in terms of key indicators as well as demonstrating the benefits of improving performance through key interventions. ASSET uses data from the RCP audit as well as data from Hospital Episodes Statistics.

8. The Department will be raising the profile of stroke with commissioners by publishing a commissioning guide for stroke later in the year, which will advise commissioners on key issues to consider when commissioning stroke services to ensure a good quality stroke service. This will be accompanied by a version of ASSET developed specifically to support commissioners.

9. DH has asked the National Institute for Health and Clinical Excellence (NICE) to develop a guideline that will cover acute treatment of stroke. This will be published in 2008 and will provide a benchmark against which Trusts will be monitored by the Healthcare Commission as part of the Annual Health Check process.

[2] *http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf*

PAC conclusion (iii): In most European countries stroke is regarded as a neurological condition first and foremost, rather than an older people's condition. In Sweden on average patients take just three to five hours to arrive on a stroke unit with early assessment of and access to rehabilitation. In England the median time to arrival on a stroke unit is 2 days and access to rehabilitation is patchy within and between hospitals. In leading hospitals in Australia, thrombolytic (clot-busting) drugs are given to around 9% of eligible patients compared to one per cent in England. The Department should benchmark performance on these key performance indicators with other leading countries to identify areas where further lessons may be learned.

10. DH accepts the importance of learning from the experience of other countries in the development of our strategy. DH is working with colleagues who helped develop a new stroke strategy in Canada and will consider the examples of good practice in Sweden and Australia highlighted by the Committee. There are also examples in England, as in Australia, of thrombolysis being delivered to a much higher proportion of eligible patients than the national average and of rehabilitation being delivered in a well-coordinated way. Some centres in the UK are world class and the strategy will aim to bring all Trusts up to the level of the best.

11. Benchmarking against other countries on specific indicators can be unreliable and the World Health Organisation advises caution: "The comparability of data between countries is also limited, owing to difference in definitions and recording practices."[3] However, the Department is keen that data on international best practice is used to inform the development of stroke services in England. For example, the Department is working on a tool for commissioners that will compare the performance of individual hospitals against an aspirational level that has been informed by international best practice.

PAC conclusion (iv): The last clinical audit of stroke showed that only 22% of stroke patients had a scan on the same day as their stroke, and most waited more than two days. Scans for stroke patients are being delayed, though 'time lost is brain lost', and research shows that scanning patients immediately costs less, and results in better patient outcomes than scanning later. All suspected stroke patients should be scanned as soon as possible after arrival at the acute hospital, ideally within three hours, and none should wait more than 24 hours for a scan. All Accident and Emergency and Radiology departments should have protocols in place for the rapid admittance and referral for scanning of stroke patients.

12. DH agrees with the recommendation. The RCP guidelines state "brain imaging should be undertaken as soon as possible in all patients, within 24 hours at most of onset unless there are good clinical reasons for not doing so" and DH is taking action to support Trusts to achieve this. ASSET reinforces the value of immediate scanning for stroke patients, particularly its importance for delivering thrombolysis, and demonstrates the improvements to outcomes and lengths of stay that can be made by putting a system in place to enable this.

[2] WHO Health for All (HFA) database notes

13. The evidence that scanning stroke patients immediately is the most cost-effective strategy was published in 2004. Stroke services will need time to assimilate this knowledge, although some centres are already routinely providing CT scans within 4 hours for stroke patients. ASSET highlights the benefits of early scanning as well as the fact that, as most stroke patients receive a brain scan at some point in their stay, providing an early scan will, in most cases, not be an additional cost.

14. One of the project groups developing recommendations for the national stroke strategy is looking at the emergency response to stroke. This group has been tasked with recommending how to overcome cultural and organisational barriers to delivering urgent scanning to stroke patients where appropriate. Agreed protocols for rapid admittance and referral for scanning are one way of achieving this and some stroke services are already doing this. The group will also cover the need for protocols for rapid transfer of stroke patients by the ambulance service.

PAC conclusion (v): There are 640 patients per stroke consultant, compared with 360 patients per cardiac consultant. The limited number of health professionals with training in stroke is a barrier to providing high quality acute care and rehabilitation. Future workforce planning targets should enable the NHS to move to a position where there are as many stroke consultants per patient as heart disease consultants per patient.

15. The Department accepts that increasing the number of health professionals with training in stroke is important to increasing the quality of care and rehabilitation stroke patients receive. For many years, stroke was viewed as an inevitable part of getting old and it is only in recent years that experts have come to a consensus that much can be done to prevent and treat stroke. Stroke has only recently become a medical sub-specialty, unlike coronary heart disease, which has been a major focus of the specialty of cardiology for over 80 years.

16. The training programme for stroke consultants only takes about one year, which presents opportunities to increase numbers relatively quickly. DH has begun discussions with the relevant bodies on options to achieve this. One mechanism is to convert vacant geriatric training posts into stroke training posts. Earlier this year the Specialty Advisory Committee for Geriatric Medicine agreed to review the suitability of any unfilled posts for transfer to stroke medicine.

17. One of the project groups developing recommendations for the national stroke strategy is looking at workforce issues. The group is looking at the full range of health and social care professionals that work with stroke patients, including both their number and their training. The group is considering different models of service provision and ways of working. Stroke teams should have the competencies and skills to deliver high quality care for stroke patients, but local services should have the freedom to determine the composition of the team that best provides those competencies. This may result in a different number of stroke consultant sessions compared to the current numbers of heart disease consultant sessions.

