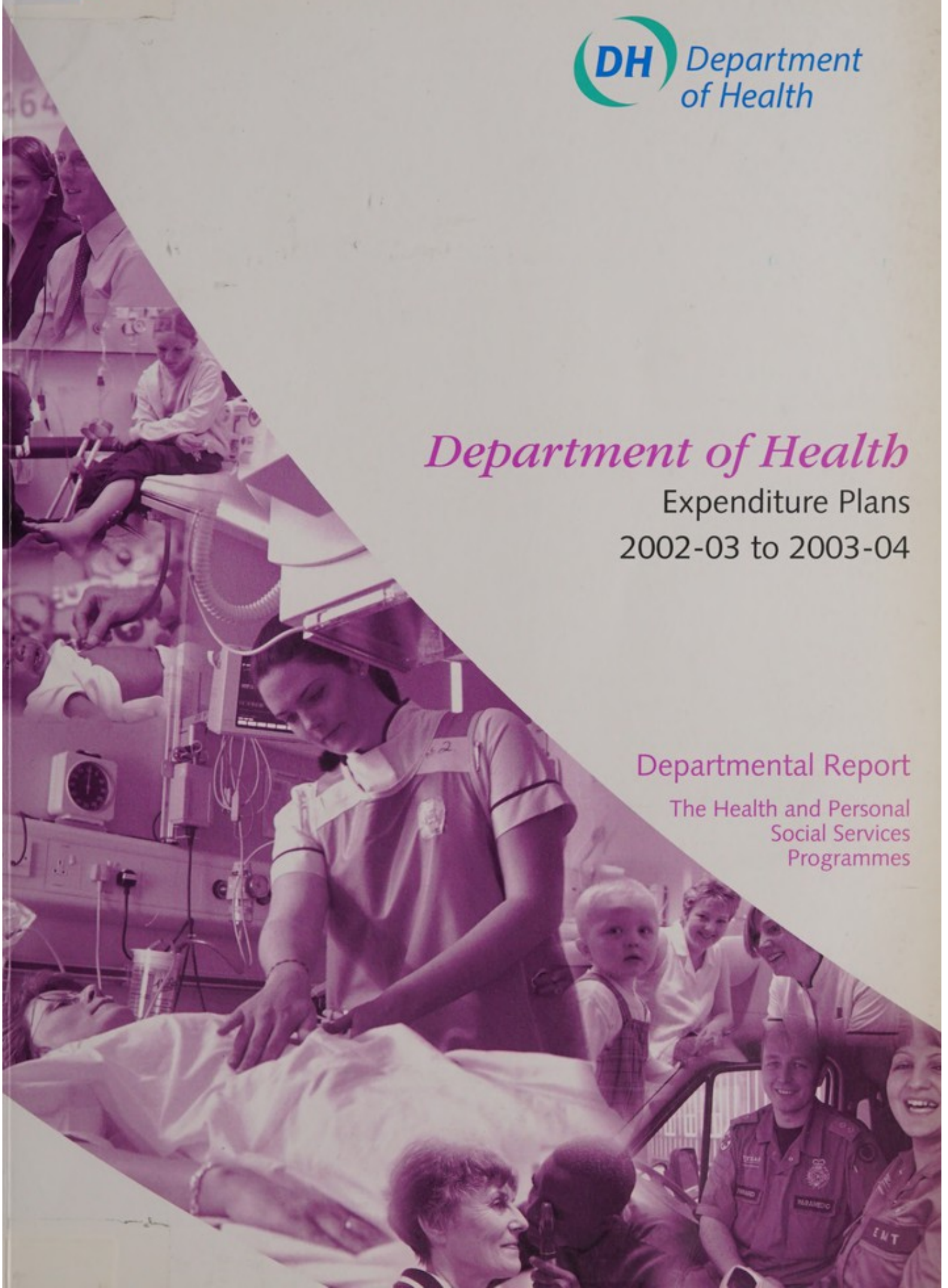
Departmental report : 2002/03-2003/04 / Department of Health ; presented to Parliament by the Secretary of State for Health and the Chief Secretary to the Treasury.



Department of Health

Expenditure Plans
2002-03 to 2003-04

Departmental Report

The Health and Personal Social Services Programmes

This is part of a series of departmental reports which, along with the Main Estimates 2002-03 and the Supplementary Budgetary Information 2002-03 and the document *Public Expenditure: Statistical Analyses 2002-03*, present the Government's expenditure plans for 2002-03 to 2003-04. The plans were published in summary form in the Budget documentation.

The complete series of departmental reports is also available as a set at a discounted price.

Expenditure Plans

2002-03 to 2003-04

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

July 2002

Cm 5403

£19.50

Contents

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

This report and those of 1998, 1999, 2000 and 2001 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 twelfth annual report of the Department of Health. This provides a full account of government spending and activities across the field of health and social care following the launch of the NHS Plan in July 2000. The Plan set out a ten-year programme of investment and reform, in order to deliver a genuinely patient-centred health service. Early indications are that the extra resources earmarked for the years 2001-04 are already producing results.

We have employed more staff – 31,000 extra nurses and 9,000 more doctors in five years. We have opened a dozen new hospitals, and achieved the first increase in bed numbers for a generation. We have developed new types of care through High Street walk-in centres and the NHS Direct help-line. We have cut waiting times, so seven out of ten people now have their operation within three months. And we have put better cancer services and better heart care among our top priorities. Thanks to the hard work of dedicated staff, the NHS is getting better.

The Budget in April 2002 represented a defining moment for the NHS. Unprecedented levels of extra investment were raised from general taxation, providing the largest-ever sustained increase in NHS funding – an average 7.4 per cent real growth in England over each of the next five years.

By 2008 this new money will provide 15,000 extra doctors, 35,000 nurses, 30,000 therapists and scientists. There will be thousands more beds. And we will open 42 new hospitals, 750 primary care centres and expand NHS Direct. In fact the Budget has given the NHS the best chance it has ever had to transform health care in our country.

But when the British people are asked to put more in, they have every right to expect more out. The new money cannot be just for more of the same – it has to buy a different sort of health service. The 'acid test' for this investment is that it must secure an expansion in capacity, an increase in productivity, and an improvement in performance.

So in the wake of the shift in power to the NHS frontline introduced in April 2002, the next steps in delivering the NHS Plan will involve the most radical reforms so far – with greater diversity of provision and more choice for patients.

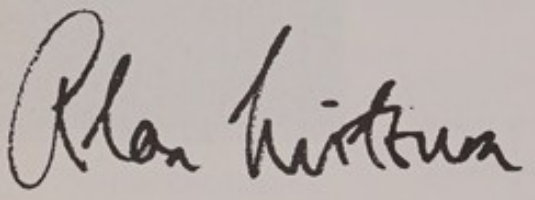
We will set up an independent regime of healthcare regulation, audit and inspection. We will ensure every primary care trust provides an annual 'patient prospectus' to each household in the locality. And we will introduce a streamlined financial system of payment by results, in which cash follows the patient.

The NHS Plan set out the direction of travel under previous spending plans. Now we can go further and faster than before in developing a new model of care, that retains the original values of the NHS but enables it to face the future with confidence – putting people first.

We will enforce rigorous national standards for health and social care. We will publish clear information about clinical and managerial performance. We are devolving decision-making to local communities. We will enable patients to make informed choices about where, when and how they are treated. And we are treating staff better – through fairer pay and flexible methods of working – so they are better able to serve the needs of patients.

Other measures in the pipeline will give the NHS the freedom to improve local services to patients. We will extend the private finance initiative, encourage joint ventures with the private and voluntary sectors, maximise the NHS use of spare private sector hospital capacity, and bring overseas clinical teams into the country to work for the NHS. Soon the first NHS foundation hospitals will be identified, with new freedoms to raise standards of care further.

As a country we should be proud of the NHS, and proud of the people working in it. The ethos of the NHS and its staff expresses the values of the nation. With this programme of unprecedented investment, matched to radical reform, we can make the NHS work for the health of the whole country. The best of the NHS is yet to come.



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 Hutton MP

The NHS and Delivery

Responsibility for: NHS Human resources (including Waiting and Access Task Force); Primary care services; Capital (including Capital and capacity Task Force); Commissioning; NHS treatment for asylum seekers; London Regional.

Minister of State for Health, MS (C):
Jacqui Smith MP

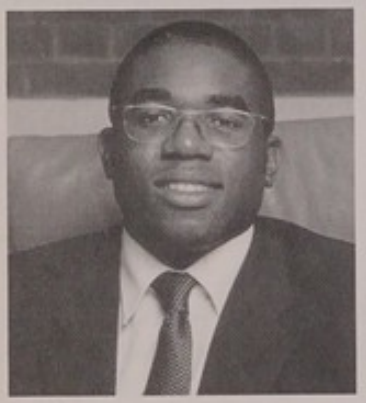
Social Care, long term care, disability and mental health

Responsibility for: Long term care for the elderly (including Older People's Taskforce); Nursing and residential care; Intermediate Care; Children's Social Care; General Personal Social Services; Care Trusts (shared responsibility with MS (H)); Mental Health services, including Mental Health Taskforce; Prison health services; Long term conditions, including Long Term Conditions NSF and diabetes and Renal services; Disability services, including Community equipment services; Northern and Yorkshire Region.

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

Performance and Quality

Responsibility for: NHS Performance Management (including Performance Taskforce); Clinical Quality (including Quality Taskforce); National Institute for Clinical Excellence (NICE); Commission for Health Improvement (CHI); National Patient Safety Agency (NPSA); Clinical Assessment Agency; Procurement; Counter Fraud; Pharmaceutical Industry; Medicines licensing and Medical Devices; Genetics and Biotechnology; R&D; Statistics; IT; Executive Agency Management; and Departmental Management.



Parliamentary Under-Secretary of State, PS (H): David Lammy MP

Emergency care and public involvement

Responsibility for: Emergency care including Winter and NHS Direct; Patients focus including CHCs, complaints, clinical negligence, organ retention, the hospital environment (including the Patient and Public Involvement Taskforce); HAZs; Pharmacy services; Optical services; Dental services/Flouridisation; Drugs/Alcohol/Crime; Reconfiguration policy; NHS Plus/Occupational Health; Appointments; Road Traffic Act; Defence Medical Services; South East and South West Regions.

