DH Department of Health

Department of Health

The Government's Expenditure Plans 2001-2002 to 2003-2004
and Main Estimates 2001-2002

Departmental Report

The Health and Personal
Social Services Programmes

This is part of a series of departmental reports (Cm 5102 to 5123) accompanied by the document *Public Expenditure: Statistical Analysis, 2000–2001* (Cm 5101), which present the Government's expenditure plans for *2001–2002* to *2003–2004*.
The complete series is also available as a set at a discounted price.

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The Government's Expenditure Plans

2001-2002 to 2003-2004

and Main Estimates 2001-2002

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

March 2001

Cm 5103 **£18.50**

Contents

		Page
Foreword by the Secretary Of State		1
Ministerial Responsibilities		3
Structure of the Department of Health		5
Chapter 1:	Introduction	7
Chapter 2:	Delivering Better Public Services – Progress	9
Chapter 3:	Expenditure Plans	21
Chapter 4:	Investment	33
Chapter 5:	The NHS Plan – a Plan for Investment, A Plan for Reform	39
Chapter 6:	Breakdown of Spending Programme	45
Chapter 7:	Activity, Performance and Efficiency	53
Chapter 8:	Managing the Department of Health	71
List of Annexes		75
Bibliography		115
List of Figures		119
Glossary		121
Full Contents List		125

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, 1999 and 2000 are available on the Internet at http://www.doh.gov.uk/dohreport/

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 eleventh annual report of the Department of Health.

In the past, the debate about health and social care focused on resources, or the lack of them. Not any more. The March 2000 budget set out the largest level of sustained real terms growth over any four year period in NHS history. Since then, the NHS has received a further £120 million from the Treasury Capital Modernisation Fund (TCMF) for investment in coronary heart disease – £50 million in 2000-2001 and £70 million in 2001-2002.

In the budget of 7th March 2001, the Chancellor announced further resources for the NHS in England: on average an extra £275 million per year for the next three years. This means that the annual average real terms increase in NHS expenditure is now 6.6 per cent (compared to the 6.3 per cent announced in the 2000 budget).

During the period 1999-2000 to 2003-2004, government expenditure on the NHS will have risen by over 50 per cent to £57 billion (over 37 per cent in real terms).

Now the questions about funding have been answered it is time to concentrate on the real issue – delivering better health, and faster, fairer more convenient services. Reforming the way the health service works, so that in future, the patient is at the centre of everything we do.

In July 2000, after extensive consultation, we published the NHS Plan – a ten year programme for reform. The Plan sets out exactly how we will deliver a health service fit for the 21st century. How we are investing in 7,000 extra beds over the next few years and 100 new hospital schemes over the next decade. And investing in nearly 10,000 more consultants and GPs, 20,000 more nurses and 6,500 other health professionals over the next four years.

Increasing capacity is vital, but on its own it is not enough. We also have to change the way the NHS works, to make the most effective use of these extra resources. We have to drive up standards, so that everyone can expect the same high quality of care. And we have to release the full potential of NHS staff, who have been instrumental in drawing up the Plan, and who are among the most effective advocates for change.

That is why the NHS Plan introduces a new Modernisation Agency to spread best practice, and a National Performance Fund worth £500 million by 2003-04, to raise standards across the NHS. In future there will be a system of inspection and accountability for all parts of the NHS. The best performers will be given greater autonomy to use their share of the performance fund, and those who need more time will receive assistance from the Modernisation Agency.

Nurses and other health professionals will be given the bigger roles that their qualifications and expertise deserve. We are cutting waiting times for treatment, expanding cancer screening programmes, and giving patients greater choice and new protection, for example against delays caused by cancelled operations. In future we want to see closer working between health and social services. We will support this with an extra £900 million investment in intermediate care by 2003-04, and new Care Trusts, combining health and social services. And we want to provide dignity, security and independence in old age including higher standards of care for older people and a new Care Direct Service.

Taken together, these and the other changes outlined in the NHS Plan represent an unprecedented opportunity to transform not just the quantity of care available, but also the quality. The standards we have set are challenging, but we are confident they can be delivered, because the Plan will be implemented in the same inclusive way it was drawn up – with the active involvement of NHS staff, patients' representatives, and other experts.

As I write this foreword, the legislation required to enable many of the Plan's key reforms is going through Parliament. The last year has proved that there is universal support within the NHS for our overall aim: to reshape the NHS from the patient's point of view. This Departmental report is an early account of some of the progress we are making.

Rt Hon Alan Milburn MP

Secretary of State for Health

Ministerial Responsibilities

Secretary of State:
The Right Honourable Alan Milburn MP

Overall responsibility for the work of the Department of Health; Individual responsibility for NHS finance; NHS resource allocation; NHS central budgets; Performance monitoring; Management costs & NHS efficiency; PFI & NHS capital; NHS Estates; Strategic communications; sponsorship including health exports.

Minister of State for Health, MS (H):
John Denham MP

Responsibility for: NHS strategy and planning; Waiting lists and times; Clinical quality inc NICE, CHI; Primary Care; Human resources in the NHS; NHS pay and conditions; Medical training and education; Medical workforce planning; Regional NHS casework for London.

Minister of State for Health, MS(C):
John Hutton MP

Responsibility for: Adult social services; Personal social services resources and performance; Services for elderly people including the NHS; Continuing care; Long term care; Services for carers; Health Action Zones; Services for people with mental illness; Special hospitals; Homeless mentally ill; Disabilities including people with sensory and learning disabilities; Children's social services; Adoption and fostering; Child protection; Statistics; Road Traffic (NHS Charges) Act; Regional NHS Case work for Northern & Yorkshire.

Parliamentary Under-Secretary of State (Lords), PS (L): Lord Hunt of King's Heath

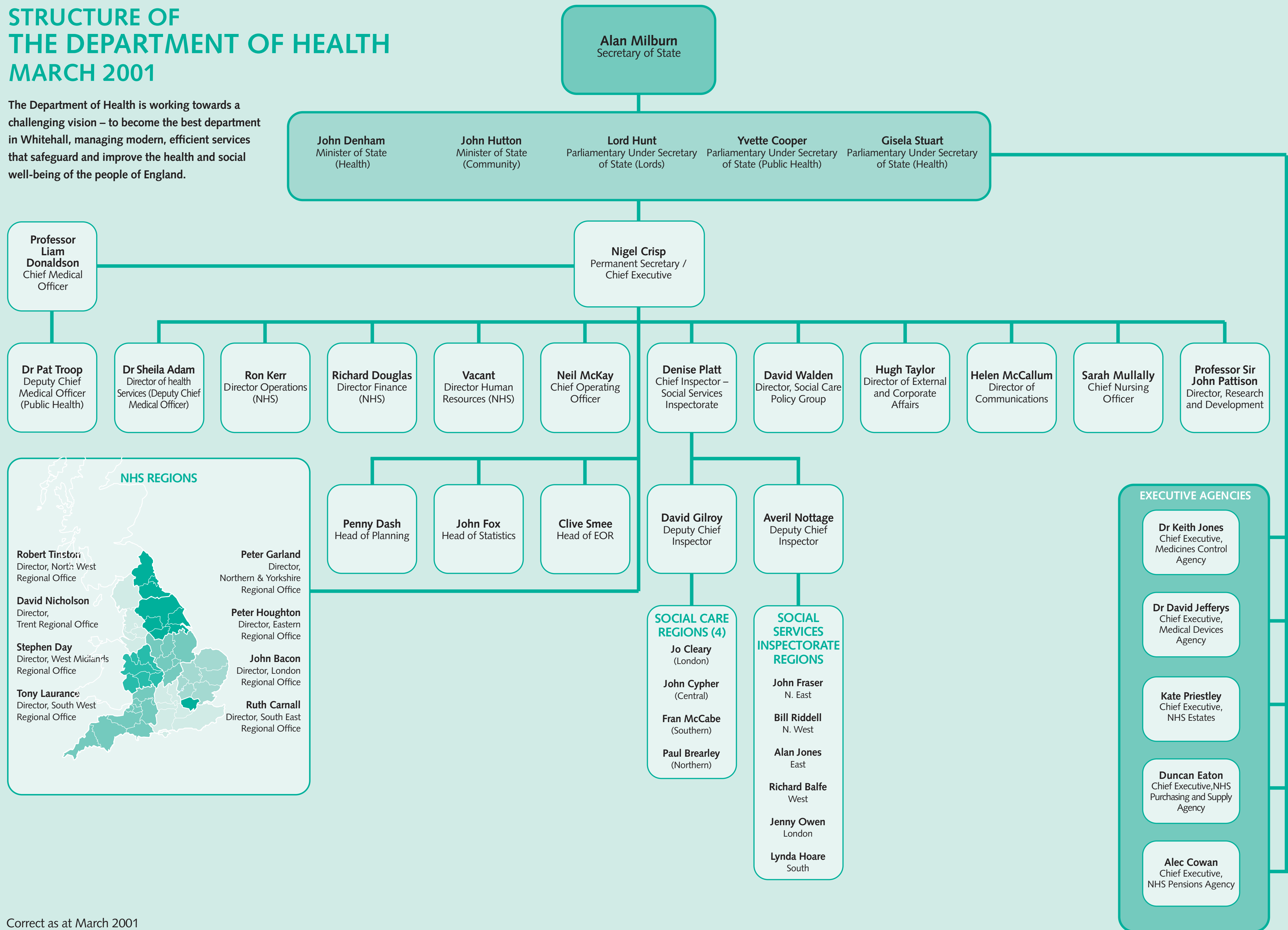
Responsibility for Health services development; Renal services; National Service Framework for Diabetes; Pharmaceutical industry (including the PPRS); Community pharmacy; Pharmaceutical services including prescribing and drugs bill; Medicines; Medical devices (including licensing); Transplants; Blood; Research and Development; General dental services; General optical services; Counter-Fraud services; Nursing strategy (including recruitment and retention); Professions Allied to Medicine; Defence medical services; Regional NHS casework for Eastern & North West.

Parliamentary Under-Secretary of State, PS (H): Gisela Stuart MP

Responsibility for: NHS Direct; Winter planning; Emergency services; Information technology; Patient Confidentiality; Other international affairs; Complaints; Clinical negligence; CHCs; NHS Charter; European issues; Food hygiene (including the Food Standards Agency); Drugs and alcohol misuse; Private health care sector; Policy on NHS appointments; Regional casework for South East & South and West.

Parliamentary Under-Secretary of State, PS (PH): Yvette Cooper MP

Responsibility for *Saving Lives: Our Healthier Nation*; Public health in the NHS; Cancer; Coronary heart disease; Ethnic health; Health education and promotion; Health Development Agency; Health inequalities; Nutrition; Substance misuse; Communicable diseases including AIDS; Immunisation; Women's health and related issues; Maternity and child health; Sure Start; Abortion; Family planning; Teenage pregnancy; HFEA and related issues; Genetics & gene therapy; Spongiform encephalopathies; Regional NHS casework for Trent & West Midlands.



STRUCTURE OF
THE DEPARTMENT OF HEALTH
MARCH 2001
The Department of Health is working towards a challenging vision – to become the best department in Whitehall, managing modern, efficient services that safeguard and improve the health and social well-being of the people of England.
Alan Milburn
Secretary of State
John Denham
Minister of State (Health)
John Hutton
Minister of State (Community)
Lord Hunt
Parliamentary Under Secretary of State (Lords)
Yvette Cooper
Parliamentary Under Secretary of State (Public Health)
Gisela Stuart
Parliamentary Under Secretary of State (Health)
Professor Liam Donaldson
Chief Medical Officer
Nigel Crisp
Permanent Secretary / Chief Executive
Dr Pat Troop
Deputy Chief Medical Officer (Public Health)
Dr Sheila Adam
Director of health Services (Deputy Chief Medical Officer)
Ron Kerr
Director Operations (NHS)
Richard Douglas
Director Finance (NHS)
Vacant
Director Human Resources (NHS)
Neil McKay
Chief Operating Officer
Denise Platt
Chief Inspector – Social Services Inspectorate
David Walden
Director, Social Care Policy Group
Hugh Taylor
Director of External and Corporate Affairs
Helen McCallum
Director of Communications
Sarah Mullally
Chief Nursing Officer
Professor Sir John Pattison
Director, Research and Development
NHS REGIONS
Robert Tinston
Director, North West Regional Office
David Nicholson
Director, Trent Regional Office
Stephen Day
Director, West Midlands Regional Office
Tony Laurance
Director, South West Regional Office
Peter Garland
Director, Northern & Yorkshire Regional Office
Peter Houghton
Director, Eastern Regional Office
John Bacon
Director, London Regional Office
Ruth Carnall
Director, South East Regional Office
Penny Dash
Head of Planning
John Fox
Head of Statistics
Clive Smee
Head of EOR
David Gilroy
Deputy Chief Inspector
Averil Nottage
Deputy Chief Inspector
SOCIAL CARE REGIONS (4)
Jo Cleary (London)
John Cypher (Central)
Fran McCabe (Southern)
Paul Brearley (Northern)
SOCIAL SERVICES INSPECTORATE REGIONS
John Fraser N. East
Bill Riddell N. West
Alan Jones East
Richard Balfe West
Jenny Owen London
Lynda Hoare South
EXECUTIVE AGENCIES
Dr Keith Jones
Chief Executive, Medicines Control Agency
Dr David Jefferys
Chief Executive, Medical Devices Agency
Kate Priestley
Chief Executive, NHS Estates
Duncan Eaton
Chief Executive, NHS Purchasing and Supply Agency
Alec Cowan
Chief Executive, NHS Pensions Agency
Correct as at March 2001

1. Introduction

1.1 This is the eleventh annual report of the Department of Health, providing financial information about its spending programme. The Department of Health is responsible for the stewardship of over £48 billion of public funds. It advises Ministers on how best to use funding and other mechanisms to achieve their objectives, implements their decisions and supports Parliamentary and public accountability.

1.2 Chapter three of this report provides information on the Government's expenditure plans for 2001-02 and Chapter six provides a breakdown of the spending programme.

1.3 The introduction of Resource Accounting and Budgeting (RAB) will change the way departments plan and manage their spending internally. For the first time, the Departmental Report presents main expenditure plans in resource terms **(Figure 3.1)** as well as the 2001-02 Main Estimates in resource terms **[Annex A]**.

Department of Health

1.4 The health programme is funded mainly by central Government. The Department of Health sets overall policy on all health issues, including public health matters and the health consequences of environmental and food issues. It is also responsible for the provision of health services, a function which it discharges through the National Health Service (NHS) including independent contractors such as General Medical Practitioners (GPs), dentists, pharmacists and opticians. The Department of Health is responsible for managing performance against its statutory responsibilities.

1.5 The Personal Social Services (PSS) programme consists largely of spending by local authorities. The Department of Health sets the overall policy for the delivery of PSS and provides advice and guidance to local authorities. The programme is financed in part by central Government grants and credit approvals, but most local authority PSS revenue expenditure depends on decisions by individual local authorities on how to spend the resources available to them.

1.6 There are two complementary documents to this report, published by the Department of Health:

- The *Annual Report of the Government's Chief Medical Officer*[1.1], which reports on the state of public health in England, explains changes in the factors which influence public health and identifies areas where improvements could be made; and,
- The *Annual Report of the Chief Social Services Inspector*[1.2], which reports on the state of social care services in England and also describes the work done by the Social Services Inspectorate to improve standards.

1.7 The Government also publishes a *Government Annual Report*[1.3], which covers the delivery of the Government's programme to create a modern Britain and a decent and fair society.

The Modernisation Programme

1.8 The Government is transforming the health and social care system so that it produces faster, fairer services that deliver better health, and narrow health inequalities. Modernising how people access health and social care is key to achieving the overarching aim of helping people to live longer, healthier and more independent lives.

NHS Plan

1.9 The *NHS Plan*[1.4], was announced by the Prime Minister and the Secretary of State for Health on 27 July 2000. This set out the strategy for investment and reform in the NHS, alongside the Public Service Agreement targets for the NHS and Social Services.

1.10 Chapter five of this Report sets out how the Department will implement the targets detailed in the Plan.

Public Service Agreement

1.11 The aims and objectives of the Department of Health are enshrined in the Public Service Agreement (PSA) which was published in the HM Treasury White Paper *Public Services for the Future: Modernisation, Reform, Accountability*[1.5] in December 1998. Chapter two of this report sets out the aims and objectives and records progress being made to achieve detailed targets.

1.12 The 2000 Spending Review builds on the success of these PSAs by setting challenging targets for the next three years focused clearly on priorities. The PSAs in the White Paper, *2000 Spending Review: Public Service Agreements, July 2000*[1.6] focus on the key improvements in services. A summary table for the SR 2000 PSA targets is given in Chapter two of this Report.

1.13 The Department has also published its *Service Delivery Agreement* (SDA)[1.7], which sets out how it will deliver the PSA targets, and how it will ensure good value for money in their operations.

2. Delivering better public services – progress

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. The Government also made a commitment to linking 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 (PSAs) for the full range of the Government's objectives.

2.2 A list of the Department of Health's aims and objectives, as set out in the White Paper, followed by a detailed analysis of the PSA targets resulting from the CSR are set out in the paragraphs below.

The Department of Health Aim and Objectives

Aim

2.3 The Department of Health's overall aim is to improve the health and well being of the people of England, through the resources available, by:

- Supporting activity at a national level to protect, promote and improve the nation's health;
- Securing the provision of comprehensive, high quality care for all those who need it, regardless of their ability to pay or where they live or their age; and
- Securing responsive social care and child protection for those who lack the support they need.

Objectives

2.4 The key objectives in pursuing these aims are:

A. To reduce the incidence of avoidable illness, disease and injury in the population.

The Department of Health will do this by:

- Working across government and with a range of agencies to improve the health of the public;
- Providing accurate and accessible information on how to reduce the risk of illness, disease and injury;
- Encouraging people to live healthily; and
- Raising standards and setting targets to galvanise and encourage widespread improvements in public health, and in particular a narrowing of current inequalities in health status.

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

The Department of Health will do this by:

- Providing family health services which are accessible to people wherever they live;
- Reducing the number of people waiting, and the time they have to wait, for treatment;
- Improving clinical and cost effectiveness in the NHS; and
- Ensuring that the NHS prioritises treatments according to clinical need, not people's ability to pay, nor where they live, their age nor who their GP is.

C. 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.

The Department of Health will do this through the NHS programme by:

- Providing care according to individual need regardless of organisational boundaries;
- Helping people to live independently, and supporting them wherever possible in their own homes;
- Giving people who need it access to effective care; and through Local Authority Social Services, by;
- Securing appropriate and effective social care for those who lack the means or other support to get the help they need.

D. To maximise the social development of children within stable family settings.

The Department of Health will do this by enabling local authorities, with resources and guidance, to:

- Secure appropriate and effective social care to prevent significant neglect or abuse and to support families; and,
- Assume where necessary sufficient parental responsibility in relation to individual children.

2.5 In addition the Department of Health has the following performance objectives:

E. 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.

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

Departmental Objectives and Public Service Agreement Targets Analysis

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

PSA Target	Measure	Progress
Reduction in the death rate from cancer amongst people aged under 75 by at least 20 per cent by 2010 from a baseline of 139.7 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from cancer amongst people aged under 75.	Trend data not yet available.
Reduction in death rate from heart disease and stroke and related illnesses amongst people aged under 75 years by at least 40 per cent by 2010, from a baseline of 139.6 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from heart disease and stroke and related illnesses amongst people aged under 75.	Trend data not yet available.
Reduction in the death rate from accidents by at least 20 per cent by 2010, from a baseline of 16.2 per 100,000 population for the three years 1995 to 1997.	Death rate from accidents and adverse effects.	Trend data not yet available.
Reduction in serious accidental injury relating to admission to hospital by at least 10 per cent by 2010, from a baseline of 197,000 admissions for the financial year 1995-96.	Hospital admissions for serious accidental injury requiring a hospital stay of four or more days.	Trend data not yet available.
Reduction in the death rate from suicide and undetermined injury by at least 20 per cent by 2010, from a baseline of 9.1 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from suicide and undetermined injury.	Trend data not yet available.

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

PSA Target	Measure	Progress	
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.	**Achieved**	1.039 million, 119,000 below the inherited level, as at the end of January 2001. Average waiting time is also decreasing.
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.	**On course:**	97.1 per cent of patients suspected of breast cancer able to see a specialist within 2 weeks at September 2000. Data being collected for all other cases of cancer.
Establish *NHSDirect*, 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*.	**Achieved:**	*NHS Direct* has been national since 22 September 2000.
Improve access to and quality of primary care services through investment in line with locally agreed Primary Care Investment Plans. Key targets are:			
a) Increase equity in the national distribution of GPs. From growth of approximately 0.6 per cent whole-time equivalent GPs in 1997 over 1996, there will be progress towards a national average annual increase of 1 per cent whole-time equivalent GPs by 2002, using a range of new initiatives and with local variations to take account of the need to concentrate on deprived and remote areas;	Percentage national average annual increase in GPs.	**On course:**	Forecast growth for 2000-01 is 0.5 per cent – if achieved such a growth would translate to an extra 721 GP WTEs since March 1999.
b) Increase investment in practice staff – 500 new practice nurses will be appointed by 2002;	Number of new practice nurses.	**On course:**	Forecast for March 2001 shows 10,845 practice nurse WTEs, an increase of 404 on March 2000. This is an increase of 625 from the March 1999 baseline.

PSA Target	Measure	Progress	
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.	**On course:**	Year end 1999-2000 indicated that 598 improvements were made. Plans are in place for a further 559 improvements during 2000-01.
Connect all GP surgeries which use clinical computer systems to the *NHSnet* by the end of 1999 and all other surgeries by the end of 2002, so that more information and services can be offered closer to people's homes. As at November 1998, less than 10 per cent of GP practices were directly connected to *NHSnet*.	Percentage of GP surgeries connected to *NHSnet*.	**On course:**	'Project Connect' will deliver integrated computer systems linking the NHS, local hospitals and local doctors which will be available to GPs at their own desktop. Each GP and other members of the primary healthcare team will have their own e-mail and access to on-line health information on *NHSnet* and the internet. Electronic test results will be integrated into patient's records. The Project Connect target is to achieve a 95 per cent connection rate by the end of March 2001 and 100 per cent by the end of March 2002. At 4 January 2001, 82 per cent of general practices have been connected to the *NHSnet* and 94 per cent of practices have signed that they will comply with the security and confidentiality requirements of *NHS net*.
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.	**On course:**	NICE completed 16 technology appraisals between 1 December 1999 and 31 December 2000. NICE has formed an additional Appraisal Committee to enable it to increase its appraisal output in line with the provisions of the NHS Plan.
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.	**Achieved:**	GP Survey Results published October 1999. CHD survey results published December 2000 Expert reference group established.
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.	Annual Value of efficiency gains as a proportion of health authority unified allocations.	**Slippage:**	Final figure not yet available.
The Department of Health 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 and calculated on a regional basis.	**On course:**	at December 2000.
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.	**Achieved:**	73.8 per cent, September 2000 data.
Move at least half of those practices with a generic prescribing rate currently below 40 per cent to above that level by the end of March 2002, from a baseline of 598 practices < 40 per cent to 295 practices < 40 per cent.	Proportion of GP practices with a generic prescribing rate below 40 per cent moved above 40 per cent.	**Achieved:**	126 < 40 per cent, June 2000 data.
A 50 per cent reduction in prescription charge evasion (compared to 1998 levels) by the end of 2002-03.	Percentage reduction in prescription charge evasion.	**On course:**	Between November 1998 and July 1999, there was a reduction in patient prescription charge evasion of £48 million, around 41 per cent.

PSA Target	Measure	Progress	
£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.	**On course:**	During the year 2000, £3.96 million was recovered from pharmaceutical contractors, equating to 66 per cent of the recovery target. At present, a further £1.47 million is due to be recovered from contractors as a result of case settlements agreed during the last year.

Objective C: 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	
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 per cent over the five years up to 2002-03, compared with an annual average rate of 3.5 per cent over the last five years.	Annual average per capita rate of growth in emergency admissions of over 75 year olds.	**On course:**	Figures suggest that between year end 1997-98 and year end 2000, the annual average per capita rate of growth in emergency admissions of people aged 75 and over will be around 1.4 per cent. The growth target has been reduced from 3 per cent to 2 per cent.
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 per cent.	Average emergency psychiatric admission rate.	**On course:**	12.9 per cent actual rate, September 2000.
Achieve efficiency and other value for money gains in Personal Social Services expenditure equivalent of 2 per cent in 1999-2000 and 2000-01 and 3 per cent in 2001-02.	Value of efficiency and other value for money savings.	**On course:**	2.3 per cent estimated for 2000-2001.
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.	**Achieved:**	This relates to the Prevention grant. 100 per cent at October 1999.

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

PSA Target	Measure	Progress	
Improve the continuity of care given to children looked after by local authorities by reducing to no more than 16 per cent in all authorities, the proportion of such children who have three or more placements in one year by 2001. As many as 30 per cent of children currently experience 3 or more placements per year in some authorities, within a national average of 20 per cent.	Percentage of authorities with more than 16 per cent of children looked after who have 3 or more placements.	**On course:**	The national figure improved from 18.6 per cent to 17.8 per cent at March 2000. 34 per cent of councils reported figures higher than the target. However, information from the autumn monitoring for 2000 indicates that councils are generally confident of reaching the target, with only some outliers unlikely to do so.
Improve the educational attainment of children looked after by local authorities, by increasing to at least 50 per cent by 2001 the proportion of children leaving care aged 16 or above with a GCSE or GNVQ qualification and to 75 per cent by 2003. Information from surveys indicates that at present the proportion of children looked after who gain qualifications can be as low as 25 per cent.	The percentage of children leaving care with a GCSE or GNVQ qualification.	**Slippage:**	The first nationally available data show that 30 per cent of children leaving care during 1999-2000 had a single GCSE or GNVQ. However, this is first year of data collection and improvement is expected.
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 19 per cent of children on the child protection register being re-registered (i.e. target of 17.2 per cent re-registrations to be reached by 2002).	The proportion of children registered during the year on the Child Protection Register who had been previously registered.	**Achieved:**	14 per cent re-registrations, 1999-2000 data.

Departmental Operations and PSA Productivity Target Analysis

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

PSA Target	Measure	Progress	
Achieve efficiency and other value for money gains in Departmental operations equivalent of 2.5 per cent in 1999-2000, 2000-01 and 2001-02 while fulfilling the Department's business plan within the running costs total (measured by the annual rate of gain).	Delivery of the Business Plan objectives within the running costs settlement.	**On course:**	The Department has continued to meet its Business Plan objectives within the three year running cost settlement agreed in the Comprehensive Spending Review.
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.	**On course:**	The latest position is that 96 per cent of bills are being paid promptly during 2000-01.
To continue to regularly and systematically review services and operations over a 5-year period, in line with Government policy in the handbook *Better Quality Services*[23]. It will agree a programme by September 1999 setting out which services will be reviewed each year, with the intention to review at least 60 per cent of services by March 2003.	Percentage of services reviewed.	**On course:**	The Department is on track to carry out BQS reviews of at least 60 per cent of its services by March 2003.
To put forward proposals by 31 March 1999, on measures to increase the proportion of the Department's business undertaken electronically in line with the Government's commitment to increase such business to 25 per cent by 2002.	Percentage of business undertaken electronically.	**On course:**	The Department has increased the number of Electronic Service Delivery targets it is committed to, and details of current progress and future plans can be found on the internet at http://www/citu.gov.uk/esd/esdreps.htm
As part of the new Framework for Managing Human Resources in the NHS, targets for managing sickness absence have been set consistent with the Cabinet Office recommendations of a reduction of 20 per cent by April 2000. Performance improvement targets will also be set for NHS Trusts on Managing Violence to Staff in the NHS aimed at reducing the levels of absence due to sickness or injury caused by violence.	Ratio of violent incidents to total numbers of staff.	**Data being collected:**	Data not yet available. Targets have been set for managing violence and sickness: To reduce the number of incidences by 20 per cent by the end of 2001-02; To reduce the number of incidences by 30 per cent by the end of 2003-04.
To propose targets for reducing staff sickness absence by February 1999 which will be agreed with the Cabinet Office by June 1999.	The number of sick days per staff year.	**Achieved:**	The Department has agreed with Cabinet Office and the Treasury, targets for reducing its levels of sickness absence. We aim to bring absence levels down to 7.9 days per staff year by 2001, and down to 6.8 days per staff year by 2003. These targets equate to reductions of 14 per cent and 26 per cent respectively.
The Department of Health will also be taking steps to improve the effectiveness of internal purchasing, based on the recommendations of the CSR report on improving civil government procurement. New IT systems will be introduced to improve procurement, and better training and guidance will be given to staff. Key targets are:			
a) Decisions on best use of the Government Procurement Card in the Department by January 1999;	Decision made within time scale.	**Achieved:**	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.	**Achieved:**	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.	**Achieved:**	Website went live December 1999.

Public Service Agreement targets – PROGRESS

2.6 Very good progress has been made towards the Department's Public Service Agreement targets with most targets well on course to be achieved. The Department hopes to continue this progress, when it reports fully on the Spending Review PSA targets in the spring 2002 departmental reports.

2.7 To complement the drive to reduce waiting lists and times and to provide a more patient centred service, around 170 third wave pilots joined the National Booked Admissions Programme in September 2000. This further expansion of the programme will see all acute trusts in England booking some patients in at least two specialties or high volume procedures from March 2001. It is an important step towards meeting the PSA target of two thirds of all outpatient appointments and inpatient elective admissions pre-booked by 2003-04 on the way to 100 per cent pre-booking by 2005.

2.8 There has been, and will continue to be, improved access to fast and convenient services with the NHS working more efficiently and treating more patients than ever before. The introduction of *NHSDirect*, which now covers the whole of England and Wales, has proved a particular success. There have been about four million calls for advice. The more recent launch of *NHSDirect* Online provides a gateway to high quality and authoritative health information on the internet. The website can be found at *www.nhsdirect.nhs.uk* and is currently receiving over 165,000 hits a day, or over 1 million per week.

2.9 As a result of constructive discussions with the General Practitioners Committee of the BMA, a revised *GPNet* programme has now been established, known as Project Connect. This programme will deliver integrated computer systems linking the NHS, local hospitals and local doctors which will be available to GPs at their own desktop. Each GP and other members of the primary health care team will have their own e-mail and easy access to on-line health information on *NHSnet* and the internet. Electronic test results will be integrated into patients' health records. Positive progress has been made towards meeting this target.

2.10 A total of 40 NHS walk-in centres have been approved as pilots. Of these, 36 were open at the end of December 2000 with the remainder to open by the end of August 2001. NHS walk-in centres have been set up to provide convenient access to treatment for minor ailments and injuries, as well as advice and information. They are located in major towns and cities across the country and open from 7am-10pm Monday - Friday and 9am-10pm Saturday and Sunday. They complement other NHS providers such as GPs, GP Out Of Hours services, A&E departments and *NHSDirect*.

2.11 In September 2000, the Department published *Modernising NHS Dentistry: Implementing the NHS Plan*[(2.4)], with proposals for up to £100 million expenditure across 2000-01 and 2001-02 on improving oral health and the quality of dental treatment as well as widening the availability of NHS dental care. (See also Chapter five).

2.12 NICE's initial work programme was agreed with the Department of Health and the National Assembly for Wales and was launched on 4 November 1999. This sets clear quality standards which the NHS will be expected to meet. Between the 1st December 1999 and 31st December 2000 NICE completed 16 technology appraisals. NICE also have a programme of clinical guidelines, with the first expected to be published in March 2001.

2.13 The *Quality Protects Programme (England)*[(2.5)] , launched in September 1998, is a key part of the Government's strategy for tackling social exclusion and focuses on helping some of the most disadvantaged and vulnerable children in society. Following the spending review the Programme has been extended from three years to five years and funding has been increased from £375 million to £885 million over the period. Quality Protects has already begun to deliver its aims of ensuring effective protection and improved life chances for children in need and in particular children in local authority care. For example we have seen: 500 more 'children looked after' adopted this year compared with last (a 23 per cent increase); looked after children experiencing fewer placement moves; a reduction in re-registrations on the child protection register; and more support being given to care leavers. For 2000-01 the QP grant to local authorities has been increased from £75 million to £120 million and will further increase each year to £290 million in year 2003-04. £60 million over three years has been specifically earmarked to improve services for disabled children and their families.

2.14 *The Departmental Investment Strategy*[(2.6)] (see also Chapter four), which was published last year, sets out the capital investment plans for the next three years and beyond. It explains how capital resources are to be redirected and managed so as to contribute to the achievement of the Department of Health's objectives and key targets.

2.15 In the 2000 Spending Review, which set new plans for public spending for 2001 to 2004, the Government has further developed PSAs in order to prioritise the most important goals and reforms it wants to deliver. These targets are set out in the White Paper, *Spending Review 2000: Public Service Agreements 2001-04* [(2.7)], July 2000 and will be fully reported on in the spring 2002 departmental reports.

2.16 The White Paper, *Modernising Government*[(2.8)], published in March 1999 is a statement of the Government's vision for reform and modernisation of the delivery of public services. These principles provide a means of achieving the results of the PSA targets.

2.17 A summary table setting out the new PSA targets is shown below. Detailed progress to be recorded in the spring 2002 reports. The table incorporates many of the old CSR PSA targets. Some, however, have already been achieved, for example 'to establish *NHSDirect* so that everyone in England has access to a 24 hour telephone advice line staffed by nurses by December 2000' and so these are not included.

Department of Health Public Service Agreement, SR2000

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

1. Reduce substantially the mortality rates from major killers by 2010: from heart disease by at least 40 per cent in people under 75; from cancer by at least 20 per cent in people under 75; and from suicide and undetermined injury by at least 20 per cent.
   Key to the delivery of this target will be implementing the National Service Frameworks for coronary heart disease and mental health and the National Cancer Plan.
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.
   - Starting with HAs, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole;
   - Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.

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

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 per cent pre-booking by 2005.
4. Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005.
5. To secure year-on-year improvements in patient satisfaction, including standards of cleanliness and food, as measured by independently audited local surveys.

Objective III: Effective delivery of appropriate care

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.
7. Improve the life chances for children in care by:
   - Improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004
   - Improving the educational attainment of children and young people in care by increasing from 4 per cent in 1998 to 15 per cent in 2004 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*-C
   - Giving them the care and guidance needed to narrow the gap by 2004 between the proportions of children in care and their peers who have had a final warning or are convicted.
   - Maximising the contribution adoption can make to providing permanent families for children:

     by bringing councils' practice up to the level of the best, by 2004-05, to increase by 40 per cent the number of looked after children, and aim to exceed this by achieving, if possible, a 50 per cent increase;

     achieve this without compromising on quality, so maintaining current levels of adoptive placement stability;

     cut out drift and unnecessary delay for children by ensuring the adoption process takes place to timescales consistent with those set out in the National Standards; councils are expected to meet these targets by 2004-05. A specific target will be set when the standards have been finalised, and councils will be expected to meet this target by 2004-05.
   - The Government will work with all the relevant stakeholders to develop appropriate ways to get regular information on the success of permanent placements, including adoption (for example, through voluntary anonymous surveys and through the new post-adoption and post-placement support services). It will use this information to help develop and set targets that focus on the success and stability of all permanent placements. We will aim to set such targets by 2004-05.
8. Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008.

Objective IV: Fair access

9. Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.

Objective V: Value for money

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 5 years, with agreed milestones for 2003-04.

Targets from Cross-Departmental Reviews

2.18 The Spending Review was informed by fifteen cross-departmental reviews of issues that might benefit from a joint approach involving two or more Government departments.

Health Inequality

2.19 Work is progressing to meet the national health inequalities targets, as set out in the table on page 15 of this report.

Sure Start

2.20 Sure Start aims to improve the health and well being of families and children in many of the most disadvantaged areas in the country before and from birth, so that children can flourish at home and when they go to school. The first 128 programmes are now up and running, with a further 66 who have drawn up plans and will start work from Spring 2001. A fourth wave of programmes was announced in January 2001, and are planning towards an Autumn 2001 start. Each local programme is different, to meet local needs, but each delivers a range of core services. In Sure Start areas all new parents are visited within two months of a birth to introduce them to Sure Start services. Each programme offers enhanced childcare, play and early learning opportunities and better access to health services. Parents are offered a range of help and advice - from parenting groups to healthy eating to training for work. The Sure Start Unit aims to establish 500 programmes by 2004, reaching a third of all children aged under four who live in poverty. More information may be found on the internet at *www.surestart.gov.uk*.

Action Against Illegal Drugs

2.21 The aim of this initiative is to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs. Work is in hand to estimate the numbers in treatment for problem drug misuse through the 2000-01 census. The census results will be available by 30 June 2001 in provisional form and refined by 31 August 2001. Further statistical analysis will be done to assess the quality of the data, including cross checks with Regional Drug Misuse Databases (RDMD) returns. From 2001-02 the RDMD databases will yield annual information on those in treatment, as well as those entering treatment. It will also provide a consistent basis for measuring increases thereafter. These numbers will be published annually from here on so it will be possible to measure progress against targets each year; it is planned to make the data available by the end of December for the preceding financial year.

2.22 At the moment RDMD data indicates a steady increase in the numbers entering treatment, showing a 7 per cent increase in the numbers reporting entering treatment for the first time or after a six month break, in the six month period between 31 March 1999 and 30 September 1999.

Modernising Government Action Plans

Change Programme

2.23 The vision for the Department of Health is to:

- safeguard and improve health and social wellbeing;
- modernise health and social services; and
- be the most effective and responsive Department in Whitehall.

2.24 Through the Department's continuing change programme we aim to build a modern department which will:

- have strong and visible leadership;
- have a well managed, diverse workforce with appropriate skills;
- have a strong sense of common purpose;
- be outcome focused not process driven;
- be centred on patients and users;
- be imaginative, open to new ideas and use evidence in working out solutions to problems;
- prioritise rigorously and continuously;
- use programme management techniques to work effectively across boundaries;
- use project management techniques to plan work and deliver to timetable;
- exploit IT and information to work in new ways; and
- live the values in the *New Understanding*[2.9]

2.25 Work in hand, or planned, to address strategic priorities, embed core values and focus the Department on its vision includes:

- A wide-ranging review of the Department and its functions planned for spring 2001. The review and its outcome will dominate the Department's change programme in 2001-02;
- An integrated business planning and performance management system;
- The introduction of a 360° feedback system for senior staff and use of staff surveys;
- An audit of all corporate systems and practices to ensure they comply with core values;
- An ambitious *Better Quality Services* programme for a fundamental review of all Departmental business over a five year period to test and improve the quality of its work;
- A draft statement of values on working hours and tackling the long hours culture;
- An intranet health information system-Care & Health Information Portfolio (CHIP) which provides ministers, managers and staff with up to date information to support their work;
- The Management of Electronic Documents Strategy (MEDS) which aims to help staff manage electronic documents and records effectively;
- A monthly bulletin from the Permanent Secretary and Chief Executive giving staff an overview of corporate events in order to support greater understanding of policies and announcements.

- Work to modernise and strengthen our skills through better interchange, external recruitment and training and development in key areas such as project management and policy skills; and,
- Following the whole Department's accreditation as an Investor in People (IIP) in January 1999, a team of staff were trained to act as internal IIP assessors and participated in 2000 in the first phase of a cycle of Post-Recognition Reviews. The reviews form part of a process leading towards a potential recommendation to an external recognition panel for re-recognition of the Department's IIP accreditation in 2002.