18. DH has moved away from setting central workforce planning targets, but is working closely with the Workforce Review Team, who carry out workforce planning on behalf of the NHS in England and the lead post-graduate dean for stroke, to ensure that the limitations caused by the current level of stroke consultants are factored into annual recommendations about planning priorities for the NHS.

PAC conclusion (vi): Hospital staff are not always sufficiently well informed on how to respond to stroke. The education and training provided to new triage nurses and junior doctors should include awareness of stroke and the need for urgent brain scans for stroke patients. The Department should train stroke consultants to interpret scans and make immediate treatment decisions. It should also continue to develop its telemedicine programme so that, by 2007, staff managing stroke patients can access neuro-radiological expertise remotely.

19. DH accepts this conclusion. The RCP audit shows that continuing education in stroke for staff on stroke units has improved in recent years, from 74% in 2002 to 92% in 2006 for qualified staff and from 64% in 2002 to 88% in 2006 for unqualified staff. However, in 2006 only 57% of sites had continuing education in stroke for qualified staff on other wards and 55% for unqualified staff.

20. All qualified nurses and doctors will have a basic awareness of stroke as part of their training. It will be important that all staff, including triage nurses and doctors, involved in the initial identification stage are well informed on how to respond to stroke. This will require a cultural change to ensure that stroke is regarded as urgent and as part of this the national stroke strategy will recognise the importance of treating stroke as a medical emergency. The workforce project group developing recommendations for the strategy are looking at the education and training provided to all staff who work with stroke patients to build on recent improvements.

21. Training on the interpretation of scans is currently available for a range of clinicians. New roles have been introduced, including advanced and consultant radiographers. This means that radiographers are being trained to interpret and report specific types of scans. Training is also planned for clinicians who are not radiologists, for example, some senior doctors working in Accident and Emergency Departments will be trained to interpret scans undertaken on suspected stroke patients. DH is working with NHS Employers on the Large Scale Workforce Change project to ensure that neuroradiology skill development is prioritised. In addition, an imaging workforce strategy is being developed as part of the National Imaging Work Programme. This will be available early in 2007.

22. Deployment of the Picture Archiving and Communications System (PACS), currently underway, will enable the development of remote reporting via a telemedicine programme. It will enable staff managing stroke patients to access neuro-radiological expertise remotely. PACS should be fully implemented across secondary care services next year.

PAC conclusion (vii): By increasing the proportion of stroke patients who spend the majority of their time in hospital on a stroke unit by 25%, around 550 deaths per year could be prevented. Although most hospitals now have such a unit, only around two thirds of stroke patients spend time on one, and what constitutes a stroke unit varies considerably between hospitals. All stroke patients should be admitted to a specialist stroke unit as soon as possible following diagnoses of their stroke. The Department needs to communicate clear guidelines for an acceptable stroke unit and Primary Care Trusts should deliver acute stroke care through a stroke unit that meets these guidelines. The Department should set challenging targets to improve the proportion of patients treated on a stroke unit.

23. DH agrees that it is desirable that all stroke patients should be admitted to a stroke unit as soon as possible after initial assessment.

24. *The National Service Framework for Older People (2001)*[2] has driven forward improvements so that all Trusts that treat stroke patients now have a specialist stroke service. These services were unusual ten years ago. Recent evidence has demonstrated the benefits of that specialist stroke service being delivered on a dedicated ward. There have been significant increases in the number of stroke units since this evidence was published in 2004. The RCP audit shows that between 2004 and 2006 the proportion of Trusts that treat stroke patients that have a stroke unit increased from 82% to 96%. It is expected that the proportion of stroke patients being treated on a stroke unit will also have increased over this period. The results of the second phase of the audit, which covers more detailed clinical data including whether a patient stayed on a stroke unit, will be published in March 2007.

25. ASSET enables Trusts to model the improvements in outcomes and lengths of stay that can be made by increasing the proportion of stroke patients treated on a stroke unit. Improved care results in shorter stays for patients and the greater patient throughput enables more stroke patients to benefit from stroke unit care. This builds on the information provided through the RCP audit by specifying the benefits to the Trust of driving forward improvements.

26. The RCP gives guidance on what a stroke unit should include. The RCP highlights five characteristics that have been shown to be markers of stroke unit organisation and their audit records the proportion of units with these characteristics. In 2006 95% of stroke units had four or all five features compared with 90% in 2004 and 72% in 2002. The RCP has developed six further criteria for assessing the quality of an acute stroke unit using the consensus of an expert working group. The results of the RCP audit show that the proportion of Trusts with a stroke unit meeting five or six of the criteria has increased from 33% to 41% between 2004 and 2006. This shows that there has been progress, but there is still room for improvement.

27. The stroke commissioning guide that the Department will publish later in the year will assist Primary Care Trusts (PCTs) to ensure that the service they commission meets the appropriate standards by highlighting key issues to consider when commissioning stroke services. DH is also developing a toolkit for commissioners based on ASSET, which will enable PCTs to model the benefits to be gained by commissioning acute stroke care through a stroke unit that meets the RCP guidelines.