Parliamentary Under-Secretary of State, PS (PH): Hazel Blears MP

Public health

Responsibility for: Public Health protection and prevention; Cancer, including Cancer Taskforce; Tobacco; Health inequalities (including Inequalities Taskforce); Embryology; Maternity; Sure Start; Children's Health (including Children's Taskforce); Sexual health and HIV, AIDS; Blood; Teenage Pregnancy; International health business; Foods Standards Agency; BSE and vCJD; Complementary and alternative medicine; Trent and West Midlands regions.

THE DEPARTMENT OF HEALTH

DH Department of Health

Board Directors

Nigel Crisp
Permanent Secretary/NHS Chief Executive

SERVICE, POLICY & PROGRAMMES

David Fillingham	Access
Liam Donaldson, Chief Medical Officer	Public Health & Clinical Quality
Sheila Adam	Specialist Health Services
Denise Platt	Children, Older People & Social Care Policy
Sarah Mullally, Chief Nursing Officer	Public Involvement, Nursing, Mental Health, Disability & Allied Health Professions

NHS & SOCIAL CARE INTERFACE

Directorates of Health & Social Care
- London
- South
- Midlands & East
- North

John Bacon, London	
Ruth Carnall, South	
David Nicholson, Midlands & East	
Peter Garland, North	
Modernisation Agency	David Fillingham
Social Services Inspectorate	Denise Platt, Chief Inspector

CORPORATE FUNCTIONS

Research Analysis & Information	Human Resources	Finance and Investment	Corporate Affairs	Policy & Planning	Strategy Unit	Communications
John Pattison	Andrew Foster	Richard Douglas	Hugh Taylor	Andy McKeon	Chris Ham	Sian Jarvis

EXECUTIVE AGENCIES

MEDICAL DEVICES	MEDICINES CONTROL	NHS PURCHASING AND SUPPLY	NHS ESTATE	NHS PENSIONS
David Jeffreys, Chief Executive	Keith Jones, Chief Executive	Duncan Eaton, Chief Executive	Peter Wearmouth, Chief Executive	Alex Cowan, Chief Executive

How to use this Report

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

Chapter 1 – Introduction

Introduces the report and the Department's overarching direction.

Chapter 2 – Delivering Better Public Services

This section outlines the aims and objectives of the Department. We also list the progress against those targets set following the 1998 and the 2000 Spending Reviews. The 2000 Review was also informed by 15 cross-departmental reviews of issues that may benefit from a joint approach involving two or more Government departments. Progress is also shown against these as well as our Modernising Government action plans.

Chapter 3 – Expenditure

Chapter 3 provides information on the Government's expenditure plans up until 2007-08 and includes details of expenditure in 2001-02. Supplementary tables to this chapter can be found in the Annexes.

Chapter 4 – Investment

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

Chapter 5 – The NHS Plan, a Plan for Investment; a Plan for Reform

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

Chapter 6 – Breakdown of Spending Programme

This provides a breakdown of spending across our main programme areas (NHS, Family Health Services and Personal Social Services, etc) as well as providing such breakdowns as spend per head of population and by age profile.

Chapter 7 – Activity, Performance and Efficiency

Chapter 7 is broken down into four main areas: Activity; Performance; Efficiency and Personal Social Services activity, performance and efficiency. It provides such activity data as hospital activity, in-patient and out-patient waiting trends as well as those services provided by General and Personal Medical Services. It also demonstrates how we are making improvements in our performance and efficiency that will enable the effective delivery of services.

Chapter 8 – Managing the Department of Health

This section outlines the running costs, staffing, recruitment policy and senior civil service salaries of the Department as well as describing the environment in which we operate.

Annexes

The Annexes provide a list of the Non-Departmental Public Bodies (NDPBs), NHS Bodies and Agencies that help the Department discharge its functions. There is also an account of the Department of Health's spend on publicity, advertising and sponsorship. The Annexes also contain tables that are supplementary to other sections in this report.

1. Introduction

THIS CHAPTER COVERS:

1.1 This is the twelfth 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 £58 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.

Chapter 3 of this report provides information on the Government's expenditure plans for 2002-03 and Chapter 6 provides a breakdown of the spending programme and an analysis of the activity, performance and efficiency with which these resources have been used.

The introduction of Resource Accounting and Budgeting last year changed the way in which departments plan and manage their spending internally. This report presents the main expenditure plans in resource terms.

This report has been produced and published under a new reporting framework. It was developed in consultation with departments, Parliament and others. The new framework is intended to give departments more freedom to produce streamlined reports accessible to a wider audience. For the first time, supplementary performance information will be published with the Resource Accounts later in the year.

Department of Health

1.2 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.

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.

There is a complementary document to this report, published by the Department of Health:

- 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.

A Challenging Work Programme

1.3 There have been many major achievements this year. The setting up of new activities and bodies such as the Modernisation Agency, the National Care Standards Commission, the Social Care Institute of Excellence and Appointments Commission are all notable achievements. There has been new legislation, new policy and a renewed focus on delivery. This year has also seen the start of a more widespread programme of change through the Shifting the Balance of Power initiative that will empower local clinicians and managers to ensure that services better reflect the needs of the local community.

Shifting the Balance of Power

1.4 The NHS Plan sets out a vision for service designed around the patient – a service of high quality and national standards which is fast, convenient and uses modern methods to provide care where and when it is needed. Such a service will not only be designed around patients but also be responsive to them, offer them choices and involve them in decision making and planning.

The Secretary of State announced on 25 April 2001 a programme to shift the balance of power within the NHS away from central government and towards front line staff and their patients. Under the arrangements set out by the Secretary of State local clinicians and managers, working in Primary Care Trusts and NHS Trusts, will be empowered to ensure that local services reflect the needs of the local community. Further details can be found in Chapter 2 of this report.

The Modernisation Programme

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

independent lives. The NHS Modernisation Agency was formed in April 2001 to support the NHS with the radical and sustainable changes required. The Agency's work programme for its first year focuses on the NHS Plan targets, improving organisational performance and the drive for improved quality.

NHS Plan

1.6 The *NHS Plan*[1.3] was announced by the Prime Minister and the Secretary of State for Health on 27 July 2000. This sets out the strategy for investment and reform in the NHS, alongside the Public Service Agreement targets for the NHS and Social Services.

Chapter 5 of this report sets out how the Department will implement this plan and provides further details about progress to date.

Public Service Agreement

1.7 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*[1.4] in December 1998. Chapter 2 of this report sets out the aims and objectives and records progress being made to achieve detailed targets.

The 2000 Spending Review builds on the success of these PSAs by setting challenging targets over three years (2001-02 to 2003-04). The PSAs are set out in the White Paper, 2000 *Spending Review: Public Service Agreements, July 2000*[1.5]. A summary table for the SR 2000 PSA targets and the progress to date is given in Chapter 2 of this Report.

The Department has also published its *Service Delivery Agreement* (SDA)[1.6], which sets out how it will deliver the PSA targets, and how it will ensure good value for money in their operations.

Budget 2002

1.8 In his Budget statement on 17th April 2002, the Chancellor announced further resources for the health service in England over the five years 2003-04 to 2007-08. This provided the NHS with the largest ever sustained increase in funding of any five-year period in the history of the NHS. The Budget is a defining moment for the NHS. Now the NHS is on a stable financial footing to face the future with confidence. The changes will take time but the benefits for patients are already beginning to come through.

2. Delivering better public services – progress

THIS CHAPTER COVERS:

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

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 and the SR2000 are set out in the paragraphs and tables below.

The Department of Health Aims and Objectives

Aim

2.2 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 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

2.3 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 local agencies and groups on a range of measures designed 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 is their GP.

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 palliative 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 responsibility in relation to individual children.

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 Public Service Agreement Targets (CSR 1998) 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.	**Not Yet Assessed:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of the strategy. Data for 1998/99/00 (3 year average) show a rate of 130.9 deaths per 100,000 population – a reduction of 6.3 per cent from the baseline (1995-97).
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.	**Not Yet Assessed:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the effects of the strategy. Data for 1998/99/00 (3 year average) show a rate of 120.5 deaths per 100,000 population – a reduction of 13.7 per cent from the baseline (1995-97).
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.	**Not Yet Assessed:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of the strategy. Data for 1998/99/00 (3 year average) show a rate of 16.3 deaths per 100,000 population – a very slight rise of 0.5 per cent from the baseline (1995-97).
Reduction in the rate of hospital admission for serious accidental injury by at least 10 per cent by 2010, from a baseline estimate of 314.4 admissions per 100,000 population for the financial year 1995–96.	Rate of hospital admission for serious accidental injury requiring a hospital stay of four or more days.	**Not Yet Assessed:** There are insufficient data points yet to establish a trend. Performance indicators are single financial year figures, available annually. Latest available data (for financial year 1998/99) are prior to the start of the OHN health strategy in July 1999. Therefore too early to yet assess the effects of the strategy. Single year data for financial year 1998/99 show a rate of 315.2 admissions per 100,000 population – a very slight rise of 0.3 per cent from the updated baseline estimate based on revised HES data.
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.	**Not Yet Assessed:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of the strategy. Data for 1998/99/00 (3 year average) show a rate of 9.4 deaths per 100,000 population – a rise of 4.1 per cent from the baseline (1995-97).

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:**	1.050 million, 108,000 below the inherited level, as at the end of December 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.	**Nearly met:**	95.9 per cent of patients with suspected cancer able to see a specialist within 2 weeks at March 2002. This figure stands at 98.5 per cent for breast 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.