2.26 Action taken, or to be taken, to achieve much greater diversity in the Department's workforce includes:

- Local work area plans being used as the basis for identifying corporate priorities which will include awareness training in diversity issues for all managers;
- Targets have been set to help ensure our workforce reflects the diversity of the people we serve – particularly at senior levels;
- The appointment of a race equality adviser for the Department;
- The creation of a new Senior Civil Service post to head the Department's internal Employment Diversity Unit;
- The launch of a new complaints procedure, Fairness and Respect at Work (FARAW); and,
- Mainstreaming diversity into the working competence of staff through the delivery of cultural competence training and other measures.

Policy Decisions

2.27 One of the key recommendations in the *modernising government* white paper was that the government would ensure that policy making delivered "creative, robust and flexible policies, focused on outcomes". Action to achieve this includes producing and delivering an integrated system of impact assessment and appraisal tools in support of sustainable development, covering impacts on business, the environment, health and the needs of particular groups in society. This system is currently being developed at an inter-departmental level, and in the meantime departments are being encouraged to make more use of the available tools. The Department of Health, through its intranet, made available to all of its staff at the beginning of the year a checklist for policy makers that includes all of the available impact assessment and appraisal systems.

Better Regulation and Regulatory Impact Assessments (RIAs)

2.28 There is a strong commitment throughout the Department and its Agencies to improving the quality of regulation and to regulation that is necessary, fair, affordable, simple to understand, and which will command public confidence. The importance of adopting the Better Regulation Task Force's five principles of good regulation (transparency, accountability, targeting, consistency and proportionality) is accepted as an integral part of the Department's work. But the need to maintain a careful balance of interests continues to be recognised. 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.

2.29 The Department of Health is not a major regulatory Department. Of the 4 Bills and 42 regulations introduced by the end of December 2000, 3 Bills (The Care Standards Bill which received Royal Assent in July, The Health and Social Care Bill and The Tobacco Advertising and Promotion Bill) and only 10 Regulations imposed costs on business, charities or voluntary bodies. Ten Regulatory Impact Assessments (RIAs) were published and placed in the House Libraries. The Department successfully implemented the Cabinet Office Regulatory Impact Unit (RIU's) new electronic Forward Look database of new regulations which will have an impact on business etc. The Department is now able to monitor the progress of the 46 regulations currently on the database.

2.30 The Department reviewed all of its 76 administrative forms sent to businesses and the voluntary sector. This resulted in the abolition of 14 forms and simplification of 11. These forms will be reviewed annually to ensure that only those which are absolutely necessary remain in use, and that these are as straightforward to complete as possible.

2.31 During the year, the Department made a substantial input to the Better Regulation Task Force's reports on *Alternatives to State Regulation*[2.10] (July 2000) and *Protecting Vulnerable People* [2.11] (September 2000). As sponsoring the Department for the *Protecting Vulnerable People* report, the Department of Health co-ordinated the Government's response. The Department also became actively involved in the Cabinet Office Public Sector team's new project on reducing the current level of GP paperwork. The aim of this project was that GPs will be able to spend more time improving the service they deliver and less on paperwork. A Panel comprising doctors, patient groups and NHS administrators advised the project.

2.32 The Medicines Control Agency and the Medical Devices Agency have agreed to draw up implementation plans for the adoption of the Concordat (a blueprint for fair, practical and consistent enforcement of regulations affecting business, charities and the voluntary organisations), early in 2001. This means that five of the Department's enforcement bodies will have adopted the Concordat. The total includes The Human Fertilisation and Embryology Authority, the Central Council for Education and Training in Social Work, the Department of Health Unit responsible for non-NHS clinics and hospitals approved to perform termination of pregnancy and pregnancy advice bureaux. They adopted the Concordat during 2000. Ministers have also given a commitment that the National Care Standards Commission in England (coming into operation in 2002) will adopt the Concordat.

Responsive Public Services

2.33 Detailed analysis by PSA target is given at paragraphs 2.6 to 2.14. The Department of Health is making strides in these and other areas to ensure it can improve its service to the public and meet the challenges of the 21st century.

2.34 Care Direct originates from a government cross cutting review to improve services for older people. It will provide a single gateway, predominantly for older people, to get information about social care, health, housing and social security benefits and to help them access these services more easily. Care Direct will be piloted in six Local Authorities (LAs) in the South West in 2001-2002 and there will be a further 18 pilots in the following year. Subject to full evaluation and Ministers' decision, roll out will begin on an incremental basis thereafter.

2.35 All NHS hospital trusts and PCTs/PCGs will be required to carry out regular patient satisfaction surveys from April 2002. They will be expected to publish the results in the annual Patients' Prospectus and to account for what action they are taking to deal with the concerns raised by patients. Financial rewards for trusts will be linked to survey results. The Department of Health is currently developing the methodology for surveys to be carried out locally by NHS organisations, and will issue guidance later in the year.

2.36 The Access Task Force aims to achieve improvements across the whole health care system in the speed and convenience with which people can access services. This includes access in primary care – giving rapid appointments for GPs and other professionals, offering people access to NHS dentistry when they ask, extending information and advice – for example via NHS Direct, easier access to medicines and pharmaceutical advice, abolishing waiting lists and replacing them with booking systems within target waiting times. When people get to hospital, the Task Force aims also include reducing cancelled operations and speeding up access to emergency services – with ambulance response times and the length of time people spend in A&E departments.

Quality Public Services

2.37 The Department of Health has reviewed approximately 20 per cent of its services and activities in order to improve efficiency, effectiveness and value for money and is on schedule to deliver its PSA target.

2.38 Benchmarking is considered a fundamental part of the review process and has so far been conducted through the use of informal as well as formal networks. Experiences so far have found the process to add real value and the Department is also promoting the use of the Public Sector Benchmarking Service.

2.39 Informal networks have been established internally, with best practice being shared with other government as well as outside bodies and DH actively participates in formal Cabinet Office cross-cutting working groups. Further work is being carried out to develop a more strategic approach.

Information Age Government

2.40 The Department of Health has established a working group to support the Departmental Information Age Government (IAG) Champion. This group is supported by an IAG Co-ordinator and is responsible for ensuring the Department responds to central initiatives and contributes to the development of IAG policy.

2.41 The Department has reported twice during 2000, in May and November, on its progress towards meeting the Government's targets for electronic service delivery. Four services are currently identified:

- Provide information for patients and carers – roll out of *NHS Direct* and *NHS Direct Online* was completed this year and information on National Service Frameworks has been placed on the Departmental web site;
- Provide access to NHS performance information – on target for 2002;
- Provide access to patient health records – on target for 2005;
- Provide an appointment booking service – on target for 2005.

2.42 The Department published its internal e-Business strategy, *Painting the Big Picture*[2.12], in November. It also completed a review of the NHS strategy *Building the Information Core: Implementing the NHS Plan*[2.13] in January. The former will continue to be developed with the next revision due in April 2001. Updates to the NHS strategy will be more dynamic, covering progress on implementation as well as refining plans for new developmental activity. Both strategies underpin implementation of the NHS Plan.

2.43 In December the Department sponsored the "Having a Baby" Life Event on the Ukonline Citizen Portal and in January started work on a "Becoming a Carer" Life Event. It is also contributing to Life Events sponsored by other departments.

2.44 The Department is currently considering how it should implement the recommendations arising from the *Successful IT: Modernising Government in Action*[2.14] Report. Many of the Report's principles are already embedded within its own and NHS processes. However further work will be necessary to address the requirements for the appointment of Senior Responsible Owners (SROs) and the conduct of Gateway Reviews in particular.

2.45 The Department implemented a Departmental Information Asset Register (IAR) in July. In October GPs were enabled to hold electronic patient records and a national cryptography strategy for the NHS was published in January. The Department has continued to develop the policy briefing system, Care and Health Information Portfolio (CHIP), and has started to address CHIP's relationship to the Knowledge Network. Planning has started for the adoption of the Government Interoperability Framework (e-GIF) in both the NHS and the Department.

Public Service

2.46 The whole of the Department of Health was recognised as an Investor in People (IIP) in January 1999; one of the first Whitehall Departments to do so. The Department is actively progressing with its re-accreditation in 2000-01 and working toward the new standard. Achieving to this standard confirms our commitment to our staff.

2.47 The first stage of the post recognition review was completed in August 2000 and covered 40 per cent of the organisation. Our post-recognition review is intended to ensure that we are maintaining continuous improvement against the IIP standard. The results of the first stage report were published in October 2000.

2.48 The next and final stage is planned to take place between September and December 2001 and will cover the remaining 60 per cent of the Department. This next stage needs to find evidence of significant improvements if we are to retain our accreditation when an IIP post recognition review panel considers our case in March 2002.

2.49 Other initiatives to value staff and to support modernisation are outlined in paragraphs 2.23 to 2.26.

3. Expenditure

3.1 The Department of Health is responsible for the stewardship of over £48 billion of public funds in 2001-02. This Chapter provides detailed information on the Government's expenditure plans up to 2003-04. A breakdown of the spending programme can be found in Chapter Six.

Introduction of Resource Accounting and Budgeting (RAB)

3.2 The introduction of Resource Accounting and Budgeting means that as of 1 April 2001 all Government Departments are required to budget and report to Parliament on a resource basis. Until 31 March 2000 this requirement was on a cash basis. This is the first Departmental Report to present expenditure plans in resource terms. It also includes, for the first time, the Main Estimates for 2001-02 presented on a resource basis. These are attached at **Annex A.**

3.3 With the move to resource budgeting the basis for presenting expenditure information within this report will vary depending on the period covered. In most cases, information on NHS expenditure to 2000-01 will be on a cash basis. Details of expenditure from 2001-02 onwards will be on a resource basis.

3.4 **Figure 3.1** summarises the resource plans for the Department of Health. More detailed resource plan information is provided in **Annex A3**.

3.5 **Figure 3.2** summarises cash plans from 1995-96 until 31 March 2001. **Figure 3.3** summarises local authority expenditure in cash terms.

Figure 3.1: Resource Plans Summary Table[1]

£ million

	1998-99[1] outturn	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Department of Health						
Total Spending in DEL	38,992	40,928	45,301	49,805	54,688	59,207
Spending in Equal Opportunities Fund (EOF) DEL			#	#	#	#
Total Spending in AME	2,263	1,874	1,933	1,851	1,948	2,061
of which						
non cash AME	2,263	1,874	1,933	1,851	1,948	2,061
Consumption- The Resource budget						
Resource DEL	38,232	40,014	43,859	47,717	52,314	56,495
EOF DEL			#	#	#	#
Resource AME	2,263	1,874	1,933	1,851	1,948	2,061
of which						
Non-cash item in Resource AME	2,263	1,874	1,933	1,851	1,948	2,061
Total Resource Budget	40,495	41,888	45,792	49,567	54,262	58,556
Adjustment to reach operating cost	-4,520	-5,952	-6,191	-6,283	-6,463	-6,573
Net Operating Costs	35,975	35,935	39,601	43,284	47,798	51,983
Adjustment to reach voted total		#	#	#	#	#
Net Total Resources (Voted in Estimates)	35,975	35,936	39,601	43,284	47,798	51,983
Investment- The Capital Budget						
Capital DEL	760	914	1,442	2,088	2,374	2,712
EOF DEL						
Total Capital budget	760	914	1,442	2,088	2,374	2,712
Adjustment to reach voted capital	-1,103	-1,204	-1,191	-1,458	-1,548	-1,601
Net Capital expenditure (voted)	-343	-290	251	631	826	1,110

1 Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary. Figures for 1998-99 should therefore not be compared with those for later years as data may be incomplete or not available.

2 Figures may not sum due to rounding

3 Amounts below £0.5 million are not shown but indicated by a #

Figure 3.2: Summary Cash Plans

Vote Section		1995-96 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 estimated outturn
							£ million
Departmental Programmes in Departmental Expenditure Limits							
Health Services							
1A	National Health Service hospital, community health, family health (discretionary) and related services and NHS trusts	27,661	28,472	30,025	31,929	34,817	38,942
1B-F	National Health Service Family Health Services (non-discretionary)	3,505	3,700	3,846	3,940	4,220	4,415
2A-G	Departmental administration[1]	325	297	281	268	296	318
2H-J	Central health and miscellaneous services	495	527	513	470	548	553
	DUP						120
	Total health services	**31,985**	**32,997**	**34,664**	**36,608**	**39,881**	**44,348**
	Other services						
2K	Personal social services	30	30	32	32	34	42
2L-V	Central government grants to local authorities	772	638	532	674	607	620
	Credit approvals	145	105	69	54	57	56
	Total Department of Health						
	Departmental Expenditure in Departmental Expenditure Limits	**32,933**	**33,769**	**35,297**	**37,368**	**40,578**	**45,066**
	Of which:						
	Central government's own expenditure	31,615	32,944	34,611	36,695	39,964	44,079
	Public corporations (excluding nationalised industries)	401	83	85	-55	-50	311
	Central government support to local authorities	918	743	601	728	664	676
	Equal Opportunities Fund in Departmental Expenditure Limits						
2W	Equal Opportunities Fund						#
	Main departmental programmes in Annually Managed Expenditure						
3A	Pensions	614	647	793	211	446	701

1 Includes Trading Funds - Medicines Control Agency (MCA) and NHS Estates Agency.

2 Totals may not sum due to rounding.

3 Amounts below £0.5 million are not shown, but indicated by a #.

Figure 3.3: Local Authority Expenditure

	1995-96 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 estimated outturn
						£ million
Department of Health						
Main Local Authority (LA) expenditure						
Current spending						
Personal social services[1]	**7,327**	**7,943**	**8,454**	**9,059**	**10,050**	**10,254**
Port Health[2]	4	4	4			
Total current spending	**7,331**	**7,947**	**8,458**	**9,059**	**10,050**	**10,254**
Capital spending						
Personal social services	160	136	107	83	82	113
Total net capital spending	**160**	**136**	**107**	**83**	**82**	**113**
of which:						
Gross spending	200	193	150	136	128	170
Gross receipts	*-40*	*-57*	*-43*	*-53*	*-46*	*-57*
Total Local Authority expenditure	**7,491**	**8,083**	**8,565**	**9,142**	**10,132**	**10,367**

1 From 1998-99 figures include Welfare to Work LA Expenditure where shown.

2 From 1997-98 figures for port health are no longer separately identifiable and will be covered by DETR returns.

NHS Expenditure Plans

3.6 The Government is committed to a modernised NHS able to deliver fast, convenient and high quality services. Delivering a modern NHS needs both investment and reform. In the Budget last year the Chancellor announced the largest ever sustained increase in NHS expenditure for any four-year period. Since then the NHS has received a further £120m from the Treasury Capital Modernisation Fund (TCMF) for investment in Coronary Heart Disease – £50m in 2000-01 and £70m in 2001-02. In the Budget of 7 March 2001, the Chancellor announced further resources for the NHS in England: an average of £275 million extra a year for the next three years. These funds will be used to help improve services for patients, for example by replacing old Nightingale wards, and to boost recruitment and retention of key NHS staff.

Figure 3.4: NHS Net Expenditure (England) 1995-96 to 2003-04

£ billion

	1995-96 outturn[1]	1996-97 outturn[1]	1997-98 outturn[1]	1998-99 outturn[1]	1999-00 outturn[2]	2000-01 estimated outturn[2]	2001-02 plan[2]	2002-03 plan[2]	2003-04 plan[2]
NHS Net Expenditure	32.3	33.3	35.0	37.0	40.3	44.6	48.7	52.6	57.0
Net percentage real terms change (%)		-0.1	2.2	2.7	6.4	8.9	6.6	5.3	5.6

1 Expenditure in resource terms for years 1995-96 to 1998-99 has been estimated by assuming that year on year growth in resource terms was the same as that for cash.

2 Net NHS expenditure in resource terms as reported in figure 3.8.

3.7 **Figure 3.4**, sets out NHS expenditure in resource terms between 1995-96 and 2003-04. This shows that the annual average real terms increase in NHS expenditure since 1999-2000 is now 6.6 per cent compared to the 6.3 per cent announced in the 2000 budget. Average annual real terms growth over the next three years is still planned at around 5.9 per cent.

3.8 In July 2000, the NHS Plan was published, setting out the Government's ten-year strategy for reform. This report sets out the expenditure plans for delivering the NHS Plan in more detail.

The Health and Personal Social Services Programmes

3.9 The health and personal social services programmes consist of:

- NHS Hospital and Community Health Services, and discretionary family health services. This covers hospital and community health services, prescribing costs and discretionary general medical services funded from Health Authority Unified Allocations, and 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);
- NHS Family Health Services (FHS) non discretionary, covering the remuneration of general medical practitioners, the cost of dental services, general ophthalmic services and most fees and allowances for dispensing and pharmaceutical services;
- Central Health and Miscellaneous Services (CHMS), providing services which are administered centrally, for example, certain public health functions and support to the voluntary sector;
- Provision of social care by local authorities, supported by the Department of Health and the Department of Environment, Transport and the Regions' programmes; and,
- Administration of the Department of Health.

National Health Service, England – By area of Expenditure

3.10 **Figure 3.5** shows the areas in which funds are spent in cash terms for years 1995-96 to 2000-01.

Figure 3.5: National Health Service, England – By Area of Expenditure (cash)

£ million

	1995-96 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 estimated outturn
Departmental Programmes In Departmental Expenditure Limits						
National Health Service Hospitals community health, family health (discretionary) and related services and NHS trusts						
Current expenditure						
Gross	27,310	28,690	30,757	33,019	35,951	39,547
Charges and receipts[1]	-1,363	-1,536	-1,801	-1,872	-2,061	-2,072
Net	25,947	27,154	28,956	31,147	33,890	37,475
Capital expenditure						
Gross	1,996	1,711	1,539	1,282	1,477	2,043
Charges and receipts[1]	-282	-393	-471	-500	-549	-575
Net[2]	1,714	1,318	1,068	782	928	1,468
Total						
Gross	29,306	30,401	32,297	34,301	37,428	41,590
Charges and receipts[1]	-1,645	-1,928	-2,272	-2,372	-2,610	-2,647
Net	27,661	28,472	30,025	31,929	34,817	38,942
National Health Service family health services (non-discretionary)[3]						
Current expenditure						
Gross	4,192	4,383	4,558	4,704	5,022	5,265
Charges and receipts	-687	-683	-713	-764	-802	-850
Net	3,505	3,700	3,846	3,940	4,220	4,415
Departmental administration[4]						
Current expenditure						
Gross	332	306	295	289	298	331
Charges and receipts	-20	-22	-28	-37	-22	-27
Net	311	284	268	252	276	305
Capital expenditure						
Gross	14	13	13	17	23	17
Charges and receipts	#	#	#	#	-3	-4
Net	14	13	13	16	20	13
Total						
Gross	345	319	309	305	321	348
Charges and receipts	-20	-22	-28	-37	-25	-31
Net	325	297	281	268	296	318

Figure 3.5: National Health Service, England – By Area of Expenditure (cash) (continued)

£ million

	1995-96 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 estimated outturn
Central health and miscellaneous services						
Current expenditure						
Gross	579	616	622	628	658	682
Charges and receipts	-92	-99	-116	-167	-126	-146
Net	487	517	505	461	532	536
Capital expenditure						
Gross	8	9	8	9	16	17
Charges and receipts						
Net	8	9	8	9	16	17
Total						
Gross	587	625	629	637	674	699
Charges and receipts	-92	-99	-116	-167	-126	-146
Net	495	527	513	470	548	553
Total National Health Service						
DUP						
Current expenditure						120
Capital expenditure						
Total						120
Current expenditure						
Gross	32,412	33,995	36,232	38,640	41,929	45,826
Charges and receipts[1]	-2,162	-2,339	-2,658	-2,839	-3,011	-3,095
Net	30,250	31,656	33,575	35,801	38,918	42,731
Capital expenditure						
Gross	2,018	1,734	1,560	1,308	1,515	2,076
Charges and receipts[1]	-282	-393	-471	-500	-552	-579
Net	1,736	1,341	1,089	808	963	1,497
Total						
Gross	34,430	35,729	37,793	39,947	43,444	47,903
Charges and receipts[1]	-2,445	-2,732	-3,129	-3,339	-3,564	-3,674
Net	31,985	32,997	34,664	36,608	39,881	44,348
Net percentage real terms change (%)		-0.1	2.2	2.7	6.4	9.3

1 Includes NHS trust receipts/charges. For current, £331 million in 1995-96, £388 million in 1996-97, £459 million in 1997-98, £527 million in 1998-99, £620 million in 1999-00, and estimated £620 million in 2000-01. For capital, £72 million in 1995-96, £116 million in 1996-97, £231 million in 1997-98, £157 million in 1998-99, £283 million in 1999-2000 and an estimated £277 million for 2000-01.

2 HCHS capital includes all NHS trust capital expenditure, ie that funded from charges to health care purchasers and that financed from the External Finance Limit.

3 Figures for FHS non discretionary expenditure between 1998-99 and 2000-01 are not comparable because of transfers to FHS discretionary provision, principally to fund successive waves of Personal Medical and Personal Dental Service pilots.

4 Includes Trading Funds – Medicines Control Agency (MCA) and NHS Estates Agency.

5 Totals may not sum due to rounding.

6 Amounts below £0.5 million are not shown but indicated by a #.

3.11 **Figure 3.6** compares net expenditure on the NHS in 2000-2001 with the planned expenditure figures for 2000-2001 published in last year's report.

Figure 3.6: Comparison of Net NHS Expenditure Plans for 2000-2001 with those in last year's Departmental Report (Cm 4603)

£ million

	Departmental Report 2001-02 Figure 3.5	Departmentsl Report 2000-01 Figure 3.4	2000-01 difference
HCHS current	37,475	37,247	228
HCHS capital	1,468	1,708	-240
FHS current	4,415	4,155	260
Departmental administration	318	301	17
CHMS	553	573	-20
DUP	120	250	-130
NHS Total	44,348	44,234	114

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 3.7**.

Figure 3.7: Main areas of change (£10 million or over) to the Spending Plans presented in last year's Departmental Report (Cm 4603)

2000-01		Difference	
HCHS current	228 including:	437	Transfers from HCHS capital
		-220	Transfers to FHS non discretionary
		12	Transfers from CHMS
HCHS capital	-240 including:	50	In year addition from Treasury Capital Modernisation Fund for investment in Coronary Heart Disease
		117	Take up of End Year Flexibility (EYF)
		34	PFI schemes taken on balance sheet as a result of FRS5
		-437	Transfers to HCHS revenue
FHS non discretionary	260 including:	220	Transfer from HCHS revenue
		40	Take up of EYF
Departmental Admin	17		No adjustments above £10 million to report
CHMS	-20 including:	12	Transfer to HCHS revenue
DUP	-130 including:	-130	Transferred to 2001-02 HCHS revenue for expenditure, through early take up of EYF

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

3.13 **Figure 3.8** shows the main area in which funds are spent on a resource basis for years 1999-2000 to 2003-04. Details of NHS expenditure in the United Kingdom on the same basis are shown in **Annexes A8 and A9.**

Figure 3.8: National Health Service, England – By Area of Expenditure (resources)

					£ million
	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Departmental Programmes In Departmental Expenditure Limits					
National Health Service Hospitals community health, family health (discretionary) and related services and NHS trusts					
Current expenditure[1]					
Gross	36,284	39,906	44,036	46,278	50,127
Charges and receipts	-1,991	-1,996	-2,034	-2,034	-2,034
Net	34,292	37,910	42,002	44,244	48,092
Capital expenditure					
Gross	1,365	1,928	2,300	2,527	2,706
Charges and receipts	-549	-575	-351	-270	-270
Net	816	1,353	1,949	2,257	2,436
Total					
Gross	37,649	41,834	46,337	48,805	52,833
Charges and receipts	-2,540	-2,571	-2,385	-2,304	-2,304
Net	35,108	39,263	43,952	46,501	50,529
National Health Service family health services (non-discretionary)[1]					
Current expenditure					
Gross	5,061	5,283	4,728	6,046	6,303
Charges and receipts	-802	-838	-899	-898	-898
Net	4,259	4,445	3,829	5,148	5,405
Central health and miscellaneous services and departmental administration[3]					
Current expenditure					
Gross	955	1,012	1,083	1,108	1,168
Charges and receipts	-128	-162	-143	-146	-155
Net	827	849	940	962	1,014
Capital expenditure					
Gross	40	32	32	30	30
Charges and receipts	-3	-4	#	#	#
Net	37	28	32	30	30
Total					
Gross	995	1,044	1,115	1,138	1,198
Charges and receipts	-131	-166	-143	-146	-155
Net	864	878	971	992	1,043

Figure 3.8: National Health Service, England – By Area of Expenditure (resources) (continued)

£ million

	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Departmental Programmes in Departmental Expenditure Limits					
Total National Health Service					
Current expenditure					
Gross	42,299	46,201	49,847	53,431	57,598
Charges and receipts	-2,921	-2,997	-3,076	-3,078	-3,087
Net	39,378	43,204	46,771	50,353	54,511
Net percentage real terms change (%)		7.8	5.6	5.0	5.6
Capital expenditure					
Gross	1,405	1,960	2,332	2,557	2,736
Charges and receipts	-552	-579	-351	-270	-270
Net	853	1,381	1,981	2,287	2,466
Net percentage real terms change (%)		59.2	39.9	12.6	5.2
Total					
Gross	43,705	48,161	52,179	55,989	60,333
Charges and receipts	-3,474	-3,576	-3,428	-3,348	-3,357
Net	40,231	44,585	48,752	52,641	56,976
Net percentage real terms change (%)		8.9	6.7	5.3	5.6
GDP as at 7 March 2001	100.0	101.8	104.3	106.9	109.6

1 Includes DUP, and for years 2001-02 to 2003-04 the 2001 Budget additions for the NHS of (i) £90m, £90m and £90m in revenue and (ii) £210m, £205m and £150m in capital.

2 Figures for FHS non discretionary expenditure between 1998-99 and 2002-03 are not comparable because of transfers to FHS discretionary provision, principally to fund successive waves of Personal Medical and Personal Dental Service pilots.

3 Includes expenditure on certain key public health functions such as environmental health, health promotion and support to the voluntary sector.

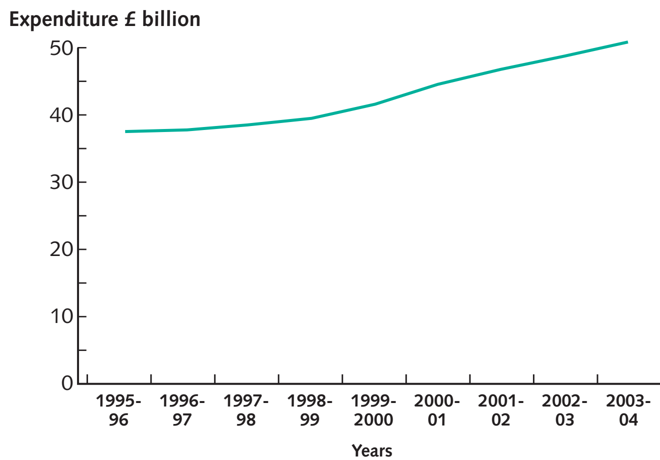
4 Figures may not sum due to rounding.

5 Amounts below £0.5 million are not shown but indicated by a #.

NHS Expenditure Trends (cash)

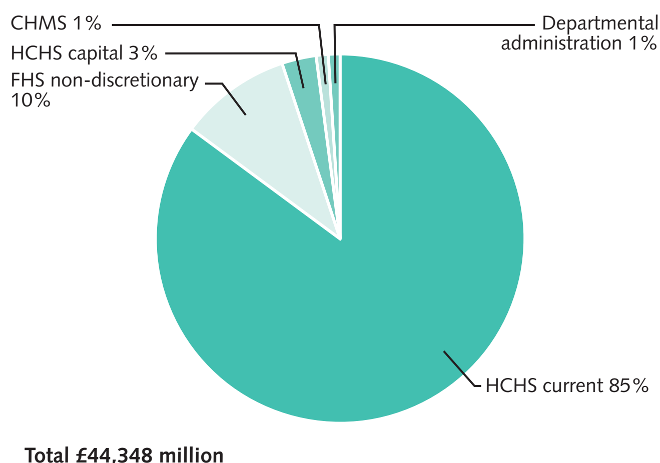
3.14 NHS Net Expenditure (cash) in 2000-2001 is estimated to be over £44 billion, an increase of 9.3 per cent in real terms (measured by the GDP deflator) since 1999-2000. The gross figure is forecast to be nearly £48 million.

Figure 3.9: NHS Net Expenditure Growth in Real Terms (2000-01 prices)



3.15 The largest part of NHS spending is on Hospital and Community Health Services, discretionary family health services and related services. For 2000-2001 the estimated outturn position in net current expenditure is forecast to be £37.5 billion and £1.5 billion on net capital expenditure. Within overall NHS net expenditure, the total for non-discretionary FHS is expected to account for £4.4 billion in 2001-02. The remainder will be spent on Central Health and Miscellaneous Services and Departmental Administration. **Figure 3.10** contains the breakdown of NHS Net Expenditure, 2000-2001 (Estimated Outturn).

Figure 3.10: NHS Net Expenditure, 2000-01 (Estimated Outturn)



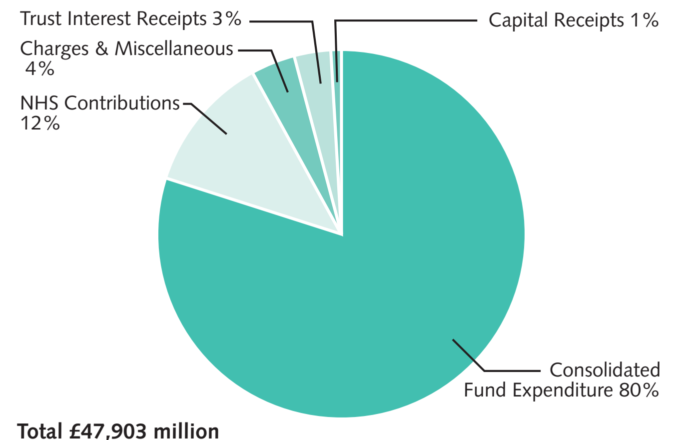
Total £44,348 million

NHS Sources of Finance

3.16 The NHS is financed mainly through general taxation with an element of National Insurance contributions. In 2000-2001 it is estimated that 92.6 per cent of gross NHS spending in England will be met from these two sources, 80.4 per cent from the Consolidated Fund, that is, from general taxation, and 12.1 per cent from the NHS element of National Insurance Contributions. Decisions taken in public spending rounds relate to the total amount of spending to be financed through public expenditure. Changes in sums raised by the NHS element of National Insurance Contributions (for example, because of an increase in earnings) therefore do not in themselves provide more or fewer resources for the NHS in total, but merely change the balance of funding between the taxpayer and the contributor. The remainder of the NHS Expenditure comes from charges and receipts, including land sales and the proceeds from income generation schemes.

3.17 **Figure 3.11** represents NHS sources of finance for 2000-01 and **Figure 3.12** shows the trend in sources of finance for the NHS from 1995-96 to 2000-01.

Figure 3.11: NHS Sources of Finance, 2000-01



Total £47,903 million

Figure 3.12: NHS Sources of Finance[1], 1995-96 to 2000-01

Percentages unless otherwise shown

Financial Year	NHS Gross expenditure (£m)[1]	NHS Net (Public) expenditure (£m)[1]	Total Public	Consolidated Fund expenditure	NHS Contributions	Total from other sources	Capital receipts	Charges and Miscellaneous	Trust interest receipts
1995-96	**34,430**	31,985	92.9	80.4	12.5	7.1	0.8	3.6	2.7
1996-97	**35,729**	32,997	92.4	79.9	12.5	7.6	1.1	3.7	2.9
1997-98	**37,793**	34,664	91.7	79.0	12.7	8.3	1.2	3.8	3.2
1998-99	**39,947**	36,608	91.6	78.1	13.5	8.4	1.3	4.0	3.1
1999-00	**43,444**	39,881	91.8	79.2	12.6	8.2	1.3	3.9	3.0
2000-01	**47,903**	44,348	92.6	80.4	12.1	7.4	1.1	3.7	2.7

1 Expenditure figures as shown in Figure 3.5.

Complementary Sources of Funding

New Opportunities Fund

3.18 *The National Lottery Act*[3.1] set out plans for reforming the National Lottery. This included the creation of a new good cause, the New Opportunities Fund (NOF), which provides complementary funding for health, education and the environment. So far there have been three tranches of funding released for NOF.

3.19 The first tranche was launched in January 1999, where the Fund provided £232.5 million in England (£300 million UK) to support a series of targeted initiatives, one of the first of which is to establish a network of healthy living centres which offer families and individuals fitness checks, fitness routines and advice on diet and healthy lifestyles. These centres will share a common objective to help people improve their health and wellbeing, both physically and mentally, with the support of their local health authority, of local GPs and other health providers. All of the funding has to be committed by 2002 for projects which can last up to 2007.

3.20 A further £116 million for England (£150 million UK) was made available from the New Opportunities Fund (NOF) in September 1999. In England £23 million is being used to fund palliative care for adults with cancer, and £93 million will be used to fund the purchase of cancer equipment such as linear accelerators and MRI scanners (see also paragraphs 5.43 and 5.48). The third tranche of money for the NOF was recently announced. This will make available £232.5 million in England (£300 million UK) to improve palliative care for children, and for adults with cancer and other life threatening diseases. The money will also be used to improve the prevention, detection, treatment and care of people with CHD and stroke, and cancer.

Personal Social Services (PSS) Expenditure

3.21 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 six, paragraphs 6.29 to 6.34, gives details on PSS revenue provision.

3.22 **Figure 3.13** shows total local authority current and capital expenditure on PSS. Between 1990-91 and 2000-01 local authority PSS net current expenditure has increased by 82 per cent in real terms. The large growth in 1993-94 reflects the Community Care Reforms.

Figure 3.13: Expenditure on Local Authority Personal Social Services

£ million

	1990-91 outturn	1995-96 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 budget	2000-01 budget
Current expenditure							
Gross[1]	4,698	8,393	9,263	9,984	10,847	–	–
Charges[1]	486	1,079	1,320	1,530	1,788	–	–
Net[2]							
Cash	4,213	7,314	7,943	8,454	9,059	10,050	10,254
Real terms[3]	5,622	8,316	8,750	9,057	9,435	10,226	10,254
Capital expenditure							
Gross	166	200	180	150	140	129	–
Income	34	40	44	43	53	46	–
Net	132	160	136	107	83	82	–
Total local authority expenditure							
Gross	4,864	8,593	9,443	10,134	10,987	–	–
Charges/income	520	1,119	1,364	1,573	1,841	–	–
Net	4,345	7,474	8,079	8,561	9,146	10,133	10,254

Source: RO and RA Las Returns

1 Gross expenditure and income from charges figures are not available for 1999-2000 and 2000-01.

2 The net figures quoted in this table for 1995-96 exclude capitalised redundancies, which are included in Figure 3.3.

3 At 2000-01 prices.

4. Investment

Policy context

4.1 Investment is key to the modernisation of the NHS. The aim is to transform the NHS so that it produces faster, fairer services that deliver better heath and tackle health inequalities. The *Departmental Investment Strategy*[4.1], which was published last year, sets out the capital investment plans for the next three years and beyond that are needed to deliver this transformation.

4.2 Capital investment is needed for the NHS to expand and modernise. The capacity of the NHS will be increased to improve access and treat more patients. Old and rundown equipment and buildings will be replaced or upgraded to make them suitable for providing modern health care. There will be a particular focus on the clinical priorities: coronary heart disease, cancer, services for older people, and mental health services.

4.3 To deliver this programme, NHS capital investment will rise to over £3.1 billion in 2001-02 including land sale receipts and investment generated through the Private Finance Initiative. Over the next three years capital resources are set to rise on average each year by over 8 per cent in real terms.

4.4 **Figure 4.1** summarises the Department's capital expenditure plans to 2003-04. **Figure 4.2** shows the disposition of 2001-02 capital resources. **Annex A6** provides information on the relationship between capital expenditure recorded in the accounts, Estimates and budgets.

Figure 4.1: NHS Capital Spending 2000-01 to 2003-04 (Resources)

£ million

	2000-2001 Forecast Outturn	2001-2002 Plan	2002-2003 Plan	2003-2004 Plan
Government Spending	1,381	1,981	2,287	2,467
Percentage Real Terms Growth		39.9	12.6	5.2
Receipts from Land Sales	579	351	270	270
Percentage Real Terms Growth		-40.9	-25.0	-2.4
PFI Investment	632	788	811	832
Percentage Real Terms Growth		21.6	0.4	0.1
Total	**2,592**	**3,120**	**3,368**	**3,569**
Percentage Real Terms Growth		17.4	5.3	3.4

Real Terms Growth calculated using 7th March 2001 GDP deflators.

Figure 4.2: Disposition of 2001-02 Capital Resources

£ million

Total Capital Investment		**3,120**
Less: PFI Investment		-788
Gross HCHS Capital		**2,332**
Less:		
Costs associated with the retained estate	20	
NHS Trust receipts	141	
Unallocated Provision[1]	260	
Transfer to revenue for Primary Care	54	
Other NHS Capital	32	-507
HCHS Capital available for allocation		**1,825**
To be allocated as follows:		
Central Budgets		**24**
Regional Offices:		
General Allocations	1,247	
Secure Hospitals - Fallon Enquiry	9	
Additional Medical Students	8	
Renal Services	9	
Pathology	8	
Cancer	53	
Coronary Heart Disease	80	
Waiting Lists - Action on Programmes	75	
Quality	8	
Mental Health	44	
Junior Doctor Working Hours	2	
Decontamination and Sterilisation facilities	100	
Cataract Treatment	8	
Investment in Primary Care	150	
Total to NHS Trusts/Health Authorities/ Primary Care Trusts		**1,801**

1 Element of NHS capital programme awaiting to be allocated. Includes 2001 Budget addition of £210 million.

Priorities for Capital Investment in 2001-02

4.5 In 2001-02 HCHS capital resources will be targeted at the following specific health areas:

- **Cancer Equipment** – this is in two parts, the second tranche of a £100 million programme of investment started last year to purchase state of the art equipment to diagnose and treat cancer more effectively, and a further amount is targeted at modernising and expanding the breast screening service to women aged 65-70.
- **Coronary Heart Disease (CHD)** – this will be used to purchase modern cardiac equipment to implement the standards set out in the *CHD National Service Framework* [4.2] and the NHS Plan.
- **Mental Health** – this is aimed primarily at implementing the recommendations of the *Tilt Report* [4.3]. It will enable improvements to the security at each of the three High Security Special Hospitals and will also facilitate high secure discharge from those hospitals to more appropriate settings. In addition, a programme of investment started last year to implement the findings of the Fallon Enquiry by increasing security at the three High Security Special Hospitals.
- **Reducing Waiting Lists and Times** – this is to support sustainable reductions in waiting lists and times through the development of the three new Action On Programmes: Action On Orthopaedics; Action On ENT; Action On Dermatology.
- **Decontamination and Sterilisation Facilities** – this is to fund the latest stage in the Department's strategy to minimise the threat from variant Creutzfeldt Jakob Disease (vCJD) by ensuring that surgical instruments are cleaned and sterilised to the highest standards possible.
- **Primary care** (from the Treasury Capital Modernisation Fund) – to be used for a range of initiatives, including: NHS Direct, investing in dentistry treatment, and improving premises.
- **Additional Medical Students** – this is to continue the programme of investment started last year to support the intake of additional medical students.
- **Renal Services** – this is aimed at bringing on stream new facilities for new and existing patients with end stage renal failure.
- **Pathology Modernisation** – this will complete the programme of investment started in 1999-2000 to support exemplar projects that take forward the modernisation of NHS pathology services.
- **Quality Initiatives** – this is in two parts. £6 million is to support the creation of on site nurseries for staff, and £2 million to fund the set up costs of the National Clinical Assessment Authority to support medical performance.
- **Junior Doctors Working Hours** – this will fund improvements to doctors' living and working conditions to bring accommodation and catering facilities up to the new standards recently agreed with the BMA. It will also enable NHS trusts to buy equipment which will help junior doctors reduce their working hours.