28. DH accepts that treatment on a stroke unit should be the norm, with the exception of a small number of patients – for example those receiving palliative care – who may be treated more appropriately in other settings. There are a range of levers for making change happen – from commissioning arrangements and inspections through to patient power and internal pressure from frontline staff working in stroke teams. The Department will be looking at which mechanisms are most suitable to achieve the range of objectives recommended by the expert project groups helping us to develop the strategy.

PAC conclusion (viii): The risk of stroke in the four weeks following a transient ischaemic attack (TIA, 'mini stroke') is around 20%. All providers of primary and secondary care should have protocols in place for the referral of suspected or confirmed TIA patients, reflecting the Royal College of Physicians' guidelines that all patients in whom a diagnosis is suspected should be assessed and investigated within seven days. The indicator in the Quality and Outcome Framework for assessing primary care practices performance in relation to suspected stroke patients and which simply states "referral for a scan" should be amended to reflect the time bound element in the above protocol.

29. DH agrees with the recommendation that all primary and secondary care providers should have protocols for the referral of suspected or confirmed TIA patients. The *National Service Framework for Older People*[2] included a milestone that by April 2004 PCTs should have ensured that every general practice is using a protocol agreed with local specialist services for the rapid referral and management of those with TIA. A review by the Healthcare Commission of progress in implementing the National Service Framework, published in March this year, showed that all of the communities inspected had agreed protocols in place. The Healthcare Commission monitors Trusts' progress in implementing National Service Frameworks as part of their annual review process.

30. The RCP audit shows that the number of TIA clinics has been increasing and the waiting times for those clinics have been falling. 78% of Trusts now have a TIA clinic compared with 65% in 2004. The average wait for a TIA clinic has fallen from 14 days in 2004 to 12 days in 2006. There is still some way to go to ensure that all patients with a suspected TIA are seen within seven days, but the progress is encouraging.

31. The Quality and Outcomes Framework (QOF)[4] has proved an important lever in improving the prevention of stroke and the additional 30 points on atrial fibrillation, a key risk factor, are a further welcome development. However, it must be noted that the Department does not have control over amendments to the points and indicators within the Framework. This is negotiated between NHS Employers, the independent employers' organisation, and the British Medical Association. Time bound referral is something to consider through the QOF revisions in future years. However, the first priority must be to ensure rapid access services are in place in all areas of the country. One of the project groups developing recommendations for the national stroke strategy has been tasked with looking at improving services for patients who have had a TIA or minor stroke.

32. It will also be important to increase GPs' general understanding of stroke to ensure they direct patients experiencing symptoms to call 999. The project group developing recommendations on prevention and public awareness for the national stroke strategy is also considering raising awareness among health professionals.

[4] *http://www.nhsemployers.org/primary/primary-890.cfm*

PAC conclusion (ix): By reducing to 14 days the maximum waiting time for surgery for patients with narrowing (stenosis) of the carotid arteries in the neck, around 250 strokes a year could be prevented, yielding savings to the NHS of around £4 million. TIA patients with diagnosed stenosis should not have to wait longer than 14 days after their TIA for surgery.

33. DH agrees with this recommendation. Research shows that the benefit of surgery is maximal when patients undergo surgery within the first two weeks after their TIA.[5]

34. ASSET demonstrates the improvements in outcomes and lengths of stay that can be achieved though all patients accessing a one-stop TIA clinic within seven days of their TIA, which is the first step to achieving timely surgery. It also provides local data on carotid surgery to enable Trusts to see the average waiting time for a carotid endarterectomy. The RCP is currently conducting a national audit to assess the process of care and outcomes from carotid endarterectomy against the available evidence base, which will provide a fuller picture of the current position.

35. The project group developing recommendations for the national stroke strategy on services for people who have had a TIA or minor stroke are looking at improving provision of rapid access to TIA services. The group is working on options for ensuring that referral to surgery is much more rapid than is currently the case.

PAC conclusion (x): Three times more women die of a stroke than of breast cancer each year, and stroke is the major cause of adult disability, but public awareness of stroke and how to prevent it is low. The Department should run an awareness campaign for stroke, focussing on its symptoms and the fact that it is a medical emergency requiring a 999 response. In developing this campaign, it should consider particularly how to engage with groups at higher risk of stroke, such as people of Afro-Caribbean and South Asian ethnicity.

36. DH accepts that awareness of the symptoms of stroke needs to be raised – both among the workforce and the public. One of the project groups has been tasked with developing recommendations on how public awareness of stroke in general can be raised and what the key messages should be. Consideration of mechanisms for reaching different audiences, including people from African-Caribbean and South Asian communities, will be part of this work.

37. DH has funded a project by The Stroke Association to produce and promote information leaflets targeted to the African Caribbean community. DH is currently funding a further project by The Stroke Association, targeting South Asian communities, to produce written and recorded information – in Punjabi, Bengali, Gujarati, Urdu and Hindi – about practical steps individuals can take to reduce their risk of stroke. The Food Standards Agency is also working with The Stroke Association on a project looking at the eating habits and salt intake of African Caribbean, South Asian and Chinese communities.

[5] Rothwell PM, Eliasziw M, Gutnikov SA, Warlow CP, Barnett HJM. Effect of endarterectomy for symptomatic carotid stenosis in relation to clinical subgroups and to the timing of surgery. Lancet 2004; 363: 915-924.