PSA Target	Measure	Progress	
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.	**Achieved:**	Growth between September 2000 and September 2001 was 1.1 per cent whole-time equivalent for all medical practitioners.
b) Increase investment in practice staff – 500 new practice nurses will be appointed by 2002;	Number of new practice nurses.	**Achieved:**	There was an increase of 805(WTE), 952(headcount) practice nurses between September 1998 and September 2001.
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.	**Achieved:**	Year end 1999-00 indicated that 598 improvements had been made, and year end 2000-01 indicated a further 566. The PSA target was therefore met a year early with 1,164 improvements having taken place by April 2001 with more schemes underway.
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*.	**Achieved:**	At September 2001, 97.2 per cent of general practices are connected to the *NHSnet* and 93.6 per cent of practices have their local area networks connected. All remaining GPs and new practices will be tackled as part of the wider *ClinicianConnect* project which is addressing the provision of NHS Net access, e-mail and browser for all NHS staff. 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.
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.	**Partly met:**	NICE completed 15 technology appraisals between 1 January 2001 and 31 December 2001 (to give a total of 31 completed appraisals), many of which covered more than one technology. There are a further 40 appraisals (and 4 reviews of appraisals) in its work programme. The Department now assesses the workload of NICE using an improved measure which applies different weights, know as 'appraisal units' to different appraisals. These take account of complexity and the number of technologies covered by individual appraisals. The new measure does not map directly to the 1998 PSA target but NICE is likely to have produced 30 appraisal units in 2000-2001.

PSA Target	Measure	Progress	
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 in December 2000. Cancer survey results to be published in Spring 2002. Trust-based survey (acute hospitals) now underway – reporting in time to inform the summer 2002 performance ratings. Primary care survey also being given go-ahead by SofS(25/01/02) – will report to timetable above.
Achieve efficiency and other value for money gains in the NHS equivalent to 3 per cent per annum of Health Authority unified allocations a year for the next three years.	Overall delivery of PSA targets.	**Achieved:**	The best measure of health authority efficiency is the extent to which other targets have been achieved.
The Department to ensure that all NHS Trusts set a target of at least 3 per cent in 2000-01 for procurement savings and that delivery of these savings is monitored.	Assessed as part of the national efficiency targets (unit costs) and calculated on a regional basis.	**Achieved:**	NHS trusts had their non-pay budgets reduced by an equivalent amount. Delivery is being monitored by the NHS Purchasing and Supplies Agency in conjunction with the Audit Commission.
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:**	April to September 2001 the average generic prescribing rate in England was 75.8 per cent.
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:**	75< 40 per cent, Dec 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 (pharmaceutical patient fraud) of £48 million, around 41 per cent.
£15 million savings from action on contractor fraud (representing £6 million in cash recoveries and £9 million in prevention savings) over the period 1999-00 to 2001-02.	Increase in amount recovered from action on contractor fraud and reduction in money lost through prescription fraud perpetrated by NHS contractors.	**Achieved:**	Between December 1998 and February 2002, £7.47 million was recovered from action on contractor fraud. Prevention savings of £9.3 million have been made between December 1998 and March 2002.

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:**	From year end 1997-98 to year end 2000-01, compound growth in the per capita rate of emergency admissions of people aged 75 and over was 1 per cent. Using forecasts as of Quarter 2 2001-02 implications are that this 'average' growth will be 0.8 per cent. Targets for 2001-02 have moved from a 3 per cent growth rate to 2 per cent. (For 2002-03 the emphasis will be on emergency admissions for all ages rather than just for those aged 75 and over. This is because it is felt that an over 75 indicator could produce a perverse incentive to keep older people out of hospital when it is appropriate for them to be there. The over 75s indicator will continue to be used for benchmarking purposes, but accountability and performance targets will be based on the all ages indicator, or will move to that basis as soon as possible. Because of the good progress that has been made in this area, the over 75s target of 2 per cent will be kept for all ages in 2002-03).
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.	**Slippage:**	The latest end year forecast suggests a whole year rate of 12.7 per cent, but it might still be possible to achieve 12.3 per cent in the final quarter. With the implementation of new service models such as assertive outreach and crisis resolution, a further fall in readmission rates is expected, but this might not manifest itself until 2002-03.
Achieve efficiency and other value for money gains in Personal Social Services expenditure equivalent of 2 per cent in 1999-00 and 2000-01 and 3 per cent in 2001-02.	Value of efficiency and other value for money savings.	**Almost met:**	The estimated efficiency gains for the three years were 2.1 per cent, 2.3 per cent and 2.5 per cent. The total efficiency gain over the three years was therefore an estimated 7.1 per cent, against a total three year target of 7.2 per cent.
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 March 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.	**Slippage:**	(Achieved by 78 per cent of councils but missed by 22 per cent.) The provisional data suggests that 78 per cent of councils met the target but we expect this percentage to be significantly lower on the basis of final child level data. This is an improvement on last year when 62 per cent met the target. Since 1997 the national percentage of children experiencing 3 or more placements has decreased by 1.5 percentage points from 19.6 per cent in 1997-98 to 18.1 per cent in 1999-2000.
Improve the educational attainment of children looked after by local authorities, by increasing to at least 50 per cent by 2001 the proportion of children leaving care aged 16 or above with a GCSE or GNVQ qualification and to 75 per cent by 2003. Data published for the first time in October 2000 set a baseline figure of 30 per cent.	The percentage of children leaving care at age 16+ with a GCSE or GNVQ qualification.	**Slippage:**	Latest data (published October 2001) showed that in year ending 31 March 2001, 37 per cent of young people leaving care at 16+ achieved 1 or more GCSE/GNVQ. Up from 30% in previous year.
By 2004, the proportion of children aged 10-17 and looked after continuously for a least a year, who have received a final warning or conviction, should be reduced by one-third from September 2000 position. To reduce the proportion from 10.8 per cent to 7.2 per cent.	PAF Performance Indicator C18, which compares the prevalence of final warnings and convictions among looked after children with their peers.	**Slippage:**	Data not yet available.
Reduce the proportion of children who are re-registered on the child protection register by 10 per cent by 2002 from the baseline for the year ending March 1997 of 18 per cent of children on the child protection register being re-registered (i.e. target of 16.2 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, 2000-01 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 1999-00, 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.
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:**	During 2000-01 the department paid 95 per cent of invoices within 30 days.
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*. 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:**	Specific Better Quality Services activity has been overtaken by the recent fundamental review of the Department's services and activities. This has been carried out in the spirit of BQS with Cabinet Office being kept fully aware of progress. The review has generated a programme of change that focuses on our Delivery Contract and aims to improve efficiency and effectiveness.

PSA Target	Measure	Progress	
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.	**Achieved:**	The Department has already delivered 32 per cent (13 out of 41) of identified services. Details of current progress and future plans can be found on the internet at **www.doh.gov.uk/ebusiness**
As part of the new Framework for Managing Human Resources in the NHS, targets for managing sickness absence have been set consistent with the Cabinet Office recommendations of a reduction of 20 per cent by April 2000. Performance improvement targets will also be set for NHS Trusts on Managing Violence to Staff in the NHS aimed at reducing the levels of absence due to sickness or injury caused by violence.	Measurement of the time staff are absent from work as a proportion of staff time available.	**Data collected for 2000-01 being analysed:**	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 as agreed with the Cabinet Office.	The number of sick days per staff year.	**2001 data not yet published:**	The Department agreed with Cabinet Office and the Treasury targets for reducing its levels of sickness absence. We aimed to bring the absence levels down to 7.9 days per staff year by 2001 and down to 6.8 days per staff year by 2003.
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

NHS Net

2.4 *NHSnet* has continued to develop as the backbone of the NHS IM&T strategy, providing a secure environment within which the NHS can exchange clinical and administrative messages to improve patient care and speed up general communications. Virtually all GPs are now connected and attention is being concentrated on ensuring that all NHS staff within Trusts have desktop access to common tools such as e-mail and browser. Wherever practical, central purchasing arrangements for hardware and software are being made which maximise the collective buying power of the NHS and drive down costs. Plans are also in hand to extend the network to include other key healthcare organisations such as opticians and dentists.

Primary Care Access

2.5 The NHS Plan target sets out that

'by 2004, all patients will be able to see a primary care professional within 24 hours and a GP within 48 hours'

This approach reflects the patient centred theme of the NHS Plan. It means that patients should be seen by a GP within 48 hours or a primary care professional within 24 hours if the patient wishes. Equally, patients may wish to be seen at a more convenient time to them outside the target's timescales or to wait longer to see their preferred GP or health professional. Similarly, in rural areas, location may be a greater priority for an individual patient than when they want to be seen.

Access Fund

£54.5 million was allocated in 2000-01 to kick-start this programme of primary care modernisation. In order to facilitate faster progress towards delivery of the access targets the primary care access fund for 2002-03 (which was announced and issued with main allocations to Health Authorities (HSC 2001/024)) has been increased by an earmarked £83.5 million to £168 million.

Adoption

2.6 The number of looked after children adopted has continued to increase from 2,732 in 1999-2000 to 3,067 in 2000-01 – an increase of 12.3 per cent. This increase has been achieved whilst maintaining current levels of adoptive placement stability. The percentage of adoptive placements ending in adoption remained at 92 per cent in 2000-01 – the same level as in 1999-2000. In December 2001 a new target was set for the timescale within which children should be placed for adoption. The new target is for 95 per cent of looked after children to be placed for adoption within 12 months of the decision that adoption is in the child's best interests.

Patient Surveys

2.7 The timetable for delivering the acute hospital (inpatient) NHS Trust survey is on track to deliver patient information for the national performance ratings, to be published in the summer. Guidance to support acute Trusts in carrying out the survey was placed on the DoH website before Christmas. After clearance by Ministers of the final mandatory questionnaire, plus associated optional questions, the survey went live on the website on Jan 7th this year. Hardcopies of the guidance (which will be useful for subsequent years' surveys) have also now been sent to acute Trusts.

The surveys are now underway, and the Department of Health has clarified that data should be sent to the 'central data bank' by the end of April. The processed data from a total of 189 Trusts will then be returned to DH by late May, so that it can inform the performance ratings.

The Department of Health is working up a system to determine if adequate progress is being made vis-à-vis the key stages of the survey.

We have also been investigating possibilities to extend the acute IP survey to other Trusts. At present, a way forward has been agreed for primary care. Here, a GP patients'-based survey (samples drawn from the electoral register), has been agreed to provide outcomes (this year). Essentially the survey is a re-run of the 1998 GP survey (undertaken by NATCEN), with some minor improvements.

Ultimately, the results will provide feedback upon all primary care organisations (PCTs and PCGs) – linking to a similar timetable as per the acute IP survey. This will ensure that findings and fed in to the summer's published performance ratings.