4.6 From within the £1,247 million general allocations available to Regional Offices in 2001-02 the following specific objectives will be addressed:

- Sustainable reductions in Waiting Lists and Times.
- Elimination of mixed sex accommodation to continue the programme started in 1999-2000.

  The Government is committed to achieving single sex accommodation. Preliminary analysis of monitoring returns from HAs show that we are on track to achieve single sex accommodation. We are working closely with trusts that are reporting difficulties to devise action plans that will help them comply with our aims by the target date.
- Compliance with fire safety and other statutory requirements.
- Compliance with Section 21 of the Disability Discrimination Act.

Maximisation of Block Capital

4.7 In addition to the above priorities, the Chancellor's Budget statement on 7th March included a £210 million investment in the NHS in 2001-2002. This will be targeted at improving hospital infrastructure and equipment, maternity unit modernisation to improve standards of care, and provision of childcare facilities to help recruit and retain nursing staff.

4.8 The use of block capital is again to be maximised in 2001-02 to bring about smaller scale improvements across the NHS rather than expenditure being focused on a few large projects. Regional Offices have been instructed to ensure that a minimum of 55 per cent of their capital resources are allocated as block. Other than in exceptional circumstances, individual NHS trusts will receive an increase in their block allocation.

Restrictions on Capital to Revenue Transfers

4.9 As in previous years, a limit has been set on capital to revenue transfers in 2001-02 to control the amount of capital that can be transferred to support revenue expenditure. This will ensure that capital resources are expended on capital investment as intended.

Three Year Regional Allocations

4.10 For the first time, Regional Offices have been given indicative capital allocations for each year of the current spending review. This will enable better planning of regional capital programmes by providing a level of planning certainty around availability of future resources.

Treasury Capital Modernisation Fund

4.11 There is £228 million available from the Treasury's Capital Modernisation Fund in 2001-02 to support innovative capital investment projects. The £228 million is to be used as follows:

Figure 4.3: Treasury Capital Modernisation Fund

	£ million 2001-02
Coronary Heart Disease	70
Cataract Treatment	8
Primary Care	150
Total	**228**

Public Private Partnerships

4.12 The Private Finance Initiative (PFI) is now firmly established as a key component of the Government's strategy to modernise the NHS. On current plans the PFI will provide nearly £800 million of capital investment in 2001-02.

4.13 The past year saw the first three of the 'first wave' of major PFI schemes finish construction and become operational (Carlisle, Dartford and Gravesham, South Buckinghamshire). Work on site has also started at 3 of the 4 major London PFI schemes, 2 of which reached financial close in 2000. In total 16 major PFI schemes are under construction, of which 5 are on schedule to become operational during 2001.

4.14 The PFI model is also successfully continuing to deliver a number of small and medium sized mental health and community schemes, for example schemes for new mental health facilities at Newham Community Health NHS Trust and Northern Birmingham Mental Health NHS Trust reached financial close in 2000. The mental health PFI schemes at Oxleas NHS Trust and Sussex Wealds and Down NHS Trust were the first to become operational and take patients during 2000. The £3.7 million community hospital scheme at Dawlish in Devon opened in July 2000. There are also a number of joint schemes between health and social services, including the £4 million health centre at Sedgley, West Midlands which will open next year.

4.15 The *NHS Plan*[4.4] commits the NHS to further expansion in new hospital building and an extended role for the PFI. Under the Plan over 100 new hospital schemes will be delivered between 2000 and 2010 and private sector investment under the PFI will rise to £7 billion over the same period. The 100 hospital schemes include the 34 major and 29 medium sized PFI hospital schemes already in procurement or completed and the schemes to be given the go-ahead from 2001 onwards, subject to each scheme demonstrating value for money.

4.16 To complement PFI, the NHS Plan commits the NHS to new forms of Public Private Partnerships (PPP) which will be one of the vehicles used to increase investment and resources in the health sector. The Capital and Capacity Taskforce, one of the 9 NHS Plan implementation teams, will oversee the initiatives in development. The initiatives include:

- the development of a new generation of **Diagnostic and Treatment Centres** to increase the number of elective operations which can be treated on a single day. These Centres will separate routine hospital surgery from hospital emergency work so they can concentrate on getting the waiting times down. The NHS in partnership with the private sector will develop 20 centres by 2004 of which 8 will be fully operational by this date;
- a number of PPP arrangements connected with the delivery of the **Information for Health** strategy. These include PFI or managed service type arrangements for electronic patient records and picture archiving systems. Private sector partners are also likely to be involved in the development of IT networks to link "hub centres" with smaller "spoke units" to share information and diagnoses;
- a joint venture between the Department of Health and Partnerships UK (PUK) – the NHS Local Improvement Finance Trust **(NHS LIFT)** – a new equity stake company is to be set up to modernise the primary healthcare infrastructure. This aim is to bring in £1 billion of new investment to this area over the next 3-4 years;
- investigating the scope for private sector involvement in support services to help increase the number of CT and MRI scanners, linear accelerators and dialysis stations.

Capital Prioritisation

4.17 All investment schemes with a capital value over £20 million are submitted to the Capital Prioritisation Advisory Group (CPAG) for consideration. The schemes are assessed by CPAG who report to Ministers. Schemes are then prioritised where health need is greatest and facilities poorest. A huge capital programme is currently underway in the NHS. To date, 68 major hospital developments worth over £7.5 billion have been given the go-ahead. Six of these developments are already completed and operational, and a further 19 are already under construction. **Figure 4.4** lists all major schemes given the go-ahead since May 1997.

Figure 4.4: Capital Value of Major Schemes given go-ahead since 1 May 1997

Scheme	£ million Capital Value
PFI completed and operational:	
Dartford & Gravesham NHS Trust	94
Carlisle Hospitals NHS Trust	65
South Buckinghamshire NHS Trust	45
Greenwich Healthcare NHS Trust	93
Total PFI Schemes completed and operational	**297**
PFI Schemes reached Financial Close with work started on site:	
Norfolk and Norwich NHS Trust	158
North Durham Health Care NHS Trust	61
Calderdale Healthcare NHS Trust	65
South Manchester University Hospitals NHS Trust	66
Bromley Healthcare NHS Trust	118
Barnet & Chase Farm Hospitals NHS Trust	54
Worcester Royal Infirmary NHS Trust	87
Hereford Hospitals NHS Trust	64
South Durham Healthcare NHS Trust	41
South Tees Acute Hospitals NHS Trust	122
Swindon & Marlborough NHS Trust	96
Kings Healthcare NHS Trust	64
Leeds Community NHS Trust	47
St George Hospital NHS TRUST	49
University College London Hospitals NHS Trust	404
Hull & East Yorkshire Hospitals NHS Trust	22
West Middlesex University Hospitals NHS Trust	60
Total PFI Schemes reached Financial Close with work started on site	**1,578**
Other Prioritised Schemes:	
Barts & The London NHS Trust	620
Central Manchester Healthcare/Manchester Children's Hospitals NHS Trusts	199
Dudley Group of Hospitals NHS Trust	68
West Berkshire Priority Care NHS Trust	30
Newcastle Upon Tyne Hospitals NHS Trust	124
Walsgrave Hospitals/Coventry Healthcare NHS Trusts	178
Leeds Teaching Hospitals NHS Trust	125
Oxford Radcliffe Hospitals NHS Trust	71
Havering Hospitals NHS Trust	148
Portsmouth Hospitals NHS Trust	75
Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust	61
Southern Derbyshire Acute Hospitals NHS Trust	177
Gloucestershire Royal NHS Trust	32
University Hospital Birmingham NHS Trusts	291
Bradford Hospitals NHS Trust	116
Avon & Western Wiltshire Mental Helath NHS Trust	68
North West London Hospitals NHS Trust	56
East Kent Hospitals NHS Trust	102
University Hospitals of Leicester NHS Trust	286
Lewisham Hospital NHS Trust	44
Peterborough Hospitals/North West Anglia Healthcare NHS Trusts	135
Salford Royal Hospitals/Salford Community Health Care NHS Trusts	114
Maidstone & Tunbridge Wells/Invicta Community Care NHS Trusts	175
Pinderfield & Pontefract Hospitals NHS Trusts	164
Forest Healthcare NHS Trust	184
Brighton Health Care NHS Trust	28
United Bristol Healthcare NHS Trust	104
Kings Mill Centre for Health Care Services NHS Trust	66
Barnet & Chase Farm Hospitals NHS Trust	41
Mid Essex Hospitals NHS Trust	80
Essex Rivers Healthcare NHS Trust	79
Hull & East Yorkshire Hospitals NHS Trust	39
North Middlesex Hospitals NHS Trust	73
North Staffordshire Hospital/North Staffordshire Combined Healthcare NHS Trusts	224
Other Prioritised Schemes (continued):	
Plymouth Hospitals NHS Trust	101
St Helens & Knowsley Hospitals NHS Trust	211
Walsall Hospitals/Walsall Community Health NHS Trusts	43
Royal Wolverhampton Hospitals NHS Trust	110
Paddington Basin	460
Oxford Radcliffe Hospitals NHS Trust	28
Southampton University Hospitals NHS Trust	52
South Devon Healthcare NHS Trust	65
Tameside & Glossop Acute Services NHS Trust	41
Total Other Prioritised PFI Schemes	**5,488**
Publicly Funded Schemes:	
Publicly Funded Schemes Completed and Operational:	
Rochdale Health Care NHS trust	24
Central Sheffield University Hospitals NHS Trust	24
Total Publicly Funded Schemes Completed and Operational	**48**
Publicly Funded Schemes with work started on site:	
Royal Berkshire & Battle Hospital NHS Trust	74
Guys and St. Thomas' NHS Trust	50
Total Publicly Funded schemes with work started on site	**124**
Total Major Investment Given The Go-Ahead	**7,535**

1 Figures may not sum due to rounding.

2. Capital value of PFI schemes is defined as: Total capital cost to the private sector including the cost of land, construction, equipment, and professional fees, but excludes VAT, rolled up interest and financing costs such as bank arrangement fees, band due diligence fees, banks' lawyers fees and third party equity costs.

3 AS PFI procures a service, capital values shown are necessarily estimates.

Asset Disposal

4.18 The *Sold on Health* report [4.5] was launched in May 2000 as part of HMT's Public Services Productivity Panel initiative. The recommendations in the report, produced by NHS Estates through an expert panel from both the public and private sectors, were based on a whole estate lifecycle review approach, including planning, procurement, operation and disposal. The recommendations are intended to increase efficiency within the processes, reduce waste and generate both savings and accelerated income for the NHS. A major programme of work is in hand implementing the recommendations, which include:

- A national framework and regional overviews for the procurement, operation and disposal of the NHS estate;
- A corporate approach to the disposal of surplus estate and the achievement of best value;
- A performance management framework and incentives for NHS Trusts to get the best out of their estate and invest resources where the need is greatest; and,
- A programme for better capital procurement including new partnering relationships with the private sector to structure the process and deliver better value for money.

An acceleration of the disposal of surplus land and buildings, reducing costs and releasing additional funds for the NHS.

Pooled Budget Arrangements

4.19 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. For social care, new investment has been primarily in revenue, which allows Local Authorities to commission, develop or purchase services, to launch joint funded partnerships and to develop innovation through the successful launch of the Private Finance Initiative in social care.

Invest to Save Budget

4.20 The Government has stated its intention to deliver public services in a more integrated and co-ordinated way, and the Invest to Save Budget will encourage public sector bodies to work more closely together to deliver services in a joined up, innovative, locally responsive and more efficient fashion.

4.21 By providing more assistance towards the cost of innovative projects, which may need upfront funding not otherwise available, the Invest to Save Budget will seek to realise the gains, which they can offer in terms of efficiency savings and/or benefits to the public. Invest to Save is a practical example of the Government's commitment to Modernise Government.

Round 1

4.22 In 1999 the Invest to Save Budget was introduced to encourage partnership and cross-boundary working by Government Departments. In Round 1 the Department of Health, working with the Home Office and the Department of the Environment, Transport and the Regions, secured additional resources of nearly £8 million over three years to pilot schemes to test the feasibility of joint control centres for ambulance, police, fire and coast guard services.

Round 2

4.23 In Round 2 the invitation to submit bids to the Invest to Save Budget was extended to local authorities and health authorities. The Department of Health submitted 33 project bids including those from health authorities and local authority social services departments.

4.24 Twenty of the projects sponsored by the Department of Health were successful and were awarded a total of nearly £7.8 million additional funding over three years. A high proportion of the successful projects seek to improve joint working and sharing of information between health services and local authority social service departments.

Round 3

4.25 Again in Round 3 invitations to submit bids were extended to local authorities and health authorities. Key criteria were for projects, which involved the electronic delivery of services, had a citizen focused approach or which tackled the root causes of social problems.

4.26 The Department of Health submitted 30 project bids of which 21 were successful. The successful projects are:

- Ashfield Primary Care Group – Information for Innovative Integrated Intermediate Care;
- Barking & Havering Health Authority – Electronic register of young people who self harm;
- Barnet Health Authority – Helping patients with the medical and social aspects causing and resulting from medical conditions;
- Brent & Harrow Health Authority – CIT on-line advice, information and communication service;
- Cambridgeshire Health Authority – Electronic network to provide help and advice for relatives of prisoners;
- Croydon Health Authority – co-ordination of the out of hours services across Croydon to extend the range and quality of services available;
- Department of Health – Development of tactile communication system for persons with combined auditory and visual deficit;
- Doncaster Health Authority – Primary Care as a community resource;
- Dudley Health Authority – Alcohol Arrest Referral Scheme;
- Kent Drug Action Team – One Stop Interactive Communications Pathway;
- Kingston & Richmond Health Authority – Across Boundaries Collaboration Project;
- North Nottinghamshire Health Authority – Development of multi-agency teams for children with disabilities and their families;
- North Primary Care Group – Demand Responsive Transport Services;
- Rotherham Health Authority - Using IT systems to develop services for older people in a variety of community settings;
- South Staffordshire Health Authority – Connecting with young people - reducing risks of unplanned teenage pregnancy;
- Southern Derbyshire Health Authority – Drug Market Response Group;
- Substance Misuse Advisory Service – Advisory service for commissioners and strategists involved in primary care based drug dependency treatment;
- Tees Health Authority – Shared Information system on substance misuse;
- Wakefield Health Authority – development of a "Wakefield" branded health internet portal. This portal would provide an easy access route into all relevant local health information and related on-line services as they become available;
- Wakefield Health Authority – I.T. system to support the operational delivery of the Immediate Support at Home Service; and,
- Wakefield Health Authority – Multidisciplinary electronic care planning to support effective mental health services.

5. The NHS Plan – a plan for investment, a plan for reform

Summary of NHS Plan

What is the NHS Plan?

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

5.2 It was prepared through an inclusive process, which included the largest consultation exercise ever undertaken within the health service.

5.3 The NHS Plan sets out how an NHS fit for the 21st century will be delivered – delivering better health, and faster, fairer services. It provides a unique opportunity for patients, staff, professions and Government to modernise the NHS and reinvent it for the new century.

5.4 The NHS Plan tackles the systemic weaknesses, which have held back the health service and those working in it by setting out a programme for a new relationship between the patient and health service – a National Health Service shaped from the patient's point of view.

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

What does the Plan aim to achieve?

5.6 The NHS Plan sets out a programme of change, underpinned by ten core principles, which aims 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.

5.7 More money will fund extra investment in NHS facilities, for instance:

- 7,000 extra beds in hospitals and intermediate care;
- over 100 new hospitals by 2010 and 500 new one-stop primary care centres;
- over 3,000 GP premises modernised and 250 new scanners;
- clean wards – overseen by 'modern matrons' – and better hospital food; and,
- modern IT systems in every hospital and GP surgery.

5.8 It will also fund extra investment in staff, for instance:

- 7,500 more consultants and at least 2,000 more GPs;
- 20,000 extra nurses and 6,500 extra therapists; and,
- 40 per cent more medical school places and childcare support for NHS staff with 100 on-site nurseries.

5.9 However, this investment has to be accompanied by reform. The NHS is being redesigned around the needs of the patient.

5.10 A new system of earned autonomy will devolve power from the Government to the local health service as modernisation takes hold.

5.11 The Department of Health will set national standards, matched by regular inspection of all local health bodies by an independent inspectorate, the Commission for Health Improvement.

5.12 The National Institute for Clinical Excellence (NICE) will help ensure that cost effective drugs like those for cancer are not dependent on area of residence. A Modernisation Agency is being set up to spread best practice.

5.13 Local NHS organisations that perform well for patients will get more freedom to run their own affairs. There will also be a £500 million performance fund. However, the Government will intervene more rapidly in those parts of the NHS that fail their patients.

5.14 For the first time social services and the NHS will come together with new agreements to pool resources. There will be new Care Trusts to commission health and social care in a single organisation. This will help prevent patients – particularly old people – falling in the cracks between the two services or being left in hospital when they could be safely in their own home.

5.15 For the first time there will be modern contracts for both GPs and hospital doctors. NHS doctors work hard for the NHS, but the contracts under which they work are outdated. There will be a big extension of quality-based contracts for GPs in general, and for single-handed practices in particular. The number of consultants entitled to additional discretionary payments will rise from half to two-thirds to match their contribution to the NHS. Newly qualified consultants will not be able to do private work for perhaps seven years, in return for access to higher pay.

5.16 For the first time nurses and other staff, not just in some places but everywhere, will have greater opportunity to extend their roles. By 2004 over half of them will be able to supply medicines. £280 million is being set aside over the next three years to develop the skills of staff. All support staff will have an Individual Learning Account worth up to £300 per year. The number of

nurse consultants will increase to 1,000 and a new role of consultant therapist will be introduced. A new Leadership Centre will be set up to develop a new generation of managerial and clinical leaders, including modern matrons with authority to get the basics right on the ward.

5.17 For the first time patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works:

- letters about an individual patient's care will be copied to the patient;
- patients' views on local health services will help decide how much cash they get;
- patient advocates will be set up in every hospital;
- if operations are cancelled on the day they are due to take place the patient will be able to choose another date within 28 days or the hospital will pay for it to be carried out at another hospital of the patient's choosing; and,
- patients' surveys and forums to help services become more patient-centred.

5.18 For the first time there will be a concordat with private providers of healthcare to enable the NHS to make better use of facilities in private hospitals – where this provides value for money and maintains standards of patient care. NHS care will remain free at the point of delivery – whoever provides it.

5.19 Patients will see waiting times for treatment cut as extra staff are recruited:

- by 2004 patients will be able to have a GP appointment within 48 hours and there will be up to 1,000 specialist GPs taking referrals from fellow GPs;
- long waits in accident and emergency departments will be ended; and,
- by the end of 2005 the maximum waiting time for an outpatient appointment will be three months and for inpatients, six months.

5.20 The treatment of cancer, heart disease and mental health services – the conditions that kill and affect most people will improve with:

- a big expansion in cancer screening programmes;
- an end to the postcode lottery in the prescribing of cancer drugs;
- rapid access chest pain clinics across the country by 2003;
- shorter waits for heart operations; and,
- hundreds of mental health teams to provide an immediate response to crises.

5.21 Older people use the NHS more than any other group. This Plan will provide them with both better and new services:

- nursing care in nursing homes will be free;
- by 2004 a £900 million package of new intermediate care services to allow older people to live more independent lives;
- national standards for caring for older people to ensure that ageism is not tolerated;
- breast screening to cover all women aged 65 to 70 years; and,
- personal care plans for elderly people and their carers.

5.22 The NHS Plan will bring health improvements across the board for patients but for the first time there will also be a national inequalities target. To help achieve this we will:

- increase and improve primary care in deprived areas;
- introduce screening programmes for women and children;
- step up smoking cessation services; and,
- improve the diet of young children by making fruit freely available in schools for 4-6 year olds.

Implementation of the NHS Plan

5.23 The implementation of the NHS Plan has been underway for some months now and, whilst this Plan is unashamedly long-term, a number of key achievements have already been delivered.

How is the Department of Health taking forward the process of implementation?

5.24 The Modernisation Board, chaired by the Secretary of State, has now met three times and will continue to meet on a quarterly basis. The main purpose of the Board is to oversee the process of the implementation.

5.25 Taskforces have been set up to drive forward the implementation of the NHS Plan across the areas of coronary heart disease, cancer, mental health, older people, children, inequalities and public health, workforce, capital and capacity, quality and improving access. Each taskforce has developed detailed workplans based upon deliverables within the Plan (details in paragraph 5.55).

5.26 In December 2000 the *NHS Plan Implementation Programme* [5.2] was published. This set out the priorities for expansion and reform in 2001-02 and the framework for implementation. It was followed by detailed guidance on the *Service and Financial Frameworks* [5.3], which capture agreed action, investment and activity contributing to NHS Plan targets. This effectively ensures that delivery of the NHS Plan becomes mainstream business for health and social services.

Actions achieved to date

5.27 The response to the NHS Plan within the service has been enthusiastic. Staff have responded well to the challenge.

5.28 With the additional facilitation of the regional offices a number of key achievements have already been delivered. These include:

- £31 million allocated to improving hospital cleanliness announced on 31 July 2000;
- 10 new Fast Track teams to provide rapid response for heart attack patients were announced on 15 August 2000;

- the first comprehensive NHS Cancer Plan was launched on 27 September 2000;
- new arrangements to allocate over £40 million to reward the hardest working consultants were announced on 18 October 2000;
- three year financial allocations were made to health authorities on 14 November 2000;
- expansion in the number of Personal Medical Services (PMS) pilots was announced on 7 December 2000; and,
- £100 million worth of investment in new equipment and services to combat stomach cancer and heart disease.

A Strategy for NHS Dentistry

5.29 The NHS Plan reiterated the Government's commitment to ensuring that by September 2001 everyone who needs NHS dentistry will be a phone call away from finding it. In September 2000 the Department published *Modernising NHS Dentistry: Implementing the NHS Plan*[5.4], with proposals for up to £100 million expenditure across 2000-01 and 2001-02 on improving oral health and the quality of dental treatment as well as widening the availability of NHS dental care.

5.30 In 2000-01 the Department made the £4 million Dental Care Development Fund available to health authorities so they could help local dentists expand their practices and treat more NHS patients. It also implemented a new scheme, worth £20 million a year, rewarding dentists' commitment to the NHS. By March 2001 the Department had established about 40 main dental access centres providing NHS treatment to patients unable to register with a dentist, and more centres will open later in the year. In 2001-02, as well as continuing to reward commitment, the Department will make available up to £35 million for the modernisation of dental practices and up to £6 million for a second Dental Care Development Fund.

The NHS Cancer Plan

5.31 The *NHS Cancer Plan*[5.5] was published on 27 September. It provides a comprehensive framework for the development of cancer services over the next five to eight years. The main aims of the Cancer Plan are:

- to save lives;
- to ensure people with cancer get the right professional support and care as well as the best treatments;
- to tackle the inequalities in health that mean unskilled workers are twice as likely as professionals to die from cancer; and,
- to build for the future through investment in the cancer workforce, through strong research and through preparation for the genetics revolution, so that the NHS never falls behind in cancer care again.

5.32 Money has already been identified to allow implementation of the Plan, and by 2003-04 an additional £570 million will be invested in cancer care.

Prevention

5.33 A target has been set to reduce smoking among manual groups from 32 per cent in 1998 to 26 per cent by 2010 to narrow the health gap between manual and non-manual groups.

Local targets will be introduced to cut smoking rates in the 20 health authorities with the highest smoking rates.

5.34 Diet plays an important part in cancer prevention. The Government, working with the food industry will develop a national five-a-day programme to increase fruit and vegetable consumption. Pilots for a national school fruit scheme for children aged four to six have now begun.

Screening and early detection

5.35 The breast screening programme will be extended to cover women aged 65-70. Two-view mammography will be introduced at every screen. Screening for women over 70 will be available on request. These changes will be phased in and will be in place for everyone by 2004.

5.36 New screening technologies are to be introduced to the cervical screening programme.

5.37 Other screening programmes will be introduced if and when they are proven to be effective. Pilot studies are already underway for colorectal screening. Other possibilities for future screening programmes are prostate, lung and ovarian cancers.

5.38 £2.5 million is to be used to provide endoscopy training for GPs, nurses, surgeons and gastro-enterologists. Endoscopy is a key diagnostic procedure for bowel cancers.

Treatment

5.39 New and challenging cancer waiting times targets have been set out. These will be achieved over a period of time. Achieving these targets will depend on continued NHS reform, and the recruitment of the necessary staff.

5.40 Funding rising to £15 million will support the extension of Cancer Services Collaboratives. The nine existing collaboratives have been successful in streamlining care, and reducing delays for patients at all stages of diagnosis and treatment. The Cancer Services Collaborative programme will be in place across the country 2003-04.

5.41 Together with Macmillan Cancer Relief, £3 million will be invested to appoint a lead clinician for cancer to every Primary Care Group. The benefits to both patients and the primary care team are already proven.

Palliative Care

5.42 By 2004 NHS funding for specialist palliative care will have increased by £50 million. For the first time NHS investment in palliative care will match that of the voluntary sector.

5.43 The New Opportunities Fund have also committed £23.25 million for a palliative care programme, *Living with Cancer*. Initiatives will specifically be targeted at ethnic minority and socially deprived groups.

5.44 Working with Macmillan Cancer Relief and Marie Curie Cancer Care and other key stakeholders, £2 million will be spent on providing additional training for district and community based nurses on the principles and practice of palliative care provision.

Staffing

5.45 By 2006 there will be nearly 1,000 extra cancer specialists – an increase of nearly one third and by 2004 there will be an additional 20,000 nurses.

5.46 Cancer services are also leading the way in developing new roles for staff. Traditional boundaries are being broken down (particularly in pilot sites for diagnostic and therapeutic radiography) and staff are being trained and supported to take on additional responsibilities – allowing doctors to concentrate on treating more patients.

Equipment

5.47 Over the next three years there will be a further 50 MRI scanners, 150 replacement and 50 additional CT scanners, 45 linear accelerators, modern treatment planning computers and simulation equipment, all used to diagnose and treat cancer. 23 pathology services will also be modernised at a cost of £15 million.

5.48 £93 million from the New Opportunities Fund is being used to buy over 300 pieces of cancer equipment, which includes equipment for the breast screening programme, 56 linear accelerators and 33 MRI scanners.

The National Beds Inquiry

5.49 The National Beds Inquiry, *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services*[5.6], issued for consultation on 10 February 2000, found evidence of significant inappropriate or avoidable use of acute hospital beds. It identified huge variations between health authorities in the use of acute hospital beds. In many cases these variations corresponded to variations in levels of use of non-hospital services. The Report set out three possible future scenarios as a way of focusing debate. Responses to the consultation (a summary is available at: *www.doh.gov.uk/nbi*) endorsed the NBI's broad findings.

5.50 The consultation, which closed on 15 May 2000, met with general agreement to the NBI finding that the long term trend in reductions in general and acute beds is not compatible with the requirement to improve access to care and cannot be sustained. A consistent message has been that there should not be further disinvestment from acute services until such time that the investment in 'care closer to home' had been made and that services had developed to the appropriate level and had been shown to be effective.

5.51 Planning guidance was issued to the NHS and councils on 15 February 2001 (*Implementing the NHS Plan: Developing services following the National Beds Inquiry* HSC 2001/003: LAC (2001)4). The guidance requires each health authority, in partnership with councils and other partners in the local health and social care economy, to:

- examine the information about their current pattern of use of services, relative to other areas, as evidenced by the Local Variation Analysis conducted as part of the NBI which had recently been updated;
- consider what changes will be needed to make their contribution to the NHS Plan's objectives for 7,000 additional beds by 2004; and,
- feed this analysis into their local performance and modernisation audit and submit their proposals, signed off by all partners, to the appropriate NHS and Social Care Regional Offices, indicating what proposals are intended to be included in the 2001-02 Health Improvement Programme (HImP).

5.52 To assist in this process, the Department prepared a model to help local health and social care economies to produce estimates of their future requirements for general and acute services and beds, and for community and intermediate care facilities in 2003-04, in line with the targets in the NHS Plan. All health authorities, in partnership, were required to use this model in the analysis and development of proposals. The model, together with a user guide and the population estimates for 1998 and projections for 2003 and the full updated Local Variations Analysis data which are required to use it, has been made available to the NHS. The model will be updated in the summer to incorporate 1999-2000 data and information about residential and nursing home beds.

The Next Steps

5.53 The Modernisation Board together with the taskforces will continue to oversee and drive forward the process of implementation. The Department is currently in the process of developing appropriate means of monitoring implementation.

5.54 The Department will continue to ensure that implementation is driven forward as part of an inclusive process of partnership working and that the patient remains at the heart of everything that is done.

The Taskforces and their Objectives

5.55 Detailed workplans, which will be monitored routinely, are now in place for each taskforce. The taskforces and their high level objectives are shown below:

Access

- improve access to care in line with patients' need;
- improve access to GPs and primary care teams;
- extend the range of specialist services in primary care;
- extend the role of NHS Direct;
- improve access to NHS Dentistry;
- make it easier for patients to obtain the right medicines;
- introduce booking systems;
- cut maximum waiting times for inpatient and outpatient treatment;

- reduce the number of cancelled operations; and,
- reduce time emergency patients spend in A&E and eliminate unnecessary trolley waits.

Cancer

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

- improve prevention;
- improve screening;
- develop primary care;
- cut waiting for diagnosis and treatment;
- improve treatment;
- improve care;
- invest in staff;
- invest in equipment and facilities;
- improve information;
- invest in research; and,
- improve the implementation systems.

Capital and Capacity

Increase and improve capital and capacity within the system, including IT infrastructure.

- put in place further major expansion of hospital building;
- modernise and develop the estate;
- invest in modern primary care premises;
- invest in new equipment for cancer, CHD and renal dialysis;
- develop extra capacity and use investment to reshape service;
- invest in up-to-date information systems; and,
- develop a capital strategy for the NHS.

Coronary Heart Disease

Improve care of patients with CHD and reduce mortality and morbidity of CHD.

- improve prevention;
- change clinical practices;
- improve management of CHD in primary care;
- expand revascularisation capacity and improve access;
- modernise service delivery;
- develop the workforce;
- improve information; and,
- develop communications.

Children

Improve children's health and social care services.

- improve children's health services and address health inequalities;
- maximise NHS and Social Care input to cross-government programmes for children;
- develop child and adolescent mental health services. Implement *'Quality Protects'*[5.7];
- improve safeguards for children;
- improve adoption services; and,
- improve services for disabled children.

Mental Health

Improve care of patients with mental illness and reduce mortality and morbidity from mental illness.

- improve mental health promotion;
- improve mental health in primary care and access to services;
- develop specialist services for people with severe mental illness;
- implement *'Caring for Carers'*[5.8];
- reform mental health legislation;
- improve services for people with severe personality disorder;
- develop the workforce;
- improve research and development; and,
- improve performance management/implementation systems.

Quality

Improve the quality of clinical care and ensure a more patient focused service.

- improve patient and public representation;
- improve clinical quality across primary and secondary care;
- ensure a better quality environment; and,
- provide more and better information for patients.

Older People

Improve the care provided to older people.

- assure standards of care;
- extend access to services;
- ensure fairer funding;
- promote independence;
- help older people to stay healthy; and,
- develop links between health and social services.

Public Health & Reducing Inequality

Improve public health services and reduce level of inequalities in health status.

- set targets to steer national effort in tackling health inequalities;
- improve NHS access for all by placing health inequalities in the mainstream of the service;
- address root causes of inequalities by fostering new partnerships across government;
- reduce levels of obesity and increase physical activity;
- make occupational health services widely available through NHSPlus;
- increase smoking cessation facilities, especially for manual groups;
- reduce illicit drug misuse among young people, targeting high risk groups;
- increase uptake of fruit and vegetables to improve diet and nutrition;
- reduce conception rates among under 18s and reduce risk of social exclusion; and,
- widen access to screening.

Workforce

Increase numbers of staff within the service and implement skills mix changes.

- increase staff numbers;
- improve working lives;
- modernise pay, contracts and pay-related incentives;
- modernise education, training and development;
- implement new ways of working; and,
- modernise workforce planning.

Performance Working Group

Advise on the design and implementation of a system and approach to performance management that enables the NHS to deliver the NHS Plan locally and to learn how to continually improve. Provide practical advice on:

- development of planning for continuous performance improvement in the NHS and at the interface with Social Care;
- implementation of Traffic Lighting NHS organisations;
- development of the concept of Earned Autonomy;
- the operation of the National Performance Fund and incentives;
- support and intervention in failing organisations; and,
- support excellent organisations to spread good practice.

6. Breakdown of spending programme

Health and Community Health Services

HCHS Resources by Sector

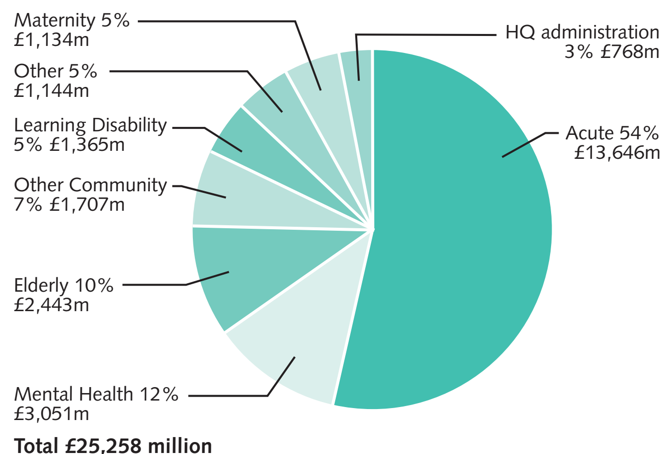
6.1 **Figure 6.1** shows the breakdown by service sector of health authority gross current expenditure on the Hospital and Community Health Services (HCHS) in 1998-99, the latest year for which disaggregated data are available. (The figure includes capital charges, but does not include spending on General Medical Services (GMS) discretionary and other related services.) For this reason the total differs from the figure shown in **Figure 3.5.**

6.2 The proportion of HCHS expenditure by programme of care is as follows:

- acute services 54 per cent;
- mental health 12 per cent;
- services intended primarily for the elderly 10 per cent;
- learning disabilities 5 per cent;
- maternity 5 per cent; and,
- other services 14 per cent.

6.3 The proportion of community health services has continued to increase, rising to approximately 16 per cent in 1998-99. This has risen from about 13 per cent in 1988-89 and reflects the changing patterns in care.

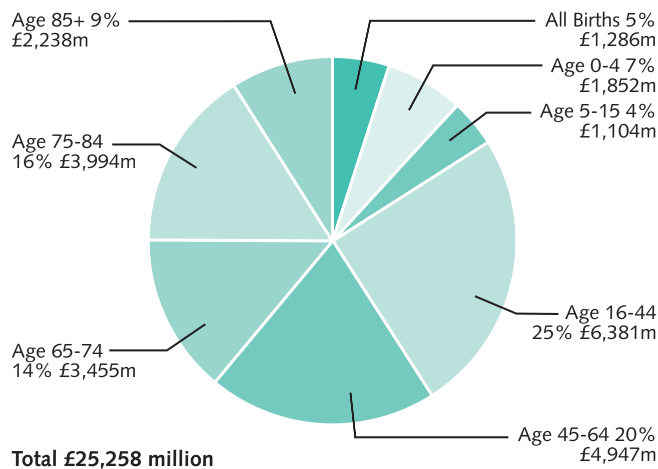
Figure 6.1 Hospital and Community Health Services gross current expenditure by sector, 1998-99



HCHS Current Resources by Age Group

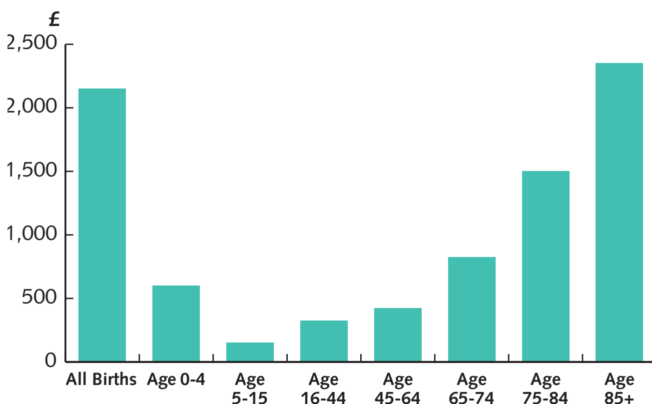
6.4 **Figure 6.2** shows that in 1998-99 people aged 65 and over accounted for approximately 39 per cent of total expenditure, a group however that make up approximately 16 per cent of the population. This is mainly because approximately 42 per cent of acute expenditure and significant proportions of 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, 1998-99



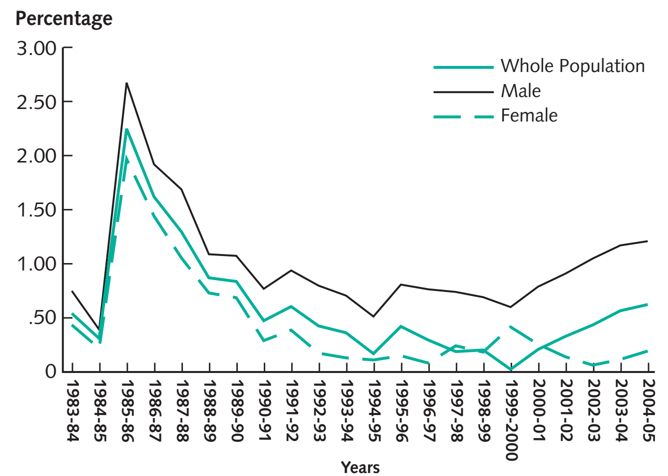
6.5 **Figure 6.3** shows the estimated expenditure in 1998-99 on HCHS for each age group, expressed as a cost per head of the population. High costs are associated with each birth, but cost per head then falls steeply, remaining low through young and middle age groups, before rising sharply from age 65. This reflects the greater use of health services by older people.

Figure 6.3: Hospital and Community Health Services Gross Current Expenditure Per Head of Population, 1998-99



6.6 The changing demographic make up of the population affects the demand for NHS care. **Figure 6.4** shows that demographic pressures averaged 0.4 per cent per year over the 10 year period to 1998-99. Over the next 10 years, to 2008-09, the expected effect averages 0.5 per cent per year.

Figure 6.4: Estimated Growth in HCHS Expenditure required due to whole population, male and female demographic changes: Year on year percentage increases



Allocation of HCHS Resources

6.7 Revenue allocations to health authorities for 2001-02 were announced in November 2000. A further allocation of £140 million was announced in February 2001. More details of the allocations can be found in *2001-02 Health Authority Revenue Resource Limits Exposition Book*[6.1].

6.8 The sum available for HCFHS current for 2001-02 is £41,615 million.

6.9 **Figure 6.5** summarises the way in which national HCFHS revenue translates into health authority allocations.

Figure 6.5: Distribution of Revenue Resources, 2001-02

	2001-02 £ million	Percentage increase over previous year
HCFHS current	**41,615**	**9.4**
Capital charges and other funding adjustments	1,492	
Total available	**43,107**	
Deployed as:		
CFISSA [1]	**5,890**	
Total for Health Authorities	**37,217**	**8.9**

1 Centrally Funded Initiatives and Services and Special Allocations.

Centrally Funded Initiatives and Services and Special Allocations (CFISSA)

6.10 The CFISSA programme provides central funding to implement the NHS Plan and other initiatives. It includes funding for:

- clinical priorities;
- education and training for doctors, dentists and nurses;
- research and development;
- primary care;
- improving health; and,
- tackling waiting.