38. DH has identified all the relevant areas of its existing public health communications activity, and has already begun to include specific messages about stroke where appropriate, for example in its tobacco campaigns work. Other channels are being used, like the Department's public facing health promotion magazines (Prime, Your Life, Fit) which carry features about the risk factors, and the signs and symptoms of stroke. Information about stroke has also been updated and given more prominence on the NHS Direct and Direct Gov websites.

PAC conclusion (xi): Stroke survivors and their carers need support from many different health and social services, but about 50% of carers are not receiving needs assessments. The Department should improve the provision of information to stroke carers, so they become aware of the services available to support them. Community services should be improved so that patients in the community are not overlooked. The Department should take into account in particular the needs of stroke survivors who live on their own, and may be particularly vulnerable to being overlooked by health and social care services.

39. DH agrees with this recommendation. The Government recognises the valuable contribution and the important concerns of carers, and has taken action through the *National Strategy for Carers*[6] to ensure that the support needed by carers, including those caring for someone who has had a stroke, is available. The Government has given carers a right to an assessment of their needs and taken action to ensure that carers are aware of this right. Some carers will choose not to take up the offer of an assessment, but the Government has provided the framework for needs to be assessed and met.

40. The White Paper *Our Health, Our Care, Our Say*[7] published in January 2006 sets out a range of further measures to improve support for carers. The National Strategy for Carers will be updated and extended, a helpline will be established to offer advice to carers and an Expert Carers' Programme will be developed which will provide training for carers to develop the skills they need. All these measures will benefit those who are caring for someone who has had a stroke.

41. High quality community services are crucial to improving outcomes and quality of life for people who have had a stroke. The number of community stroke teams is increasing, although there is still some way to go. The RCP audit shows that the percentage of Trusts in England with a community stroke team increased from 27% in 2004 to 34% in 2006. *Our Health, Our Care, Our Say* sets out a new strategic direction for improving the health and well-being of the population, and focuses on a strategic shift to locate more services in local communities that are closer to people's homes. This focus on community services will benefit stroke patients.

42. Stroke survivors who live on their own should have equal access to stroke services as other stroke survivors. *Our Health, Our Care, Our Say* recognises the importance of outreach services to support those who find it difficult to access services, which will include those that live alone.

[6] http://www.dh.gov.uk/assetRoot/04/04/93/23/04049323.pdf

[7] http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

43. One of the project groups developing recommendations for the national stroke strategy is looking at services for stroke survivors once they have left hospital. This group will be considering the rehabilitation needs of stroke survivors as well as how to improve access to practical support, advice and information for both stroke survivors and carers.

PAC conclusion (xii): Most of the burden of stroke occurs after discharge but post-hospital support services for stroke patients are often difficult to access. During their hospital stay patients have access to on call help and care but on discharge the transition from hospital to home can be traumatic. Around half of stroke patients receive rehabilitation services that meet their needs in the six months following discharge falling to 25% 12 months after discharge. The Department should evaluate the merits of Early Supported Discharge initiatives and other ways of improving access to therapies, and promote the early adoption of those that can be shown to reduce hospital stay and improve patients' chance of recovery.

44. The Department agrees with this recommendation. The benefits of Early Supported Discharge (ESD) for people with moderate levels of disability as a result of stroke have been demonstrated in research published in 2005. The provision of an ESD team is one of the interventions included in ASSET. Trusts can use ASSET to see the impact introduction of an ESD team in their area would have on outcomes for their patients and lengths of stay in hospital. ASSET is being used by local NHS Trusts to make the case for introducing ESD teams in their area.

45. However, more knowledge is needed about the best service delivery model for rehabilitation for those with mild and severe disabilities. DH is currently exploring options for evaluation of services for these groups of stroke survivors. A small working group is being established as part of the strategy work to specifically consider ESD schemes.

46. The project group developing recommendations on services for stroke survivors once they have left hospital for the national stroke strategy is looking at how to ensure that rehabilitation services, and other support services, meet the needs of people who have had a stroke in the longer term as well as during the transition period.

Fifty-fourth Report

Department for Culture, Media and Sport

UK Sport: supporting elite athletes

1. UK Sport uses National Lottery and Exchequer money to support elite athletes competing at the highest levels of sport for the United Kingdom or Great Britain by providing funding, through its World Class Pathway Programme, to National Governing Bodies (NGBs) of sport and to individual athletes. During the Athens Olympic cycle from April 2001 to March 2005, UK Sport awarded £83.5m for 17 Summer Olympic and 15 Paralympic sports. In Athens, Great Britain finished 10th in the Olympic medal table, achieving UK Sport's target of 8th to 10th, and 2nd in the Paralympic medal table missing the target of 1st. This matched the overall Team GB performance achieved in Sydney and significantly improved upon the medal table position attained in Atlanta in 1996 (where we came 36th in the Olympic medal table). Nevertheless, despite this success, the majority of funded sports did not meet the individual medal targets they had agreed with UK Sport and 10 sports delivered no medals. At the time of the Committee's hearing, UK Sport had awarded funding of £98m for the Beijing Olympic cycle from 2005 to 2009. For all the sports that under performed in Athens, UK Sport has cut funding and/or reduced the number of athletes supported for Beijing. UK Sport has also identified a number of sports, which it expects to do better in the future, including athletics, and is working closely with them to help achieve this objective.