For next year, the Department proposes to work-up a survey tool which reflects a more comprehensive range of PCT services. Development of a survey for mental health services is also likely.

Work is also due to begin on development of guidance for the Patient Prospectus documents – these will be the key vehicle within which survey outcomes are conveyed to the public, along with local plans of action arising from such findings.

The Survey's outcome is one element of a whole raft or trust-based performance data leading to 'star ratings', from which financial benefits could be forthcoming. Further information is contained in Chapter 7.

Waiting and Booking

2.8 The NHS Plan set ambitious targets for reducing waiting times: ultimately to cut waiting times for a hospital out-patient appointment to a maximum of three months and for in-patient treatment to six months by 2005.

This will be achieved in stages. The first step was to ensure no one was waiting longer than 15 months for in-patient treatment by April 2002. £30 million was allocated to trusts to assist early delivery of this target. By the end of December 2001 68 per cent of NHS Trusts had achieved the target of having no 15 month waiters. By the end of March 2002 this had increased to 99 per cent. At the end of March 2002 the number of patients waiting more than 15 months for in-patient treatment was at the lowest level on record. In addition the number of patients waiting more than 12 months for in-patient treatment is at its lowest level since

1996. Already nationally 70 per cent of in-patients are admitted within three months of going on a waiting list.

To reduce out-patient waiting times, the first step was to achieve a maximum waiting time for a first out-patient appointment of 26 weeks (six months). At the end of March 2002 94 per cent of NHS Trusts had no-one who had been waiting over 26 weeks for a first out-patient appointment. Nationally there were 831 waiting more than 26 weeks for an initial out-patient appointment in the whole of the rest of the NHS, but 337 at RUH Bath. This is the lowest figure since records began.

As part of the NHS Plan, the way in which appointments are made for hospital admissions will be abolished in all NHS trusts and replaced with booking systems. These allow patients to pre-book hospital consultant appointments or admission dates for operations that are convenient for them. All acute hospital trusts now have booking systems in place in at least two specialties/high volume procedures. Since September 2001, all health economies have been involved through the 4th wave of the booking programme and by the end of 2005 *all* patients will be able to book their appointments and hospital admission dates.

Departmental Public Service Agreement Targets Analysis (2000)

The 1998 Comprehensive Spending Review (CSR) made an important step forward in delivering improvements in services, through the innovation of Public Service Agreements (PSAs). The 2000 Spending Review continues that process by setting out further targets including targets on improving value for money and efficiency. It signals the Government's priorities and its strategic agenda for the next three years.

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

PSA Target	Measure	Progress
Target 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.	Death rate from heart disease and stroke and related illnesses amongst people aged under 75. Death rate from cancer amongst people aged under 75. Death rate from suicide and undetermined injury.	**Heart Disease – Not Assessed:** Too early yet to assess the full effects of the strategy, since latest available data overlap the start of the strategy. However, movement to date is towards the target. Data for 1998/99/00 (3 year average) show a rate of 120.5 deaths per 100,000 population – a reduction of 13.7 per cent from the 139.6 baseline (1995-97). **Cancer – Not Assessed:** Too early yet to assess the effects of the strategy, since latest available data overlap the start of the strategy. However, movement to date is towards the target. Data for 1998/99/00 (3 year average) show a rate of 130.9 deaths per 100,000 population – a reduction of 6.3 per cent from the 139.7 baseline (1995-97). **Suicide/undetermined injury – Not Assessed:** Too early yet to assess the effects of the strategy, since latest available data overlap the start of the strategy. However, movement to date is away from the target. Data for 1998/99/00 (3 year average) show a rate of 9.4 deaths per 100,000 population – a rise of 4.1 per cent from the 9.1 baseline (1995-97).
Target 2: Our objective is to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country. *Specific national targets for infant mortality and life expectancy were announced in February 2001 (based on 1997-99 figures):* 1. Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole. 2. Starting with health authorities, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole. 3. By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15 per cent by 2004 and 50 per cent by 2010, while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter.	1. Mortality in infancy by social class. 2. Life expectancy by Health Authority. 3. The under 18 conception rate. (Number of conceptions to under 18 year olds, per thousand females aged 15-17.)	1. **Not Assessed:** The data are updated annually, and national data for 2000 were published on 8/11/01. However, these pre-date the setting of the target, so it is too soon to comment on change. Infant mortality rates are higher among children whose fathers are employed in manual occupations than among the total population, and this gap has widened in the most recent years. Latest figures for England & Wales (1998-00) show that the overall infant mortality rate (for all social classes) is 5.5 per 1,000 live births, compared with 5.9 per 1,000 for those in manual social groups. The target aims to narrow this gap by 2010. Note that the target will need, in due course, to be redefined to take account of the change in social classifications introduced this year by ONS. 2. **Not Assessed:** The data are updated annually. The most recent data, published in February 2002, relate to the period 1998-2000. They pre-date the setting of the target so it is too soon to comment on change. In 1998-2000 the average life expectancy at birth in the bottom quintile of health authorities was 1.7 years less than in England as a whole for women, and 2.1 years less for men. Life expectancy was 78.5 and 80.2 years respectively for women and 73.3 and 75.4 years respectively

PSA Target	Measure	Progress
		for men. Over the last year, the gap between the quintile of areas with the lowest life expectancy and the national average has stayed the same for both sexes. The areas covered will need to be reconsidered following the implementation of 'Shifting the Balance of Power'. 3. **On Course:** The under 18 conception rate fell by 6.2 per cent between 1998 and 2000. During 2001, every top tier local authority area produced a ten-year local teenage pregnancy strategy. Within local strategies, all areas have agreed under 18 conception rate reduction targets of between 40 and 60 per cent by 2010 to underpin delivery of national targets while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter. The first full year of implementation of local strategies will end in March 2002. **Next Steps:** A cross-government consultation exercise on achieving these targets finished on 9 November 2001. • Complete the cross cutting review. • Publish health inequalities implementation plan in 2002. • Develop work programmes and links with Government Offices of the Regions to improve co-ordination. Local Teenage Pregnancy Partnerships to submit annual progress reports and updated action plans by end March 2002, with assessment of these completed by the end of June 2002. On-going programme of work to implement the national Teenage Pregnancy Strategy and targets, both nationally and locally, including targeted work with those most at risk of teenage pregnancy in high rate areas.
Target 3: Patients will receive treatment at a time that suits them in accordance with their clinical need: two-thirds of all outpatient appointments and inpatient elective admissions will be pre-booked by 2003-04 on the way to 100 per cent pre-booking by 2005.	Modernisation Agency monthly project progress reports.	**Met:** Since March 2001, every acute Trust has been booking patients in at least two specialties or high volume procedures. **On Course:** The 4th wave of the National Booked Admissions Programme was launched in September 2001. This will extend the range and depth of booking in the NHS.
Target 4: Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by end of 2003.	Number of patients on NHS waiting lists.	**Out-Patient: Slippage.** Interim target was to achieve a maximum waiting time of 26 weeks by March 2002. There were 831 patients waiting more than 26 weeks for an initial out-patient appointment in the whole of the rest of the NHS, but 337 at RUH Bath. • 94 per cent of patients were seen within 26 weeks of referral by their GP, of which 75 per cent were seen within 13 weeks. • There are now 89,000 (31.4 per cent) fewer over 13 week waiters than this time last year. **In-Patient: On course.** Interim target is to achieve maximum waiting time of 15 months by March 2002. There were 4,200 over 15 month waiters in December 2001. • The number of over 15 month waiters rose by 1,819 between March 2001 and June 2001 but has been falling slowly since. • Almost two-thirds of all Trusts met the reduced maximum inpatient waiting time target of 15 months at the end of December 2001. • Around 70 per cent of inpatients are treated within 3 months. • The number of over 12 month waiters is half the level it was at during the peak in June 1998 (56 per cent). • 31,400 patients waiting over 12 months, this is a fall of 1,625 (4.9 per cent) since the last month, and 17,000 (35.3 per cent) lower than December last year. However, the figure is still 36.5 per cent above profile (8,400).

PSA Target	Measure	Progress
		• 29,584 patients waiting over 12 months, this is a fall of 1,772 (5.7 per cent) since the last month, and 17,636 (37.3 per cent) lower than January last year. However, the figure is still 41.8 per cent above profile (8,723). These are challenging targets but we are on course to deliver. The most recent figures we have show a comprehensive upturn in performance. If the target is breached it will only be a handful of cases.
Target 5: To secure year-on-year improvements in patient satisfaction/experience, including: (i) standards of cleanliness and food, as measured by independently audited local surveys. (ii) PALs coming on-stream (by end April 2002).	Results of Surveys. Findings of Surveys 'converted' into summer 2002 Performance Ratings. Patient prospectus to convey local findings. Findings used locally, nationally and within cancer networks. Quarterly Monitoring. Compliance by NHS Trusts for 2001 targets.	**Cleanliness: On course.** No hospitals rated as 'red' for cleanliness; in six months six Trusts have moved from red to green. (Autumn 2001 data.) First-ever *National Standards* published and included in Performance Assessment Framework. From 2002 all Trusts will have to comply with standards. **Next steps (i):** A further round of unannounced visits to all NHS acute trusts will commence in February 2002 to ensure standards have been maintained or improved. This round of visits will also consider hospital food and mixed sex accommodation. Following this, visits to non-acute sites will take place over the remainder of the year. From Autumn 2002 a revised assessment procedure will be introduced which will expand the areas considered to include other 'patient experience' issues. Detailed survey guidance pack to be issued to the NHS by end of November. Patients' views to be collected through patient surveys and work with PALS. Detailed survey guidance pack was issued in January 2002. Expand 'patient experience' concept into new areas and establish on-going programme of inspections. The Trust-based IP survey (acute hospitals) went live on 7 January 2002. Data will be fed into the central bank by the end of April and made available to the Department of Health – for aggregating into performance ratings, from late May onwards. DH will provide guidance on local use of survey findings, so that Trusts can establish local improvement plans. A national survey of primary care has also been commissioned (via NATCEN) – this to inform the performance ratings, as per timetable for IP survey. The remainder of the survey programme and its 'roll-out', to be agreed with Ministers during Spring 2002. National Cancer patient survey will report by Summer 2002. **Progress:** On course. The next steps supporting the survey programme include (i) establishing COMMS strategy to underpin publication of findings, (ii) development of a 'template' guide for Patient Prospectuses. **Next Steps (ii):** PALs will provide 'on the spot' help to patients, their families and carers. PALs' role to resolve concerns/complaints, etc, prior to them becoming serious or entering the formal complaints system. **On Course:** Patient Public Involvement (PPI) compiling (mid-March) an overview of progress towards establishing PALs across all Trusts. Expectation is that that it is on course (to be confirmed via Q1 return). **Hospital Food:** **On Course:** The Better Hospital Food Panel was established by the Secretary of State in September 2001. This brings together experts from the NHS (caterers, managers, nurses, dietitians) and private sector from organisations with experience in providing customer focused services. The Panel will act in an advisory capacity on the future direction of the Better Hospital Food programme. The NHS has moved a long way towards implementing the first phase of the programme. A website (www.betterhospitalfood.com) has been