6.11 **Figure 6.6** provides details of the CFISSA programme for 2001-02.

Figure 6.6: Centrally Funded Initiatives and Services and Special Allocations (CFISSA), 2001-02

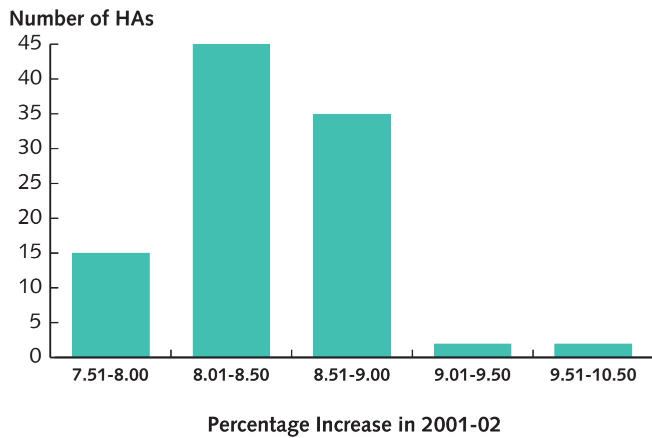
Budget type	Budgets	Amounts (£000s)
Funding to Implement the NHS Plan:	Educating & Training	2,502,730
	R&D	478,551
	Primary Care	234,506
	Improving Health	205,500
	HR and Quality	243,497
	Tackling Waiting	124,921
	Clinical Priorities (includes funding for cancer, coronary heart disease, mental health and critical care)	261,994
	IM&T	141,377
	Drugs misuse	101,152
	Older People	6,300
	Hospital Food	10,000
	Screening	6,260
	Performance Fund	60,000
Sub Total		**4,376,788**
CFISSA budgets issued with HA Allocations:	Includes funding for Health Action Zones, Dreadnought Unit and Teratology	53,435
Sub Total		**53,435**
Statutory Bodies and Budgets funding contracts:	Mental Health Act Commission	3,275
	Mental Health Review Tribunals	11,680
	National Blood Authority	19,250
	Prescription Pricing Authority	54,847
	UK Transplant Service Authority	4,293
	Community Health Councils	23,324
	Medical Practices Committee	477
	MDA Evaluation Programme	2,400
	Dental Practice Boards	21,358
	Health Outcomes	1,650
	High Security Infectious Disease Units	454
	London	86,910
	NICE	12,457
Sub Total		**242,375**
Other Central Budgets:	Includes funding for HIV/AIDS Treatment & Care and HIV/AIDS Prevention	1,217,066
Sub Total		**1,217,066**
GRAND TOTAL		**5,889,664**

Unified allocations

6.12 £37,217 million was distributed to health authorities as unified allocations. The range of health authority percentage increases was from 10.55 per cent to 8.25 per cent, with an average of 8.9 per cent.

6.13 **Figure 6.7** shows the distribution of increases by health authority.

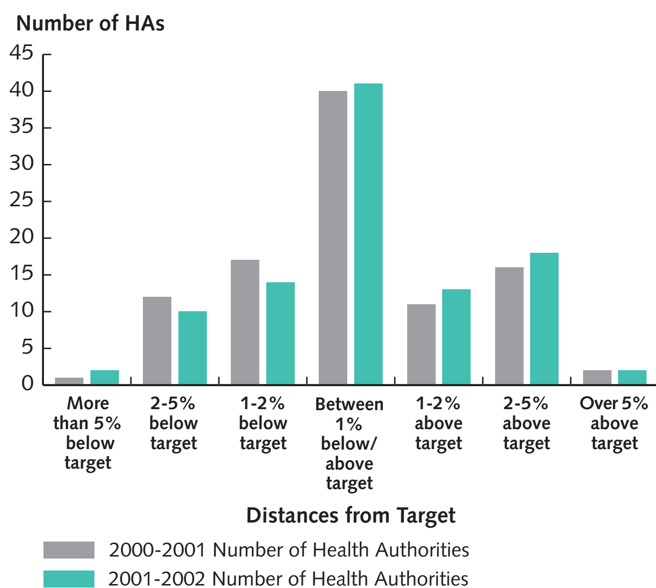
Figure 6.7: Unified Allocations - Distribution of Increases, 2001-02



6.14 **Figure 6.8** shows health authorities':

- 2000-01 distances from unified target
- 2001-02 distances from unified target

Figure 6.8: Health Authorities' Distance from Unified Target (DFT), 2000-01 and 2001-02



Review of resource allocation

6.15 A wide ranging review of the weighted capitation formula is currently taking place. The aim is to produce a fairer means of allocating resources. A key criterion of the new formula will be to contribute to the reduction of avoidable health inequalities.

6.16 The review of the formula is being carried out under the auspices of the Advisory Committee on Resource Allocation (ACRA) which has National Health Service management, GP and academic members.

6.17 We are adopting an incremental approach. ACRA will be making regular reports as the review proceeds. We will move towards fairer resource allocation as improvements become possible.

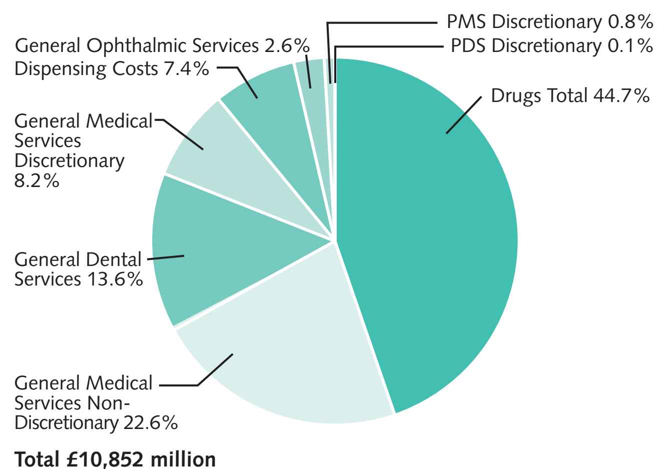
6.18 As a first step, for 2001-02 ACRA have recommended that an interim health inequalities adjustment be introduced. This recommendation was accepted and £130 million for this adjustment has been shared between 53 health authorities.

Family Health Services

Family Health and Personal Medical and Dental Services Resources

6.19 **Figure 6.9** shows the distribution of gross expenditure on FHS of £10,852 million in 1999-2000 among the constituent Family Health Services.

Figure 6.9: Family Health and Personal Medical and Dental Services gross expenditure, 1999-2000



Drugs Bill

6.20 The drugs bill is the cash amount paid to contractors (mainly pharmacists) for drugs, medicines and certain listed appliances which have been prescribed by GPs, less Pharmaceutical Price Regulation Scheme (PPRS) receipts. The 1999-2000 FHS drugs bill outturn was £4,833 million in cash terms, this represents an 11.4 per cent increase on the previous year, mainly due to a sharp rise in the cost of generic drugs in 1999-2000. This was much higher than the average increase of 8.4 per cent over the previous five years.

6.21 Important factors in the 2000-01 bill include:

- Action has been taken to stabilise the generics market after a turbulent year in 1999-2000. It is estimated that the savings in 2000-01 from price reductions in generics ahead of and in response to the statutory Maximum Price Scheme (MPS) put in place in August 2000 will be around £240-£250 million;
- the PPRS price-cut came into effect on 1 October 1999. 2000-01 will be the first full year of savings.

6.22 **Figure 6.10** illustrates the cash increase in the FHS drugs bill, 1990-91 to 1999-2000. **Figure 6.11** shows the percentage growth in the FHS drugs bill 1990-91 to 1999-2000.

Figure 6.10: Family Health Services Drugs Bill (Cash), 1990-91 to 1999-2000

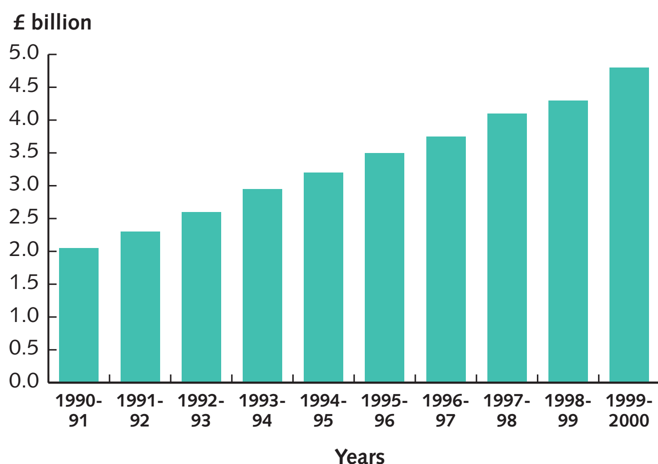
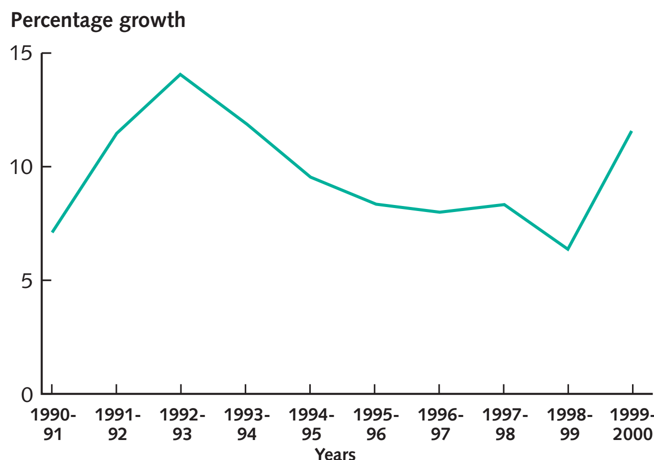


Figure 6.11: Family Health Services Drugs Bill – Percentage Growth (Cash), 1990-91 to 1999-2000



Breakdown of spending programme

FHS Gross Expenditure

6.23 **Figure 6.12** shows the gross expenditure by service, the real terms increase and the growth of discretionary and non-discretionary expenditure. (Discretionary and non-discretionary expenditure were previously referred to as cash limited and non-cash limited.)

Figure 6.12: Family Health Services Gross Expenditure, 1990-91 to 1999-2000

	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	£ million % real terms growth 1990-91 to 1999-2000
Drugs Total[2]	**2,091**	**2,335**	**2,651**	**2,980**	**3,252**	**3,506**	**3,808**	**4,107**	**4,356**	**4,852**	**76.9%**
GMS Non-Discretionary	1,484	1,656	1,768	1,840	1,902	1,965	2,073	2,198	2,243	2,451	**25.9%**
GMS Discretionary	464	600	686	715	723	754	800	835	878	885	**45.4%**
Total GMS	**1,948**	**2,256**	**2,454**	**2,555**	**2,625**	**2,719**	**2,873**	**3,033**	**3,121**	**3,336**	**30.6%**
PMS (discretionary)[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	37	84	
GDS[3]	1,041	1,248	1,308	1,223	1,281	1,292	1,325	1,349	1,439	1,479	**8.3%**
PDS (discretionary)[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	12	
Dispensing Costs	561	603	658	677	679	706	746	768	781	808	**9.9%**
GOS[4]	111	141	172	192	213	223	237	241	240	281	**93.1%**
Total	**5,752**	**6,583**	**7,243**	**7,627**	**8,050**	**8,446**	**8,989**	**9,498**	**9,978**	**10,852**	**43.8%**

1 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 and therefore do not include the full year cash value of any related capital investment by NHS trusts.
2 Since 1999-2000 the drugs budget has been part of the unified allocation. Before this point the budget was separated into Discretionary and Non-Discretionary. The breakdown of these can be seen on Departmental Reports issued before April 2001.
3 The GDS figures have been adjusted from previous reports to include the cost of refunds to patients who incorrectly paid dental charges
4 Expenditure on GOS increased in 1999-2000 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.
5 1999-2000 allocation for cash limited GMS/drugs are now part of unified allocations and excluded from this table.
6 Cash figures drawn from relevant Appropriation Accounts apart from PMS and PDS data which is drawn from HAs' I&E accounts.

6.24 With the move to unified allocations, all drugs expenditure is now within health authority cash limits.

Central Health and Miscellaneous Services

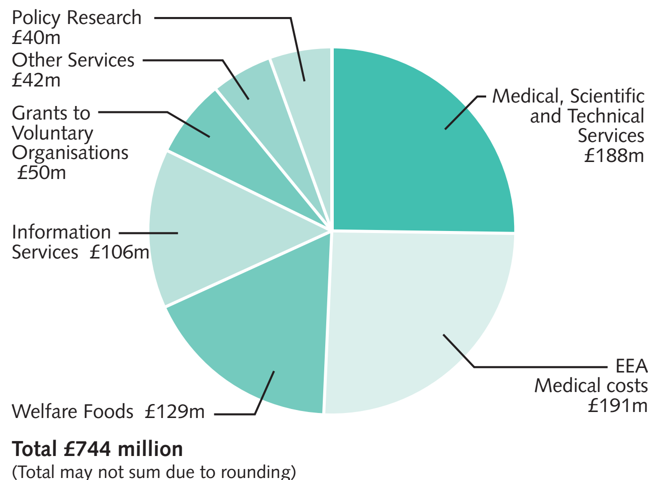
Central Health and Miscellaneous Services Resources

6.25 The Central Health and Miscellaneous Services budget includes:

- the Welfare Food Scheme;
- EEA medical costs for treatment given to United Kingdom nationals by other member states. This continues to grow as a result of increases in the number of people treated and the treatment costs in member states;
- expenditure on medical, scientific and technical services, virtually all of which is for the Public Health Laboratory Service Board, the National Biological Standards Board, the Microbiological Research Authority and the National Radiological Protection Board; **(See also Annex C)**
- grants to voluntary organisations, mainly at a national level, across the spectrum of health and social services activity.

6.26 **Figure 6.13** provides details of gross expenditure on Central Health and Miscellaneous Services for 2001-02.

Figure 6.13: Central Health and Miscellaneous Services Gross Expenditure, 2001-02 (Main Estimate)



Total £744 million
(Total may not sum due to rounding)

Personal Social Services

Personal Social Services Revenue Provision

6.27 In 2001-02 £9,848 million will be available for social services, 6.2 per cent more than in the current financial year. The vast majority of these resources will be distributed to authorities through the standard spending assessments, while the remainder will be distributed through specific and special grants. **Figure 6.14** below sets out the revenue resources available for social services in 2001-02.

Figure 6.14: Personal Social Services Revenue Provision 2001-02

	£ million
Total PSS Provision	**9,848.5**
of which:	
Standard Spending Assessments	8,955.4
Special Grants, Total	**672.8**
of which:	
Promoting Independence Grant	296.0
Children's Services Grant	291.8
Carers' Grant	70.0
Placing More Charges on Homes Grant	15.0
Specific Grants, Total	**220.3**
of which:	
Mental Health Grant	147.4
Training Support Programme	47.5
AIDS Support Grant	16.5
Drug and Alcohol Misusers' Grant	8.9

Personal Social Services Capital Resources

6.28 The Government provides capital resources for personal social services by means of credit approvals (permission to borrow) and a specific grant for secure accommodation for young people. Credit approvals may be either used for any local authority service (Basic Credit Approvals – BCAs), or are targeted on particular services or projects (Supplementary Credit Approvals – SCAs).

6.29 Local authorities may also use revenue and certain receipts from the sale of capital assets on capital projects. Capital receipts can be spent on any local priority, including personal social services.

6.30 For 2001-02 the BCAs for personal social services will be £37 million. Annual Capital Guidelines (ACGs) of £44 million will be distributed to local authorities for personal social services (ACGs comprise BCAs plus receipts taken into account). SCAs will be available for services for mentally ill people (£15.6 million) and for people with AIDS/HIV (£3.1 million). A £6.2 million capital grant will be available for the provision of additional secure accommodation for children. There is a new capital grant of £3 million this year and a further £25 million in each of 2002-03 and 2003-04 to help local councils to improve their information management. The initial £3 million is to be used to set up a small number of demonstration projects to tackle some of the key issues arising from *Information for Social Care*[6.2].

How the Resources are Used

6.31 Apart from the element funded by specific and special grants, local authorities are free to choose how much to spend on social services, what services they provide, and how to allocate resources between services. The figures below show the actual expenditure by local authorities on personal social services in 1998-99. **Figure 6.15** shows gross expenditure by client group in 1998-99. **Figure 6.16** displays the breakdown by type of provision.

6.32 In 1998-99, gross expenditure in England on personal social services was just under £11 billion. Local authorities' expenditure on services for older people and children accounted for nearly three-quarters of this spend. The largest items of expenditure were for residential care (48 per cent) and day care (36 per cent). Within spending on residential care, most was spent on residential and nursing home care provided by the independent sector. Just under half of all expenditure on day care services involved spending on home care and day centres.

Figure 6:15: Local Authority Personal Social Services Gross Expenditure by Client Group, 1998-99

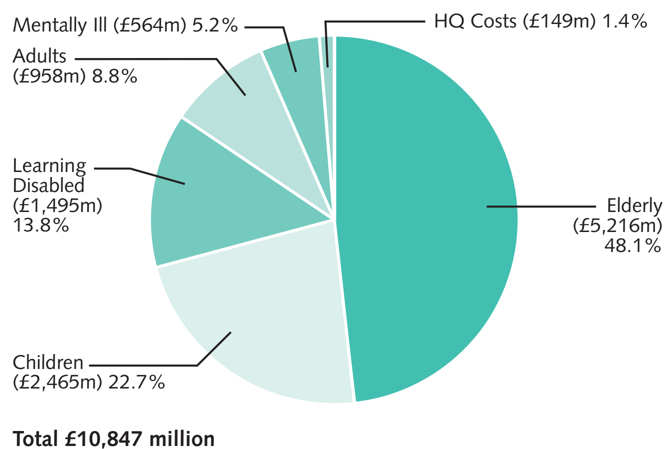
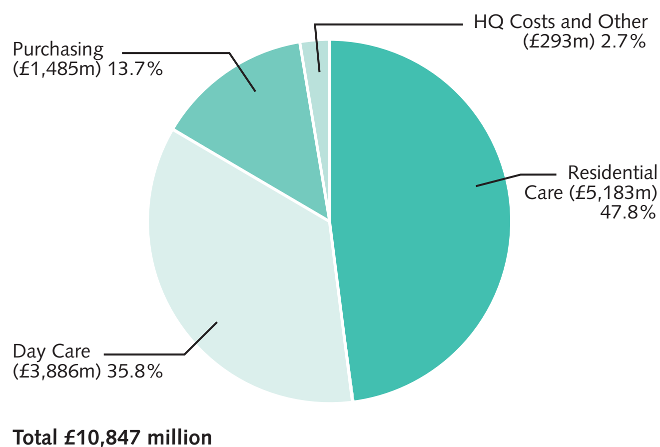


Figure 6.16: Local Authority Personal Social Services Gross Expenditure by Type of Service, 1998-99



7. Activity, performance and efficiency

NHS

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 1998-99 and 1999-2000 for first outpatient attendances was 3 per cent. Over the last ten years, the number of first outpatient attendances for all specialties grew by 32.6 per cent;
- the percentage increase between 1998-99 and 1999-2000 for total FCEs was 1.5%[1]. Total FCEs for the last ten years grew by 39.7 per cent[1], during this period total day case FCEs increased by 206 per cent;
- the percentage increase between 1998-99 and 1999-2000 for total general & acute FCEs was 2.1 per cent[1]. Total general & acute FCEs for the last ten years grew by 48.2 per cent[1], during this period day case FCEs grew by 208 per cent.

[1] *The data for 1999-2000 is slightly incomplete and has not yet been adjusted to account for shortfalls in the number of records submitted, or for missing or invalid clinical information (e.g. diagnosis). Great care must be exercised when comparing HES figures for different years - especially if any of the data is labelled provisional. Fluctuations can occur for a number of reasons, e.g. organisational changes, reviews of best practice within the medical community, the adoption of new coding schemes and data quality problems that are often year specific. These variations can lead to false assumptions about trends.*

Figure 7.1: Hospital Activity Trends, 1989-90 to 1999-2000

	1989-90 (1)	1995-96 (1)	1996-97 (1)	1997-98 (1)	1997-98 (2)	1998-99 (2)	1999-2000 (2)	% change (2) 1998-99 to 1999-2000
Ordinary admissions (3) (thousands)								
General and acute (4)	5,230	6,340	6,395	6,514	6,996	7,030	7,085	0.8
Geriatrics	447	555	545	524	542	542	531	-2.2
Maternity (5)	918	1,053	1,108	1,096	780	815	813	-0.3
All specialties (6)	7,477	8,263	8,369	8,459	8,541	8,563	8,588	0.3
Day cases (thousands)								
General and acute (4)	1,152	2,741	2,869	3,036	3,029	3,377	3,542	4.9
All specialties(6)	1,163	2,774	2,907	3,071	3,086	3,421	3,580	4.6
All finished consultant episodes (thousands)								
General and acute (4)	6,829	9,081	9,264	9,549	10,025	10,407	10,627	2.1
All specialties (6)	8,639	11,037	11,275	11,530	11,627	11,984	12,168	1.5
New outpatients (first attendances) (thousands)								
General and acute (4)	7,621	10,128	10,415	10,643		10,919	11,294	3.4
Geriatrics	60	101	110	107		108	113	5.0
Maternity (8)	689	585	588	590		565	554	-2.0
Mental Health	207	271	285	290		287	282	-2.0
Learning disabilities	3	5	6	6		6	7	7.7
All specialties (6)	8,519	10,989	11,294	11,529		11,778	12,136	3.0
New A&E (first attenders) (thousands)	11,207	12,462	12,484	12,794		12,811	13,167	2.8
Ward attenders (7)	900	1,013	1,026	1,034		1,068	1,073	0.4
Average length of episode (ordinary admissions) (days)								
General and acute (4)		6.5	6.3	6.0		5.9	5.8	-1.7
Geriatrics		19.2	18.9	18.1		17.4	16.8	-4.0

1 Consultant episode data from the Department of Health return KP70.

2 Consultant episode data for 1997-98 (grossed), 1998-99 and 1999-2000 data are derived from ungrossed Hospital Episode Statistics. From 1998-99 HES data are used to report hospital inpatient activity levels,because HES data are now more timely and more accurate. HES based data for 1997-98 differ from KP70 data because HES data consisently report activity according to the specialty of the consultant involved. Some Trusts report KP70 data for some specialties according to the specialty of treatment. 1999-2000 HES data is provisional (version 2).

3 The method of data collection for well babies was revised in 1995-96.

4 General and acute is the sum of geriatric and acute.

5 The maternity sector includes delivery episodes and birth episodes not resulting in well babies.

6 Well babies are included.

7 From April 1992 patients seen by medical staff on a ward are recorded as outpatients rather than ward attenders.

8 Obstetrics and GP Maternity outpatient attendances.

Community Health Services Activity

7.2 Statistics on community health services from the professions allied to medicine over the period 1990-91 to 1999-2000 are shown in **Figure 7.2**. Following a decline in the late 1980s, activity increased and remained at much the same level in most areas of community and cross-sector activity during the 1990s.

Figure 7.2: Community Health and Cross-Sector Services Activity Statistics

Thousands

Number of episodes (1) (2)	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
Health visiting	3,600	3,700	3,700	3,700	3,700	3,700	3,700	3,600	3,600	3,400
Community nursing services (total)	2,600	2,700	2,800	2,800	2,900	3,000	3,000	2,900	3,000	2,900
District nursing	2,100	2,200	2,200	2,200	2,300	2,300	2,300	2,200	2,300	2,200
Community psychiatric nursing	250	270	300	340	360	380	380	370	360	350
Community learning disability nursing	21	21	21	22	23	24	26	26	29	26
Specialist care nursing	190	220	270	270	260 (3)	280	280	310	320	330
Chiropody services	910	940	970	1,010	980	950	980	940	900	860
Clinical psychology	140	150	160	170	180	190	200	200	190	190
Occupational therapy	740	840	880	940	1,020	1,100	1,130	1,150	1,160	1,190
Physiotherapy	3,200	3,300	3,400	3,500	3,900	4,100	4,100	4,100	4,200	4,200
Speech & language therapy	240	250	270	290	300	300	320	330	330	330
Community dental services	1,226	1,251	1,259	1,221	1,212	1,153	1,132	1,096	967	869

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 completed this year).

2 Estimated national totals based on those NHS trusts supplying data.

3 The range of staff groups included under specialist care nursing changed in 1994-95.

4 Includes a small number of discontinued episodes of care.

General and Personal Medical Services (GPMS)

7.3 **Figure 7.3** provides key information about current General Medical Services.

Figure 7.3: Key Statistics on General & Personal Medical Services (GPMS)

	1989-90	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	% Change 1989-90 to 1999-2000	% Change 1998-99 to 1999-2000
Staffing										
Number of General Medical Practitioners [1]	25,608	26,289	26,567	26,702	26,855	27,099	27,392	27,591	7.7	0.7
Number of GP practice staff (WTE) [1] [2]	37,546	53,952	51,833	59,255	59,318	60,579	61,331	63,087	68.0	2.9
Number of practice nurses (WTE) [1] [2] (included in practice staff)	4,632	9,605	9,099	9,745	9,821	10,082	10,358	10,689	130.8	3.2
Organisation										
Number of practices [1]	n/a	9,142	9,100	9,062	8,999	9,003	8,994	8,944	n/a	-0.6
Average list size at 1 October each year [1] [3]	1,971	1,902	1,900	1,887	1,885	1,878	1,866	1,845	-6.4	-1.1
Consultations										
Total number of consultations (millions) [4] [5] [6]	251	261	265	265	270	*	251	*	n/a	n/a
Total number of consultations per GMP [4] [5] [6]	9,790	9,920	10,000	9,920	10,100	*	9,150	*	n/a	n/a
Expenditure										
Total General Medical Service (£000s) [7]										
Discretionary (Cash limited) [8] [9]	0	650	698	747	785	835	878	885	n/a	5.1
Non-discretionary (Non-cash limited)	1,402	1,840	1,902	1,965	2,073	2,198	2,243	2,451	74.8	9.3
Total	1,402	2,490	2,600	2,712	2,858	3,033	3,121	3,336	137.9	6.9
Expenditure										
Total Personal Medical Services (£000s)	n/a	n/a	n/a	n/a	n/a	n/a	38	84	n/a	121.1
Total General Medical Services per GMP (£ cash)	54,749	94,716	97,866	101,565	106,423	111,923	113,938	120,909	120.8	6.1
Total General Services per GMP at real terms 1999-2000 prices (£)	60,388	104,432	106,419	107,314	109,084	118,862	121,003	129,373	114.2	6.9
Discretionary (Cash limited) expenditure per GMP (£ cash)	0	24,725	26,273	27,975	29,231	30,813	32,053	32,076	n/a	0.1
Discretionary (Cash limited) expenditure per GMP at real terms 1999-2000 prices (£)	0	27,294	28,569	29,559	29,962	32,723	34,201	34,321	n/a	0.4
Real terms expenditure per consultation (1999-2000 prices) (£)	n/a	10.52	10.67	10.81	10.85	n/a		n/a	n/a	n/a

1 Source: GMS Census 1 October. Data refers to unrestricted principals & equivalents (Unrestricted Principals, PMS Contracted and PMS Salaried GPs).

2 Decrease in GP practice staff whole time equivalents (WTE) in 1994-95 due to under reporting, primarily by GP fundholders.

3 Average list size is calculated per Unrestricted Principal or equivalent in PMS (ie. excluding Assistants, LIZ Assistants and Associates) whether full, three quarter, half-time or job share.

4 Source: General Household Survey.

5 Data for 1997 and 1999 are unavailable as there was no General Household Survey for these years.

6 Consultations data is a three year moving average except 1996-97 (where only two years' data were available) and 1998-99 (where only one year's data were available).

7 All cash information taken from Appropriation Accounts.

8 Discretionary (Cash limited) expenditure commenced 1990-91. With the move to unified allocations, all discretionary expenditure will be within health authority cash limits from 1999-2000.

9 GP fundholding IT costs are excluded from GMS cash limit.

10 PMS expenditure relates to PMS Pilots, waves 1 and 2a (October 1999 starters) only.

Personal Medical Services

7.4 Personal Medical Service 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.

7.5 Over 80 innovative PMS schemes were established in 1998 with a further 99 second wave pilots that went live in October 1999. An additional 77 second wave pilots further became operational from 1 April 2000. These pilots will provide Doctors who have taken up PMS pilot status, with the ability to negotiate contracts directly with their health authorities to better reflect the needs of the practice population.

Pharmaceutical Services

7.6 **Figure 7.4** provides information on pharmaceutical services.

Figure 7.4: Family Health Services – Key Statistics on Pharmaceutical Services

Pharmaceutical Services [1]		1989-90	1995-96	1996-97	1997-98	1998-99	1999-2000	% Change 1989-90 to 1999-2000	% Change 1998-99 to 1999-2000
Prescriptions (millions) [2]		387.2	484.9	498.3	510.3	524.7	542.6	40.1	3.4
Number of contracting pharmacies [3, 4]		9,694	9,787	9,775	9,785	9,782	9,767	0.8	-0.2
Average number of prescriptions dispensed by pharmacy and applicance contractors		35,124	43,996	45,329	46,297	47,759	49,641	41.3	3.9
Cost of pharmaceutical services per prescription in real terms	*Gross*	9.02	9.71	9.89	10.06	10.02	10.43	15.6	4.1
(1999-2000 prices) £ [2, 5]	*Drug*	7.13	8.08	8.27	8.47	8.50	8.94	25.4	5.2
	Remuneration	1.89	1.63	1.62	1.59	1.52	1.49	-21.2	-2.0
Cost of drugs and appliances in real terms (1999-2000 prices) (£m) [2, 6]		2,747	3,910	4,086	4,301	4,441	4,833	75.9	8.8
Perecentage of all prescription items which attracted a charge [7]		22.2	16.2	14.4	14.6	14.6	14.9	n/a	n/a

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 1999-2000 relates to the period Feb 1999 to Jan 2000) 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 Figure for 1989-90 refers to 31 December. Figures for subsequent years refer to 31 March (eg. 1995-96 is number as at 31 March 1996).

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 by community pharmacists and appliance contractors.

General Dental Services

Recent Trends

7.7 The volume of general dental service dentistry was unchanged in 1999-2000. The number of general dental practitioners continues to increase, by 3 per cent in the year to September 1999 and by 15 per cent in the last 10 years. Registration numbers for both adults and children at September 1999 were similar to the numbers at September 1998. This follows earlier falls in registrations, caused by the reduction in the registration period to 15 months. There were about 26 million adult courses of treatment during 1999-2000, similar to the number in 1998-99 and 14 per cent higher than in 1989-90. An adult course of treatment cost an average of £39 in 1999-2000, the same in real terms as in the previous two years. The reduction of 17 per cent since 1989-90 reflects a reduction in the amount of complex or advanced treatments. Key activity measures are set out in **Figure 7.5**.

7.8 There were about 26 million adult courses of treatment during 1999-2000, similar to the number in 1998-99 and 14 per cent higher than in 1989-90.

Figure 7.5: Family Health Services – Key Statistics on General Dental Services, England

General Dental Services [1]	1989-90	1995-96	1996-97	1997-98	1998-99	1999-2000	% Change 1989-90 to 1999-2000	% Change 1998-99 to 1999-2000
Number of general dental practitioners [2]	15,351	15,951	16,336	16,728	17,245	17,715	15	3
Adult courses of treatment (thousands)	22,809	24,752	24,580	25,268	26,171	25,915	14	-1
Adults registered into continuing care (thousands) [3] [4]	n/a	19,994	19,524	19,383	16,721	16,649	n/a	0
Children registered into capitation (thousands) [3] [4]	n/a	7,292	7,270	7,367	6,775	6,821	n/a	1
Average gross cost of an adult course of treatment (1999-2000 prices) (£) [5]	47	42	41	39	39	39	-17	0

1 General Dental Services are the care and treatment provided by independent high street dentists who provide services under arrangements made with HAs.

2 Principals, assistants and vocational trainees at 30 September.

3 Number of patients registered as at 30 September. Registrations only began with the introduction of the new dental contract from 1 October 1990. From September 1996, new registrations were reduced to 15 month periods unless renewed, affecting registration numbers from December 1997 onwards.

4 Since May 1994 the Dental Practice Board has improved procedures for eliminating duplicate registrations. This may have produced a downward pressure on the levels of registration after this period.

5 From 1995-96 onwards, costs are based on item of service fees and adult continuing care payments. For 1989-90, the cost covers item of service fees only. Changes in the average cost are affected by changes in the dental work carried out in a course of treatment.

General Ophthalmic Services

7.9 The number of sight tests increased by 34 per cent in 1999-2000 over the previous year as a result of the Government's decision to extend eligibility for free NHS tests to everyone aged 60 and over from 1 April 1999. A 3 per cent fall in the number of optical vouchers issued was linked to some shrinkage in the size of the eligible population groups (and the number issued still represented a 51 per cent increase over the levels seen in 1990-91). Key activity measures are set out in **Figure 7.6**.

Figure 7.6: Family Health Services – Key Statistics on General Ophthalmic Services

General Ophthalmic Services	1990-91	1995-96	1996-97	1997-98	1998-99	1999-2000	% Change 1990-91 to 1999-2000	% Change 1998-99 to 1999-2000
NHS sight tests (£000's) [1]	4,154	6,512	6,808	6,991	6,992	9,399	126	34
Optical vouchers (£000's) [2]	2,432	3,815	3,967	3,935	3,777	3,662	51	-3
Number of opticians [3]	6,431	6,778	6,939	7,091	7,305	7,517	17	3

1 From 1 April 1999, eligibilty for NHS sight tests was extended to all patients aged 60 and over.

2 The voucher scheme was introduced on 1 July 1986 to help certain priority groups with the provision of spectacles. Figures show the number of vouchers reimbursed to practitioners in the year, including payments for complex appliances.

3 Optometrists and Ophthalmic Medical Practitioners at 31 December.

Performance

NHS Performance Assessment Framework

7.10 The *NHS Performance Assessment Framework* [7.1] was published in April 1999. The NHS Plan endorsed the Framework as a single system for measuring, assessing and rewarding NHS performance. The Framework highlights six areas of performance which, taken together, give a balanced view of the NHS's performance:

- health improvement;
- fair access;
- effective delivery of appropriate health care;
- efficiency;
- patient/carer experience; and,
- health outcomes of NHS care.

7.11 The Framework is supported by a set of performance indicators, first published in June 1999. A second set published in July 2000 gave improved coverage of primary care, patient experience and NSF priorities. The next set of indicators will include a set of specific NHS Trust based indicators which will complement the health authority set.

7.12 Performance of NHS organisations will be assessed against the national performance indicators using a system of traffic lights. Traffic light status will determine the level of intervention and scrutiny organisations may be subject to. Criteria for the traffic lights will combine performance against the core national standards set by the Department's PSA (Chapter 2) and relative performance against the performance indicators.

7.13 Organisations classed as 'green' will be meeting all core national targets and will score in the top 25 per cent of organisations on the Performance Assessment Framework, taking account of 'value added'. Green status reflects both outstanding absolute performance against core national targets and relative performance against the wider Performance Assessment Framework measures. The 25 per cent threshold for green status will be reviewed periodically.

7.14 Green-light organisations will be rewarded with greater autonomy and national recognition. They will be subject to lighter touch monitoring by the Regional Offices, have greater freedom to decide the local organisation of services, and automatic access to the National Performance Fund.

7.15 Yellow organisations will be meeting all or most national core targets, but will not be in the top 25 per cent of Performance Assessment Framework performance. Red organisations will be those who are failing to meet a number of the core national targets. Red status will result from poor absolute standards of performance, triggering action to ensure a 'floor' level of acceptable performance is achieved throughout the NHS.

Management Costs

7.16 The Government has taken action to ensure that over the five years ending in March 2002, £1 billion that would have otherwise been spent on bureaucracy will be freed up for patient care. Savings have been achieved through reductions in health authority costs and NHS trust management costs, as well as through savings in GP fundholder management allowances. Further savings are being achieved through targeting reductions in those NHS trusts with proportionally higher management costs, and NHS trusts undergoing mergers. GP fundholder management allowances have been re-deployed to support the running costs of Primary Care Groups. Savings are also being sought through organisational mergers, pooling and sharing of services locally. Over the four years from 1997-98 to 2000-2001 £800 million that would otherwise have gone on bureaucracy has been freed up for patient care. This meant that we are well on course to achieve the £1 billion target. Within the NHS Plan a further, longer term commitment on management costs has been made, so that by 2004 the share of NHS spend on management costs will be cut so that a higher share of every pound spent goes into frontline patient care.

Health Authorities

7.17 Health authorities' planned costs for 2000-2001 are £561million.

7.18 The focus is now on ensuring that current expenditure on health authority costs is targeted at supporting improvements in health and healthcare, by supporting those health authorities currently under-investing in functions critical to the delivery of the Government's objectives. This is being achieved through maintaining firm further downward pressure on high cost health authorities.

NHS Trusts

7.19 NHS trusts' planned costs for 2000-01 are £1,289 million.

Financial Performance of Health Authorities

7.20 In 2000-01 there were 99 health authorities responsible for assessing the health needs of their local population and commissioning health services in line with national and locally agreed priorities. Health services are commissioned from NHS trusts, Primary Care Trusts and other providers of healthcare.

7.21 Health authorities were responsible for spending £37.5[1] billion on patient care in 1999-2000 (the comparable figure for 1998-99 being £34[2] billion). In doing so they were expected to manage their resources and live within the cash limited allocation made available to them. Health authorities receive their income almost entirely from the Department of Health (in the form of cash allocations).

[1] *The 1999-2000 figure includes £22.5 billion commissioned by Primary Care Groups.*
[2] *The 1998-99 figure includes £5.9 billion commissioned by GP Fundholders.*

7.22 In 1999-2000 all health authorities managed their expenditure within the cash limited allocations made available to them. However, in their year-end financial statements health authorities reported an income and expenditure **deficit** in 1999-2000 of £52 million. This compares with a **surplus** of £18 million in 1998-99. For 2000-2001, the NHS is forecasting a surplus.

7.23 The deficit in 1999-2000 can be attributed to the way in which the NHS was funded (where cash was only made available when required) and the way the NHS accounts for expenditure. In particular, expenditure relating to clinical negligence cases has to be recognised in the accounts when the incident takes place even though it might be years before the case is settled and cash paid. However, this has now changed with the introduction of Resource Budgeting & Accounting (RAB) across all Government departments on the 1 April 2001 – the focus of which is resources consumed rather than cash.

7.24 One of the consequences of the introduction of RAB is that 1999-2000 will be the last year in which health authorities will report their financial results in terms of income and expenditure. With effect from the 1 April 2000, the way health authorities account for and report financial performance has changed. The income and expenditure account has been replaced by an Operating Cost Statement. As a consequence, reporting the financial performance of health authorities on the basis of income and expenditure surpluses and deficits is no longer appropriate. Instead, health authorities have a duty to achieve operational financial balance (OFB). OFB measures the ability of health authorities to contain their annual expenditure (on an accruals basis) within an approved limit set by the Department of Health. Control of expenditure through OFB is not the same as cash limit control. The statutory duty on health authorities not to exceed their cash limit is unaffected by the above changes.

7.25 Change in the reporting format of health authorities to an Operating Cost Statement rather than an income and expenditure account has been supported and welcomed by the National Audit Office, the Audit Commission and H.M.Treasury. The change to an Operating Cost Statement approach is consistent with other Government departments and complements the introduction of RAB. NHS trusts will continue to report financial performance on an income and expenditure account basis.