PAC conclusion (i): UK Sport requires the sports it funds to sign up to targets, but has yet to do so itself for 2012. Now that it knows the resources available, UK Sport should decide its medal table targets for 2012 and reflect these in the targets it agrees with individual sports. UK Sport should review the targets in the light of performance in Beijing in 2008.

2. UK Sport accepts the Committee's conclusion, in so far as the ultimate goal for 2012 has been identified for both Olympic and Paralympic success (being 4th in the Olympic Medal table and moving towards 1st in the Paralympic). Sports currently have annual targets for medals up to Beijing 2008, with resources allocated accordingly via a 'no compromise' basis (that is, resources are directed only at those athletes with the greatest potential to win medals), and UK Sport will monitor progress on an annual basis. These targets form the basis of UK Sport's own targets in their new Funding Agreement agreed with the Department for Culture, Media and Sport (DCMS) for 2005-2008. UK Sport's medal target for the Olympics in Beijing is to move towards the top 8 in the final medal table and for the Paralympics the target is to finish 2nd in the medal table. However no formal targets on an individual sport basis for London 2012 will be set until after a full review of performance in Beijing, and the agreement of a new Funding Agreement with the DCMS.

PAC conclusion (ii): UK Sport is continuing to fund sports which disappointed in Athens, including the 10 sports which won no medals despite receiving nearly £14 million in total. To secure best value from its funding, UK Sport should: follow up its review of sports' performance in Athens to make clear for individual sports the actions required to do better in Beijing, and embed implementation of these actions into its monitoring of national governing bodies; make clear to sports what level of performance will be required for them to continue to receive funding during the course of the Beijing cycle, and the circumstances in which funding might be withheld.

3. UK Sport accepts the Committee's recommendations. A key part of its performance strategy for Beijing and then London is the implementation of a 'no compromise' approach, where resources are targeted at those sports and athletes most likely to win medals. As well as a funding agreement between the NGB and UK Sport, there is an agreed performance plan, which sets out the performance targets for each year based on the most significant international competition. In addition, UK Sport has established a range of performance and governance criteria – known as 'funding triggers' – that the sports are required to meet in order to access the additional funding made available for London 2012. The sports understand what is expected of them and how they will be monitored, and UK Sport is committed to reporting publicly to ensure full transparency and accountability on the investment of public funds. UK Sport reports on progress towards the performance targets at regular quarterly review meetings with DCMS.

PAC conclusion (iii): Greater value could be secured from UK Sport's spending on sports science and medicine where take-up is lower than for other services such as coaching. UK Sport should work with national governing bodies to communicate the benefits of sports science and medicine to athletes and their personal coaches. UK Sport should also decide what would represent a cost-effective level of take-up for the services it funds and, if this is not achieved, consider if its money might be better spent elsewhere.

4. UK Sport accepts the Committee's conclusion. UK Sport acknowledge that promoting effective sport science and sports medicine is crucial and has included a dedicated amount in all funding awards made to the NGBs, including the additional Exchequer investment made available to support elite athletes for London 2012. Since 1 April 2006, UK Sport has assumed responsibility for the English Institute of Sport (EIS). This has made a significant difference to the ability of UK Sport to influence take-up and they are now working with the EIS to ensure maximum value and that the sports are using the services efficiently and effectively.

PAC conclusion (iv): UK Sport currently generates no sponsorship income, so the aim of securing £100 million of sponsorship ahead of 2012 is challenging. The Department and UK Sport should draw on specialist fundraising expertise for this new area of work and see what lessons can be learned from others – from the sporting community itself, from other sectors in this country, and from overseas.

5. DCMS and UK Sport accept the Committee's conclusion. UK Sport commissioned an independent report into its current fundraising opportunities, including information on the activity of other sporting organisations both in the UK and internationally. On receipt of the report, UK Sport has submitted its own paper to DCMS on fundraising opportunities, including consideration of the aim of securing £100 million and ways in which that might be addressed. DCMS is now examining various options and will agree the way forward with HM Treasury based upon the report's findings.

PAC conclusion (v): Victory by one one-hundredth of a second in the men's 4 x 100 metre relay on the last day of the Athens Olympics made the difference between UK Sport achieving and missing its medal table target. The value of medal targets is limited by the fact that the margin between success and failure can be tiny and mask absolute improvements in performance. UK Sport needs a more rounded package of performance measures, which go beyond medals won to look at, for example, whether athletes are improving their personal bests or world rankings.

6. UK Sport accepts the Committee's conclusion. The Funding Agreement between DCMS and UK Sport has as its focus the achievement of medals in major international sporting competitions, and this remains the primary method by which international performance will be measured. Nevertheless, the Funding Agreement, and UK Sport's own performance targets with NGBs, also requires other measurements of progress to be used, such as how many athletes are moving into medal zone (top 8) in each sport. It should be noted that high performance sport is increasingly competitive, where the margin between victory and defeat is becoming ever smaller. Furthermore, there can never be any certainty of outcome in sport, and that is what makes sport so popular. That said, UK Sport's 'no compromise' approach aims to minimise the risk of failure by focusing its resources on those athletes with the greatest chance of success.

PAC conclusion (vi): For three years running, in reporting to Parliament and the public, UK Sport and the Department overstated performance against the target for medals won at major international championships. In compiling the results, UK Sport included 83 medals won in events not taken into account in setting the target, thereby turning underperformance into apparent success. UK Sport and the Department should check performance information to ensure that only accurate figures are reported.