PSA Target	Measure	Progress
		established for NHS catering managers – now over 1,500 members. This includes the National Dish Selector of recipes together with supporting, nutritional analysis, recipe-costing module and purchasing specifications for all ingredients used in NHS Dish Selector recipes. The programme of 'Leading Chef' dish development continues, and at the end of January there were 112 with a further 35 in development. Details of the next phase in the programme are being developed, but are likely to concentrate on: improving services so that patients experience more enjoyable mealtimes with improved choice and higher standards; reducing levels of waste; and services to children and the elderly. **Next steps:** A patient-focused Catering Questionnaire, based on those issues which patients say are important, together with a survey pack is to be issued to NHS to assess patients' views of NHS catering services. The Patient Environment Action Team programme of visits will review progress against 2001 targets in all hospitals A manual 'Catering in a modernised NHS' will be developed and issued to the NHS during 2002. This will provide advice and 'Best Practice' guidance on the range of issues which go to ensure successful provision and management of modern NHS catering services. The NHS Estates Returns Information Collection (ERIC) now includes the requirement for Trusts to report on the implementation of the Better Hospital Food targets. The first returns including this information are due to be sent to NHS Estates by 30 April 2002.
Target 6: Provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over 75 on from hospital. We expect at least 130,000 people to benefit and we shall monitor progress in the Performance Assessment Framework.	Performance Assessment Framework: i) Reducing preventable hospitalisation: reducing growth of the per capita rate of emergency admissions and ensuring that the rate of emergency re-admissions within 28 days of discharge from hospital does not increase. ii) Reduction in delay: reduction in the average number of beds occupied by people aged 75 and over who have their discharge delayed.	**On Course:** • The NHS is currently on target to meet existing targets to reduce preventable hospitalisation (measured by per capita rate of emergency admissions of people aged 75 and over). Forecasts for 2001-02 suggest compound growth of 0.8 per cent. • Rates of delayed discharge for patients aged 75 and over are falling. Nationally in Quarter 2 2001-02 the rate of delay was 12 per cent, showing improvement from Quarter 2 2000-01 position of 13 per cent. • A Baseline census on Intermediate Care conducted in August 2001 suggested there should be an additional 983 beds throughout 2001-02 than in 2000-01.
Target 7: Improve the life chances for children in care by:		
• Improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004.	The percentage of children leaving care at age 16+ with 5 or more GCSEs at grades A*-C.	**Slippage:** **Care leavers** – the Department plans to publish this data for the first time in Autumn 2002. Latest data for year end 31 March 2001 showed that 5 per cent of care leavers achieved 5 or more GCSEs at grade A*-C, up from 4 per cent in previous year. Significant progress will be needed if 2004 PSA target is to be met.
• Improving the educational attainment of children and young people in care by increasing from 4 per cent in 1998 to 15 per cent by 2003-04 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*-C.	OC1 data collection – the percentage of children leaving care at 16+ with 5 or more GCSEs at grade A*-C.	**On Course:** **Educational attainment** – latest figure 5 per cent in year end 31 March 2001 – up from 4 per cent in the previous year.

Target 7: Improve the life chances for children in care by:		
• Giving them the care and guidance needed to narrow the gap in offending between looked afer children and their peers. By 2004, the proportion of children aged 10-17 and looked after continuously for at least a year, who have received a final warning or conviction, should be reduced by one-third from September 2000 position. This provides a target to reduce the proportion from 10.8 per cent to 7.2 per cent.	Youth Offending PAF C18: Final Warnings and Convictions of Children Looked After.	**Not Yet Assessed:** **Looked after Children receiving cautions/convictions** – target agreed Nov 2002 of reduction from 10.8 per cent to 7.2 per cent by 2004.
• Maximising the contribution adoption can make to providing permanent families for children without compromising on quality, so maintaining current levels of adoptive placement stability. Specifically, by bringing councils' practice up to the level of the best, by 2004: – to increase by 40 per cent the number of looked after children who are adopted, and aim to exceed this by achieving, if possible, a 50 per cent increase, up from 2,700 in 1999-2000; – to increase to 95 per cent the proportion of looked after children placed for adoption within 12 months of the decision that adoption is in the child's best interests, up from 81 per cent in 2000-01.	**Numbers:** The number of looked after children adopted during the year. Measured using AD1 data collection. **Timescales:** The percentage of those looked after children who are adopted during the year who were placed for adoption within 12 months of the best interest decision. Measured using AD1 data collection. **Stability:** The percentage of those looked after children whose placement for adoption ended during the year, whose placement ended as a result of an adoption order being made. Measured through the SSDA 903 return.	**Adopted children :** **Numbers - On course:** Latest figures show 3,067 looked after children were adopted in 2000-01 up from 2,732 in 1999-2000 – an increase of 12.3 per cent. **Timescales - Not assessed:** A new target has been set for timescales from best interest decision to placement. **Stability - On course:** Placement stability maintained at 92 per cent of placements for adoption ending in adoption in 2000-01 – the same rate as 1999-2000.
Target 8: Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008.	Returns from the National Drug Treatment Monitoring System, which provides details on the number of drug misusers entering treatment.	**On course:** We are currently on track to meet the target. The number of users entering treatment in the six months up to September 2000 was 33,100. This is an estimated annual increase of 16 per cent since September 1998.
Target 9: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.	Quarterly PCT survey of GP practice appointment availability. Targets and interim milestones embedded in the NHS performance management arrangements – the targets are in the PFF; reflected in SaFFs with annual milestones, and are monitored on a quarterly basis.	**On Course:** Achievement of the targets is now monitored as part of the Department's Quarterly Performance Monitoring arrangements. 2001-02 milestone of 60 per cent achievement was met for access to a GP and very narrowly missed (by less than 1 per cent for access to a primary care professional). This outturn represents a significant improvement from the starting position, but more improvement is required to achieve the 2002-03 milestones of 90 per cent. This will be helped by the earmarked increase of £83.5m in the PCT primary access fund and by the NPDTs spread strategy through its 11 new local centres.
Target 10: The cost of care commissioned from trusts which perform well against indicators of fair access, quality and responsiveness, will become the benchmark for the NHS. Everyone will be expected to reach the level of the best over the next five years, with agreed milestones for 2003-04.	Reference Cost Index	**On course:** Early indications are that the variation is reducing.

Targets from Cross-Departmental Reviews

The 2000 Spending Review was informed by fifteen cross-departmental reviews of issues that might benefit from a join approach involving two or more Government departments. Some of these reviews resulted in targets which appeared in the Department's Public Service Agreement.

Health Inequalities

2.9 Following the setting of two national health inequalities targets, as set out on page 18 of this report, the Department of Health conducted a public consultation in Autumn 2001 on the actions needed to tackle health inequalities and meet the targets. The consultation ranged across Government and across sectors at national, regional and local levels on how these targets will be delivered.

The Government is also conducting a cross-cutting Spending Review (CCSR) on health inequalities as part of the current spending round which will determine spending priorities from 2003-04. The review provides an opportunity for the whole Government to focus on health inequalities and establish priorities for action that will deliver the national targets. The views expressed in response to the consultation are informing this process. An interim document outlining more fully the responses to the consultation will be published in Spring 2002 and a delivery plan on health inequalities will be published later in the year. These documents will be available at: www.doh.gov.uk/healthinequalities.

The life expectancy target is also a target for the Government Intervention in Deprived Areas (GIDA) initiative following on from the Department of Health's commitment in the GIDA Spending Review 2000 to set specific targets for improving outcomes in deprived areas.

Action Against Illegal Drugs

2.10 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 was undertaken to estimate the numbers in treatment for problem drug misuse through a census. The census results showed that there has been an overall increase from 71,977 users entering treatment in 1999-2000 to 78,733 users entering treatment in 2000-01, an increase of 9 per cent. As it is estimated that to achieve the target of increasing the number of drug misusers in treatment by 100 per cent by 2008 there needs to be a year on year increase of those entering treatment of around 7 per cent per year. The Department of Health with the NTA (National Treatment Agency) is on track to meet its target. The National Drug Treatment Monitoring System (NDTMS) provides data on trends in the use of drug treatment services. We are currently carrying out a major review to the system to modify and improve the collection of data from treatment services.

Cross-Government Initiatives

Sure Start

2.11 Sure Start aims to improve the health and well being of families and children in many of the most disadvantaged areas in the country. The focus is on children under the age of four, so that children get a better start in life and can flourish when they go to school.

Each local programme is tailored to meet local needs, but all deliver 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 on issues ranging from healthy eating to training for work.

Sure Start aims to establish 500 programmes by 2004, reaching a third of all children aged under four who live in poverty. So far, 437 programmes have been announced. 250 of these programmes are delivering services and a further 187 programmes are in the pipeline.

The Sure Start Unit is currently looking at how it can influence services in non-Sure Start areas. To this end, it has invited areas with several programmes to consider developing a more strategic and co-ordinated approach to the services they offer citywide.