7.26 The additional resources announced in the 2000 budget has meant that the vast majority of NHS organisations are forecasting achieving financial balance. However, there are a small number managing deep-seated problems which require significant change in the way services are provided and will take time to resolve. The Department is working closely with these health bodies with the aim of restoring financial balance as soon as possible.

Financial Performance of Trusts

7.27 NHS trusts are responsible for the provision of healthcare. They receive most of their income from commissioners of health care (mainly health authorities). NHS trusts aim to deliver improved healthcare outcomes with increasing efficiency and effectiveness within the resources available to the health service.

7.28 There were 377 operational NHS trusts in 1999-2000.

7.29 NHS trusts have three main financial duties:

- to break-even on an income and expenditure basis;

  this is the prime financial duty for NHS trusts and is known as the break-even duty. NHS trusts normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. The interpretation of the **statutory financial duty** for NHS trusts to break-even was clarified in 1997-98. This recognises that although NHS trusts are expected to achieve a balanced position on their income and expenditure account each year, there may be reasons for NHS trusts to report deficits in one year which may be offset by surpluses achieved in another year(s). This is particularly relevant to situations where NHS trusts must recognise costs in advance of cash outlay, for example for clinical negligence or pension costs, and when managing the recovery of an NHS trust with serious financial difficulties. A run of three years may be used to test the break-even duty, but in exceptional cases the Department of Health may agree to a five year time-scale.

- to absorb the cost of capital at a rate of 6 per cent of average relevant net assets; and,
- to meet, or come within agreed limits of flexibility, the external financing limit set by the Department of Health.

7.30 In total, NHS trusts reported a deficit for 1999-2000, on an accruals basis, of £76 million[1], compared to a £35 million deficit in 1998-99. Whilst NHS trusts did report a deficit in 1999-2000, none breached their statutory financial duty to break-even 'taking one financial year with another' (see previous paragraph). Trusts overall are predicting a surplus for 2000-2001.

7.31 Similar to the approach taken with health authorities, the Department of Health has made it clear that NHS trusts should balance their finances in-year and not put off tackling financial problems – but again this should not be at the expense of proper service provision.

7.32 The Department of Health also assesses the financial performance of NHS trusts on a regular basis as part of its performance management role.

[1] *after national accounting adjustment agreed with National Audit Office.*

Payment of Bills by NHS Trusts

7.33 All NHS trusts are expected to conform to Government Accounting Regulations and the Better Payment Practice Code. NHS trusts should pay external suppliers within 30 days of receipt of goods, or a valid invoice, whichever is the later, unless covered by other agreed payment terms.

7.34 Performance has improved considerably since compliance has been monitored, and a large number of NHS trusts are prompt payers, but further improvement is still required before the current target of 95 per cent is attained. The national average is just over 83 per cent of bills paid on time and the Department of Health continues to target poorly performing NHS trusts, working with supplier organisations and promoting the work of the Better Payment Practice Group.

Fraud and Corruption

7.35 Fraud and corruption take away resources from important services. The Government is committed to reducing all losses to fraud and corruption in the NHS to an absolute minimum and to hold it permanently at that level, releasing resources for better patient care and services. Incorporating counter fraud action into all aspects of departmental work will help ensure that PSA targets on effectiveness, efficiency and quality can be achieved.

7.36 There are two PSA targets relating to fraud and these are referred to in chapter 2 of this report.

7.37 The Department has adopted a comprehensive, integrated and professional approach to deal with these problems, as set out in the strategic document *Countering Fraud in the NHS* [7.2] published in December 1998. The Directorate of Counter Fraud Services (DCFS) is the specialist directorate set up to implement this strategy by following the counter fraud business process model: identifying the nature and scale of the problem; developing a clear counter fraud strategy; creating an effective structure to implement the strategy; and taking action in key areas of NHS spending.

7.38 The DCFS programme of fraud measurement exercises is providing the first ever robust estimates of losses to fraud in all areas of NHS spending, through an innovative and rigorous measurement methodology. The first two measurement exercises on patient prescription charge fraud, comparing figures from November 1998 and July 1999, show that since the introduction of the strategy, losses in this area have already been reduced by £48 million or around 41 per cent. On contractor prescription fraud, results of the baseline measurement exercise in pharmaceutical services are due to be announced by the end of the financial year 2000-01. Progress against the target of prevention of £9 million of this type of fraud will be tracked by repeated measurement exercises. Progress against the target of recovery of £6 million in this area will be monitored by the new Pharmaceutical Fraud Team.

7.39 The DCFS has created an effective structure to implement the strategy. The Counter Fraud Operational Services now has eight regional teams, one national proactive team and a specialist Pharmaceutical Fraud Team (superseding the Fraud Investigation Unit at the Prescription Pricing Authority). These are assisted by Local Counter Fraud Specialists based in every health authority and NHS trust. All staff are fully trained at the new Counter Fraud Training Services centre, undergoing specialist, professional training accredited by Portsmouth University. A Dental Fraud Team is also planned for later this year.

7.40 Much progress has been made towards achievement of DCFS objectives, including new reporting systems for fraud to ensure weaknesses are identified and inform the revision of policy and procedures. Work has been carried out in the following generic areas:

- Creation of an anti-fraud culture so that fraud is not tolerated.

  The *Counter Fraud Charter* [7.3] originally published in December 1999 has since been signed by two more professional associations (The Royal College of Nursing and The Association of British Dispensing Opticians) and also 114 patient representative groups to show our joint commitment to tackle fraud and corruption growing through partnerships with other key organisations.

  Meetings have been held with key staff and managers of every health authority and NHS trust to explain the counter fraud strategy and their role within it. Similar meetings have also been held with local professional committees.

  Following the Secretary of State Directions issued to all health authorities and NHS trusts in December 1999, Directions were issued [in December 2000] to all Primary Care Trusts to set out their role in the strategy and requiring them each to appoint a Local Counter Fraud Specialist.

- Maximum deterrence of fraud.

  There has been extensive publicity of every counter fraud initiative undertaken to implement the strategy, all of which helps to maximise the deterrent effect of these measures.

- Successful prevention of fraud.

  Following the success of Point of Dispensing checks introduced in pharmacies in April 1999 to prevent patient prescription charge fraud, equivalent checks were introduced in dental services on 13 November 2000 and in optical services on 19 February 2001.

  The DCFS is also actively involved in working with colleagues to ensure that new NHS initiatives being taken forward under the NHS Plan, such as the Electronic Prescribing Project, are designed and implemented in ways that minimise opportunities and risks of fraud.

- Prompt detection of fraud.

  A new confidential Fraud and Corruption Reporting Line, the first of its type to exist within the NHS, was launched on 13 December 2000. This will allow practitioners, contractors, patients and others who come into contact with the NHS to report any suspicion of fraud knowing that their call will be dealt with expertly and confidentially.

- Professional investigation of all fraud detected, or reported.

  All Counter Fraud staff, including Local Counter Fraud Specialists in health authorities and trusts, undergo professional training accredited by Portsmouth University, to ensure that all investigations are carried out to a professional standard in a fair and objective manner.

  Accredited training is reinforced by guidance in the new NHS Fraud and Corruption Manual issued to all accredited Counter Fraud Specialists and Finance Directors in health authorities and NHS trusts.

- Consistent use of appropriate legal action, sanctions and methods of redress.

  The specialist training and guidance ensure that all available sanctions are applied consistently where fraud is found, including criminal prosecution, civil court action, and disciplinary action within NHS and professional regulatory organisations where this is relevant. Similarly, redress is sought through all available means in order to maximise recovery of money lost through fraud.

  The new Penalty Charge, introduced under *The Health Act 1999* [(7.4)], for patient evasion of NHS charges was implemented with effect from 1 December 2000.

7.41 The overall combined effect on reducing levels of fraud will be demonstrated through the DCFS Measurement exercises. Already action has so far resulted (as at January 2001) in 472 ongoing investigations involving 491 suspects. There have been 22 successful prosecutions, 10 civil cases and 34 disciplinary. The investigations include 93 GPs, 24 hospital doctors or surgeons, 33 dentists, 39 opticians, 134 pharmacists, 102 NHS employees, 14 external contractors or suppliers and 18 patients. There are also 32 miscellaneous cases.

7.42 The National Assembly for Wales has recently agreed to follow the business process and structure established by the DCFS in England. There will be a separate operational team, based in South Wales and part of the existing counter fraud operational service, inclusion in measurement exercises and policy support from within DCFS.

Efficiency

NHS Efficiency

7.43 The *Reference Costs 2000* publication [(7.5)], issued in November 2000, details the national average cost for a range of treatments and procedures for the 1999-2000 financial year. It no longer covers just inpatient and day case treatments, but also other aspects of secondary and specialist health care. In total 69.4 million inpatient, outpatient and Accident and Emergency episodes are included, as well as separate information on critical care services, radiotherapy treatment, and certain community-based therapy services.

7.44 This information now covers 88.4 per cent of annual expenditure on services provided by hospitals, and 7.25 per cent of expenditure on community services. Indeed, the total cost of services included in the publication accounts for 60.6 per cent of all hospital and community health service expenditure (£14.9 billion).

7.45 Due to this increased coverage of service expenditure, it has been decided that efficiency targets will be based upon the reference cost information. Improvement in unit costs will make a contribution to delivering efficiency and value for money improvements. This is only one strand in the overall approach to NHS performance and the use of a number of indicators to assess overall performance of NHS organisations as detailed in the NHS Plan.

HCHS Cost Weighted Activity Index

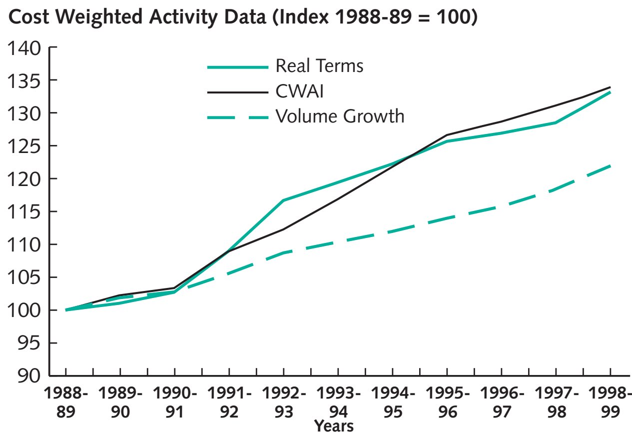
7.46 Improvements in Hospital and Community Health Services (HCHS) efficiency can be estimated by comparing the rate of increase in both activity and resource inputs (expenditure). A faster increase in activity than in expenditure, after allowing for changes in input costs, constitutes an efficiency gain.

7.47 **Figure 7.7** shows the overall activity levels, which have increased by approximately 34 per cent, in the ten year period between 1988-89 and 1998-99. Over the same period, HCHS expenditure, expressed in volume terms (i.e. the cash increase given to the NHS after allowing for inflation specific to the NHS), increased by 22 per cent.

7.48 The difference between the two measures reflects the increase in efficiency within the HCHS over the past ten years, in this case 10 per cent.

7.49 Expenditure in real terms (i.e. after allowing for GDP inflation) increased by approximately 33 per cent over the 10 year period from 1988-89. This is of the same order as the rise in overall HCHS activity (34 per cent). It follows that HCHS unit costs have kept pace with output unit costs in the economy as a whole, of which the GDP is a measure.

Figure 7.7: HCHS Cost Weighted Activity Index

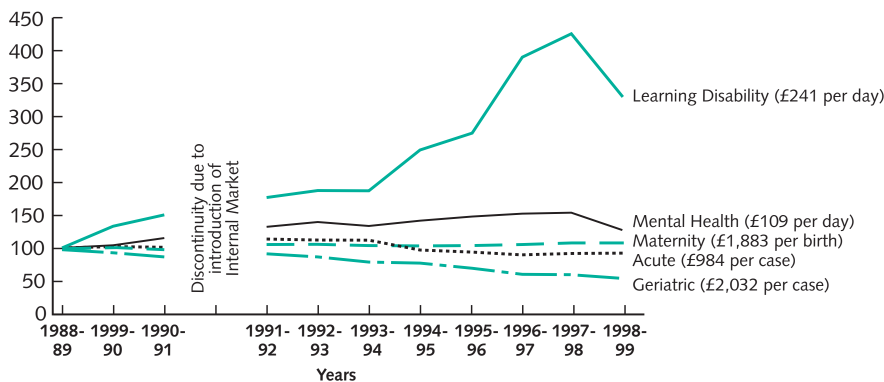


Unit Costs

7.50 Overall unit costs in the hospital sector have tended to fall in real terms in the last ten years, as efficiency improvements have been made. However, the position varies depending on the category of care being delivered. These differences between categories of care in the last year have narrowed as the cost of Learning Disability bed days has fallen. **Figure 7.8** shows how unit costs have moved in real terms across the five major categories of hospital inpatient care. In summary:

- inpatient care for acute and geriatric patients show falling unit costs as reductions in length of stay, a shift towards day cases and other efficiency gains have been made; and,
- the cost of inpatient care for learning disability patients has shown a marked decrease over the last year as the number of inpatient bed days has risen.

Figure 7.8: Average Unit Costs by Category of Care 1988-89 to 1998-99 (Index 1988-89 = 100)



Personal Social Services

Childrens Services Activity

7.51 **Figure 7.9** gives a summary of Personal Social Services for children and families.

Figure 7.9: Children Receiving Personal Social Services – a summary

						Numbers and percentages
	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
Children looked after by local authorities at 31 March	49,500	50,500	51,000	53,300	55,500	58,100
% aged under 10	37	39	40	42	43	43
% in foster care	65	65	65	66	65	65
% in children's homes	14	13	12	12	11	11
% with three or more placements during year	20	21	20	20	19	18
Registrations to child protection register during year	30,400	28,300	29,200	30,000	30,100	29,300
% whose reason was sexual abuse	24	22	21	20	19	17
% that were re-registrations	16	18	19	19	15	14
All adoptions during year	5,500	5,400	4,600	4,000	4,400	4,800
adopted from care	2,000	1,900	1,900	2,100	2,200	2,700

7.52 Key points are that:

- the number of children looked after by councils has been increasing, to 58,100 at 31 March 2000. This followed a long-term decline which came to an end in 1994, when 49,300 children were looked after at 31 March;
- over that period an increasing proportion of children looked after have been aged under 10;
- the number of children placed on the child protection register has been relatively stable; and,
- the number of children adopted from care has been increasing recently, particularly in 1999-2000 when there were 2,700 'children looked after' adopted.

Adults' Services Activity

7.53 **Figure 7.10** gives a summary of Personal Social Services provided to adults. Adults' services include all services provided to individuals of 18 or over. The users range from those who have just reached adulthood to the most elderly in the population.

Figure 7.10: Adults Receiving Personal Social Services – a summary

							Numbers, percentages and rates
	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
All adults aged 18 or over							
Households receiving home care	514,600	538,900	512,400	491,100	479,100	447,200	424,000
of which, percentage receiving intensive home care (1)	12	15	21	25	28	31	34
People supported in residential care	119,158	137,480	153,164	170,277	176,534	181,220	186,761
People supported in nursing care	25,154	43,238	57,246	66,058	72,904	73,467	74,378
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)						3.5	3.6
supported in residential care	6,307	7,060	6,661	7,175	5,908	5,909	6,215
supported in nursing care	1,450	2,278	2,683	3,181	2,826	3,185	3,406
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)						1.7	2.1
supported in residential care	4,164	5,214	6,520	6,838	7,912	8,704	8,835
supported in nursing care	268	601	850	1,127	1,365	1,504	1,616
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)						2.3	2.2
supported in residential care	17,459	20,294	22,169	24,761	25,102	26,866	28,322
supported in nursing care	189	296	642	685	927	933	1,007
in other groups							
supported in residential care	1,401	1,792	1,697	2,145	2,341	1,962	1,753
supported in nursing care	135	189	226	278	335	297	259
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)						82	84
supported in residential care	89,827	103,120	116,117	129,358	135,271	137,779	141,636
supported in nursing care	23,112	39,874	52,845	60,787	67,451	67,548	68,090

Care in own homes comes from a survey week, 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.

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.

7.54 Key points are that:

- 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;
- the number of households receiving care in their own homes has fallen, though the proportion of these households receiving a large amount, or 'intensive' home care has increased. There is also evidence that in 1999-2000 there were more people helped to live at home by means of services wider than home care; and,
- the number of people supported by councils in residential or nursing care has increased following 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 PSS Performance Assessment System

7.55 The White Paper *Modernising Social Services* (7.6) set out new arrangements to assess the performance of each council with social services responsibilities within the wider Best Value regime which applies to all local government services. Performance assessment pulls together information from a number of sources to provide a comprehensive overview of the performance of each council:

- Performance Data – the 50 performance indicators associated with the PSS Performance Assessment Framework (PAF) provide an overview of performance at the year-end. Performance indicators allow direct comparison between councils and over time and allow targets to be set and monitored. The new banding presentation introduced for 1999-2000 allows this to be done more easily. A subset of these indicators are also Best Value performance indicators. However indicators only indicate, and information from the following sources is required to get a round picture.

- Evaluation – in-depth SSI inspections of the quality aspects of social services and SSI/ Audit Commission Joint Reviews of the performance of all the council's social services responsibilities. The SSI will carry out at least three inspections of every council in each five-year period (one on childcare, one on services for older people or on mental health services, and another on a priority policy area). The Joint Review Team will visit each council once every five years.
- Monitoring – the SSI Regional Offices (SCR) are in frequent contact with councils and monitor progress in achieving national objectives and targets twice a year. They also follow up concerns arising from performance indicators, inspections and joint reviews.

Best Value

The duty of Best Value – to deliver services to clear standards covering both cost and quality, by the most effective, economic and efficient means available – is included in the Local Government Act 1999. It came into force on 1 April 2000 for all local government services, including social services.

The aim of the Best Value process is to secure continuous improvements in performance, and to deliver services that bear comparison to the best. Councils must review their services over a five year period and demonstrate that they have taken into account the four 'C's – Challenge, Compare, Consult, Compete. They must also produce annual performance plans.

7.56 The five PSS PAF performance domains (which are also the Best Value domains) are used as an organising framework for all this information (see diagram on following page). This helps the Department each year to collate all the available information and assess the overall performance of each council. SSI SCR use this evidence to carry out *annual review meetings* with councils where priorities for improvement are discussed and actions agreed, and to advise external auditors on the signing off of Best Value Performance Plans.

7.57 The aim is to improve the services that people receive by:

- helping councils to develop their own performance management arrangements, compare their performance with others and make a contribution to the Government's objectives and priorities by improving their own performance;
- ensuring that social care issues are appropriately addressed in Best Value Performance Plans;
- helping councils to improve their services to the public through better use of information and evaluation of their own performance in comparison with others;
- ensuring that the corporate management and political scrutiny arrangements promote better social services that contribute to community well-being;
- ensuring that councils work effectively with the NHS to address joint health and social care policy and service delivery issues;
- ensuring that councils work effectively with other local government departments and external agencies;
- assessing councils' progress in implementing the Government's policies for social care, in meeting national targets and in achieving best value;
- identifying and promoting good practice; and,
- identifying councils that are performing poorly and ensuring that they take action to improve.

Efficiency in Social Services

7.58 The Public Service Agreement (PSA)[7.7] includes a target *'to achieve efficiency and other value for money gains equivalent to 2 per cent of gross PSS expenditure for 1999-2000 and 2000-01 and 3 per cent in 2001-02'.*

7.59 Efficiency gains are achieved where:

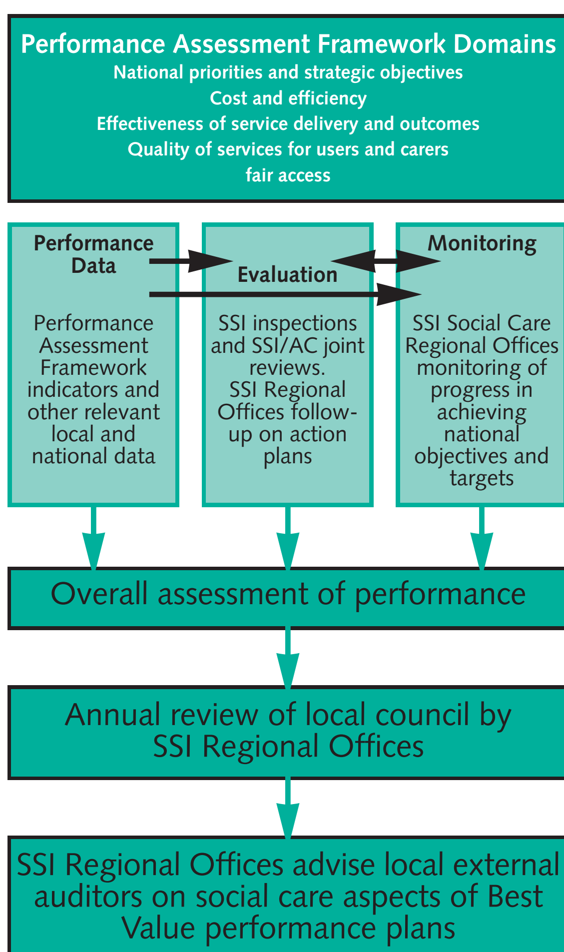
- the same services are provided and the same outcomes achieved for less cost;
- better services are provided and better outcomes are achieved for the same cost; and,
- better services are provided and better outcomes are achieved for more cost, where the improved outcomes more than justified the additional cost.

7.60 The Performance Assessment System aims to drive improvements in efficiency in the following ways:

- one of the five domains of performance is cost and efficiency, recognising that this is one of the important aspects of performance in general;
- of the indicators it contains, two are Best Value top quartile target indicators, where councils must move towards the performance of the top 25 per cent of councils over five years. These broad-based cost indicators are specified such that improvements can be made both by commissioning care at lower cost and, more importantly, by shifting the pattern of care from residential to home settings;
- the twice yearly monitoring exercises capture evidence of local initiatives to improve efficiency, both to demonstrate efficiency improvements and allow the spread of best practice;
- the Public Services Productivity Panel carried out a study on improving efficiency through more effective commissioning. Its report, *Out in the Open*[7.8], was published in June 2000; and,
- further work is to be undertaken to develop new measures of cost effectiveness, covering cost together with quality and outcomes.

Future developments and the interface agenda

7.61 The performance indicators will continue to be developed via a PSS PAF Development Group, which includes council representatives. The interface between health and social services is increasingly important, as highlighted in the NHS Plan. The interface indicators subgroup, which reports to both the PSS PAF Development Group and the NHS Performance Indicators Working Group and also has council and health authority representation, will take forward development work in this area.



Performance in 1999-2000

7.62 Data for 37 of the 50 performance indicators associated with the PSS PAF were published on 13 October 2000 in *Social Services Performance in 1999-2000*[7.9]. (A list of indicators can be found in **Annex F**). In addition as part of the new performance assessment arrangements for social services, the SSI Regional Offices carried out two trial in-year performance assessment exercises during 1999-2000. Using these two sources of information together gives a more rounded picture of performance. The main messages from these two sources were:

General

7.63 On childrens welfare, monitoring showed that 60 per cent of councils had made significant progress in implementing their Management Action Plans to improve child and family services through the Quality Protects initiative. Most others have made some progress. Recruitment difficulties had caused slippage in some councils, requiring tighter project management in future.

7.64 On promoting independence, monitoring showed that all councils were expected to meet the minimum planning conditions governing both the Prevention and Carers' special grants. Councils varied markedly in the creativity and comprehensiveness of their prevention strategies for older people. Most councils were engaging well with carers and their representative organisations in developing services responsive to their needs.

7.65 Overall the performance indicators showed an improvement (of the indicators that can be compared, 16 showed an improvement, 3 worsened and 2 stayed the same). Performance still varies between councils for many of the indicators but the variation is less than in 1998-99 (the inter-quartile range decreased for 16 indicators, increased for 10 and was unchanged for 1). Some councils are performing very well against many indicators; others are not.

7.66 The results for London still often appear to be different to those for Shire counties and Unitary councils, for example, with better performance in helping older people to live at home (PAF PIs C28, C32), apparently worse performance in adoption (C23) and higher levels of relative spend on family support (E44); the results for metropolitan districts tend to lie in between. Costs in London and the South East are often higher because of higher wage rates.

7.67 All 150 councils provided data for the vast majority of indicators but there were some gaps for new indicators and three councils were unable to supply any expenditure data in time for inclusion. Data quality improved over the last year but there is still room for further improvement. There should be significant improvements in the future as definitions and guidance are developed in the light of experience.

National Priorities and Strategic Objectives

7.68 The majority of councils were maintaining a good level of progress towards national priority objectives, but approximately a quarter had some difficulties with the scale, speed and complexity of the agenda.

7.69 Progress against targets set for children's services has been mixed. Improvements in stability of placements for children looked after (PAF PI A1) must accelerate if the target of 16 per cent or less is to be met by all councils by 2000-01. The educational attainment of care leavers (A2) is very low (30 per cent) and the majority of authorities must make significant improvements if the 2000-01 target of 50 per cent and the 2002-03 target of 75 per cent are to be achieved. The national target of 17.2 per cent for re-registrations on the child protection register (A3) has already been met (although 30 per cent of councils report re-registrations

in excess of the target). It appears that the previous upward trend has been reversed.

7.70 Performance at the interface, for which health and social care are jointly accountable, is also mixed, with emergency admissions for older people on course to meet the target (PAF PI A5), good progress being made towards the target for emergency psychiatric re-admissions (A6), but delayed discharges (D41– in Quality) increasing. Data is not yet available for hospital admissions due to falls or hypothermia (C33 – in Effectiveness) but there was a fall between 1997-98 and 1998-99.

7.71 On mental health services, monitoring showed that:

- over 400 schemes had been initiated to help in reducing suicide rates;
- over 200 new Community Mental Health Teams were being established; and,
- three-quarters of councils were making good progress in developing their Mental Health Joint Investment Plans in partnership with Health and others, though much remained to be done to improve information sharing.

7.72 New joint schemes to improve access to mental health services were being established or planned in most councils.

Cost and Efficiency

7.73 The in-year performance monitoring by SSI ROs at the half-year point showed that:

- an estimated efficiency gain of 2.1 per cent was achieved, exceeding the 2 per cent target;
- around half of the councils were strongly engaged with the efficiency agenda;
- many councils were successfully introducing new ways of working which made better use of their resources, although they were finding it hard work to reduce costs and improve outcomes;
- nearly 60 per cent of individual authorities expected to meet or exceed the target; and,
- the scope for current and future efficiency gains was closely related to the cumulative amount of savings made in past years.

7.74 The balance between care in home settings and in residential homes needs to improve (PAF PI B11) although in London intensive home care for adults and older people showed an improvement from an already high level.

7.75 The proportion of children looked after in foster placements or placed for adoption has remained fairly stable (PAF PIs B7 and C22 – in Effectiveness).

7.76 Real terms increases have been seen in costs (PAF PIs B8-10 and B12-17). There does not appear to have been any progress towards the Best Value Top Quartile targets for B8 and B12.

Effectiveness of Service Delivery and Outcomes

7.77 Progress has been made towards achieving statutory inspection obligations. Only one council failed to inspect all their children's homes (PAF PI C25) and 24 councils failed to inspect all their adult residential care homes (C34) (9 managed 99 per cent of inspections but 15 failed to achieve that level).

7.78 Twenty councils estimated in the in-year monitoring that they would not have discharged their full statutory responsibilities in regulating child day care facilities by the end of the year, citing the establishment of posts and difficulty recruiting local inspectors as principle causes.

7.79 Review procedures for child protection cases worsened with only 29 councils reviewing all their cases and one in six reviews not taking place when they should. Ten councils reviewed less than two-thirds of cases (PAF PI C20).

7.80 Duration on the child protection register (PAF PI C21) reduced slightly overall and 29 per cent of councils had less than 15 per cent of de-registrations relating to children who had been on the register continuously for two years or more.

7.81 There was an increase in the proportion of looked after children adopted from 4.0 per cent to 4.7 per cent (PAF PI C23), representing an increase of some 500 children.

7.82 Progress appears to have been made in delivering services to promote the independence of adults and older people. There were falls in permanent admissions of supported residents to residential/nursing care (PAF PIs C26 and C27) and increases in households receiving both intensive and low-intensity home care (C28, C29[1], C31[1] and C32[1]) for all client groups except adults with learning disabilities (C30[1]).

Quality of Services for Users and Carers

7.83 Despite improvements, 11 per cent of users are not receiving items of equipment costing less than £1,000 within three weeks (PAF PI D38) and 21 per cent are not receiving a statement of their needs and how they will be met (D39). Further improvements are needed if the top quartile targets of 95.57 per cent and 90.85 per cent respectively are to be met.

7.84 Almost one in ten single adults and older people are not allocated single rooms when they go into permanent residential and nursing care (PAF PI D37) and four councils reported that less than two-thirds of such people were allocated a single room.

7.85 Long term stability of children looked after (PAF PI D35) showed little change and performance is still not acceptable for 55 per cent of councils.

Fair Access

7.86 The percentage of expenditure that goes on family support (PAF PI E44) increased slightly to 36 per cent.

1 Reported data for C29-32 are not directly comparable with those for 1998-99 because the definition has been improved to include a wider variety of services but the 1998-99 data has been adjusted onto the new basis.

Breakdown of Efficiency Gains

	Efficiency gains	
	£ millions	% efficiency gain
Efficiency gains from all sources	237.2	2.3
Efficiency gains from the preset calculation	102.4	1.0
The difference in the unit costs of services provided in the public and independent sectors	33.9	0.3
The use of family placements for children as a substitute for care in children's homes	27.5	0.3
The substitution of residential services for older people with packages of care at home	24.5	0.2
The reduction in management and administration costs	16.6	0.2
Efficiency gains from local initiatives	134.8	1.3
Better use of human resources, eg reductions in absence through sickness or fewer agency staff	35.8	0.4
Better commissioning, eg outsourcing home adaptations for older people	34.5	0.3
Modernising service delivery, eg getting jobs for disabled people in place of day services	28.6	0.3
Better use of assets, eg reductions in absence through sickness or fewer agency staff	23.1	0.2
Better working practices	12.9	0.1

7.87 Eighteen per cent of councils have fewer children in need from minority ethnic groups than might be expected from their population make-up (PAF PI E45). This may mean that they are not reaching the minority ethnic communities in their areas.

Performance in 2000-2001

7.88 In this first full year of the new performance assessment system for social services, the results of inspections, joint reviews and bi-annual monitoring were brought together for the purpose of overall assessment, leading to annual review meetings with all councils with social services responsibilities. A fuller account of progress and issues arising from this process will be published in the Chief Inspector's Annual Report in the summer of 2001.

7.89 Meanwhile, in-year monitoring by SSI's Social Care Regions shows variable progress across the range of targets for social services set by DH. These are described in turn below.

National Priorities and Strategic Objectives

7.90 The percentage of children looked after with three or more placements during the year continues to fall. On average 12.7 per cent of **looked after children will be moved three or more times** in 2000-01 falling to 10.9 per cent in 2003-04.

7.91 Last year **looked after children** were around six times less likely to **achieve five or more GCSEs at grades A*-C** than all children. The differential is forecast to fall to around four times this year and to around two by 2003-04.

7.92 Many councils are experiencing difficulty in securing suitable educational placements for looked after children following a move – especially where there are emotional and behavioural difficulties.

7.93 The level of employment, training or education amongst young people aged 19 who were looked after at age 16 should be at least 60 per cent of the level amongst all young people of the same age in their area by 2001-02; and 75 per cent by 2003-04. Three quarters of councils expect to meet the target for 2001-02 whereas only half plan to meet the target for 2003-04.

Cost and Efficiency

7.94 The overall national estimated **efficiency gain of 2.3 per cent** exceeds the national target. Of this total, £102 million or 1.1 per cent derives from preset calculations designed to measure the increased proportion of services that are generally better for service users but also less expensive. The remaining element of the efficiency gain (1.3 per cent) is calculated from other local initiatives.

7.95 Better use of human resources contributes most, with efficiency gains of £35.8 million (0.4 per cent), whereas better working practices contributes the least at £12.9 million (0.1 per cent). However, in general the efficiency gains are fairly evenly spread across all areas.

Effectiveness of Service Delivery and Outcomes

7.96 Councils **report a steady increase in the number of** young children looked after in foster placements or placed for adoption **from 82 per cent in 1999-2000, to around 84 per cent in 2000-01 and around 87 per cent in 2003-04.**

7.97 Forecasts of performance show that supported admissions of older people to **residential/nursing care** continue to fall. On average, councils expect 122 out of every 10,000 to be admitted in 2000-01 compared to 124 in 1999-2000.

7.98 The levels of **older people helped to live at home** in 2001 is forecast to be 'acceptable or better' in half of the councils with social services responsibilities and 'very good' in a fifth.

7.99 Less than half of councils has **direct payment schemes** for older people, though nearly all plan to have one by end of 2001. A very small proportion of direct payments (3 per cent) is jointly funded with health.

7.100 The average expected percentage increase in the numbers of **substance misusers participating in treatment**/care programmes is 28 per cent, exceeding the national target of 10 per cent.

7.101 All councils expect to meet their **inspection** obligations for children's homes in 2000-01, however four councils do not expect to carry out all necessary inspections of residential care homes for adults and older people.

7.102 Not all councils are expecting to meet target requirements for **registration of day care**. 10 per cent do not expect to do so for full day care; 30 per cent do not expect to meet requirements for child minders and sessional day care.

7.103 Implementation of **Health Act flexibilities** is most advanced in learning disability services and mental health services, followed by older people's services. However, even for these user groups less than a third of councils are making significant progress.

Quality of Services for Users and Carers

7.104 The target to implement local **joint charters** for long term care by June 2000 has not been achieved everywhere, though most councils expect to have published a charter by the end of 2000.

7.105 Good progress is being achieved towards the target that all **mental health service users on the enhanced Care Programme Approach** should have a written care plan by March 2001.

Fair Access

7.106 87 per cent of councils have an insufficient **supply of foster-carers** and 69 per cent an insufficient **supply of adopters**. The situation with adopters is particularly acute in Inner London. Numbers are similar for supply of black and ethnic minority foster-carers and adopters.

7.107 There is a serious shortage of high support and emergency **accommodation for young people leaving care**.

8. Managing the Department of Health

Running Costs and Staffing Tables

8.1 The Department comprises 13 directorates dealing with various aspects of the organisation's work (eg Health Services, Social Care and Public Health) and eight regional offices. Directors, including Regional Directors, report to the Chief Executive/Permanent Secretary. External and Corporate Affairs Directorate provides the support infrastructure required by Ministers, the Chief Executive/Permanent Secretary and other directorates.

8.2 The provisions for the administration of the Department appears, for past years, in the 2000-01 *Supply Estimates* [(8.1)] for Class II, Vote 2 and for future years they appear in the 2001-02 Request for Resources 2 (see **Annex A**).

8.3 The Department continues to manage its resources within the bounds set by the Spending Reviews. Detailed information on Departmental administration costs is given in **Figure 8.1**. Information on staffing levels is provided in **Figure 8.2**.

8.4 No maladministration payments were made in 2000.

Non-Departmental Public Bodies (NDPBs), NHS Bodies and Agencies

8.5 The Government's proposals in *QUANGOs – opening the doors* [(8.2)] are designed to make NDPBs more open, and the system of appointments to their boards more transparent. Departments must aim to reduce, wherever possible, the number of quangos they sponsor. Those which remain must command public confidence and be able to attract new people.

8.6 The Department's quangos are now operating under these proposals wherever possible and practicable and have introduced measures to increase public accountability and confidence. The Department's eight executive NDPBs have members' codes, published registers of interests and Internet sites. Where practicable and appropriate they are also holding open meetings; summary reports of meetings are published on Internet sites, in annual reports or press releases where possible. Executive NDPBs and SHAs undergo formal reviews at least every five years which assess fundamental issues such as the need for the body, its current status and its performance. As customer for these reviews, the Department

Figure 8.1: Administration Costs

						£ million
	1998-99 outturn[(1)]	1999-2000 outturn	2000-01 estimated outturn	2001-02 Plans	2002-03 plans	2003-04 plans
Department of Health						
Gross administration costs:						
Paybill	4	149	175			
Other	283	129	131			
Total administration costs	287	279	305	314	319	327
Related receipts	-11	-5	-7	-2	-2	-2
Net expenditure	276	273	299	311	317	325
Gross Controlled Administration Costs Limit [(4)]				312		
NHS Pensions Agency [(2)(3)]	18	17	18	16	16	16
NHS Purchasing and Supplies Agency			19	20	20	20
Medical Devices Agency [(2)(3)]	9	7	8	8	8	8
Running costs by control area:						
Net control area:						
NHS Estates Agency [(5)]						
Gross expenditure	13					
Net expenditure						
Outside administration costs limits						
Non-cash administration costs in AME	21	20	27	21	21	26

1 Figures from 1998-99 Resource Accounts, no further breakdown of split between paybill and other available.
2 A Next Steps Executive Agency.
3 These figures are included in the Department of Health figures above.
4 Figure is net of allowable receipts.
5 A Next Steps Agency until 31 March 1999. From 1 April 1999 has operated as a Trading Fund.

Figure 8.2: Staff Numbers

1 April – 31 March	1995-96 actual	1996-97 actual	1997-98 actual	1998-99 actual	1999-2000 actual	2000-01 estimated	2001-02 plans	2002-03 plans	2003-04 plans
									Staff-years
Department of Health (Gross Control Area)									
Civil Servants (full-time equivalents)	3,801	4,309	4,091	4,081	4,200	4,448	4,479	4,479	4,479
Overtime	43	40	40	40	40	0	0	0	0
Casuals	239	137	116	98	101	63	72	72	72
Total	**4,083**	**4,486**	**4,247**	**4,219**	**4,341**	**4,511**	**4,551**	**4,551**	**4,551**
NHS Estates Agency (Net Control Area)[1]									
Civil Servants (full-time equivalents)	101	138	142	236	263	306	317	317	317
Overtime	2	0	0	0	0	0	0	0	0
Casuals	1	1	2	6	7	20	20	20	20
Total	**104**	**139**	**144**	**242**	**270**	**326**	**337**	**337**	**337**
Medicines Control Agency [2]									
Civil Servants (full-time equivalents)	356	378	413	492	490	436	468	454	441
Total Department of Health	**4,543**	**5,003**	**4,804**	**4,953**	**5,101**	**5,273**	**5,356**	**5,342**	**5,329**

1 The NHS Estates Agency became a trading fund on 1 April 1999.
2 The Medicines Control Agency became a trading fund on 1 April 1993.

follows the guidance on their conduct which was revised by the Cabinet Office in January 2000[8.3].

8.7 In 1999 the Department introduced a new approach to the management of the performance of its arm's length bodies (NDPBs, Agencies and special health authorities). The new approach is continuing to develop and aims both to strengthen and maintain working relationships with these bodies and to ensure that each has a comprehensive performance management framework in place. This new work has concentrated on structural improvements, mainly in the form of new guidance which is available both to the bodies themselves and their sponsor branch within the Department. The guidance promotes sound management techniques, and now also requires these bodies to consider their work programme from the perspective of contributing to the achievement of the *NHS Plan*[8.4]. A senior Departmental sponsor has been appointed for each body. Although supported by the sponsor Branch, the senior sponsors remain directly responsible for ensuring that each body is performing well and that proper systems are in place for monitoring performance and assessing achievement. For the future, this new approach will concentrate on aiming to introduce improvements in the performance management of arm's length bodies.