7. DCMS and UK Sport accept the Committee's conclusion, and acknowledged at the PAC hearings the error in reporting. This has now been remedied and a new and revised Funding Agreement between the two bodies has been agreed in which there is much more certainty and understanding of what is being measured. DCMS and UK Sport are committed to ensuring that such a situation does not recur.

PAC conclusion (vii): UK Sport's funding submission for 2012 referred to an ultimate goal of finishing 4th in the 2012 Olympics, though the published funding agreement between the Department and UK Sport said the target was 5th. Yet, when recalled by the Committee, the Department and UK Sport maintained there was no target and attributed the confusion to their inappropriate use of the term 'target'. The Department has accepted that they should have been more forthcoming when they originally gave evidence to the Committee. Starting with the new funding agreement, performance expectations need to be unambiguous and clearly explicable both to the Committee and to Parliament as a whole.

8. DCMS and UK Sport accept the Committee's conclusion. The new Funding Agreement between DCMS and UK Sport and all other attendant documents, such as UK Sport's Business Plan, are unambiguous in terms of language and terminology and accompanied by notes and a glossary of terms to ensure understanding and avoid the potential for confusion in the future.

PAC conclusion (viii): The national emphasis on sporting elites should not be at the expense of promoting wider participation in sport. Sport is not just about medals or a celebrity culture, but is about the benefits of taking part. It will be important therefore to maintain a balance between promoting world class and mass participation activities.

9. DCMS accepts the Committee's conclusion. Winning the 2012 Olympic Games has given greater focus to our Olympic and Paralympic sports. The additional Exchequer funding announced by the Chancellor in March this year is to enable Team GB to deliver its best performance in recent history at the London Games. The money will be spent in support of twenty six Olympic and eighteen Paralympic sports. However, DCMS wants to see the Games lead to a significant increase in sports participation. DCMS will therefore continue to ensure that significant funding is directed to grass roots sport from the National Lottery. The Government has set out its priorities for sport in the Public Service Agreement (PSA) target to increase the take up of sporting opportunities by adults and young people from priority groups by increasing the number who participate in sport by 3% by 2008. This is being complemented by an ambitious facilities programme – by 2006 the Government and National Lottery will have committed over £1 billion to develop new or refurbished public sports facilities. The national school sport strategy's prime objective – a joint Department for Education and Skills and DCMS PSA target – is to increase the percentage of 5-16 year olds who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum, to 75% by 2006 and 85% by 2008. The long-term ambition – by 2010 – is to offer all children at least four hours of sport. The National School Sport survey 2004/2005 showed that 69% of pupils in School Sport Partnerships spend a minimum of two hours in a typical week on high quality PE and school sport within and beyond the curriculum. The 2005/2006 Survey is due to be published in the near future and DCMS and DfES are confident that the target will be met.

Fifty-sixth Report

H M Prison Service

Serving time: prisoner diet and exercise

1. The Committee previously reported on prison catering in 1998. Since then the Prison Service (PS) had made good progress in reducing catering costs and improving the quality of catering. The PS has placed a high priority on providing prisoners with a decent diet and the opportunity to exercise. These factors help maintain well-ordered prisons, which allow prisoners to participate in other activities and prisons themselves to cope with other pressures. The PS has succeeded in providing a diet that is broadly in line with the government's nutritional recommendations. In addition some 40% of prisoners took part in Physical Education activities across the PS.

PAC conclusion (i): The Committee's 1998 recommendation that meals should be served within 45 minutes of cooking had still not been met at 37% of the prisons visited by the National Audit Office (NAO). The PS should aim to meet this recommendation at all prisons. It should set a timetable for removing barriers to meeting the target and introduce methods to reduce the time between preparation and serving, such as staggering meal times between prisons or wings served by the same kitchen.

2. The PS will continue to aim to meet this recommendation. The standard shows the Service's commitment to reducing – to an absolute minimum – the time delay between the end of cooking and food service by continually improving catering processes, procedures and practices. This improvement process will continue and performance in meeting this standard has improved in 2005-06 with 88% of prisons audited achieving either full compliance or only requiring minor action to achieve compliance.

3. Whilst the PS acknowledges the importance of this standard it is worth noting that full implementation of the recommendation would be highly expensive and the PS is therefore unable to guarantee fully meeting this standard in all prisons at all times. The speed and scale of further improvements needs to be balanced against the importance of funding other areas such as security measures and programmes aimed at reducing re-offending.

PAC conclusion (ii): The Committee's 1998 recommendation that prisoners should not wait more than 14 hours between meals has still not been met at around half of prisons. The PS's audited catering standards should include a requirement that the gap between meals should not exceed 14 hours to encourage prison Governors and caterers to reduce the time that prisoners wait between meals.

4. The PS accepts the conclusion that prisoners should not have to wait more than 14 hours without being provided with something to eat and drink. For this reason, the current audit baseline on the gap between meals states that: "Where prisoners are locked up in the evening and the time between the evening meal and the next meal exceeds 14 hours establishments specify and provide an additional snack and hot drink for consumption later than the evening meal". The PS feels that this ensures a balance between meeting the needs of prisoners and providing a decent regime without creating significant additional pressures on resources and will, for the foreseeable future, retain that standard.