Sure Start has also identified and responded quickly to the need for additional support for families and young children in rural areas and in pockets of deprivation in otherwise affluent areas. Thirteen Sure Start programmes are currently operating in rural areas. In addition, fifty mini Sure Start programmes are currently being developed in conjuction with Neighbourhood Nurseries, Early Excellence Centres or other key services for young children which supports a rural or isolated community. These are backed by £22 million over two years, aimed at reaching 7,500 children under four living in rural areas or pockets of deprivation.

Twenty Sure Start Plus pilot programmes have been established in areas where there were high rates of teenage pregnancy to provide personal, co-ordinated support for pregnant teenagers and teenage parents under the age of 18.

More information can be found on the internet at www.surestart.gov.uk

Neighbourhood Renewal

2.12 The Department continues to work closely with the Social Exclusion Unit on a range of issues including the education of children in care, young runaways, ex-prisoners, and transport and social exclusion.

DH is implementing the Government's National Strategy for Neighbourhood Renewal, which aims to ensure that within 10-20 years no one is seriously disadvantaged by where they live, by improving health services in deprived neighbourhoods and tackling health inequalities, see national targets on page 18.

DH is working with other departments to develop Local Strategic Partnerships, which are key to neighbourhood renewal and to the Government's intention to rationalise local partnership and planning arrangements. Work is progressing to develop Health Improvement and Modernisation Plans and to ensure these align with local strategic planning arrangements for Community and Neighbourhood Strategies under Local Strategic Partnerships. This will support the effective engagement of local communities and the voluntary sector.

Sustainable Development

2.13 The profile of the Government's strategy on sustainable development has continued to rise this year. The Department has striven to match this cross-government activity which encompasses a commitment to raise the profile of sustainable development at all levels, improve the Department's performance in contributing to sustainable development as well as maintaining oversight of the Department's environmental performance. Sustainable development is also an over-arching aim of the 2002 Spending Review.

Hazel Blears (whose other responsibilities are detailed at the beginning of this report) is the Department's 'Green Minister'. The Green Minister's Committee was reformed in June 2001 and is now a formal Sub-Committee of the Cabinet Committee ENV. Dr Gabriel Scally (Regional Director of Public Health, South West Region) is the Department's Senior Official for sustainable development.

Health *('expected healthy years of life')* remains one of the 15 key headline indicators in the Government's Sustainable Development Strategy for the UK. The indicator is considered to be a good predictor of mortality and has remained constant over the last decade. The indicator will next be updated in August 2002.

The investment in the health service that is a keystone of the NHS Plan will support the basic pillars of the Government's sustainable development strategy. The NHS Plan recognises that good health depends upon social, environmental and economic factors such as housing, education and nutrition and specific targets have been set to reduce health inequalities. This thinking has sustainable development aims at its heart.

The Department has been involved in important international initiatives such as the development of the European Union's Community Environment Action Programme (6TH EAP), a programme for Community action on the environment for the next ten years. The Department works closely with other government departments to develop and co-ordinate the UK interest in developing an international framework for protecting and improving environment and health. A World Summit on Sustainable Development will be held in August 2002 in South Africa. The Prime Minister was the first World Leader to announce his intention to attend this Summit. This event will re-invigorate global commitment towards achieving sustainable development and give fresh impetus to the international sustainable development process.

Modernising Government Action Plans

Change Programme

2.14 The purpose of the Department is to improve the health and well being of the population. A wide ranging review of the Department and its functions was carried out in Spring 2001 to ensure that this really was the focus of activity, taking into account implementation of 'Shifting the Balance of Power' (discussed in more detail later in this chapter). The outcome of the review is now being implemented and will create a Department that is clearly focused on delivery of improvements for patients, clients and the public. The major changes include establishing a Department with:

- a smaller group of key priorities;
- a single top team working across health and social care;
- an open approach to involving stakeholders and partners;
- a determination to decentralise activity and authority;
- a focus on doing only those things which only it can.

The changes in processes and structure (some of which have already taken place) will need to be accompanied by changes in behaviour and culture, with a process for continuous learning and improvement. This major change programme will equip the Department to support effectively those at the front line of service delivery; and do so by ensuring that the Department has the right people, adding real value, and performing strongly.

Specific projects being undertaken as part of the change programme include:

- ensuring closer more effective involvement of patients service users and the public in all relevant Departmental business, policy development and implementation;
- making the Department more accessible by creating a Public Interface Unit;
- development and promulgation of good practice in policy making and implementation;
- developing and implementing integrated corporate governance, business planning and performance management arrangements;
- establishing new arrangements for developing leadership, managing senior appointments and career planning in the NHS and the Department;
- creating a learning and development strategy to reflect business need;
- the introduction of new pay and rewards systems;
- development and implementation of a Knowledge Management Strategy to provide 'joined up', comprehensive information.

Through the change programme we want to build a modern Department which will have a well managed, diverse workforce with appropriate skills. The Department has benefited from having a Senior Civil Service post heading its Employment Diversity Unit. Action taken, or to be taken to achieve much greater diversity in the Department's workforce include:

- Local Equality Action Plans used as a means of measuring progress and responding to identified staff equality priorities;
- A one day valuing diversity and race awareness training has been commissioned and is currently being rolled out for all staff with follow up training activities being planned to meet the specific needs of business areas;
- Targets have been set to help ensure our workforce reflects the diversity of the people we serve – particularly at senior levels;
- After a year's operation of its complaints procedure the Department's Fairness and Respect at Work policy has been revised to emphasise local accountability with local Directors taking responsibility for managing the Department's response to complaints of bullying and harassment.

Policy Making

2.15 The Department of Health has been changing the way policy is developed with an increasing focus on engaging those we serve and our frontline staff in policy development, and addressing the implications for implementation at a much earlier stage. An example is the development of National Service Frameworks, which are one of a range of measures to raise quality and decrease variations in service through setting national standards. The Department has also been working with other Government Departments to incorporate an assessment of the impact their policies may have on the health of the population and access to NHS services into a tool being offered for use throughout Whitehall when developing policies. This tool and set of guidance notes will be piloted in several Government Departments in 2002.

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'. A number of recent key policy developments have addressed the principles described in the CMPS *Better Policy Making* Report launched in November 2001. A programme of actions to improve policy management within the Department was identified in Spring 2001 with key stakeholders, as part of a wider review of the Department led by the Permanent Secretary. An example of action is the development of a database of policy submissions. The NHS Plan provides a focus for policy making in the Department and in development engaged wide representation in determining the priority changes that patients and NHS staff most want to see. Ongoing engagement is being taken forward through the NHS Modernisation Board. This is a group made up of senior health and social care professionals, frontline staff, managers and patients' representatives who meet with the Secretary of State to discuss progress and guide priorities.

Better Regulation and Regulatory Impact Assessments (RIAs)

2.16 There is a strong commitment throughout the Department of Health (including 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 publishing good quality Regulatory Impact Assessments is accepted as an integral part of the Department's work. But we continue to maintain a careful balance of interests between protecting public health and safety, the vulnerable and those at risk whilst avoiding unnecessary burdens on business, charities, voluntary organisations or the public sector.

The Department of Health is not a major regulatory Department. Of the 3 Bills and 88 regulations introduced between January and the end of December 2001, only 9 Regulations imposed costs on business, charities or voluntary bodies. 9 Regulatory Impact Assessments (RIAs) were published and placed in the House Libraries. 5 of the 9 RIAs published supported the major reforms under the Care Standards Act 2000. As a result, these reforms will provide a more independent, consistent and coherent regulatory system for the care providers and stronger protection for vulnerable adults and children in residential care, as well as safeguards for vulnerable people receiving other social care services.

EU Directives and Regulations underpin most of the UK medicines, medical devices, tobacco and public health law. The Department and Agencies recognise the importance of effective links, formal and informal, with other Member States and European institutions. The MCA and MDA in particular interacts on many levels in Europe and participate actively in a range of activities including early discussion about regulatory proposals.

Following the enactment of the Regulatory Reform Act 2001, the Government committed itself in Summer 2001 to producing the *Regulatory Reform: The Government's Action Plan*[2.8]. The Plan which is wide ranging, covering reform at all levels, across all sectors and by all routes was published in February 2002. One of the key aims of the Action Plan is to reduce the paperwork burden on frontline NHS and Social Care staff and give them more time for the delivery of patient and user care. Of the proposed 280 plus new measures, 22 fall to the Department of Health.

The Department also made a useful contribution to the National Audit Report *'Better Regulation: Making Good Use of Regulatory Impact Assessment'*[2.9] published November 2001. The report included 3 of the Department's RIAs as examples of good practice to illustrate what Departments and Agencies can do to apply the RIA process to good effect so that they achieve the five principles of good regulation: transparency, proportionality, targeting, consistency and accountability.

The Department reviewed 18 of its 70 administrative forms it sends to businesses and the voluntary sector. This resulted in the abolition of 8 forms. These administrative forms will be reviewed annually to ensure that only those which are absolutely necessary remain in use and that they are as straightforward to complete as possible.

The joint DH and Cabinet Office report on *'Reducing GP Paperwork'*[2.5] (published March 2001) resulted in positive steps to reduce red tape during 2001-02. Phase II of the project will

build on this report to deliver more intensive and wide ranging measures to further reduce GP bureaucracy and paperwork. The Department also supports the Cabinet Office project, which began in October 2001 to cut red tape in hospitals and nurses' paperwork. This work is still ongoing. In addition to this project, work to implement the NHS Information strategy (*Information for Health,*[2.6] and its update, *Building the Information Core*[2.7]) will also have an impact on hospital and nurses' paperwork. One of the key principles of this strategy is to ensure that professionals have the information that they need to provide care to their patients, and that key patient information is only recorded once at the point at which it is collected. The introduction of electronic patient-based records for example will ensure that the amount of paper-based information and duplication of records collected and held in hospitals will be reduced.

The Department undertook a review of planning requirements it mandates from councils with social services responsibilities. The Plans Rationalisation Project, which reported during the summer, paved the way for significant progress in cutting the number of these plans. A start has been made in reducing the number of plans associated with social services grants, and further work to reduce the number of plans for cross-cutting services for social care will continue in 2002. Related to this work, the implementation of *Information for Social Care*[2.8] will reduce the amount of paperwork in social services and facilitate the more efficient and timely sharing of information between care agencies

The Medicines Control Agency and the Medical Devices Agency adopted the Cabinet Office business friendly Enforcement Concordat during 2001. This means that seven of the Department's enforcement bodies 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, the MCA and the MDA. The National Care Standards Commission in England will also adopt the Enforcement Concordat during 2002.