8.8 The Department has five executive Agencies:

- The Medical Devices Agency (MDA) – an independent review conducted in 1999 found that the MDA was performing effectively and efficiently and is regarded as a world leader in its field.
- The Medicines Control Agency (MCA) – an independent review conducted in 1999 found that the MCA was also regarded as a world leader in its field. A further review of the Agency's fees and funding is contemplated for 2001-02.
- NHS Estates (NHSE) – a quinquennial review of the Agency in 2000 commended the Agency's management regime and reinforced the strategic focus of the Agency on the Modernisation of the NHS.
- NHS Pensions Agency (NHSPA) – work is now in hand to implement recommendations from the recent five yearly review. In particular, procurement of a private sector partner for contractorisation of the Agency's non-core services is now going ahead according to programme and is expected to complete by June 2001.
- NHS Purchasing and Supply Agency (NHSP&SA) – established on 1 April 2000, the Agency is modernising and improving the performance of the NHS purchasing and supply system and will become the centre of expertise on purchasing and supply for the NHS.

8.9 The relationship between the Department and its Agencies is set out in the relevant Framework Documents which are available from the Agencies. Further details about the management of the above Agencies can be found in **Annex B**.

Public Appointments

8.10 All appointments to NHS bodies, Executive NDPBs and Advisory NDPBs sponsored by the Department are made according to guidelines laid down by the Commissioner for Public Appointments. These guidelines ensure that all appointments are made on merit, after an open and transparent recruitment and selection process, involving independent assessors.

8.11 Appointments to all NHS bodies and most NDPBs are subject to a programme of public advertisements, either nationally, locally or in specialist publications.

8.12 The Government has announced in the NHS Plan that the appointment of chairs and non-executive directors of NHS Trusts, Health Authorities and Primary Care Trusts (PCTs) will, in future, be undertaken by a new NHS Appointments Commission.

8.13 It will be established as a Special Health Authority early in 2001, making its first full round of appointments to NHS Trust and PCT boards the following October and November. The Secretary of State will publish guidance for the Commission on the qualities required of candidates for appointment, as well as goals and objectives to ensure that NHS boards are representative of the communities they serve. The Commission will report annually to Parliament on its performance and progress.

8.14 Considerable progress has been made in improving the gender and ethnic balance of the boards for which the Department is responsible. At 1 April 2000, 12.3 per cent of those appointed to NHS boards came from an ethnic minority background. At the same time, 48.7 per cent of those appointed to the same boards were women, with women appointed to 37.8 per cent of the chair posts.

Figure 8.3: Public Appointments

Number of posts (at 1 October 2000)	Chair	Member	Total
Health Authorities	99	528	627
NHS Trusts	35	1,797	2,151
Primary Care Trusts	44	235	279
Special Health Authorities	15	306	321
Advisory Non-Departmental Public Bodies	37	654	691
Executive Non-Departmental Public Bodies	8	126	134
Total	**557**	**3,646**	**4,203**

Recruitment

8.15 In the Department, external recruitment is centrally managed within Personnel/HR sections of the Agencies and Regional Offices. Well established systems are in place which ensure that all external recruitment is carried out on the basis of fair and open competition and is in accordance with the provisions of the *Civil Service Commissioners' Recruitment Code*(8.5).

8.16 The number of successful candidates in external competitions is shown in **Figure 8.4** and, as required by the Code, gives the number of women, ethnic minorities and disabled people successful at each level. The figures include the following permitted exceptions:

- 8 staff appointments made under the New Deal provisions;
- 92 secondments;
- 24 extensions to secondments;
- 7 short term appointments where highly specialised skills required;
- 9 extensions to short term appointments beyond the advertised period;
- 24 conversions of short term appointments to permanency;
- 1 reappointment of a former civil servant;
- 7 transfers into the civil service; and,
- 1 appointment of surplus acceptable candidates to shortage posts.

8.17 The review of the internal selection mechanism (Job Specific Selection) for non-Senior Civil Service staff continues. A joint Management/Departmental Trade Union Side (DTUS) Working Group has developed proposals for a new system. Consultation with DTUS and Staff Reference Groups is on-going. The proposed new internal selection system is designed to link closely with *New Understanding*(8.6) and Diversity Action Plans. It also reflects the most recent employment law changes and dovetails in with the Modernising Government Initiative. Subject to the outcome of consultation it is proposed to launch the revised system in 2001-02.

Senior Civil Service Salaries

8.18 Details of Senior Civil Service Salaries in the Department of Health are given in **Figure 8.5**.

Figure 8.5: Salaries in the Department of Health for Senior Civil Service staff in post at 1 April 2000

Payband (per annum) (*)	Number of Staff
£40,000 – £44,999	3
£45,000 – £49,999	31
£50,000 – £54,999	60
£55,000 – £59,999	76
£60,000 – £64,999	68
£65,000 – £69,999	60
£70,000 – £74,999	21
£75,000 – £79,999	25
£80,000 – £84,999	13
£85,000 – £89,999	22
£90,000 – £94,999	9
£95,000 - £99,999	7
Over £100,000	23
Total	**418**

** Salary figures include reserved rights to London Weighting and London NHS Geographical Allowance*

A Healthier Workplace

8.19 The Department has agreed with Cabinet Office and the Treasury targets for reducing its levels of sickness absence as part of the Civil Service-wide initiative to bring overall levels down by 30 per cent by 2003. The Department's targets are to bring absence levels down to 7.9 days per staff year by 2001, and down to 6.8 days per staff year by 2003. These targets equate to reductions of 14 per cent and 26 per cent respectively.

8.20 In order to reduce sickness absence levels the Department has in hand, or is planning, a number of measures aimed at safeguarding the health and safety of its workforce, and at improving the management of sickness absence.

8.21 A review of occupational health provision in the Department culminated in a revised and expanded specification for the service. This formed the basis of a tender exercise in early 2000, which resulted in the Department letting its Occupational Health contract to a new service provider with effect from 2 October 2000. The new contract provides improved services and better access for managers and staff and will assist with the better management of sickness absence. Further enhancements to the services will be discussed with the contractor in 2001.

8.22 The Department's ongoing programme of workplace risk assessments continues. A new database was developed during the year 2000 which gives the Department's Health and Safety Unit rapid access to details of all trained risk assessors, and also all trained first aid providers, and enables them to quickly identify where gaps might need to be filled.

8.23 During 1999-2000 the Department carried out a thorough review of its internal policy on smoking in the workplace in line with Government policy set out in the *Smoking Kills White Paper* (8.7). This included looking at the continuing provision of segregated smoking rooms for staff, and also what practical assistance could be given to those staff who smoke but who might like to stop. Work is now in hand to implement the review's findings in 2001.

8.24 New guidance is to be developed in 2001 for managers and staff on how to manage sickness absence. This will emphasise key actions to be taken and will aim to reinforce good practice throughout the Department. It will provide greater clarity on the respective roles and responsibilities of managers and individual members of staff in relation to managing attendance.

8.25 Work is also in hand to provide managers with easy access to up-to-date workforce information, including information pertaining to sickness absence.

Accommodation

8.26 There has been no significant change to Departmental buildings apart from the move of Eastern Regional Office from Milton Keynes to Cambridge to make more efficient use of the overall government estate and provide a more central location in the region. All Departmental buildings continue to operate at or near capacity, in London housing parts of the Food Standards Agency prior to their move to their new headquarters building early in 2001.

8.27 A study was commissioned to look at how to make more effective use of the Department's space. This will identify new ways in which our accommodation might be used to better support modern working practices.

The Environment

8.28 The Department continues to develop and implement its environmental strategy contained in *Department of Health Strategy on Sustainable Development and the Environment* (8.8). This strategy is wide-ranging, encompassing the concepts of sustainable development, environmental appraisal and environmental management, building on work already undertaken to identify significant environmental impacts and the development and introduction of strategies to improve the Department's environmental performance. The Department's Environmental Strategy Steering Group is taking forward the commitment to this strategy.

8.29 Reviews of the Department's policy on waste and Environmental Management have been undertaken and recommendations are being implemented. Provision for meeting (and exceeding) the Department's waste target has been incorporated into the new cleaning and waste contract from April 2001. Environmental aspects are a mandatory element of any contract being re-tendered.

8.30 The Department's 'Green Minister' is Yvette Cooper MP [whose other responsibilities are detailed earlier in this report]. The Department's official environmental contacts are Martin Chaplin, Head of Contract Management (operational), 020 7972 5749, and Marjorie Thorburn, Sustainable Development Team (policy), 020 7972 5158.

Figure 8.4: Recruitment into the Department of Health, 2000

	Total	Male	Female	Ethnic Minorities	Disabled
Permanent Staff joining during 2000 who are still employed by the Department of Health					
Senior Civil Service	45	21	19	5	0
Fast Stream	25	6	18	1	0
Posts at former UG6 and below	590	208	322	45	15
Total	**660**	**235**	**359**	**51**	**15**
Permanent Staff joining during 2000 who are no longer employed by the Department of Health					
Senior Civil Service	2	1	1	0	0
Fast Stream	0	0	0	0	0
Posts at former UG6 and below	83	26	49	8	0
Total	**85**	**27**	**50**	**8**	**0**
All Permanent Staff joining during 2000					
Senior Civil Service	47	22	20	5	0
Fast Stream	25	6	18	1	0
Posts at former UG6 and below	673	234	371	53	15
Total	**745**	**262**	**409**	**59**	**15**

1 These figures include all exception categories except for the two New Deal candidates.
2 All figures apart from those for the SCS exclude NHS Estates Agency Staff.

List of Annexes

A Resource Main Estimates

A1 Departmental Voted Cash Requirement

A2 Total Capital Employed by Department

A3 Consumption: Analysis of Resource Budget Spending Plans

A4 Investment: Analysis of Capital Budget Spending Plans

A5 Reconciliation of Resource Expenditure between Accounts, Estimates and Budgets

A6 Reconciliation of Capital Expenditure between Accounts, Estimates and Budgets

A7 Departmental expenditure limits and Annually Managed Expenditure: Cash to Resources Reconciliation 1998-99 to 2003-02

A8 National Health Service, United Kingdom – By Area of Expenditure (resources)

A9 United Kingdom NHS Expenditure (cash)

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 2000

E Spending on Publicity, Advertising and Sponsorship

F Performance Indicators for Social Services

ANNEX A

Resource Main Estimate, 2001-02

Introduction – RfR1

A1. About 96 per cent of central government expenditure on Health and Personal Social Services (HPSS) in England is in RfR1: the balance of voted expenditure including the Department's costs of administering expenditure is borne on RfR2. Corresponding expenditure in Scotland is shown in Scotlands' Supply Estimates 2001-02; in Wales will be shown as part of the budget for the National Assembly for Wales and in Northern Ireland is published in separate estimates.

A2. Section A: covers expenditure on the hospital, community health, discretionary family health and related services on NHS Trusts and services provided to or on behalf of the Scottish Executive, the National Assembly for Wales and Northern Ireland. This is mainly made up of current and capital expenditure of health authorities and primary care trusts to fund unified budgets which cover hospital and community health services, prescribing costs and discretionary general medical services. Health authorities and primary care trusts commission the health services needed for their populations from the unified budgets. Section A also covers central expenditure on certain national bodies (e.g. special health authorities including the Prescription Pricing Authority and the Dental Practice Board), services (e.g. purchase of vaccines) and of service specific levies for education and training and research and development.

A3. Sections B to F: covers expenditure on the non discretionary family health services provided under Part II of the NHS Act 1977. These comprise the remuneration of general medical practitioners (other than reimbursement of certain expenses which are covered by Section A), together with expenditure on general dental services, general ophthalmic services and most fees and allowances for dispensing and other pharmaceutical services. Expediture on drugs prescribed by family health service practitioners now forms part of Health Authority unified allocations in Section A.

A4. Section G: covers health authority grants to local authorities.

A5. Sections H to M: covers non cash items within annually managed expenditure.

A6. Sections N to P: covers the part of Health Authority expenditure which relates to NHS Trusts depreciation for capital expenditure, grant in aid funding of NDPBs, provision for issues of new Public Dividend Capital (PDC) and repayments of PDC, an appropriate element of National Health Service contributions paid by employers and employees and provision for financing the difference in timing where a health authority transfers its banking from a commercial cheque based system to the Paymaster's payable order system.

RfR2

A7. Sections A to D: the gross administration costs of the Department and its Agencies and the associated capital expenditure on buildings, furniture, computer and telecommunications equipment etc.

A8. Sections E: covers revenue advances to Non Departmental Public Bodies.

A9. Sections F: covers central health and miscellaneous services (CHMS) including work on regulatory and protection services and health promotion; and certain other services such as grants to voluntary organisations, research and development, information services and payments to international organisations.

A10. Section G: consists of non discretionary European Economic Area medical costs and welfare food.

A11. Section H: personal social services related payments cover expenditure on personal social services other than grants to local authorities and includes grant funding for certain NDPBs, the Training Organisations for Personal Social services and certain voluntary organisations, expenditure by the Registered homes tribunal, Protection of Children Act Tribunal, expenditure on social work training development projects and payments for joint reviews of social services departments.

A12. Sections I to S: certain grants to local authorities including social services training, provision of secure accommodation, services for people with HIV infection and AIDS, services for people for those with a mental illness, services for alcohol and drug misusers, support for carers, initiatives to promote the independence of people living in the community, for the improvement of children's services, projects funded from the Invest to Save Budget, the placing of charges on homes and improving information management. Advances to local authorities for personal social services specific and special grants are charged to the Vote at the time of issue and as final grant expenditure is not known until local authorities' accounts are audited after the end of the financial year, any necessary adjustments may be made in subsequent advances.

A13. Section T: employment subsidy from the Department for Education and Employment in respect of people employed under the Employment Opportunities Fund.

A14. Sections U to Z: covers annually managed (non cash) expenditure within RfR2.

A15. Sections AA to AH: covers trading fund income on public dividend capital and repayment of loans; capital grant in aid funding of NDPBs (National Biological Standards Board, the National Radiological Protection Board, the Human Fertilisation and Embryology Authority) and special health authorities (the Microbiological Research Authority and the Health Development Agency) and current and capital advances to the Public Health Laboratory Service, capital grants to local authorities and payments under the Animal (Scientific Procedures) Act 1986.

A16. Symbols used in this Estimate can be found in the Notes section page 86.

Part I

	£
RfR1: Securing health care for those who need it	**41,460,955,000**
RfR2: Securing social care and child protection for those who need it and at national level protecting, promoting and improving the nation's health	**1,822,732,000**
Total net resource requirement	43,283,687,000
Net cash requirement	**43,279,479,000**

Amount required in the year ending 31 March 2002 for expenditure by the Department of Health on:

RfR1: Securing health care for those who need it.

Health authorities and primary care trusts under their unified budgets, family health services (including general medical, general ophthalmic, general dental and pharmaceutical services); public dividend capital advances to trusts, education, training, research and development; centrally managed expenditure on behalf of the NHS, services provided to or on behalf of the Scottish Executive, National Assembly for Wales and Northern Ireland, and associated non cash items.

RfR2: Securing social care and child protection for those who need it and at national level protecting, promoting and improving the nation's health.

Administration, including certain expenditure on behalf of the Department of Social Security and the National Health Service in England; departmental agencies, centrally funded health and social services (including non-departmental public bodies and special health authorities some of which are administered on a United Kingdom basis); including other local government services, medical, scientific and technical services, services for disabled persons, grants to voluntary organisations and other bodies, research and development, information services and health promotion activities; provision of personal social services (including grants to local authorities); medical treatment given to people from the United Kingdom in other countries of the European Economic Area; welfare food; Home Office inspection of laboratories; grants in aid; payments and subscriptions to international organisations; prison health care; education and training for all health care professionals (excluding doctors); the Employment Opportunties Fund programme; payments made under Sector Challenge arrangements with the Department of Trade and Industry; services provided to or on behalf of the Scottish Executive, National Assembly for Wales and Northern Ireland, and associated non cash items.

The **Department of Health** will account for this Estimate.

	Net Total £	Allocated in Vote on Account £	Balance to Complete £
RfR1	41,460,955,000	18,434,703,000	23,026,252,000
RfR2	1,822,732,000	809,345,000	1,013,387,000
Total resource requirement	43,283,687,000	19,244,048,000	24,039,639,000
Net cash requirement	43,279,479,000	21,088,980,000	22,190,499,000

Part II: Subhead details

£'000

	Resources						Capital		2000-2001 Provision	1999-2000 Outturn
	1	2	3	4	5	6	7	8	9	10
	Administration costs	Other current	Grants	Gross total	Appro-priations in aid	Net total	Capital	Non-operating Appro-priations in aid	Net total resources	Net total resources
RfR1: Securing health care for those who need it	**0**	**48,911,519**	**911,107**	**49,822,626**	**8,361,671**	**41,460,955**	**1,888,836**	**1,310,000**	**38,075,092**	**34,458,572**
Spending in Departmental Expenditure Limits (DEL)										
Central government spending										
*A: Health authorities unified budget and central allocations.	0	42,239,509	356,212	42,595,721	107,720	**42,488,001**	270,836	210,000	38,371,968	34,809,322
B: FHS - general medical services.	0	1,874,020	0	1,874,020	0	**1,874,020**	0	0	2,559,020	2,474,996
C: FHS - pharmaceutical services.	0	883,555	0	883,555	0	**883,555**	0	0	854,623	811,327
D: FHS - prescription charges income.	0	2,400	0	2,400	416,041	**-413,641**	0	0	-390,667	-366,705
E: FHS - general dental services.	0	1,673,526	0	1,673,526	482,164	**1,191,362**	0	0	1,130,362	1,053,305
F: FHS - general ophthalmic services.	0	293,423	0	293,423	25	**293,398**	0	0	291,398	286,044
Support for local authorities										
*G: Health authority grants to local authorities.	0	0	448,788	448,788	0	**448,788**	0	0	442,204	403,379
Spending in Annually Managed Expenditure										
Non-cash items in annually managed expenditure										
H: Health authorities unified budget and central allocations.		707,000	0	707,000	0	**707,000**	0	0	792,103	705,508
I: FHS - general medical services.		-16,490	0	-16,490	0	**-16,490**	0	0	-15,708	-14,609
J: FHS - pharmaceutical services.		-9,219	0	-9,219	0	**-9,219**	0	0	-8,870	-5,332
K: FHS - prescription charges income.		3,458	0	3,458	0	**3,458**	0	0	3,327	0
L: FHS - general dental services.		-12,064	0	-12,064	0	**-12,064**	0	0	-11,202	-10,559
M: FHS - general ophthalmic services.		-1,604	0	-1,604	0	**-1,604**	0	0	-1,700	-1,596
Other spending outside Departmental Expenditure Limits										
N: Grant in aid to non-department public bodies, NHS trust loans and other central capital grants.	0	1,273,000	106,107	1,379,107	1,306,342	**72,765**	1,618,000	1,100,000	-182,400	-192,710
O: NHS Contributions.	0	0	0	0	6,049,379	**-6,049,379**	0	0	-5,760,371	-5,493,799
P: Other.	0	1,005	0	1,005	0	**1,005**	0	0	1,005	1
RfR2: Securing social care and child protection for those who need it and at national level, protecting, promoting and improving the nation's health	**334,713**	**400,831**	**1,230,881**	**1,966,425**	**143,693**	**1,822,732**	**52,329**	**535**	**1,535,352**	**1,477,014**
Spending in Departmental Expenditure Limits (DEL)										
Central government expenditure										
*A: Central department.	268,641	2,943	0	271,584	3,858	**267,726**	9,132	142	250,077	246,899
*B: NHS Pensions Agency.	16,262	0	0	16,262	2,000	**14,262**	268	0	15,997	16,975
*C: Medical Devices Agency.	7,878	223	0	8,101	450	**7,651**	286	0	7,741	7,288
*D: NHS Purchasing and Supplies Authority.	19,556	0	0	19,556	0	**19,556**	100	0	18,676	0

Part II: Subhead details (continued)

£'000

	Resources						Capital		2000-2001 Provision	1999-2000 Outturn
	1	2	3	4	5	6	7	8	9	10
	Administration costs	Other current	Grants	Gross total	Appro-priations in aid	Net total	Capital	Non-operating Appro-priations in aid	Net total resources	Net total resources
*E: Non-departmental Public Bodies revenue advances.	0	57,302	0	57,302	26,757	**30,545**	0	0	5,068	22,501
*F: Other services including medical, scientific and technical services, grants to voluntary bodies, research and developement and information services.	0	184,218	67,331	251,549	680	**250,869**	0	0	199,303	181,714
G: Welfare food and European Economic Area medical costs.	0	116,500	189,000	305,500	31,000	**274,500**	0	0	270,671	275,173
*H: Other personal social services.	0	48,104	17,116	65,220	348	**64,872**	42,214	0	38,004	33,619
Youth Treatment service	0	0	0	0	0	0	0	0	3,604	484
Food Standards Agency	0	0	0	0	0	0	0	0	0	333
Support for local authorities										
*I: Training support programme for social services staff.	0	0	47,500	47,500	0	**47,500**	0	0	42,500	39,000
*J: Services for people with HIV and AIDS.	0	0	16,500	16,500	0	**16,500**	0	0	16,000	14,831
*K: Services for alcohol and drug misusers.	0	0	8,850	8,850	0	**8,850**	0	0	6,780	4,550
*L: Services for people with mental illness.	0	0	149,443	149,443	0	**149,443**	0	0	128,895	114,979
*M: Provision for secure accommodation.	0	0	14	14	0	**14**	0	0	14	13
*N: Promoting Independence grant.	0	0	197,000	197,000	0	**197,000**	0	0	0	0
*O: Carers' grant.	0	0	70,000	70,000	0	**70,000**	0	0	50,000	20,000
*P: Children's services grant.	0	0	290,750	290,750	0	**290,750**	0	0	117,120	74,303
*Q Grants funded from the Invest to Save Budget.	0	0	1,235	1,235	0	**1,235**	0	0	2,825	0
*R: Long term care (placing charges on homes).	0	0	15,000	15,000	0	**15,000**	0	0	0	0
*S: Care Direct.	0	0	2,000	2,000	0	**2,000**	0	0	450	0
Services for people seeking asylum	0	0	0	0	0	**0**	0	0	6,500	11,458
Unaccompanied asylum-seeking children	0	0	0	0	0	**0**	0	0	3,000	50,847
Promoting independence: partnership grant	0	0	0	0	0	**0**	0	0	216,000	252,991
Promoting independence: prevention grant	0	0	0	0	0	**0**	0	0	30,000	20,000
Spending in Employment Opportunties Fund (EOF) Departmental Expenditure Limits										
Central government spending										
*T: Employment Opportunities Fund	0	0	0	0	10	**-10**	0	0	-10	0

Part II: Subhead details (continued)

£'000

	Resources						Capital		2000-2001 Provision	1999-2000 Outturn
	1	2	3	4	5	6	7	8	9	10
	Administration costs	Other current	Grants	Gross total	Appro-priations in aid	Net total	Capital	Non-operating Appro-priations in aid	Net total resources	Net total resources
Spending in Annually Managed Expenditure										
Non-cash items in anually managed expenditure										
U: Central department.	22,163	0	0	22,163	0	**22,163**	0	0	27,580	19,983
V: NHS Pensions Agency.	213	0	0	213	0	**213**	0	0	250	344
W: Medical Devices Agency.	0	292	0	292	0	**292**	0	0	361	329
X: NHS Purchasing and Supplies Authority.	0	77	0	77	0	**77**	0	0	0	0
Y: Other services including medical, scientific and technical services, grants to voluntary bodies, research and developement and information services.	0	319	0	319	0	**319**	0	0	632	504
Z: Welfare food and European Economic Area medical costs.	0	-9,174	0	-9,174	0	**-9,174**	0	0	-8,676	-8,342
Youth Treatment Service	0	0	0	0	0	**0**	0	0	10	5,050
Other spending outside Departmental Expenditure Limits										
AA: NHS Estates Agency - dividend on public dividend capital and repayment of loans.	0	0	0	0	23	**-23**	0	64	-6	0
AB: Medicines Control Agency - dividend on public dividend capital and payment and repayment of loans.	0	0	0	0	157	**-157**	329	329	-136	-136
AC: Grant in Aid funding of non-departmental public bodies and special health authorities.	0	0	149,819	149,819	78,400	**71,419**	0	0	82,701	68,049
AD: Provision for secure accommodation (capital).	0	0	6,228	6,228	0	**6,228**	0	0	1,965	3,589
AE: Grants funded from the Invest to Save Budget (capital).	0	0	95	95	0	**95**	0	0	1,429	0
AF: Improving information management (capital).	0	0	3,000	3,000	0	**3,000**	0	0	0	0
AG: Other.	0	27	0	27	0	**27**	0	0	27	16
AH: Central department profit and losss on disposal of assets.	0	0	0	0	10	**-10**	0	0	0	-300
Personal social services	0	0	0	0	0	**0**	0	0	0	-30
Total	**334,713**	**49,312,350**	**2,141,988**	**51,789,051**	**8,505,364**	**43,283,687**	**1,941,165**	**1,310,535**	**39,610,444**	**35,935,586**
					Accruals to cash adjustment			-634,838		
					Net cash required			**43,279,479**		

	2001-02	2001-02 £000	2000-01	2000-01 £000	1999-00	1999-00 £000
Resource to cash reconciliation						
Net total resources		**43,283,687**		**39,610,444**		**35,935,586**
Voted capital items:						
Capital	1,941,165		1,603,689		707,299	
Less non-operating AinA	1,310,535		1,352,270		997,304	
		630,630		**251,419**		**-290,005**
Accruals to cash adjustments:						
Capital charges	-207,984		45,166		29,177	
Depreciation	366,899		-381,476		-349,482	
Other non-cash items	-299		-249		-212	
Increase(+)/decrease(-) in stock	19		-20		67	
Increase(+)/decrease(-) in debtors	140,283		167,443		117,223	
Increase(-)/decrease(+) in creditors	-276,198		-324,515		-247,599	
Increase(-)/decrease(+) in provisions	-339,728		-278,217		-221,022	
Excess cash to be CFER'd	0		0		0	
		-634,838		**-771,868**		**-671,848**
Net cash required		**43,279,479**		**39,089,995**		**34,973,733**

Part III: Extra Receipts payable to the Consolidated Fund (£000)

In addition to appropriations in aid the following income relates to the department and is payable to the Consolidated Fund (cash receipts are shown in italics):

		2001-2002		2000-2001		1999-2000
	Income	*Receipts*	Income	*Receipts*	Income	*Receipts*
Operating income not classified as Appropriations-in-Aid •	-113	*-113*	-118	*-118*	-114	*-114*
Non-operating income not classified as Appropriations-in-Aid	0	*0*	0	*0*	0	*0*
Other income not classified as Appropriations-in-Aid	0	*0*	0	*0*	0	*0*
	-113	*-113*	**-118**	*-118*	**-114**	*-114*

Forecast Operating Cost Statement

for the year ending 31 March 2002

		Provision 2001-2002		Provision 2000-2001		Provision 1999-2000
	£'000	£'000	£'000	£'000	£'000	£'000
Administration Costs						
Request for Resources 2						
Staff Costs	172,584		174,833		149,312	
Other Administration costs	162,129		168,153		159,494	
		334,713		342,986		308,806
Operating income		-2,368		-16,830		-15,026
Net Administration costs		332,345		326,156		293,780
Programme costs						
Voted Expenditure						
Request for Resources 1						
Expenditure	49,822,626		46,062,030		42,125,571	
Income	-8,361,671		-7,986,938		-7,666,999	
		41,460,955		38,075,092		34,458,572
Request for Resources 2						
Expenditure	1,631,712		1,365,412		1,299,270	
Income	-141,438		-156,334		-116,150	
		1,490,274		1,209,078		1,183,120
Non-Voted Expenditure						
Expenditure	0		0		0	
Income	0		0		0	
		0		0		0
Total Net Programme costs		42,951,229		39,284,170		35,641,692
Net Operating Costs		43,283,574		39,610,326		35,935,472
Net Resource Outturn		43,283,687		39,610,444		35,935,586
Resource Budget Outturn		49,567,277		45,931,672		41,888,001

Forecast Cash Flow Statement

for the year ending 31 March 2002

	2001-2002 £'000	2000-2001 £'000	1999-2000 £'000
Net cash outflow from operating activities *(Note i)*	-42,648,356	-38,838,077	-35,263,557
Capital expenditure and financial investment *(Note ii)*	-631,010	-251,800	289,938
Receipts due to the Consolidated Fund which are outside the scope of the department's operations	0	0	0
Payments of amounts due to the Consolidated Fund	-113	-118	-114
Financing *(Note iii)*	43,279,479	39,089,995	34,973,733
Increase (+) /decrease(-) in cash in the period	0	0	0
Notes to the cash flow statement			
Note i: Reconciliation of operating cost to operating cash flows			
Net Operating Cost	43,283,574	39,610,326	35,935,472
Remove non-cash transactions	-690,579	-783,127	-695,215
Adjust for movement in working capital other than cash	-136,286	-157,473	-130,676
Use of provisions	191,647	168,351	153,976
Net cash outflow from operating activities	42,648,356	38,838,077	35,263,557
Note ii: Analysis of capital expenditure and financial investment			
Intangible fixed asset additions	322,836	276,213	63,735
Tangible fixed asset additions	0	0	0
Proceeds of disposal of fixed assets[1]	-210,152	-301,877	-269,349
Loans to other bodies	517,936	277,083	-84,691
Adjust for movements in working capital on capital expenditure and financial investment	390	381	367
Net Cash outflow for captial expenditure and financial investment	631,010	251,800	-289,938
[1] Includes profit/loss and bad debts on disposal of fixed assets.			
Note iii: Analysis of financing and reconcilliation to the net cash requirement			
From Consolidated Fund (Supply): current year expenditure	37,230,100	33,329,624	29,479,934
NHS Contributions	6,049,379	5,760,371	5,493,799
From Consolidated Fund (Supply): prior year expenditure	0	0	0
Net financing	43,279,479	39,089,995	34,973,733
Increase(-)/decrease(+) in cash	0	0	0
= Net cash flows other than financing (net outflow = +)			
Adjust for payments and receipts not related to Supply:			
CFERs received but not paid over	0	0	0
CFERs received in prior year paid over	0	0	0
	0	0	0
Net cash requirement for the year	**43,279,479**	**39,089,995**	**34,973,733**

Forecast Reconciliation of Net Operating Cost to Net Resource Outturn and Resource Budget Outturn Main Estimate

for the year ending 31 March 2002

	2001-2002 £'000	2000-2001 £'000	1999-2000 £'000
Net Resource Outturn	**43,283,687**	**39,610,444**	**35,935,586**
*Remove income scored as CFERs	-113	-118	-114
Net Operating Costs	**43,283,574**	**39,610,326**	**35,935,472**
*Add Other Consolidated Fund Extra Receipts	113	118	114
For NDPBs that score in budgets on the basis of NDPB expenditure:			
*Less grants in aid payable to NDPBs	-100,195	-110,938	-100,372
*Add cost of capital charges in respect of assets held by NDPB's	13,942	13,136	12,947
*Add net resource consumption by NDPBs including depreciation	102,119	107,069	96,325
For NDPBs that score in budgets on a non-RAB:			
*Less grant in aid payable to NDPBs to finance capital expenditure	-11,789	-9,285	-9,829
Adjustment for Public Corporations and Trading Funds			
*Add cost of capital charge in respect of net assets of Public Corporations and Trading Funds (if not already included in Public Expenditure)	1,326,149	1,293,518	1,307,751
*Reverse the deduction of dividends and interest income from Public Corporations and Trading Funds	1,306,522	1,286,606	1,306,680
*Deduct profit or add loss incurred by Public Corporations and Trading Funds	-1,242,467	-1,208,130	-1,089,777
Adjustment for Capital Grants			
*Less grants to Local Authorities to finance capital expenditure	-9,323	-3,394	-3,589
*Less grants paid to private sector by departments to finance capital expenditure	-65,542	-65,542	-51,652
Adjustment related to income from Sales of Capital Assets			
*Reverse the deduction of gains and deduct the losses incurred on disposal of assets	10	0	300
*Remove other expenditure shown in Estimates under heading "Other expenditure Outside DEL" that is outside the Resource Budget	4,775,347	4,758,339	4,473,782
NHS contributions	6,049,379	5,760,371	5,493,799
cash funding of health authorities for trust expenditure	-1,273,000	-1,001,000	-1,020,000
other minor budgets	-1,032	-1,032	-17
* Departmental Unallocated Provision	174,777	250,000	0
* NHS Contributions Cost of Collection	14,040	9,849	9,849
Resource Budget Outturn	**49,567,277**	**45,931,672**	**41,888,001**
Of which:			
Departmental Expenditure Limit (DEL)	47,716,720	43,998,614	40,014,436
Spending in Employment Opportunities Fund (EOF) DEL	-10	-10	0
Annually Managed Expenditure (AME)	1,850,567	1,933,068	1,873,565

Explanation of Accounting Officer Responsibilities

The Permanent Head/NHS Chief Executive of the Department of Health, Mr Nigel Crisp, has been appointed by the Treasury as Accounting Officer for the Department with responsibility for preparing the Department's Estimate.

The responsibilities of an Accounting Officer, including responsibility for the propreity and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Department's assets, are set out in the Accounting Officer's Memorandum issued by the Treasury and published in Government Accounting.

Appropriations in Aid

£'000

Detail	2001-2002 Provision		2000-2001 Provision		1999-2000 Outturn	
	AinA	Non-op AinA	AinA	Non-op AinA	AinA	Non-op AinA
RfR1: Securing health care for those who need it.						
Charges for accommodation, goods and services to private and NHS patients and others; income generation schemes; medical and dental education levy; income from the licensing of software; income from Ashworth Special Hospital, the Mental Health Act Commission, the Centre for Pharmacy Post Graduate Education, the Prescription Pricing Authority, the Dental Practice Board, and Regional Offices; income from the Scottish Executive, the National Assembly for Wales and Northern Ireland for services provided for devolved or reserved work. Rebates and discounts from manfacturers under the Pharmaceutical Price Regulation Scheme and Purchasing and Supply Agency arrangements.	107,720		90,011		64,684	
NHS prescription charges	416,041		393,067		368,867	
Dental charges	482,164		457,000		433,085	
Recoveries from patients in respect of incorrect claims for eligibility for general ophthalmic services	25		25		20	
Contributions by employers and employees towards the cost of the NHS	6,049,379		5,760,371		5,493,799	
Principal and interest payments on NHS Trusts loans and repayments of, and dividends on public dividend capital advances by or on behalf of NHS trusts	1,306,342	1,100,000	1,286,464	1,050,000	1,306,544	728,255
Capital income from sale of land, buildings, surplus vehicles and equipment		210,000		298,000		266,245
RfR2: Securing social care and child protection for those who need it, and at a national level, protecting, promoting and improving the nation's health.						
Administration receipts for seconded officers; Employment Opportunities Fund; staff telephone calls; staff lease cars scheme; European Fast Stream programme; recoveries from other departments and the NHS, local authorities, NHS Estates and Medicines Control Agency for goods and services, staff accommodation, reimbursement of meeting expenses and selling services into wider markets, library income and open government.	3,868		13,958		11,266	
NHS Pensions Agency: income from mis-sold pensions, assessing pensions on divorce and from contractors	2,000		1,886		344	
Medical Devices Agency receipts from manufacturers' registration scheme, product approval scheme, sales of publications, Competent Authority Activities.	450		325		384	
Licence fees, royalties and sales of publications, evaluation reports, British Pharmacopeia Chemical Reference Substances, contributions by members of the public, insurance claims, sale of cars, sector challenge receipts from Department of Trade and Industry, mobile phone research contributions.	1,028		16,077		2,538	
Income from Human Fertilisation and Embryology Authority, National Biological Standards Board, Public Health Laboratory Service, Microbiological Research Authority, Health Development Authority, Central Council for Education and Training in Social Work, General Social Care Council	105,157		103,145		90,101	
European Economic Area countries for NHS treatment of their residents	29,000		25,000		15,041	
Income from sale of subsidised dried milk	2,000		2,500		955	
Dividends on public dividend capital by the Medicines Control Agency and the NHS Estates Agency repayment of loans	180	393	142	393	136	
Sale and closure of community homes						30
Sales of land, buildings and equipment	10	142		3,877	300	2,804
	*	*	*	**	*	**
Total	**8,505,364**	**1,310,535**	**8,149,971**	**1,352,270**	**7,788,064**	**997,334**

** RfR1: Amount that may be applied as appropriations in aid in addition to the net total arising from: charges for accommodation, goods and services to private and NHS patients and others; income from income generation schemes; income in respect of medical and dental education levy; income in respect of high security psychiatric services at Ashworth Special Hospital; income in respect of the Mental Health Act Commission; income in respect of the Centre of Pharmacy Postgraduate Education; income from the licensing of software; income of the Prescription Pricing Authority and the Dental Practice Board; income from NHS prescription and dental charges; recoveries from patients in respect of incorrect claims for eligibility for general ophthalmic services; receipts from penalty charges for incorrect claims for relief from NHS charges or eligibility for general ophthalmic services; rebates and discounts from manufacturers under the Pharmaceutical Price Regulation Scheme and the Purchasing and Supply Agency arrangements; income in respect of Regional Offices; contributions from employers and employees towards the cost of the NHS; income from the Scottish Executive, the National Assembly for Wales and Northern Ireland for services provided for devolved or reserved work.*

RfR2: Administration receipts from seconded officers; Employment Opportunities Fund programme; Manufacturers Registration Scheme and Product Approval Scheme; staff telephone calls; staff lease car scheme; European Fast Stream programme; recoveries from other government departments; receipts from the Food Standards Agency; receipts from the NHS, local authorities, NHS Estates and Medicines Control Agency for goods and services; staff accommodation; reimbursement of meetings expenses and selling services into wider markets, library income and open government; receipts by the NHS Pensions Agency for dealing with missold pensions, assessing pensions on divorce and from contractors; receipts from commercial tenants in DH buildings;

licence fees and royalties; sales of publications on equipment for the disabled; sales of British Pharmacopoeia Chemical Reference substances; sale of community homes, evaluation reports, equipment, cars, buildings, furniture, waste paper and surplus items; from Competent Authority Activities and contractors; sale of publications; contributions by members of the public; insurance claims. Receipts by the Human Fertilisation and Embryology Authority, National Biological Standards Board, Public Health Laboratory Service, Microbiological Research Authority, Health Development Agency, the Central Council for Education and Training in Social Work and Gereral Social Care Council; from other European Economic Area countries for NHS treatment of their residents; sale of subsidised dried milk; receipts made under Sector Challenge arrangements with the Department of Trade and Industry, from the European Community and contributions from mobile phone industry. Refunds from communication campaigns contracts and contributions from the priivate sector towards the cost of communication campaigns. Income from the Scottish Executive, the National Assembly for Wales and Northern Ireland for services provided for devolved or reserved work.

*** Amounts that may be applied as non operating appropriations in aid arising from capital income from the sale of land, buildings, surplus vehicles and equipment, principal and interest repayments on NHS Trust loans and from Trading Funds, repayment of, and Dividends on Public Dividend Capital advances by or on behalf of NHS Trusts, Medicines Control Agency and NHS Estates Agency.*

Consolidated Fund Extra Receipts (CFERs)

						£'000
	2001-2002 Provision		2000-2001 Provision		1999-2000 Outturn	
	Income	*Receipts*	Income	*Receipts*	Income	*Receipts*
In addition to appropriations-in-aid the following income and receipts relate to the department and are payable to the Consolidated Fund:						
Operating income not classified as A-in-A						
NHS Estates Agency - interest on loans •	-12	*-12*	-12	*-12*	0	*0*
Medicines Control Agency - interest on loans •	-101	*-101*	-106	*-106*	-114	*-114*
Total	**-113**	**-113**	**-118**	**-118**	**-114**	**-114**

Notes

DEL and administration cost limits

The Department's Departmental Expenditure Limits are:

	£'000
Resource DEL	*47,716,710*
Capital DEL	*2,088,334*
The Department's Gross Administration cost limit less *allowable receipts is:*	*312,248*

Comparison of provision with final provision and forecast outturn

The provision sought for 2001-2002 is 9.2 per cent higher than both the final net provision and the forecast outturn for 2000-2001.