5. Fully implementing the recommendation in all establishments would be highly expensive in terms of staff resources, as the core day would have to be extended. The PS feels that the current standard highlights the importance of not exceeding the 14-hour gap and provides a way of ensuring that this time span is not exceeded. Whilst the PS is committed to continuing to work to achieve the recommendation, further improvements in performance will need to be balanced with the demands of other priority areas.

PAC conclusion (iii): Meals did not meet all the nutritional recommendations of the Food Standards Agency (FSA). The PS should include in its audited catering standards a requirement for caterers to provide menu options allowing prisoners to meet relevant government recommendations on nutrition. It should also use its purchasing power to offer suppliers an assured market for healthier versions of pre-prepared foods.

6. The PS accepts this recommendation and the National Audit Report *HM Prison Service Doing Time Prisoner Diet and Exercise* noted: "on the whole meals offered to prisoners meet the government's recommendations on energy and nutrients". One of the required outcomes for PS catering is that there is a multi-choice menu, which includes healthy options and reflects prisoners' preferences.

7. The PS is currently reviewing and consulting on Prison Service Order (PSO) 5000 which sets minimum catering standards and which the audited catering standards are based upon. The review includes the feasibility of including a revised catering standard on government recommendations on healthy eating.

8. The PS continues to work with existing contracted food suppliers and has identified affordable healthier, low salt, fat and sugar alternatives to traditional purchases. The PS goes to competition in October 2006 for a new grocery contract. By then all food purchase specifications will have been amended to be in line with FSA nutritional guidelines.

PAC conclusion (iv): The PS has not yet reacted to research completed in 1997, which indicated a link between nutrition and behaviour. The PS should arrange for further research to be carried out into this subject. It should: agree a timetable with its research partners to carry out further research, or if they are unable to deliver suitable research within an acceptable timetable request that the Home Office Research Development and Statistics Directorate (RDS) fund the research.

9. The PS acknowledges the issue and has for some time offered the researchers who undertook the 1997 study two establishments – HMYOI Warren The PS acknowledges the issue and has for some time offered the researchers who undertook the 1997 study two establishments – HMYOI Warren Hill and HMYOI Stoke Heath - so larger scale research on the possible effects between nutrition and behaviour could be undertaken. The original researchers are currently in the process of submitting a further research proposal. Such research is complex and expensive but if the current research proposal does not proceed the PS will see if this work might be taken forward in a different way.

PAC conclusion (v): Over half of prison kitchens provide training so that prisoners can achieve National Vocational Qualifications (NVQs) in catering. The PS should expand the number of prisons offering catering NVQs to make them available at all prisons, if necessary through modular courses where turnover is high, as we previously recommended.[8]

10. The PS will continue to work towards providing NVQ training in the prison kitchens that employ prisoners where it is sensible and cost effective to do so as one of the strengths of NVQs is that they are designed as portable modular programmes. But the key purpose of prison kitchens and the staff who are responsible for catering must remain the production of meals for prisoners. Not all prison kitchens have the facilities to offer such training and in some cases significant additional resources and investment would be needed to make this possible. It is unlikely therefore that all prison kitchens, in the foreseeable future, will be able to offer NVQs for prisoners.

11. The kitchen environment also offers other training opportunities for prisoners. For example prisoners engaged in food handling are trained in food hygiene and receive a certificate accredited by the Royal Institute of Public Health. Kitchens also offer some prisoners the opportunities to receive training and qualifications accredited by the British Institute of Cleaning Science. This is in addition to other training and qualifications offered by other regime activities such as prison industries as well as the increased drive to link basic and key skills across a wide range of regime functions.

PAC conclusion (vi): The cost of food per prisoner per day varied by over 180% between the cheapest and the most expensive in 2004-05. Variation is to be expected, but there were also large variances between prisons of the same type. The PS should investigate large variations in food costs and quality of catering between prisons and identify good practice for adoption by those with relatively high costs or poor quality of catering.

12. The PS agrees that large variations in food costs between prisons of nominally the same type should be investigated. This will become easier to achieve when the PS's new IT procurement system is fully implemented in 2007 as this will give full visibility of all purchased food items. Once this information is available the PS will identify significant outliers and explore what efficiencies may be possible.

[8] Committee of Public Accounts, *Dealing with Increased Numbers in custody*, 44th Report 2006-07 (HC 788 2005-2006)

13. Differences in the quality of catering will continue to be picked up either during the audits undertaken by the PS's Standard Audit Unit or as a result of regular visits and reports by Area Catering Managers. Where deficiencies in audits are noted action plans and or recommendations are put in place to resolve issues. In addition Area Catering Managers are increasingly taking a risk based approach targeting their work on prisons with identified catering issues. Where good practice is identified it will be circulated to catering managers.

PAC conclusion (vii): Some Muslim prisoners were refusing halal meals offered by prisons, because they did not have confidence in prisons to provide appropriately prepared religious meals. The PS's Standard Audit Unit should monitor whether prisons meet the PS's own instructions for the provision of halal meals. The PS should work with prison caterers who are successfully catering for religious diets, Muslim leaders and religious prisoners, to disseminate good practice to all prisons.

Although prisons took steps to avoid cross contamination, some 25% of them were unable to store halal meats separately from other (haram) meats. The PS should identify the prisons that are unable to store meats separately and implement a programme for rectifying the problems.