Responsive Public Services

2.17 Care Direct originates from a government cross cutting review to improve services for older people. It will provide a single gateway, for older people, to get information about social care, health, housing and benefits and to help them access these services more easily. Care Direct is being piloted in six Local Authorities (LAs) in the South West in 2001-2002 and there will be a further 14 pilots starting in Autumn 2002.

All NHS hospital trusts and PCTs/PCGs are 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 the survey results. The processed data from 189 trusts will be returned to the Department's 'central data bank' by late May so that it can inform the performance ratings. For next year, the Department proposes to work-up a survey tool that reflects a more comprehensive range of PCT services.

Quality Public Services

2.18 Specific *Better Quality Services* activity has been overtaken by the recent fundamental review of the Department's services and activities. This has been carried out in the spirit of BQS with Cabinet Office being kept fully aware of progress. This review has generated a programme of change that focuses on our Delivery Contract and aims to improve efficiency and effectiveness. Further details can be found in paragraph 2.16 above.

UK Online

2.19 The Department of Health's *e-Champion,*[2.9] supported by a working group, has continued to respond to central initiatives and contribute to the development of UK online policy. The Department is represented on most of the Office of the e-Envoy cross government groups including the e-Champions' *e-Government*[2.10] and *e-Communications*[2.11] committees.

The Department updated its *e-Business Strategy*[2.12] in the summer which included a revised list of services to be e-enabled to meet the Prime Minister's target of 100 per cent by 2005. 41 services to the citizen and business have been identified of which 13 (32 per cent) are currently available with 36 (88 per cent) expected to be operational by 2005. Services include:

- 24-hour nurse advice and health information through NHS Direct and *NHS Direct Online*[2.13] – currently available;
- access to *personal electronic health records*[2.14] – on target for 2003;
- *electronic transfer of prescriptions*[2.15] – by 2004;
- information and help for older people through *Care Direct*[2.16] – national implementation by 2005;
- *hospital appointment booking service*[2.17] – on target for 2005.

Of the five services not expected to be e-enabled two relate to the provision of welfare foods where the service is under review. The Protection of Children Act List is already partially enabled but further development will be the responsibility of the Home Office from 2002. The NHS procurement service will be e-enabled but not rolled out to the whole NHS by 2005. Finally application for, and award of, Forms E111 is subject to European legislation which is not expected to allow electronic processing before 2005.

The e-Business Strategy brings together, and is underpinned by, three separate strategies, covering the NHS, Social Care and the core Department.

- Some key components of the NHS Strategy *Building the Information Core: Implementing the NHS Plan*[2.18] were updated in *January*[2.19] 2002.
- *Information for Social Care,*[2.20] a strategic approach to information and the use of technology in social care, was published in May 2001.

- A revised version of the internal e-Business strategy, *Implementing e-Business in the Department of Health*[2.21] was published in November 2001.

The Department has also –

- sponsored a new Life Episode, *'Looking after someone'*,[2.22] which was implemented on the *Ukonline Citizen Portal*[2.23] in June 2001, as well as continued to contribute to those Episodes sponsored by other departments.
- implemented *Gateway Reviews*[2.24] for internal projects and is considering, with the Office of Government Commerce, how the process should be applied to the NHS.
- published four *Section 8 Orders*[2.25] under the *Electronic Communications Act 2000*[2.26] to support electronic prescribing and identified further areas where Orders will be considered.
- *connected 97% of GPs*[2.27] to NHSnet with 94 per cent having email access – position at 1 November 2001.
- initiated four pilots to explore health applications of Digital TV. These are being evaluated to learn lessons for possible future NHS use of this technology.
- launched a *Clinician Connect*[2.28] programme in December 2001 to provide all NHS Trust staff with access to basic email, browsing and systems facilities by March 2003.

Public Service

2.20 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. Following a Strategic Assessment Review conducted in the Spring of 2002 the External Assessor recommended that the Department of Health continue to be recognised as an Investor in People having maintained its achievement of the national standard.

Shifting the Balance of Power

Background

2.21 The NHS Plan sets out a vision for service designed around the patient – a service of high quality and national standards which is fast, convenient and uses modern methods to provide care where and when it is needed. Such a service will not only be designed around patients but also be responsive to them, offer them choices and involve them in decision making and planning.

The Secretary of State announced on 25 April 2001 a programme to shift the balance of power within the NHS away from central government and towards front line staff and their patients. Under the arrangements set out in Secretary of State's Shifting the Balance of Power speech local clinicians and managers, working in Primary Care Trusts and NHS Trusts, were to be empowered to ensure that local services reflect the needs of the local community. 'Shifting the Balance of Power' is about putting patients and staff absolutely at the heart of the NHS by empowering them and changing the culture and structure of the NHS to reflect this.

Preparing for Change

In July 2001 the Department published *Shifting the Balance of Power within the NHS – Securing Delivery*,[2.29] detailing the proposed changes and inviting responses in a discussion period. Over 400 responses were received from the service as well as the major national representative bodies. There was general support for the direction of change, although there were many queries about the detailed implementation of the proposals. *Shifting the Balance of Power – the Next Steps*[2.30] was published in January 2002. This document addressed the major issues raised in the discussion period. It set out the framework and principles for the changes but – inline with its own philosophy – left the practical arrangements, the how, when and where of working arrangements and service delivery – to be decided locally. Consultation on the boundaries of the new Health Authorities took place in Autumn 2001 and the new boundaries were subsequently confirmed along with the Chairs and Chief Executives (designate). Franchise plans were then developed by the Chief Executives outlining how they intended to run their organisations, based on a specification set by the Department.

Structural Changes

Much progress has been made in developing and implementing the structural changes:

- England's 95 previous health authorities were abolished on 1 April 2002.
- Much of the planning and commissioning work previously carried out by these health authorities has been passed to just over 300 Primary Care Trusts, which by 2004 will be controlling over 75 per cent of NHS funding.
- 28 new health authorities (set to become Strategic Health Authorities in October 2002, subject to legislation) serving populations of around 1.5 million were also established on 1 April, responsible for developing strategy and performance managing PCTs and NHS Trusts, so as to secure delivery and consistency of approach. They will in effect manage the NHS locally on behalf of the Department.
- The Department of Health has also been re-focusing to reflect the new structure. Four new Directorates of Health and Social Care became operational on 1 April with responsibility for working directly with the NHS and performance managing the new Health Authorities while the Regional Offices are to be abolished.

As a result of these changes, £100 million will be freed up by 2004 to spend on childcare facilities for NHS staff as an aid to recruitment and retention.

Delivering the NHS Plan

Plans for devolving power to locally run services – within a framework of clear national standards – were strengthened in the Department's *Delivering the NHS Plan – next steps on investment, next steps on reform*[2.31] document, published in April 2002. This document builds on the structural and cultural changes of Shifting the Balance of Power.

Further Information

Further information is available on the DH web-site at: www.doh.gov.uk/shiftingthebalance

Patient Choice Initiative

2.22 By 2005 all patients and their GPs will be able to book hospital appointments at both a time and a place that is convenient to the patient. Patients and their doctors will be able to consider a range of options. This might include local NHS hospitals, NHS hospitals or diagnostic and treatment centres elsewhere, private hospitals, private diagnostic and treatment centres, or even hospitals overseas. They will be able to compare different waiting times at different hospitals and across different specialties. GPs and referring consultants will be able to book appointments online. Patients will be able to choose the hospital and waiting time that is convenient for them at the point of referral.

On 6 December 2001 the Secretary of State for Health announced a new initiative to introduce the new system whereby patients choose the hospital rather than hospitals choosing the patient. It will begin to open up the options in 2002-03, to tackle some of the highest priorities and to pilot new approaches. The initial focus in 2002 will be on opening up new opportunities for people who are waiting too long for heart surgery; with a number of pilots for other surgical specialties in London, the North East, North West, Midlands and the South.

In the light of these pilots, further schemes will be rolled out, with the aim that by 2005, as pledged in the NHS Plan, all patients will not only have rapid access to treatment, but will also be able to choose where that treatment is carried out.

Wanless Review (Long Term Review of Health Trends)

2.23 In March 2001 the Chancellor of the Exchequer asked Derek Wanless, former Group Chief Executive of Nat West Bank, to carry out a review to examine the technological, demographic and medical trends over the next two decades that may affect the health service in the UK as a whole. In the light of those trends, the Review was charged to identify the key factors which will determine the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay.

Derek Wanless' Interim Report was published for consultation at the same time as the Pre Budget Report in November 2001 – see the Review website (www.hm-treasury.gov.uk/wanless). It identified patient and public expectations, as well as demography and technology, as key drivers of change in the NHS and social care. Department of Health staff contributed fully to the Review's analysis and an Advisory Group including top managers from the Department provided advice to the Review.

The Review's Final Report was published on 17 April 2002, outlining the trends that will drive health expenditure and estimating the resources that will be needed to deliver a high quality, responsive service over the next 20 years. It outlines the major increase in funds which will be required for the service to catch up with other countries and then keep up. The Review's forecast of the resources required was average real-terms growth of 7.1 to 7.3 per cent over the next five years. In the light of the Review, the Budget provided an unprecedented five-year settlement with an average real terms increase of 7.4 per cent between 2002-03 and 2007-08 for the NHS in England.

This historic level of funding – twice the average real-terms growth of the last twenty years – will enable the NHS to take forward the proposals for reform and modernisation which the Secretary of State outlined in *Delivering the NHS Plan*.

3. Expenditure

THIS CHAPTER COVERS:

3.1 The Department of Health is responsible for managing a budget of over £58 billion in 2002-03;

A Resource Expenditure Limit of £53.3 billion

A Capital Expenditure Limit of £2.5 billion and

Annually Managed Expenditure of some £2.6 billion covering non-cash items such as capital charges and provisions.

Figure 3.1 summarises the resource plans for the Department of Health. More detailed information is provided in **Annexes A2 and A3.**

This Chapter provides information on the Government's expenditure plans up until 2007-08, including details on expenditure in 2001-02. A breakdown of the spending programme can be found in Chapter 6.