Expenditure resting on the sole authority of the Appropriation Act

	£'000
RfR2A: United Kingdom Xenotransplantation Interim Regulatory authority ■	*112*
RfR2 F: Payments to local authorities for public health services at airports ■	*2,348*
RfR2 F: Grants to voluntary organisations to expand opportunities for unemployed people to participate in voluntary work ■	*6,900*
RfR2 F: Child Migrants Support fund ■	*300*
RfR2 H: Payments in respect of lay and user involvement in social services inspections ■	*200*
RfR2H: Remuneration for Chairman of the Central Council for Education and Training in social work's Council and its Committees ■	*45*

Expenditure in the form of adjustable advances

Section I to S and AD to AF contain certain grants to local authorities including social services training, provision of secure accommodation, services for people with HIV infection and AIDS, services for people for those with a mental illness, services for alcohol and drug misusers, support for carers, initiatives to promote the independence of people living in the community, for the improvement of children's services, projects funded from the Invest to Save Budget, the placing of charges on homes and improving information management. Advances to local authorities for personal social services specific and special grants are charged to the Estimate at the time of issue and as final grant expenditure is not known until local authorities' accounts are audited after the end of the financial year, any necessary adjustments may be made in subsequent advances.

Cash which may be retained to offset expenditure

The department estimates that it will retain £9,815,839,000 as Appropriations-in-Aid

Contingent Liabilities

RfR1:

A Statutory contingent liability exists to meet:

i. an indemnity to water undertakers in respect of costs, damages and expenses not otherwise covered by insurance arising from claims or proceedings on the grounds of alleged harm to health arising solely from fluoridation; and

ii. Overdraft guarantees for NHS trusts.

Non-statutory contingent liabilities exist to meet:

i. A letter which the Department sent to the Association of British Health Care Industries on 9 June 1992 may be construed as a letter of comfort in respect of contracts entered into by NHS trusts and hence result in a non-statutory liability. The letter was withdrawn on 17 August 1993, but a residual contingent liability may remain in respect of contracts entered into between the issue of the letter and its withdrawal.

ii. the Department has undertaken to meet the legal and other costs of medical and nursing staff engaged on clinical trials approved by the National Blood Authority (NBA) of new blood products manufactured by the Bio-Products Laboratory, a part of the BNA, and the costs of any claims for damages from patients arising from clinical trials of the new products;

iii. an indemnity to water undertakers in respect of costs, damages and expenses not otherwise covered by insurance arising from claims or proceedings on the grounds of alleged harm to health arising solely from supplying water which has been fluoridated by another water undertaker and which therefore is not covered by the statutory guarantee;

iv. an indemnity to higher education providers to cover a proportion of any redundancy costs, which may arise in respect of pre-registration nurse education which has now moved to the higher education sector should a contract of education not be renewed;

v. in the event of a nuclear emergency it would be necessary to distribute stable iodine tablets to the general public to prevent take up of radioactive iodine. The Department has undertaken to indemnify those other than qualified medical personnel distributing the tablets against any action resulting from adverse reactions; and

vi. the Department has given an undertaking to pay legal or other costs of any damage claims arising from infections contracted by foreign nationals through contaminated blood products. These claims, should they arise would result from a contract between the Bio Products Laboratory, BPL (part of the National Blood Authority) and the Canadian company Haemacure for the manufacture of a plasma based fibrin sealant product. The product would be sold exclusively in the USA.

RfR2:

A statutory liability exists to meet:

i. the Department has issued an exemption certificate to the National Radiological Protection Board in respect of any liability to its employees of the kind mentioned in Section (1) of the Employer's Liability (Compulsory Insurance) Act 1969;

ii. the department has issued an exemption certificate to the National Biological Standards Board in respect of any liability to its employees of the kind mentioned in section (1) of the Employers' Liability (Compulsory Insurance) Act 1969.

Non-statutory liabilities exist to meet:

i. the Department has undertaken to meet the cost of compensation payments arising from claims for injury arising from trials of a whooping cough vaccine developed by the Microbiological Research Authority;

ii. the Department has undertaken to meet the cost of compensation payments arising from claims for injury arising from the immunisation of voluntary donors with specialised immunoglobulin subsequently harvested and used in the treatment of new-born babies;

iii. the Government has paid £42 million to a NHS trust from which payments to haemophiliacs infected with HIV virus following treatment by the NHS with infected blood products. The Department has agreed to pay the NHS trust any sums required to make payments if the funds already provided prove insufficient;

iv. to cover the costs of the Family Fund meeting its duties, under legislation, to its staff in the event of it being wound up by Government;

v. the Department was found to be negligent in failing to stop treating patients with Human Growth Hormone by 1 July 1977 – at a time when possible consequences should have been apparent. Compensation will need to be paid to patients treated after this date who subsequently die from CJD; and

vi. the Department has undertaken to indemnify members of its Committee on Inquiry into the Personality Disorder Unit Ashworth Special Hospital. The indemnity would be for civil proceedings brought against any member of the committee in consequence of anything said or done in the course of their work in relation to the inquiry.

Grants in aid

Section RfR2 F includes grant-in-aid provision to the Family Fund Trust (£20,773 m).

International subscriptions

The UK subscription to the World Health Organisation (£14m) is included in line RfR2 F.

Symbols

Symbols used for pages 78 to 85.

Public Expenditure:

* *A section of an Estimate which contains discretionary expenditure.*

Φ *Income receipts which are classified as negative DEL or negative DEL in respect of income from capital receipts including asset sales and which are, exceptionally surrendered to the Consolidated Fund as extra receipts rather than taken on to the Estimate as appropriations in aid.*

Δ *Income receipts which are classified as negative AME or negative AME in respect of income from capital receipts including asset sales and which are, exceptionally, surrendered to the Consolidated Fund as extra receipts rather than taken on to the Estimate as appropriations in aid.*

● *Extra receipts which are classified as "other spending outside DEL" and are surrendered direct to the Consolidated Fund as extra receipts.*

Ω *Including notional expenditure in respect of capital charges offset by matching negative expenditure in column 2 of the Part II table of the Estimate Statutory authority for expenditure.*

■ *Items where provision is sought under the sole authority of Part I of the Estimate and of the confirming Appropriation Act.*
Accounting and audit arrangements for grants in aid and certain subscriptions, etc, to international organisations:

♥ *The accounts of this body are audited by the Comptroller and Auditor General and presented to Parliament.*

♦ *The accounts of this body are audited by auditors appointed by the Secretary of State (or Ministers) and presented to Parliament. The books and accounts are also open to inspection by the Comptroller and Auditor General.*

♠ *The accounts of this body are audited by auditors appointed by the Secretary of State (or Ministers) and presented to Parliament.*

National Health Service Pension Scheme

Introduction

1. This Estimate covers the payment of pensions and other benefits to persons covered by the National Health Service (NHS) Pension Scheme. The rules of the scheme are set out in the National Health Service Pension Scheme Regulations 1995 (as amended).
2. Membership of the scheme is open to most employees in the NHS and for doctors and dentists in general practice, and the benefits include payments to widows, widowers, and dependants of participants who die in service or retirement. Provision is also made for refunds of contributions to early leavers, and for the payment and receipt of transfer payments in respect of persons moving out of and into employments covered by the scheme.
3. The Estimate includes the increase payable in accordance with the Annual Review Orders made under section 59 of the Social Security Pension Act 1975.The scheme is notionally funded for the basic benefits but not for pensions increase. Part of the scheme's income consists of receipts from contributions (both employer and employee), capitalised payments for early retirements and transfers from other pension schemes.These are appropriated in aid of the Estimate to offset the expenditure on benefits.
4. The NHS Pensions Agency is responsible for administering the scheme: the related running costs are borne on the Department of Health Estimate.
5. Symbols are explained in the introduction to this booklet.

Further notes to the Estimate

Comparison of provision sought with final provision and forecast outturn

The provision sought for 2001-2002 is 76.0 per cent lower than the final net provision for 2000-2001 of £701,199 million, which is also expected to be the forecast outturn for 2000-2001.

A further breakdown of the forecast outturn for 2000-2001 is given in Chapter 3, Figure 3.2 of CM 5103.

Gross expenditure in 2000-2001 is expected to amount to £2,295 million and the provision for 2001-02 shows a decrease of 18.49 per cent on that sum. Although increases in pensions and lump sums are due to pay increases and the number of pensioners is rising, it is felt that expenditure has been overstated and a reduced estimate is therefore more appropriate.

The Estimate reflects the pensions increase of 3.3 per cent applicable from 9 April 2001. This is consistent with similar assumptions made elsewhere in the Estimate.The provision also reflects the 2000 pay increase, for which the major effective date is 1 April, which averaged about 3.6 per cent.

The number of beneficiaries continues to rise from an average of 458,886 during 2000-01 to 469,776 during 2001-02, including about 53,000 compensation cases by the year end.

The average pension, in non-compensation cases, is £5,405 a year, with 359,463 pensions in payment, with 57,229 dependants pensions in payment, averaging £3,180 a year. This compares with averages of £5,530 and £3,021 from the previous year paid to 350,055 members and 56,029 dependants. The superannuation element of recurring payments in compensation cases is expected to average about £4,211.

Resource Ambit

Amounts required in the year ending 31 March 2002 for expenditure by the NHS Pensions Agency on pensions, allowances, gratuities, transfers to alternative pension arrangements, refunds of contributions, compensation for early retirement, to or in respect of persons engaged in health services or in other approved employment.

National Health Service Pension Scheme

Part I

	£
Request for Resources 1	**172,751,000**
Total net resource requirement	**172,751,000**
Net Cash Requirement	**112,898,000**

Amount required in the year ending 31 March 2002 for expenditure by the National Health Service (NHS) Pensions Agency on:

Request for Resources 1: National Health Service pensions

Pensions, allowances, gratuities, transfers to alternative pension arrangements, refunds of contributions, compensation for early retirement, to or in respect of persons engaged in health services or approved employment.

The **National Health Service (NHS) Pensions Agency** will account for this Estimate

	Net Total £	Allocated in Vote on Account £	Balance to Complete £
Request for Resources	172,751,000	77,738,000	95,013,000
Net Cash requirement	112,898,000	50,804,000	62,094,000

Statement of Accounting Officer Responsibilities

The Treasury has appointed the Chief Executive of the NHS Pensions Agency as Accounting Officer with responsibility for preparing the Agency's Accounts and the NHS Pension Scheme Estimate and for transmitting them to the Comptroller and Auditor General.

The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of public finances for which an Accounting Officer is answerable, for keeping proper records and for safeguarding the Pension Scheme's assets, are set out in the Accounting Officers' Memorandum, issued by the Treasury and published in Government Accounting.

4 In preparing the accounts, the Accounting Officer is required to comply with the Resource Accounting Manual prepared by the Treasury, and in particular to:

- observe the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards, as set out in the Resource Accounting Manual, have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis.

5 The responsibilities of the Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Agency's assets, are set out in the Accounting Officer's Memorandum, issued by the Treasury and published in Government Accounting.

Part II: Subhead detail

£'000

Resources						Capital		2000-2001 Provision	1999-2000 Outturn
	1 Admin	2 Other Current	3 Grants	4 A in A	5 Net Total	6 capital	7 Non-operating A in A	8 Net total resource budget	9 Net total resource budget
RfR 01: NHS Pensions			**3,241,106**	**3,068,355**	**172,751**	**0**	**0**	**730,071**	**854,775**
	0	0	0	0	0	0	0	0	0
SPENDING IN ANNUALLY MANAGED EXPENDITURE:									
Non-Cash items									
A Pensions	0	0	3,241,106	3,068,355	172,751	0	0	730,071	854,775
TOTAL	**0**	**0**	**3,241,106**	**3,068,355**	**172,751**	**0**	**0**	**730,071**	**854,775**
			Accruals to cash adjustment				59,853		
			Net cash required				112,898		

Resources to Cash Reconciliation			£'000
Net total resources			172,751
Voted capital items			
Capital		–	
Less Non-operating A in A		–	–
			172,751
Accruals to cash adjustment			
Capital charges		–	
Depreciation		–	
Other non-cash items		–	
Increase/Decrease in stock		–	
Increase/Decrease in debtors		232,416	
Decrease in creditors	–	292,269	
Decrease in provisions		–	
			–59,853
Net Cash Required			112,898

Forecast Operating Cost Statement – Main Estimate 2001-2002

National Health Service Pension Scheme

	£'000	Provision 2001-2002 £'000
<u>Administration Costs</u>		
Voted Expenditure		
Staff costs	–	
Other Administration costs	–	
Gross Administration costs		–
Operating income		–
Net Administration costs		–
<u>Programme Costs</u>		
Voted Expenditure		
Expenditure	3,241,106	
Income (Including CFERs)	3,068,655	
		172,451
National Insurance Fund		
Expenditure		
[Income]		
Net Programme Costs		172,451
NET OPERATING COST		172,451
NET RESOURCE OUTTURN (EXCLUDING CFERS)		172,751
RESOURCE BUDGET OUTTURN		172,451

Forecast Reconciliation of Net Operating Cost to Net Re Outturn and Resource Budget Outturn

Main Estimate

for the year ended 31 March 2002

National Health Service Pension Scheme

	2001-2002 £'000
Net Resource Outturn	172,751
Add non-voted expenditure in the OCS	–
Add Consolidated Fund Extra Receipts in the OCS	-300
Remove provision voted for earlier years	–
Remove other adjustments	–
Net Operating Costs	172,451
add other Consolidated Fund Extra Receipts	–
Resource Budget Outturn	172,451
Of which:	
Departmental Expenditure Limit (DEL)	–
Spending in Employment Opportunities Fund (EOF) DEL	–
Annually Managed Expenditure (AME)	172,451

Analysis of Extra Receipts payable to the Consolidated Fund (£'000)

		2001-2002		**2000-2001**		**1999-2000**
	Income	*Receipts*	Income	*Receipts*	Income	*Receipts*
Excess A in A	300	300	200	200	569,807	569,807
Total	**300**	**300**	**200**	**200**	**569,807**	**569,807**

Appropriation in Aid

						£'000
		2001-2002		2000-2001		1999-2000
	provision A in A	Non-op A in A	provision A in A	Non-op A in A	outturn A in A	Non-op A in A
RfR 1 NHS Pensions						
Income from contributions receivable and transfers from other schemes	3,068,355*	0	2,414,940	0	1,791,295	0

** Amount that may be applied as appropriations in aid in addition to the net total,arising from superannuation contributions;transfer values;deductions from superannuation contributions and lump sum payments in lieu of graduated contributions;contributions equivalent premiums.*

NHS Pension Scheme
Part III: Extra Receipts payable to the Consolidated Fund

In addition to appropriations in aid the following income relates to the Department and is payable to the Consolidated Fund (cash receipts being shown in italics):

		2001-2002		2000-2001		1999-2000
	Income	*Receipts*	Income	*Receipts*	Income	*Receipts*
Operating income not classified as A in A	300	*300*	200	*200*	569,807	*569,807*
Non-operating income not classified as A in A						
Other income not classified as A in A						
Total	**300**	**300**	**200**	**200**	**569,807**	**569,807**

Forecast Cash Flow Statement

National Health Service Pension Scheme

	Provision 2001-2002 £'000
Net Cash outflow from operating activities	-172,451
Capital expenditure and financial investment	–
Inflows in respect of activities outside the scope of the department's operations	–
Payments to the Consolidated Fund	-300
Financing	172,751
Increase/decrease in cash in the period	0
Reconciliation of operating cost to operating cash flows	
Net Operating Cost	172,451
Adjust for non-cash transactions	–
Adjust for movements in working capital other than cash	–
Adjust for transfers in provision	–
Adjust for total accruals to cash adjustments for non-voted expenditure	–
Accruals to cash adjustment for CFERs that pass through the OCS	0
Net cash outflow from operating activities	172,451
Analysis of capital expenditure and financial investment	
Purchases of fixed assets	–
Proceeds from disposal of fixed assets	–
Loans to other bodies	–
Net cash outflow from investing activities	–
Analysis of Financing and Cash Requirement	
From Consolidated Fund (Supply)	172,751
From Consolidated Fund (Non-Supply)	–
From National Loans Fund	–
From Other Funds	–
Financing	172,751
Increase(-)/decrease(+) in cash	0
CFERs received but not yet paid over	0
CFERs received in prior year paid over	0
Total cash requirement for the Agency	172,751
Non-Supply Cash required	–
Net cash requirement	172,751

ANNEX A1

Departmental Voted Cash Requirement

£ million

	1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Net Total Resources (Voted)	35,975	35,936	39,601	43,284	47,798	51,983
Net Capital Expenditure (Voted)	-343	-290	251	631	826	1,110
Adjust for non-cash transaction	-307	-321	-337	-159	-172	-186
Adjust for movements in working capital		-130	-157	-136	-136	-136
Adjust for transfers from provision	-763	-221	-278	-340	-389	-482
Net Cash Requirement (voted)	34,563	34,974	39,080	43,279	47,928	52,289

1 Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary. Figures for 1998-99 should therefore not be compared.

2 Totals may not sum due to rounding.

ANNEX A2

Total Capital Employed by Department

£ million

	1998-99 outturn	1999-00 outturn[6]	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Within the Departmental Account[1][2]	17,896	16,209	16,409	16,819	17,239	17,670
Investment outside Accounting Boundary[3][4][5]	15,698	20,441	21,157	21,686	22,228	22,784
Total Capital Employed	33,594	36,650	37,566	38,505	39,468	40,455

1 This includes all entities within the DH resource accounting boundary, such as central DH, and Health Authorities.

2 Source: DH consolidated resource accounts. For 2000-01 and beyond figures are based on projected growth.

3 This includes, for example, NHS Trusts and The National Blood Authority.

4 Source: NHS Trusts summarisation schedules, and accounts of other organisations. For 2000-01 and beyond figures are based on projected growth.

5 In 2000-01 part of NHS supplies (the Purchasing and Supply Agency) and Rampton, Broadmoor and Ashworth Special Health Authorities moved inside the accounting boundary.

6 These are provisional figures.

ANNEX A3

Consumption: Analysis of Resource Budget Spending Plans

£ million

		1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Resource Budget							
Departmental Expenditure Limits (DEL)							
RfR1	**Securing health care for those who need it**						
A	Health authorities unified budget and central allocations and grants to local authorities	33,611	35,213	38,814	42,937	45,018	48,550
B-F	Family Health Services (General medical, pharmaceutical, general dental and general ophthalmic services and prescription charge income)	4,223	4,259	4,445	3,829	5,148	5,405
RfR2	**Securing social care and child protection for those who need it and at a national level, protecting, promoting and improving the nation's health**						
A-F	Central health and miscellaneous services and departmental administration including agencies	647	751	765	865	885	935
G	Personal social services	32	34	38	65	68	77
H-R	Local authority personal social services grants	679	603	617	798	1,714	1,899
	Non-voted expenditure, mainly expenditure on Non Departmental Public Bodies, Trading funds, NHS Trusts						
	Non departmental public bodies		85	97	85	87	89
	Non-voted provisions	132	150	161	190	225	270
	NHS Trusts	-1,104	-1,097	-1,212	-1,245	-1,245	-1,245
	Medicines Control Agency and NHS Estates Agency		7	4	2	1	#
	NHS Contributions – cost of collection	12	10	10	15	16	15
	DUP[2]			120	175	397	499
	Total DEL	**38,232**	**40,014**	**43,859**	**47,717**	**52,314**	**56,495**
	Of which:						
	Central government spending	38,283	40,098	44,008	47,629	51,217	55,224
	Support for local authorities	1,053	1,006	1,059	1,330	2,341	2,515
	Public corporations	-1,104	-1,090	-1,208	-1,242	-1,244	-1,245
	Of which:						
	Voted	39,192	40,860	44,679	48,494	52,833	56,866
	Non-voted	-960	-845	-820	-777	-519	-371
	Equal Opportunities Fund (EOF) DEL						
RfR2	Equal Opportunities Fund			#	#	#	#
	Total EOF			#	#	#	#
	Of which:						
	Central government spending			#	#	#	#
	Support for local authorities						
	Public corporations						
	Of which:						
	Voted			#	#	#	#
	Non-voted						

Annex A3: Consumption - Analysis of Resource Budget Spending Plans (continued)

£ million

		1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
	Annually Managed Expenditure (AME)						
RfR1	Health authorities unified budget and central allocations	1,178	706	792	707	806	955
	Family Health Services (General medical, pharmaceutical, general dental and general ophthalmic services)		-32	-34	-36	-38	-39
RfR2	Central health and miscellaneous services and departmental administration including agencies	35	18	20	14	14	19
	Non-voted expenditure, mainly expenditure on Non Departmental Public Bodies, Trading funds, NHS Trusts						
	Non Departmental Public Bodies		29	30	31	31	2
	Non Voted Provisions	-132	-154	-164	-190	-225	-270
	NHS Trusts Cost of Capital	1,194	1,307	1,292	1,325	1,360	1,365
	Medicines Control Agency and NHS Estates Agency	-12	1	-4	#	#	#
	Total AME	**2,263**	**1,874**	**1,933**	**1,851**	**1,948**	**2,061**
	Of which:						
	Central government spending	2,263	1,874	1,933	1,851	1,948	2,061
	Support for local authorities						
	Public corporations						
	Of which:						
	Voted	1,214	691	778	685	783	934
	Non-voted	1,050	1,182	1,155	1,166	1,165	1,126
	Of which non cash items in AME						
	of which:						
	Depreciation	155	365	398	384	399	417
	Cost of Capital	1,346	1,288	1,257	1,127	1,159	1,162
	Changes in Provisions and Other changes	763	221	278	340	389	482

1 Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary. Figures for 1998-99 should therefore not be compared with those for later years as data may be incomplete or not available.

2 For years 2001-02 to 2003-04 DUP includes (i) Budget 2001 additions for the NHS of £90m in each year. (ii) PSS DUP of £83m; £179m; £168m.

(iii) unallocated resources from within the Departmental Administration programme of £2m; £4m; £4m.

3 Figures may not sum due to rounding.

4 Amounts below £0.5 million are not shown but indicated by a #.

ANNEX A4

Investment: Analysis of Capital Budget Spending Plans

		1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn	2001-02 plan[2]	2002-03 plan[2]	2003-04 plan[2]
							£ million
	Capital Budget						
	Departmental Expenditure Limits (DEL)						
RfR1	**Securing health care for those who need it**						
A	Health authorities unified budget and central allocations[2]	-343	-223	-36	61	299	579
M	Shown in Estimates as Resources expenditure outside DEL		52	66	66	66	66
RfR2	**Securing social care and child protection for those who need it and at a national level, protecting, promoting and improving the nation's health**						
A-F	Central health and miscellaneous services and departmental administration including agencies	#	27	18	21	20	19
G	Personal social services	#	#	2	42	#	#
AB:AD	Local authority personal social services grants	5	4	3	9	31	31
	Non-voted expenditure, mainly expenditure on Non Departmental Public Bodies, Trading funds, NHS Trusts						
	Non departmental public bodies		21	17	17	17	17
	NHS Trusts	1,043	970	1,312	1,551	1,551	1,551
	Medicines Control Agency and NHS Estates Agency		6	5	3	2	1
	DUP[3]				262	334	391
	Credit Approvals	54	57	56	56	56	56
	Total DEL	760	914	1,442	2,088	2,374	2,712
	Of which:						
	Central government spending	-343	-123	66	469	734	1,072
	Support for local authorities	60	61	59	65	87	87
	Public corporations	1,043	976	1,317	1,554	1,553	1,552
	Of which:						
	Voted	-337	-141	53	199	415	695
	Non-voted	1,097	1,055	1,390	1,889	1,959	2,016
	Equal Opportunities Fund (EOF) DEL						
	Annually Managed Expenditure						

1 Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary. Figures for 1998-99 should therefore not be compared with those for later years as data may be incomplete or not available.

2 Figures are not comparable over the period. Plan figures include an element of capital which has yet to be allocated to NHS trusts. The figures are also net of Capital grants made by Health authorities and receipts from landsales. They do not therefore reflect total capital investment by Health Authorities.

3 For years 2001-02 to 2003-04 DUP includes (i) 2001 Budget additions for the NHS of £210m; £205m; £150m for capital. (ii) unallocated capital from within the Departmental Administration programme of £2m; £4m; £4m.

4 Figures may not sum due to rounding.

5 Amounts below £0.5 million are not shown but indicated by a #.

ANNEX A5

Reconciliation of Resource Expenditure between Accounts, Estimates and Budgets

£ million

	1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Net Resource Outturn (Estimates)	35,975	35,936	39,601	43,284	47,798	51,983
adjustments for:						
Consolidated Fund Extra Receipts in the OCS		#	#	#	#	#
Net Operating Cost (Accounts)	35,975	35,935	39,601	43,284	47,798	51,983
adjustments for:						
Other Consolidated Fund Extra Receipts		#	#	#	#	#
Full resource consumption of non-departmental public bodies		-1	#	4	6	11
Full resource consumption of public corporations	90	1,525	1,372	1,390	1,424	1,428
Capital grants to the private sector and LAs	-5	-55	-69	-75	-97	-97
Gains/losses from sale of capital assets		#		#	#	#
Voted expenditure outside the budget	4,436	4,474	4,758	4,775	4,719	4,717
Unallocated resource provision[2]			120	175	397	499
Other Adjustments cost of collection & provisions		10	10	14	14	14
Resource Budget Outturn (Budget)	40,495	41,888	45,792	49,567	54,262	58,556
of which						
Departmental Expenditure Limits (DEL)	38,232	40,014	43,859	47,717	52,314	56,495
Spending in Equal Opportunities Fund (EOF) DEL			#	#	#	#
Annually Managed Expenditure (AME)	2,263	1,874	1,933	1,851	1,948	2,061

1 Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary. Figures for 1998-99 should therefore not be compared with those for later years as data may be incomplete or not available.

2 For years 2001-02 to 2003-04 DUP includes (i) Budget 2001 additions for the NHS of £90m in each year. (ii) PSS DUP of £83m; £179m; £168m. (iii) unallocated resources from within the Departmental Administration programme of £2m; £4m; £4m.

3 Figures may not sum due to rounding.

4 Amounts below £0.5 million are not shown but indicated by a #.

ANNEX A6

Reconciliation of Capital Expenditure between Accounts, Estimates and Budgets

£ million

	1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Net Voted Capital Outturn (Estimates)	-343	-290	251	631	826	1,110
Adjustments for:						
Full capital expenditure by non-departmental public bodies		31	26	29	27	23
Full capital expenditure by public corporations	1,043	1,061	1,040	1,036	1,035	1,034
Capital grants to the private sector and local authorities	5	55	69	75	97	97
Gains/losses from sale of capital assets		#		#	#	#
Local authority credit approvals	54	57	56	56	56	56
Unallocated capital provision [2]				262	334	391
Capital Budget Outturn	760	914	1,442	2,088	2,374	2,712
of which						
Departmental Expenditure Limits (DEL)	760	914	1,442	2,088	2,374	2,712

1 Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary. Figures for 1998-99 should therefore not be compared with those for later years as data may be incomplete or not available.

2 For years 2001-02 to 2003-04 DUP includes (i) 2001 Budget additions for the NHS of £210m; £205m; £150m in each year. (ii) unallocated resources from within the Departmental Administration programme of £2m; £4m; £4m.

3 Figures may not sum due to rounding.

4 Amounts below £0.5 million are not shown but indicated by a #.

ANNEX A7

Departmental Expenditure limits and Annually Managed Expenditure – Cash to Resources Reconciliation 1998-99[1] to 2000-01

£ million

	1998-99 outturn[1]	1999-00 outturn	2000-01 estimated outturn
DEL Current Budget - Cash		40,574	44,509
Timing adjustments		124	141
Switches from current to capital budget			
Switches from capital to current budget		112	117
Capital charges on the civil estate		5	5
Non-departmental public bodies - resource consumption		2	2
Public corporations - resource consumption		217	84
NHS trusts adjustment		-1,020	-1,001
Other adjustments		1	1
Other budgeting changes			
Resource Budget DEL		40,014	43,859
DEL Capital Budget - Cash		4	557
Timing adjustments		2	2
Switches from current to capital budget			
Switches from capital to current budget		-112	-117
Non-departmental public bodies - resource consumption			
NHS trusts adjustment		1,020	1,001
Other budgeting changes			
Capital Budget DEL		914	1,442
Total DEL under cash		40,578	45,066
Total DEL under RAB		40,928	45,301
AME Current Budget - Cash			
Timing adjustments			
Self Financing Public Corporations scoring adjustment			
Other adjustments			
Other budgeting changes			
Resource Budget departmental AME			
Non cash items in Resource AME		1,874	1,933
AME Capital Budget - Cash			
Timing adjustments			
Public Corporations Capital Expenditure - Switch to DEL			
Other adjustments			
Other budgeting changes			
Capital Budget AME			
Total AME under cash			
Total AME under RAB		1,874	1,933

1 It is not appropriate to reconcile figures for 1998-99. Figures for 1998-99 are taken from the Department's Departmental Resource Account. The Resource Account does not record information on resource consumption for all bodies within the Resource Budgeting boundary, and is therefore incomplete.

ANNEX A8

National Health Service, United Kingdon – By Area of Expenditure (resources)[(1)]

£ million

	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Net NHS Expenditure					
National Health Service hospital, community health, family health (discretionary) and related services and NHS trusts[(2)]	43,188	47,944	53,240	56,473	61,211
National Health Service family health services (non-discretionary)[(3)]	5,296	5,583	5,015	6,425	6,788
Central health and miscellaneous services and departmental administration[(4)]	1,104	1,153	1,384	1,418	1,481
Total					
Net	49,588	54,680	59,638	64,316	69,480
Total at 1999/2000 prices					
(using 7.3.2001 GDP deflator)	100.0	101.8	104.3	106.9	109.6
Net	49,588	53,739	57,183	60,164	63,409
Percentage real terms change		8.4	6.4	5.2	5.4

1 Wales and Northern Ireland are not yet operating on a Resource Budgeting basis. Expenditure is therefore still reported in cash terms for these countries.

2 Includes DUP and for years 2001-02 to 2003-04, the 2001 Budget Additions of £359m, £353m and £287m.

3 Figures for FHS non discretionary expenditure between 1999-00 and 2002-03 are not comparable because of transfers to FHS discretionary provision, principally to fund successive waves of Personal Medical and Personal Dental Service pilots.

4 Includes expenditure on certain key public health functions such as environmental health, health promotion and support to the voluntary sector.

5 Figures may not sum due to rounding.

ANNEX A9

United Kingdom – NHS Expenditure (cash)

£ billion

	1999-00 outturn	2000-01 estimated outturn	2001-02 plan	2002-03 plan	2003-04 plan
Net	49.0	54.4	59.1	63.7	68.9
Gross	53.0	58.5	63.0	67.5	72.7
Total Gross Expenditure as percentage of GDP	5.8	6.2	6.3	6.5	6.7

ANNEX B

Executive Agencies of the Department of Health

Medicines Control Agency

B.1 The Medicines Control Agency (MCA) was launched as an Executive Agency in July 1991 and became a trading fund in 1993. It safeguards public health by ensuring that all medicines on the UK market meet appropriate standards of safety, quality and efficacy. This is achieved through a system of licensing, inspection, enforcement and post-marketing surveillance.

B.2 The Agency employs over 500 staff and has gross running costs of £32 million derived from fees charged to the pharmaceutical industry. These fees wholly cover the Agency's costs.

B.3 An independent review conducted in 1999 found that the MCA is performing very effectively and efficiently and is regarded as a world leader in its field.

B.4 The Agency's forward plans and targets are set out in the Annual Report which can be purchased from the Stationery Office, price £14 and the Business Plan, which can be obtained by writing to the office of the Chief Executive, Room 1628, Market Towers, 1 Nine Elms Lane, London SW8 5NQ, or from the MCA website at http://www.open.gov.uk/mca/mcahome.htm.

Medical Devices Agency

B.5 The Medical Devices Agency (MDA) was launched in September 1994. It safeguards public health by ensuring that medical devices and equipment for sale or use in the UK meet appropriate standards of safety, quality and performance. It has some 140 staff and gross expenditure of £9.1 million offset by income of £0.3 million.

B.6 The Agency investigates reports about adverse incidents involving medical devices and issues safety warnings to the NHS and other healthcare providers. It leads for the UK in negotiating and implementing a series of European Directives and enforces UK Regulations which support the Directives. It manages a programme to evaluate new medical devices which publishes about 100 reports on these each year to help the NHS make better buys. The Agency's technical and clinical staff also offer advice to a wide range of NHS customers and help set national and international safety and performance standards.

B.7 The Agency expects to see a number of significant developments during 2001-02: in working with its European partners to update the Directives and to ensure their more consistent interpretation and implementation across the EU; in promoting better practice amongst the users of medical devices; in establishing a new Advisory Group of independent experts and lay members to oversee the scientific work of the Agency and to advise the Agency on the focus of its activities; in working more closely with partners such as the National Institute for Clinical Excellence, the Commission for Health Improvement, the professions, their Royal Colleges, the devolved administrations and, of course, the various parts of the Department of Health; and in using new financial flexibilities to generate income for the Agency while providing services which further its aim, for example in running conferences with a commercial partner.

B.8 Further details can be found in the Agency's Annual Report and its Corporate Plan, both available on the Agency's website at http://www.medical-devices.gov.uk, or by phoning 020 7972 8000.

NHS Estates Agency

B.9 NHS Estates was established as an Executive Agency in April 1991. The Agency's task is to support Ministers, the Department of Health and the NHS in the management of its £23 billion estate. It employs approximately 300 staff and its turnover is £20 million.

B.10 The main objective of the Agency is to help the NHS to improve patient care through better use of the estate and Facilities Management. NHS Estates is the centre of excellence in healthcare estate design, procurement, operation and disposal in support of policy making. The Agency is currently putting full efforts into the implementation and delivery of Chapter 4 of the NHS Plan. It offers expert advice and guidance to the service, and encourages the development of estates and facilities management personnel to equip them for the future. In particular, the Agency is developing benchmarks, tools, analysis and professional support for performance management together with estate and facilities management leadership in the NHS. Expertise and advice is offered for different NHS needs including: support for the development of primary, secondary and tertiary care services; Regional Office and Health Authority aims for the estate in Health Improvement Programmes and Health Action Zones; and for property and facilities management in primary care groups and trusts.

B.11 Details of the Agency's key tasks and targets and more information about the Agency's activities can be found in the Annual Report and Accounts 1999-2000. Copies are available from The Information Centre, NHS Estates, 1 Trevelyan Square, Leeds, LS1 6AE, 0113 254 7070. The website address is http://www.nhsestates.gov.uk.

NHS Pensions Agency

B.12 The NHS Pensions Agency (NHSPA) was set up on 20 November 1992 and is responsible for the administration of the NHS Pension Scheme and the NHS Injury Benefit Scheme for England and Wales. It employs some 450 staff and its net expenditure shown in its annual accounts was £15.4 million for 1999-2000.

The Agency is tasked to ensure that:

- the NHS Scheme and its delivery contribute actively to the wider modernisation of the NHS;

- NHS staff receive a pension service that is comparable with the very best industry standards and conforms with the e-government strategic framework; and,
- the administration costs of the scheme are commercially competitive.

B.13 The Agency's Business Plan sets out the key targets and tasks associated with delivery of these objectives. More information about the Agency's activities and achievements can also be found in its Annual Report and Accounts for 1999-2000. These publications are available from the NHS Pensions Agency, Hesketh House, 200-220 Broadway, Fleetwood, FY7 8LG; 01253 774774 and at the Agency's website at http://www.nhspa.gov.uk.

NHS Purchasing and Supply Agency

B.14 The NHS Purchasing and Supply Agency was launched as an executive agency on 1 April 2000. It was derived in the main from the Purchasing and Strategy Divisions of the NHS Supplies Authority and is the centre of knowledge, expertise and excellence on matters of purchasing and supply for the NHS. The Agency functions not just as an advisory and co-ordinating body but is 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. It 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 2000 to 31 March 2001, are £19.5 million.

B.15 Further details can be found in the Agency's framework document, which can be obtained by writing to the Communications Department, Premier House, 60 Caversham Road, Reading RG1 7EB, and available on their website at http://www.supplies.nhs.uk.

ANNEX C

Other Bodies (including Executive Non-Departmental Public Bodies and Special Health Authorities)

Executive Non-Departmental Public Bodies

Central Council for Education and Training in Social Work (CCETSW)

C.1 CCETSW's role is to promote social work and social care training throughout the UK. It is the licence holder for the Training Organisation for Personal Social Services and the awarding body for qualifications in professional social work. Details of its work can be found in its annual report (available from CCETSW on 020 7278 2455). CCETSW's provisional gross expenditure was £36.2 million in 1999-2000 with a total staff of 171 whole time equivalents. The Department of Health's net grant was £29.5 million 1999-2000. CCETSW will transfer its operational responsibilities to the General Social Care Council, a new Executive NDPB with a wider remit, which is being established in England, in October 2001. The functions of CCETSW in the other three countries will pass to their equivalent Councils, subject to the completion of legislation in Northern Ireland and Scotland. For more information on the Council contact http://www.ccetsw.org.uk or Zulma Wickenden, CCETSW, Derbyshire House, London WC1H 8AD; 020 7520 3571.

The Commission for Health Improvement (CHI)

C.2 The Commission for Health Improvement (an England & Wales body) began its first work programme on 1 April 2000. CHI has completed pilot reviews of clinical governance arrangements in four NHS Trusts and two investigations.

C.3 As set out in the NHS Plan, CHI will review every NHS organisation every four years in order to assess the quality of care it provides, and more frequently where there are concerns about performance. CHI will be able to offer independent advice and expertise to the NHS on developing and improving the quality of NHS services. It will provide national leadership and external assessment of NHS clinical governance arrangements and review NHS implementation of national standards set for specific clinical services or care groups. CHI also has the ability to provide rapid assessment of local service problems and to provide recommendations to help tackle these.

C.4 The Commission is currently funded by a grant from the Department. £11.3 million has been made available for its first year, with an additional contribution from the National Assembly for Wales of £690,000.

C.5 The Chief Executive, the Director for Health Improvement, is Dr Peter Homa. He may be contacted at 10th Floor, Finsbury Tower, 103-105 Bunhill Row, London EC1Y 8TG, 020 7448 9200. Further information can be obtained from CHI's website at www.doh.gov.uk/chi or by emailing information@chi.nhs.uk.

The English National Board for Nursing, Midwifery and Health Visiting (ENB)

C.6 The Board's main statutory responsibility, under the Nurses, Midwives and Health Visitors Act 1997 is to approve educational institutions in England to provide programmes of education and training for nurses, midwives and health visitors, which meet the standards set by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). In addition, the Board is required to provide advice and guidance to Local Supervising Authorities of midwives (LSAs). The Board's gross expenditure for 1999-2000 was £7.7 million, of which £6.3 million was a Government grant. The Board employs 104 staff. The ENB is due to be abolished because of the introduction of a smaller, strategic regulatory body for nurses, midwives and health visitors. For more information about the Board contact Mr A P Smith CBE, Chief Executive, ENB, Victory House, 170 Tottenham Court Road, London W1P 0HA or by email to nwardley@enb.org.uk.