Some 70% of prisons did not use separate equipment for the production and serving of Muslim food. The PS should confirm whether all prisons are making use of separately labeled equipment.

14. The PS accepts this recommendation. The PS is not aware that numbers of Muslim prisoners are refusing halal meals on a regular basis. But the PS fully recognises that this is a sensitive area where prisoner confidence in the provenance of meals is important. Several steps have been taken to address this issue including:

- widely consulting on revisions to PSO 5000 (the PS Catering Manual). The PSO sets out mandatory actions as well as the minimum service requirement for PS caterers;
- holding a series of local and national workshops for PS caterers focusing on diversity issues;
- a key audit baseline for PS catering is that "the menu choices and meal provision reflect the religious and cultural needs of the establishment". This is already audited by the PS Standards Audit Unit. Full compliance in 2005-06 was 88%;
- encouraging prison caterers to work locally with religious leaders and, where possible, prisoners to ensure there is confidence in meals produced. As an example the catering team at HMP Brixton was awarded the 2006 Butler Trust Diversity Award. This was in recognition of the care taken to ensure all prisoners' needs were met, with particular regard to halal provision. The consumer survey used at Brixton has been adopted as an example of best practice and promulgated throughout the PS;
- detailed guidance on meeting the requirements for Ramadan are published each year.

15. The central PS team responsible for catering produce regular good practice guidelines and will produce further guidance on good practice in providing meals for Muslim prisoners as required.

16. PSO 5000 makes it mandatory that "halal products must be stored in separate conditions where facilities allow". Many prison kitchens have to deal with larger populations than they were designed for and storage space is often limited. In these cases the PSO sets out clearly that if separate storage is not possible then halal products may be stored within the same facility in an isolated designated area on a higher separate shelf clearly labelled for halal products. This clearly avoids any potential cross contamination. This policy was agreed after widespread consultation.

17. At the end of April 2006 all prisons were issued with distinctively marked equipment to be used at food servery points for the serving of Muslim food. On their regular visits to prisons Area Catering Manager's monitor the use of the equipment.

PAC conclusion (viii): The PS did not compare the cost and quality of catering against external organisations. It should compare its catering operation to other organisations; use the results of this research to identify transferable ways of reducing costs and improving the quality of catering; and implement a programme to adopt these improved processes.

18. The PS accepts the Committee's conclusion. The Service will pursue opportunities with other organisations (such as the Ministry of Defence) to identify any pragmatic solutions that may further improve the catering provision in prisons.

19. Procurement benchmarking is a key part of reducing costs. In March 2006 the PS became a member of the Office of Government Commerce (OGC) Commodities Steering Group to take forward cross-departmental collaboration with the Ministry of Defence (MoD), Department of Education (DfES) and National Health Service (NHS). Benchmarking is an integral part of this process with a particular view to securing collaboration at a local level with hospitals and schools. The PS is also a leading participant in the Food Procurement Implementation Group led by the Department for Environment Food and Rural Affairs (DEFRA). Some benchmarking has already taken place with other government departments and supermarkets for both bread and top spend items. The PS prices generally compare well.

20. As part of the work in seeking to improve quality as well as looking at the food cost base the PS is currently tendering for the supply of foodstuffs (including bread, eggs, fruit, groceries, milk, salad, single portions and vegetables).

PAC conclusion (ix): The cost of physical education per prisoner varied by over 175% between the cheapest and the most expensive prisons visited by the NAO in 2004-05. The PS should investigate large variations in the cost and provision of Physical Education, and disseminate good practice from prisons providing high quality Physical Education cost effectively, including the use of civilian instructors.

21. The PS accepts that large variations in the cost of providing physical education between prisons of nominally the same type should be further explored and understood. But there are difficulties in establishing baselines for physical education provision. Very few prisons hold identical prisoner populations or have similar facilities. Even where prisons appear to be similar there can be differences in the type of prisoner they hold. In addition some prisons have deficiencies in the provision of other activities (for example workshops and education) and if they incur higher levels of expenditure of physical education they could be covering for regime deficiencies elsewhere. Reducing physical education in these prisons would only impoverish regimes.

22. The central team responsible for physical education already disseminates good practice and guidance and will continue to do so.

PAC conclusion (x): Across the prison estate only around 40% of prisoners participated in exercise. The PS should take steps to improve the take up of exercise, in particular by the groups who could most benefit from physical activity, by for example:

(i) identifying the prisons which achieve the best participation rates for each type of prison and disseminating the good practice learnt;

(ii) identifying the prisons that do not have a full programme of activities at evenings and weekends and extending the availability of exercise at these prisons; and

(iii) monitoring the range of activities available at women's prisons and encouraging prison Governors to widen the range of activities offered to better reflect the needs and preferences of women prisoners.

23. The PS accepts the conclusion and remains committed to increasing, where possible and in the most efficient and effective way, all prisoners' participation rates in physical education. Area Physical Education Advisors have this as a core part of their role.

24. Where it is economic and safe to do so prisons offer as full a programme as possible at weekends and in the evenings. Extending availability requires additional staff or re-arranging staffing patterns – the latter inevitably leading to a shortage of provision during another part of the day. The PS will continue to make PE as available as possible to prisoners whilst balancing competing regime demands and priorities.

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