Human Fertilisation and Embryology Authority (HFEA)

C.7 The Authority was established by the Human Fertilisation and Embryology Act 1990 and commenced its work in August 1991. Its main responsibilities are to regulate and monitor the storage and use of human gametes (sperm and eggs) and embryos, and to licence clinics which offer in-vitro fertilisation and artificial insemination or undertake research on human gametes or embryos. It comprises 21 members (including the Chairman and Deputy Chairman) and has 35 staff.

C.8 The Authority's gross expenditure in 1999-2000 was £1.7 million. 70 per cent of the Authority's income is raised from licensing income, with the remaining 30 per cent from the Department of Health. Particular issues considered by the Authority included the use of pre-implantation genetic diagnosis, the storage period for sperm; and cloning. 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 web-site http://www.hfea.gov.uk Otherwise, information can be obtained from Mr Michael Evans at the Department of Health, Room 654C, Skipton House, 80 London Road, London SE1 6LH; 020 7972 6069.

Medical Practices Committee (MPC)

C.9 The MPC was originally set up under the NHS Act 1946, now consolidated in Section 7 of the NHS Act 1977. The principal function of the MPC is to ensure the equitable distribution of the General Practitioners (GP) workforce within general medical services throughout England and Wales. It does this by determining on a referral from a Health Authority whether there is, or will be, a vacancy for a GP in the locality. The Committee's gross expenditure in 1999-2000 was £0.50 million all of which was funded by the Government. The Committee's

secretariat consists of 12 on-loan departmental civil servants. Paragraph 13.11 of the NHS Plan announced the Government's intention to abolish the MPC and replace it with a single funding formula. Clauses to abolish the MPC are included in the Health and Social Bill. For more information on the Committee contact http://www.doh.gov.uk/mpc or Sarah Bird, NHS Executive, HRD-WD, Room 2W26, Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 5053.

National Radiological Protection Board (NRPB)

C.10 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 powerlines 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 1999-2000 was £14.1 million of which £6.7 million was provided by the Government. NPRB employs 316 staff.

C.11 NRPB's corporate aims and strategy together with performance against key targets can be found in their Annual Report and Accounts. For more information about the NRPB, contact Monika Temple, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5026, or NRPB's website at http://www.nrpb.org.uk.

National Biological Standards Board (NBSB)

C.12 The NBSB was set up in 1976 and functions through its executive arm, the National Institute for Biological Standards and Control (NIBSC). NIBSC creates standards for, and tests, the purity and potency of biological substances (e.g. vaccines, hormones, blood products) and 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 preparations. It has a significant research element. The Board's gross expenditure in 1999-2000 was £16.4 million of which £11.4 million was funded by the Government. It employs 279 staff.

C.13 NBSB's corporate aims and strategy together with performance against key targets can be found in their Annual Report and Accounts. For more information about the NBSB contact Richard Griffiths, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 1478, or see the NIBSC's website at http://www.nibsc.ac.uk.

Public Health Laboratory Service (PHLS)

C.14 The PHLS was set up in 1946. Its primary function is to improve the health of the population through diagnosis, prevention and control of infections and communicable diseases in England and Wales. It carries this out through a network of 8 regional groups of laboratories (46 laboratories in total) co-ordinated through its headquarters at Colindale, London which also comprises the Central Public Health Laboratory (CPHL) and the Communicable Disease Surveillance Centre (CDSC). Gross expenditure in 1999-2000 was £130 million, of which £59.2 million was directly funded by the Government. PHLS employs 3296 staff.

C.15 PHLS's corporate aims and strategy with performance against key targets can be found in their Annual Report and Accounts. **(See also Figure 1)**. For more information about the PHLS, see their website at http://www.phls.co.uk or contact Richard Griffiths, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 1478.

Figure C1: Gross Expenditure on Administration for Larger Executive Non-Departmental Public Bodies[1] (ENDPBs) 1997 to 2002

£ million	1997-98	1998-99	1999-2000	2000-01 estimated	2000-02 estimated
Central Council for Education & Training in Social Work	8.3	7.4	6.9	6.3	*
English National Board	7.4	7.8	7.6	7.7	7.4
National Biological Standards Board	1.3	1.4	1.5	1.5	1.6
Public Health Laboratory Service	4.0	4.0	4.0	3.8	4.2

1. Larger NDPBs are defined as those which have 25 or more staff and where Government grant/grant in aid accounts for more than 50 per cent of their income or trade mainly with Other Government Departments.

** Not yet available*

Special Health Authorities (SHAs)

Dental Vocational Training Authority

C.16 The DVTA exercises the functions of Health Authorities by 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. The Authority's gross expenditure in 1999-2000 was £102,925. The Authority is entirely funded by Government. From October 1999 to September 2000 the DVTA issued 1,268 vocational training numbers. 83 applications for vocational training numbers were rejected in the same period. The Authority has two staff. For further information, contact Andrea Goring, Dental Vocational Training Authority, Master's House, Temple Grove, Compton Place, Eastbourne, East Sussex BN20 8AD; 01323 431189.

Health Education Authority (HEA)/ Health Development Agency (HDA)

C.17 The White Paper *Saving Lives: Our Healthier Nation* [C1] set out the Government's intention to replace the Health Education Authority (HEA) with a new Health Development Agency (HDA). The new Agency was established on 14 January 2000.

C.18 The HEA ceased to operate from 31 March 2000. The HDA is a new body set up to raise standards of public health practice; and to provide people working to improve public health with clear evidence of what works so that organisations and individuals have the most up to date information on which they can base their work.

C.19 The HEA employed 269 staff, however the HDA is a much smaller organisation with 129 staff. The gross expenditure in 1999-2000 for the HEA was £36.8 million (including £3.5 million for redundancy and closure) of which £33.8 million was from the Department of Health (£30.5 million for service delivery and £3.3 million for redundancy and closure). More information about the HDA can be obtained from Trevelyan House, 30 Great Peter Street, London SW1P 2HW; 020 7222 5300; website http://www.hda-online.org.uk.

High Security Hospital Authorities (HSHA)

C.20 The three high security hospitals are managed by the Ashworth, Broadmoor and Rampton Hospital Authorities, which are Special Health Authorities (SHAs). The high security hospitals provide care, treatment and rehabilitation for mentally disordered individuals in the most secure hospital settings available in the NHS. Virtually all the patients are detained under the mental health legislation and, at the time of admission, would have been considered to present such a degree of danger that detention in conditions of high security was deemed necessary.

C.21 The Government has decided that the high security hospitals will become fully integrated with wider mental health services. As a result responsibility for commissioning the hospitals services was devolved from the High Security Psychiatric Commissioning Group to individual Health Authorities on 1 April 2000. Commissioning for these services is managed via the Regional Specialist Commissioning process.

C.22 The NHS Act approved the legislative framework to enable each hospital to be integrated into an existing NHS Trust. Each Regional Office with responsibility for a high security hospital is progressing this integration.

Ashworth Hospital Authority

C.23 Ashworth Hosptial Authority – manages just under 460 beds. Its revenue expenditure in 1997-98 was £46.8 million of which £46.4 million was funded by the Government via the commissioning process through High Secure Psychiatric services Commissioning team. The Authority employs 1,403 staff. For further information contact Angela Anderson, Director of Communications, Ashworth Hospital Authority, Parkbourn, Maghull, Liverpool LS1 1HW; 0151 471 2397.

Broadmoor Hospital Authority

C.24 Broadmoor Hospital Authority – provides 408 beds of which 80 are for women. Its revenue expenditure in 2000-01 was £49.2 million funded via health authority allocations. The Authority employs 1,276 staff. The Authority will be dissolved on 1st April 2001 as the hospital becomes part of the new West London Mental Health NHS Trust.

Rampton Hospital Authority

C.25 Rampton Hospital Authority – manages just under 450 beds. Its revenue expenditure in 1999-2000 was £50.6 million of which £48.8 million was funded by the Government. The Authority employs 1,350 whole time equivalent members of staff. On 1 April 2001 the Authority will cease to exist as a Special Health Authority and the Hospital will be part of the newly created Nottinghamshire Healthcare NHS Trust. This Trust will provide Mental Health and Learning Disability Services for the population on Nottinghamshire, Medium Secure Psychiatric Services for the Trent Region and High Secure Psychiatric Services for parts of England and Wales.

Family Health Services Appeal Authority (FHSAA)

C.26 The Family Health Services Appeal Authority was established as an SHA on 1 April 1995. In 1999-2000, the Authority received £971,000 Government funding, and gross expenditure was £971,000. The Authority employs 11 staff (10.5 whole time equivalents). Its role is to perform quasi-judicial appellate and other functions, devolved to it by the Secretary of State, in connection with Health Authority decisions on family health services issues arising under the General Medical Services Regulations, General Dental Services Regulations, General Ophthalmic Services Regulations, the Pharmaceutical Regulations, the FHS practitioners' terms of service with the NHS, and the Service Committee and Tribunal (Amendment) Regulations. For further information contact Ms Jenny Smith, NHS Executive, Room 7E15, Quarry House, Leeds LS2 7UE; 0113 254 5825, or from the website at http://www.fhsaa.nhs.uk.

Mental Health Act Commission (MHAC)

C.27 The Commission was set up in 1983 as a 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 hospitals 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.

C.28 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.

C.29 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 findings in relation to such deaths over the last three years and will publish a report on these early in 2001.

C.30 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 7,000 SOAD visits each year.

C.31 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 over the last two years.

C.32 There is a statutory duty on the Commission to publish a Biennial Report on its activities. The last such report was the Eighth Biennial Report, covering the period 1997-1999. The Ninth Biennial Report will be published in summer 2001. Details of the Commission's function, the discharge of that function and its findings on general issues in relation to detained patients can be found in its Biennial Reports, which also include a statement of its accounts.

C.33 The Department of Health directly funds the Commission. Its budget in 2000-01 was £2.98 million. The Commission employs 35 staff. For further information, contact Mat Kinton, Mental Health Act Commission, Maid Marion House, 56 Hounds Gate, Nottingham NG1 6BG; 0115 9437106. The Commission's e-mail address is chief.executive@mhac.trent.nhs.uk and its website address is http://www.mhac.trent.nhs.uk.

Microbiological Research Authority (MRA)

C.34 The MRA was established as a SHA in April 1994. The MRA oversees the work of the Centre for Applied Microbiology and Research (CAMR). CAMR is engaged in the investigation of highly infectious bacteria and viruses, and the production of bio-pharmaceutical products. Gross expenditure in 1999-2000 was £29 million (£21 million revenue and £8 million capital) of which £15.7 million was funded by the Department of Health (£5.7 million research, £2 million vaccine and £8 million capital investment). CAMR employs 383 staff.

C.35 CAMR's corporate aims and strategy together with performance against key targets can be found in their Annual Report and Accounts. For more information about CAMR, contact Jan Ebdon, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5570, or CAMR's website at http://www.camr.org.uk.

National Blood Authority (NBA)

C.36 The National Blood Authority is responsible for the management of the National Blood Service in England 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.

C.37 The Authority's gross expenditure in 1999-2000 was £296 million which was largely recouped through blood handling charges to hospitals and through sales of BPL products. It employs around 5,000 staff. The Authority collected over 2.9 million units of blood in 1999-2000 and supplied over 300 hospitals. 450 tonnes of plasma were fractionated at BPL. Further information, including summary financial statements, are included in the NBA's 2000 Annual Report which is available from the National Blood Authority, Oak House, Reeds Crescent, Watford WD1 1QA; 01923 486800. Website http://www.NIBSC.ac.uk.

National Institute for Clinical Excellence (NICE)

C.38 NICE is a SHA established on 1 April 1999 to provide guidance on best clinical practice to the NHS, patients and their carers.

C.39 NICE's initial work programme was agreed with the Department of Health and the National Assembly for Wales and was launched on 4 November 1999. This sets clear quality standards which the NHS will be expected to meet. The work programme consists of three main forms of guidance:

- guidance on the potential use of particular health interventions including new treatments such as pharmaceuticals, diagnostic procedures, health promotion activities etc (appraisals);

- guidance on best practice for treating particular clinical conditions (clinical guidelines and referral protocols); and,
- guidance on how clinicians can compare their current standards with best current practice (clinical audit).

C.40 NICE has an executive board consisting of four executive members (Chief Executive, Director of Resources and Planning, Communications Director and Clinical Director) and seven non-executive members. A Partners' Council of over 40 members representing the health professions, patient and carer interests, industry and academic bodies works with NICE to monitor its progress against its work programme.

C.41 NICE completed 16 technology appraisals between 1 December 1999 and 31 December 2000. NICE has published a patient-friendly version of each of its appraisals.

C.42 NICE has formed an additional Appraisal Committee to enable it to increase its appraisal output in line with the provisions of the NHS Plan. NICE is currently setting up six collaborating centres in Acute Care, Chronic Disease, Nursing and Supportive Care, Mental Health, Primary Care and Women and Children. These centres will enable NICE to produce clinical guidelines and advice on clinical audit.

C.43 For further information contact Peter Burgin/Brenda Hardcastle at the Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 6301, 0113 254 5019 or the NICE website at http://www.nice.org.uk.

NHS Information Authority (NHSIA)

C.44 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, via local implementation of the Information for Health strategy.

C.45 The Board of the NHSIA consists of a Chair, Chief Executive, three executive officers and four non-executive members. The Authority had 582 staff as at 31 December 2000. Its gross operating cost in 1999-2000 was £50 million of which the Department of Health funded £45 million.

C.46 Details of the Authority's key achievements are contained in its 1999-2000 Annual Report. This report, together with more information about the Authority's activities, is available from the Authority's website at http://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 0334 or e-mail: steven.harrison@nhsia.nhs.uk.

NHS Litigation Authority (NHSLA)

C.47 The NHSLA has five principal functions:

- to administer the Clinical Negligence Scheme for Trusts (CNST), covering liabilities for alleged clinical negligence in respect of NHS trusts where the incident occurred after 1 April 1995;
- to administer the Existing Liabilities Scheme (ELS), covering incidents which occurred before 1 April 1995;
- to act as defendant in claims against ex-regional Health Authorities following their abolition in April 1996;
- to administer the Liabilities to Third Parties Scheme, covering employer's liability, public and product liability, professional indemnity and directors' and officers' liability from April 1999; and,
- to administer the Property Expenses Scheme, providing protection for non-catastrophic losses to buildings and contents. This includes; engineering breakdown, contract works, goods in transit and fidelity guarantees from April 1999.

C.48 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 minimise suffering resulting from those adverse incidents which do nevertheless occur.

C.49 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. During the year, an IT package was developed to improve the claims handling process. The system is able to generate reports and analysis on claims by type, location and other relevant factors to help the Authority and the NHS deal even more effectively with claims and risk management in future.

C.50 The Authority's administration costs for 1999-2000 amounted to £9.6 million. At 31 March 2000 it employed 70 staff. For further information on the NHSLA contact Tom Fothergill, NHSLA, Napier House, 24 High Holborn, London WC1V 6AZ; 020 7430 8700.

NHS Logistics Authority

C.51 The NHS Logistics Authority was launched on 1 April 2000 and was derived mainly from the Wholesaling Division of the NHS Supplies Authority. The Authority provides a comprehensive wholesaling service and is involved in developing an integrated supply chain to the NHS that will deliver savings to NHS Trusts. The Authority provides supplies of healthcare products to all trusts and other health bodies in England. It also works with trusts, assisting them to streamline their own internal supply channels, to realise efficiencies and make cost savings. NHS Logistics gross expenditure in 1999-2000 was £718 million. The Authority employs around 1,500 staff.

C.52 Further information can be obtained by writing to the office of the Corporate Communications Manager, West Way, Cotes Park Industrial Estate, Alfreton DE55 4QJ; by email at Rachel.brown@logistics.nhs.uk; or telephone 01773 724261.

Prescription Pricing Authority (PPA)

C.53 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 effectively undertaken by other types of health bodies. The Authority's main functions are:

- to calculate and make payments due to pharmacists, and other NHS contractors, and calculate payments due to GPs (payment made by health authorities), for supplying drugs and appliances prescribed under the NHS (549 million prescriptions were processed in 1999-2000);
- to produce information for Health Authorities, Primary Care Groups/ Trusts, General Practitioners, the Department of Health and other NHS stakeholders about prescribing volumes, trends and costs;
- to produce the monthly Drug Tariff containing the reimbursement prices of a range of prescribable items and other remuneration rules;
- to take counter fraud measures;
- to administer the NHS Low Income Scheme (LIS). The PPA assessed some 1.07 million claims for the remission of NHS charges in respect of prescription, dental and other chargeable services in 1999-2000; and,
- to administer the Pharmacy Reward Scheme.

C.54 The Authority's gross expenditure in 1999-2000 was £53.2 million. As at 31 March 2000 the Authority employed approximately 2,720 staff 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 147, Richmond House, 79 Whitehall, London SW1A 2NS; John.Roberts@doh.gsi.gov.uk. 020 7210 5312 or at the PPA website http://www.ppa.org.uk.

United Kingdom Transplant (UKT)

C.55 The United Kingdom Transplant Support Service Authority was established on 1 April 1991. The Authority's name was changed on 12 July 2000 to United Kingdom Transplant following the Authority's Quinquennial Review. The results of the Review were published in February 2000 and made a number of recommendations relating to the operation of the Authority and its role in the 21st century. UKT supports organ transplantation throughout the UK and the Republic of Ireland. Its main objective is to facilitate the effective and equitable distribution of human organs for transplantation. 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 Authority employs around 95 whole time equivalent staff. Its gross expenditure in 1999-2000 was £6.5 million. 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. For further information on the Authority contact infoexec@uktssa-info.demon.co.uk or the Information Executive, UKT, Fox Den Road, Stoke Gifford, Bristol BS34 8RR; Tel: 0117 975 7575.

OTHER NHS BODIES

Dental Practice Board

C.56 The DPB authorises and makes payments to dentists in England and Wales for their NHS work. It also monitors activity in the provision of NHS dental treatments and fee claims and, where identified, refers evidence of fraud and/or clinical malpractice to the relevant authorities for further action. At the end of 1999-2000 the DPB employed 433 staff, and during the year approved fees amounting to almost £1.5 billion to an average 18,879 dentists, at a gross administration cost of £22.4 million. For further information contact the Chief Executive, Dental Practice Board, Compton Place Road, Eastbourne BN20 8AD; 01323 417000 or http://www.dpb.NHS.uk.

TRIBUNALS

Mental Health Review Tribunals (MHRTs)

C.57 MHRTs are independent judicial bodies and their role is to consider whether there is a need for patients to continue to be detained under the Mental Health Act 1983. The Lord Chancellor appoints the members of the Tribunal. There is a legally qualified Tribunal chairman for each of the four 'Tribunal Regions' and they are responsible for the members within their region. There is an office of the MHRT Secretariat within each of these regions employing a total of 59 Department of Health staff who arrange and clerk hearings and provide administrative support to the regional chairman. In the financial year 1999-2000 the secretariat received 20,303 applications and there were 11,573 hearings. Administrative costs, including manpower, were £1.5 million and the costs for the membership were £7.9 million. For more information about MHRT contact Margaret Burn, Head of the MHRT Secretariat, NHS Executive, Wellington House, 135-155 Waterloo Road, London SE1 8UG; 020 7972 4503.

NHS Tribunal

C.58 The Tribunal is an independent body with judicial powers, supervised by the Council on Tribunals. Its purpose is to protect Family Health Services (FHS) by deciding whether the continued inclusion of a FHS practitioner's name on a Health Authority's medical, dental, pharmaceutical or ophthalmic list would be prejudicial to the efficiency of the service in question and bring it into disrepute. If it does, it must direct that the practitioner be disqualified from providing the service. This power currently makes it the ultimate NHS disciplinary body for FHS practitioners. It has no other, lesser sanction available to it.

C.59 The NHS Tribunal has one permanent employee, the Clerk to the Tribunal, who is paid an annual retainer of £3,000. In addition, the Clerk receives fees according to the number and kind of Tribunal cases in a year. The Tribunal's gross expenditure

in 1999-2000 was £29,000. For further information contact Jenny Smith, NHS Executive, Room 7E15,Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 5825.

Protection of Children Act Tribunal (PoCAT)

C.60 The Protection of Children Act Tribunal is an independent judicial body and came into effect from 2 October 2000. It will consider appeals in England and Wales against the decisions of the appropriate Secretary of State to include an individual's name on, or decline to remove an individual's name from, the List of people considered unsuitable to work with children. It may also determine whether an individual's name should be included on the list where the Secretary of State has already provisionally included his or her name for more than nine months. The President to the Tribunal and the legally qualified chairmen are appointed by the Lord Chancellor. Lay appointments are made by the Lord Chancellor after consultation with the Secretary of State. The tribunal office, based in London, houses both the secretariat and a suite of rooms, which can accommodate public hearings. The secretariat itself comprises of four staff currently on secondment from the Department of Health. The set-up costs for the tribunal was approximately £500,000. For further information contact Karen Jones, Secretary to the Protection of Children Act Tribunal, 6th floor, St Christopher House, 90-114 Southwark Street, London SE1 0TE; 020 7921 1622.

Registered Homes Tribunal

C.61 The Registered Homes Tribunal is an independent judicial body. It was set up by statute in 1984 to hear appeals from independent sector residential care home, nursing home and children's homeowners against a decision by the registration authority to refuse, cancel or vary the registration conditions for the home. Health Authorities are responsible for registering nursing homes, local authorities for registering voluntary care homes and the Secretary of State for Health for registering children's homes.

C.62 The Tribunals operate under the Registered Homes Act 1984, the Children's Act 1989 and the Registered Homes Tribunal Rules 1984. The Department of Health provides secretariat support for the Tribunals. The Tribunal's gross expenditure in 1999-2000 was £160,000. For further information about the Tribunal contact Miss M Haywood, Registered Homes Tribunal Secretariat, Room 628 Wellington House, 133-155 Waterloo Road, London SE1 8UG; 020 7972 4034 or by email to mhaywood@doh.gsi.gov.uk.

ANNEX D

Public Accounts Committee - Reports Published in 2000

D.1 The following 7 PAC reports were published in the year 2000:

1. NHS (England) Summarised Accounts 1997-98 — 19 January[D1]
2. PFI contract for the new Dartford & Gravesham Hospital — 7 April[D2]
3. 1992 & 1998 Information Management and Technology Strategies of the NHS Executive — 13 April[D3]
4. The Management of Medical Equipment in the NHS Acute Trusts in England — 9 June[D4]
5. The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England — 23 November[D5]
6. Sir Alan Langlands Valedictory Hearing — 18 December[D6]
7. Hip Replacements – Getting it right first time — 19 December[D7]

D.2 A detailed Departmental response (Treasury Minute) has been published for the first four reports.

1. NHS (England) Summarised Accounts 1997-98

D.3 The Committee's main concerns were:

- the NHS has serious financial problems;
- fraud against the NHS should be rooted out – estimates of loss are incomplete; and,
- alarm at the volume and cost of clinical negligence cases.

D.4 Action taken on PAC conclusions and recommendations:

- between 1997 and 1998-99 the underlying deficit had improved by over £400 million to around £18 million;
- a Director of Counter Fraud Services has been appointed to ensure that fraud is tackled vigorously and measured accurately. Every health authority and NHS trust in the country is to have professionally trained staff to tackle fraud; and,
- clinical standards in the NHS has been improved by the introduction of clinical governance throughout the NHS, setting up the National Institute of Clinical Excellence and the Commission for Health Improvement.

2. PFI contract for the new Dartford & Gravesham Hospital

D.5 The Committee's main concerns were:

- failure to estimate correctly the long-term costs of the contract;
- savings are less than expected, though the scheme was still value for money;
- the Department did not fully understand the full range of risks and potential rewards available to the private sector when negotiating contracts; and,
- advisers' costs exceeded the original estimate by 700 per cent.

D.6 Action taken on PAC conclusions and recommendations:

- the PFI manual[D8], published December 1999, now explicitly requires the affordability of schemes to be considered within the overall context of the local health economy;
- the PFI manual now sets out in detail how the Public Sector Comparator should be developed and updated at every stage of the procurement process. Even though errors in estimating some of the costs were made, the scheme will still realise £5 million to the NHS; and,
- together with new standardised guidance, NHS trusts receive much greater central support. Evidence from later schemes already suggests advisers' costs are better controlled. The NHS is now a more sophisticated purchaser, and financing terms for later projects have steadily improved.

3. 1992 & 1998 Information Management and Technology Strategies of the NHS Executive

D.7 The Committee's main concerns were:

- the design and implementation of the 1992 Strategy was poor;
- disappointment at the failure to evaluate the *NHSnet* and NHS number projects from the 1992 Strategy; and,
- in view of past IT failures in the NHS the Committee would need to examine progress in about two years.

D.8 Action taken on PAC conclusions and recommendations:

- for the 1992 Strategy, the NHS Executive accept that errors occurred in some of the individual business cases and that interdependencies between projects could have been made clearer. However, the Committee acknowledge that lessons learned have influenced the design and implementation of the 1998 Strategy; and,
- the NHS Executive is committed to the undertaking of evaluations of on-going projects. Each new business case submitted to HM Treasury for approval as a component of the 1998 Strategy now contains details of supporting evaluation and review activities.

4. The Management of Medical Equipment in the NHS Acute Trusts in England

D.9 The Committee's main concerns were:

- the need to drive through with vigour the Controls Assurance Programme;
- the need to improve safety; and,
- the Department of Health should give a stronger lead to trusts to adopt best practice and benchmark their equipment holdings and maintenance costs.

D.10 Action taken on PAC conclusion and recommendations:

- the Controls Assurance Programme includes a standard on medical devices which specifically deals with the National Audit Office recommendations. The Department of Health will monitor progress against performance targets and involve auditors in this process;
- every death or injury is one too many but it is important to place these events in context of the tens of millions of patient contacts each year. The largest increase in reported adverse incidents has also occurred where the MDA has concentrated their efforts to encourage reporting; and,
- the Department of Health will continue to seek savings in expenditure on medical equipment through the effective monitoring of the Controls Assurance Standard, by ensuring that information about examples of good practice is shared widely throughout the NHS through initiatives such as the Learning Zone, and by promoting sound procurement policies.

ANNEX E

Spending On Publicity And Advertising And Income From Sponsorship 2000-01 (Estimate)

E.1 The Department runs a number of publicity campaigns directly and places contracts for others with Health Promotion England and other organisations. Forecast outturn for 2000-01 is estimated to be £48 million. The main components included in this total are given in **Figure E1**.

E.2 Following the launch of the NHS Plan[E1] in July 2000, the development of taskforces has influenced the funding of communications. Communications budgets were re-prioritised to provide communications support to each taskforce.

E.3 The estimate for this year's outturn is significantly higher than for 1999-2000, up by £19.1 million. Major factors in this are:

- following the closure of HEA in March 2000 Departmental spending on publicity and advertising is now included in this figure;
- expenditure on publicity about the health risks of smoking has risen by £3.8 million in line with the undertaking in "Smoking Kills"[E2]; and,
- higher level of spending on Child Immunisation to reassure parents about the safety of MMR vaccine.

E.4 Other new activities in 2000-01 were:

- a new awareness campaign to publicise availability of free flu jab to those aged 65 and over and at all ages in other at risk groups;
- national media campaign for NHS Direct from Autumn 2000; and,
- a new campaign aimed at teenagers to reduce the numbers of teenage pregnancies to fulfil the Government's commitment contained in the Social Exclusion Unit Report[E3] published in June 1999.

Sponsorship

E.5 Under new 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'.

E.6 The following amounts have been 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.

Sponsor	Amount received	Support received
Boots	£500,000	Promotion of Organ Donation through the Advantage Card loyalty scheme.
TDI	£7,500	Supply of 500 exterior advertising panels on buses in the London and West Midlands area.
Various	£18,600	Distribution of public information leaflet about mobile phones
Various	£15,000	Distribution of NHS Plan – Public consultation leaflet
Various	£500,000	Public consultation to inform on the NHS Plan

Figure E1: Departmental Spending on Publicity and Advertising and Sponsorship 2000-01

Campaigns run by the Department	£ million
Smoking	11.1
Workforce	6.4
Teenage Pregnancy	4.0
Flu Immunisation	1.9
Drugs	1.8
Winter 2001	2.3
Quality	1.9
Child Immunisation	4.6
Mental Health	1.5
Coronary Heart Disease	1.3
Children's Services	1.2
Fraud	1.5
Organ Donation	1.1
NHS Direct	0.8
Reciprocal Healthcare - Leaflet T6	0.6
Older People (inc Keep Warm, Keep Well)	0.8
Cancer	0.5

ANNEX F

Performance Indicators for Social Services

Performance Indicators for Social Services 2000-2001

PAF	Indicator	Service Area	Data due (where not already available)
National priorities and strategic objectives	A1 Stability of placements of children looked after	Children	
	A2 Educational qualifications of children looked after [joint working]	Children	
	A3 Re-registrations on the Child Protection Register	Children	
	A4 Employment, education and training for care leavers [joint working]	Children	Oct 02
	A5 Emergency admissions of older people [interface]	Adults	
	A6 Emergency psychiatric re-admissions [interface]	Adults	
Cost and efficiency	B 7 Children looked after in foster placements or placed for adoption	Children	
	B 8 Cost of services for children looked after	Children	
	B 9 Unit cost of children's residential care	Children	
	B10 Unit cost of foster care	Children	
	B11 Intensive home care as a proportion of intensive home and residential care	Adults	
	B12 Cost of intensive social care for adults and older people	Adults	
	B13 Unit cost of residential and nursing care for older people	Adults	
	B14 Unit cost of residential and nursing care for adults with learning disabilities	Adults	
	B15 Unit cost of residential and nursing care for adults with mental illness	Adults	
	B16 Unit cost of residential and nursing care for adults with physical disabilities	Adults	
	B17 Unit cost of home care for adults and older people	Adults	
Effectiveness of service delivery and outcomes	C18 Final warnings and convictions of children looked after	Children	Oct 01
	C19 Health of children looked after	Children	Oct 01
	C20 Reviews of child protection cases	Children	
	C21 Duration on the child protection register	Children	
	C22 Young children looked after in foster placements or placed for adoption	Children	
	C23 Adoptions of children looked after	Children	
	C24 Children looked after absent from school [joint working]	Children	Oct 01
	C25 Inspections of children's homes	Children	
	C26 Admissions of supported residents aged 65 or over to residential/nursing care	Adults	
	C27 Admissions of supported residents aged 18-64 to residential/nursing care	Adults	
	C28 Intensive home care	Adults	
	C29 Adults with physical disabilities helped to live at home	Adults	
	C30 Adults with learning disabilities helped to live at home	Adults	
	C31 Adults with mental health problems helped to live at home	Adults	
	C32 Older people helped to live at home	Adults	
	C33 Avoidable harm for older people (falls and hypothermia)	Adults	
	C34 Inspections of residential care for adults and older people	Adults	
Quality of service for users and carers	D35 Long term stability of children looked after	Children	
	D36 Users who said they got help quickly	Adults	Oct 01
	D37 Availability of single rooms	Adults	
	D38 Percentage of items of equipment costing less than £1000 delivered within 3 weeks	Adults	
	D39 Percentage of people receiving a statement of their needs and how they will be met	Adults	
	D40 Clients receiving a review	Adults	Oct 01
	D41 Delayed discharge [interface]	Adults	
	D42 Carer assessments	Adults	Oct 01
	D43 Waiting time for care packages	Adults	Oct 02
Fair access	E44 Relative spend on family support	Children	
	E45 Ethnicity of children in need	Children	
	E46 Users who said that matters relating to race, culture or religion were noted	Adults	Oct 01
	E47 Ethnicity of adults and older people receiving assessment	Adults	Oct 01
	E48 Ethnicity of adults and older people receiving services following an assessment	Adults	Oct 01
	E49 Assessments of older people per head of population	Adults	Oct 01
	E50 Assessments of adults and older people leading to provision of service	Adults	Oct 01

Data for 1999-2000 for 37 of the 50 indicators can be found in Social Services Performance in 1999-2000 which is at http://www.doh.gov.uk/paf Indicator definitions can be found at http://www.doh.gov.uk/scg/perform

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List of Figures

3.1 Resource Plans Summary
3.2 Summary Cash Plans
3.3 Local Authority Expenditure
3.4 NHS Net Expenditure (England) 1995-96 to 2003-04
3.5 NHS (England) by Area of Expenditure (cash)
3.6 Comparison of Net Expenditure Plans for 2000-01 with those in last year's Departmental Report (Cm. 4603)
3.7 Main Areas of Change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm. 4603)
3.8 NHS (England) by Area of Expenditure (Resources)
3.9 NHS Net Expenditure Growth in real terms (2000-01 prices)
3.10 NHS Net Expenditure 2000-01 (Estimated Outturn)
3.11 NHS Sources of Finance 2000-01
3.12 NHS Sources of Finance 1995-96 to 2000-01
3.13 Expenditure on Local Authority Personal Social Services
4.1 NHS Capital Spending, 2000-01 to 2003-04
4.2 Disposition of 2001-02 Capital Resources
4.3 Treasury Capital Modernisation Fund 2001-02
4.4 Capital Value of Major Schemes since 1 May 1997
6.1 NHS Hospital and Community Health Services Gross Current Expenditure by Sector, 1998-99
6.2 NHS Hospital and Community Health Services Gross Current Expenditure by Age, 1998-99
6.3 NHS Hospital and Community Health Services Gross Current Expenditure per Head of Population, 1998-99
6.4 Estimated Growth in HCHS Expenditure required due to Whole Population, Male and Female Demographic Changes: Year on Year Percentage Increases
6.5 Distribution of Revenue Resources 2001-02
6.6 Centrally Funded Initiatives and Services and Special Allocations (CFISSA), 2001-02
6.7 Unified Allocations – Distribution of Increases, 2001-02
6.8 Health Authorities' Distance from Unified Target (DFT), 2000-01 and 2001-02
6.9 Family Health and Personal Medical and Dental Services Gross Expenditure, 1999-2000
6.10 Family Health Services Drugs Bill (Cash) 1990-91 to 1999-2000
6.11 Family Health Services Drugs Bill – Percentage Growth (Cash), 1990-91 to 1999-2000
6.12 Family Health Services Gross Expenditure, 1990-91 to 1999-2000
6.13 Central Health and Miscellaneous Services Gross Expenditure, 2001-02 (Main Estimate)
6.14 Personal Social Services Revenue Provision 2001-02
6.15 Local Authority Personal Social Services Gross Expenditure by Client Group, 1998-99
6.16 Local Authority Personal Social Services Gross Expenditure by Type of Service, 1998-99
7.1 Hospital Activity Trends 1989-90 to 1999-2000
7.2 Community Health and Cross-Sector Activity Statistics
7.3 Key Statistics on General and Personal Medical Services (GPMS)
7.4 Family Health Services – Key Statistics on Pharmaceutical Services
7.5 Family Health Services – Key Statistics on General Dental Services
7.6 Family Health Services – Key Statistics on General Ophthalmic Services
7.7 HCHS Cost Weighted Activity Index
7.8 Average Unit Costs by Category of Care 1988-89 to 1998-99
7.9 Children Receiving Personal Social Services – A Summary
7.10 Adults Receiving Personal Social Services – A Summary
8.1 Administration Costs
8.2 Staff Numbers
8.3 Public Appointments
8.4 Recruitment into the Department of Health, 2000
8.5 Salaries in the Department of Health for Senior Civil Service, Staff in Post at 1 April 2000
A Resource Main Estimates
A1 Departmental Voted Cash Requirement
A2 Total Capital Employed by Department
A3 Consumption: Analysis of Resource Budget Spending Plans
A4 Investment: Analysis of Capital Budget Spending Plans
A5 Reconciliation of Resource Expenditure between Accounts, Estimates and Budgets

A6	Reconciliation of Capital Expenditure between Accounts, Estimates and Budgets
A7	Expenditure Limits and AME – Cash to Resources Reconciliation
A8	National Health Service, United Kingdom – By Area of Expenditure (resources)
A9	United Kingdom NHS Expenditure (cash)
C1	Gross Expenditure on Administration for Larger Executive Non-Departmental Public Bodies (ENDPBs)
E1	Departmental Spending on Publicity and Advertising and Sponsorship 2000-01
F	Performance Indicators for Social Services

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 NHS Executive, Health Authorities (HAs) 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 Health Authorities. 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.

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.

Discretionary

Expenditure subject to resource limit controls.

Distance from target

The difference between a Health Authority's allocation and its target fair share of resources informed by the weighted capitation formula.

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 NHS Executive. 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 repayments of Public Dividend Capital to the Department of Health on the trust's ordinating capital debt and Secretary of State loans, with an excess being invested.

Family Health Services (FHS)

Services are provided in the community through doctors in general practice, dentists, pharmacists and opticians, some 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 Health Authorities. For Personal Medical Services pilots, GP's contracts are set locally in negotiation with HA/PCTs. Funding of the FHS is demand-led and not subject to in-year cash limits at Health Authorities level, though FHS expenditure has to be managed within the overall national cash limits. The exceptions to this are certain reimbursements of practice expenses payable to doctors in general practice (GMS discretionary spending), and the costs of administration. Funding for these items is included in the unified budget. Prescribing is also one element of the unified budget along with HCHS and GP infrastructure.

General Medical Services (GMS)

Personal medical services provided by general medical practitioners, for example: giving appropriate health promotion advice, offering consultations and physical examinations, offering appropriate examinations and immunisations.

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 March 2001 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.

Guardian Ad Litem (GAL)

A guardian ad litem provides independent social care advice and investigation to the course in care and related proceedings. The guardian's role is to represent the child's interests and to make a recommendation on what outcome is in the best interests of the child.

Health Action Zone (HAZ)

A new initiative to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people.

Health Authority (HA)

The Health Authority (HA) is 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. The Health Authority has a responsibility for ensuring satisfactory collaboration and joint planning with the Local Authority and other agencies.

Health Improvement Programmes

An action programme to improve health and health care locally and led by the Health Authority. It will involve NHS trusts, Primary Care Groups, 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 Health Authorities 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 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 Health Authorities 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 resource limit, mainly "demand-led" family health services, including the remuneration and expenses of general medical practitioners, the costs of prescriptions written by them, together with all other pharmaceutical, dental and ophthalmic service costs.

Outturn

The actual year end position in cash and resource terms.

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.

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, Health Authorities, 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 will be new free standing, statutory bodies with new flexibilities and freedoms. They will have the same overall functions as Primary Care Groups but will also be able to directly provide a range of community health services, thereby creating new opportunities to integrate primary and community health services as well as health and social care provision.

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.

Real Terms

Figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

Regional Offices

The 8 NHS Executive Regional Offices were established on 1 April 1996. These offices are responsible for developing the commissioning function in the health service and for monitoring the financial performance of the NHS trusts. The Regional Offices took on the non-statutory functions of the Regional Health Authorities following their abolition on 1 April 1996.

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)

A Special Health Authority is a Health Authority which provides health services to the whole population of England, not just to a local population. Formerly the London Postgraduate Teaching Hospitals were SHAs but they are now NHS trusts. The remaining SHAs, such as the National Blood Authority, provide clinical or support services to the whole NHS.

Specific Grants

Grants (usually for current expenditure) allocated by Central Government to Local Authorities for expenditure on specified services, reflecting Ministerial priorities.

Supply Estimate

The term is loosely used for the Main Estimates, a request by the Executive 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 Health Authorities to PCGs.

Vote

See *Supply Estimate.*

Walk-In Centre

Walk-in Centres are part of a tranche of initiatives to modernise the NHS by providing quick and convenient access to basic primary care services without the need for an appointment.

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 Health Authorities target share of available resources.

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