Figure 3.1: Department of Health – Public Spending

£ million

	1998-99[1] outturn	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 plan	2003-04[2] plan
Consumption of Resources						
NHS	39,794	41,313	44,374	50,300	53,948	58,847
Personal Social Services	711	631	654	1,062	1,927	2,194
NHS pensions	623	455	522	172	-50	-50
Total Department of Health Resource Budget	**41,128**	**42,400**	**45,550**	**51,535**	**55,824**	**60,990**
Of which:						
Department of Health Departmental Expenditure Limit (DEL)	38,242	39,939	43,506	48,724	53,268	58,358
Non-cash items in AME	2,263	2,005	1,522	2,638	2,616	2,694
Other spending in AME (NHS Pensions)	623	455	522	172	-50	-51
Capital Spending						
NHS	700	908	1,318	1,745	2,401	2,898
Personal Social Services	60	61	59	112	97	97
Total Department of Health Capital Budget	**760**	**969**	**1,377**	**1,857**	**2,498**	**2,995**
Of which						
Department of Health Departmental Expenditure Limit (DEL)	760	969	1,377	1,857	2,498	2,995
Total Public Spending in Department of Health	41,888	43,369	46,927	53,392	58,323	63,985
Spending by Local Authorities on Personal Social Services						
Current	9,059	10,050	10,699	11,076		
Of which						
Funded by grants from the Department of Health	1,053	1,000	947	1,442		
Capital	83	83	93	106		
Of which						
Financed by grants from the Department of Health	60	61	57	63		

(1) Figures for 1998-99 are taken from the Department's 1998-99 Resource Account which did 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) From 2003-04 budgets are set on a stage 2 resource budgeting basis. These stage 1 resource budgeting figures are therefore indicative for that year and include Budget 2002 additions for the NHS on a stage 1 resource budgeting basis.

(3) For a more detailed breakdown of NHS expenditure in England see Figure 3.4 and in the UK see Annex A4

(4) Figures may not sum due to rounding

NHS Expenditure Plans

Budget Announcement

NHS

3.2 In his 2002 Budget the Chancellor announced expenditure plans for the NHS up to 2007-08. For the NHS in England these represent the largest ever sustained increase in any 5 year period in the history of the NHS; an annual average increase of 7.4 per cent in real terms between 2002-03 and 2007-08. Over the period expenditure on the NHS is planned to rise by 44 per cent in real terms to over £90 billion in 2007-08.

Following the Budget announcement, the Secretary of State published a document setting out how this unprecedented increase in NHS funding would be spent. *Delivering the NHS Plan*[3.1] outlines some of the improvements which will now be possible:

- Increased capacity, allowing more patients to be treated more quickly to higher standards – worth the equivalent of over 10,000 extra hospital beds by 2008
- Extra staff – with another 15,000 doctors, 35,000 nurses and 30,000 specialists by 2008
- Shorter waits for treatment – by 2005 a reduction in the maximum wait for a hospital operation to 6 months, then falling to a maximum of 3 months by 2008
- Better outcomes – for example an estimated 25,000 lives saved each year as a consequence of extra investment and reform in coronary heart disease services

Extra resources alone are not enough; it is investment plus reform which delivers results. Some of the key changes to help deliver the NHS Plan will be:

- The new Commission for Healthcare Audit and Inspection – a single, independent 'super regulator' to enforce national standards
- A streamlined financial system of payment by results, so that patients can exercise greater choice
- Greater accountability, for example through an annual 'patient prospectus' from every Primary Care Trust to each household in the locality

Figure 3.2 below sets out the spending plans for the NHS in England for the period 2002-03 to 2007-08.

Figure 3.2: Total Net NHS Expenditure in England (Stage 2 Resource Budgeting)

£ billions

	2002-03 plan	2003-04 plan	2004-05 plan	2005-06 plan	2006-07 plan	2007-08 plan
Resource (revenue expenditure)	53.5	58.5	64.1	70.0	76.7	84.1
% real terms increase		6.6	6.9	6.7	6.8	7.0
Capital Expenditure	2.2	2.8	3.4	4.4	5.2	6.1
% real terms increase		23.9	16.9	25.9	15.5	15.9
Total NHS Expenditure	55.8	61.3	67.4	74.4	81.8	90.2
Real terms growth %		7.3	7.3	7.6	7.3	7.5

These spending plans are shown in Stage 2 Resource Budgeting terms as this is the basis upon which public expenditure will be monitored and controlled as of 1 April 2003. These figures are not comparable with other expenditure figures in this Chapter. This is because we are still required to report figures consistent with the present method of budgetary control ie on a Stage 1 Resource Budgeting basis.

PSS

As part of his budget the Chancellor also confirmed central government provision for Personal Social Services (PSS), funded by both the Department of Health and the Department of Transport, Local Government and the Regions, for years 2003-04 to 2005-06. These plans mean an average annual growth in resources for PSS of 6 per cent in real terms over the 3 years. These new spending plans are set out in **Figure 3.3** below.

Figure 3.3: Funding announced for PSS by the Chancellor in the Budget

£ billion

	2002-03 plan	2003-04 plan	2004-05 plan	2005-06 plan
Total Expenditure	11.4	12.5	13.4	14.6
% real terms increase		7.6	4.3	6.2

Resource Budgeting

Resource Budgeting was introduced in April 2001 as a new method for controlling and managing public expenditure. This meant that public services would now be measured by the resources they consume, including fully accounting for capital assets, rather than the level of cash payments made in year.

Resource Budgeting is being introduced in 2 Stages;

Stage 1: Introduced in April 2001 for years 2001-02 and 2002-03. This introduced accruals accounting ie accounting for resources consumed against cash paid out. This increased the Departmental Expenditure Limit (DEL) and therefore NHS expenditure figures by around £200m a year compared to the previous cash system.

Stage 2: To be introduced from April 2003. Under Stage 2 Resource Budgeting those non-cash items that currently score in Annually Managed Expenditure (AME) will become part of Departmental Expenditure Limit (DEL). These items are:

(i) capital charges ie depreciation and cost of capital and

(ii) the cost of new provisions as opposed to the cash payments associated with settling the provisions

The move to Stage 2 Resource Budgeting increases NHS expenditure by over £2bn a year compared to Stage 1 Resource Budgeting.

The Health and Personal Social Services Programmes

3.3 The health and social services programmes consist of:

Spending on the **National Health Service** on the following programmes

- NHS Hospital and Community Health Services, and discretionary family health services. This covers hospital and community health services, prescribing costs 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; and
- Administration of the Department of Health.

Expenditure on **Personal Social Services** by way of:

- Funding provided by the Department of Health; and
- Funding provided by the Department of Transport, Local Government and the Regions.

National Health Service, England – By Area of Expenditure

Figure 3.4 shows the main areas in which funds are spent on a resource basis for years 1999-2000 to 2003-04. Details on NHS expenditure in the United Kingdom on the same basis are shown in **Annex A4.**

Figure 3.4: National Health Service, England – By Area of Expenditure (Stage 1 Resource Budgeting)

£ millions

	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 plan	2003-04[1] plan
Departmental Programmes In Departmental Expenditure Limits					
National Health Service Hospitals community health, family health (discretionary) and related services and NHS trusts					
Revenue expenditure[2]					
Gross	36,239	39,699	44,598	48,962	52,259
Charges and receipts	-1,987	-2,073	-2,099	-2,232	-2,389
Net	34,252	37,626	42,499	46,730	49,869
Capital expenditure[2]					
Gross	1,464	1,964	2,190	2,722	3,137
Charges and receipts	-593	-676	-491	-355	-270
Net	871	1,288	1,699	2,367	2,867
Total					
Gross	37,703	41,663	46,788	51,684	55,396
Charges and receipts	-2,580	-2,749	-2,590	-2,587	-2,659
Net	35,123	38,914	44,198	49,097	52,736
National Health Service family health services (non-discretionary)[3]					
Revenue expenditure					
Gross	5,075	5,219	5,081	4,576	6,205
Charges and receipts	-806	-849	-891	-898	-898
Net	4,269	4,370	4,190	3,678	5,307
Central health and miscellaneous services[4]					
Revenue expenditure					
Gross	940	991	1,150	1,058	1,119
Charges and receipts	-153	-134	-177	-124	-131
Net	787	856	973	934	988
Capital expenditure					
Gross	40	34	46	34	31
Charges and receipts	-3	-4	#	#	#
Net	37	31	46	34	31
Total					
Gross	980	1,025	1,195	1,092	1,149
Charges and receipts	-156	-138	-177	-124	-131
Net	824	887	1,018	968	1,018
Departmental Programmes in Departmental Expenditure Limits					
Total National Health Service					
Revenue expenditure					
Gross	42,254	45,908	50,828	54,596	59,582
Charges and receipts	-2,945	-3,056	-3,167	-3,254	-3,419
Net	39,308	42,852	47,661	51,342	56,163
Net percentage real terms change(%)	-	7.0	8.2	5.1	6.7
Capital expenditure					
Gross	1,504	1,998	2,236	2,756	3,168
Charges and receipts	-596	-680	-491	-355	-270
Net	908	1,318	1,745	2,401	2,898
Net percentage real terms change(%)	-	42.6	28.8	34.2	17.7
Total					
Gross	43,758	47,906	53,065	57,352	62,750
Charges and receipts	-3,542	-3,736	-3,658	-3,609	-3,689
Net	40,216	44,170	49,406	53,743	59,061
Net percentage real terms change(%)	-	7.8	8.9	6.1	7.2
GDP as at 17 April 2002	98.2	100.0	102.8	105.3	108.0

(1) From 2003-04 budgets are set on a stage 2 resource budgeting basis. These stage 1 resource budgeting figures are therefore indicative for that year and include Budget 2002 additions on a stage 1 resource budgeting basis.

(2) Includes Departmental Unallocated Provision (DUP) for 2002-03 and 2003-04 .

(3) Figures for FHS non-discretionary expenditure between 1999-00 and 2003-04 are not comparable because of transfers to FHS discretionary principally to fund successive waves of Personal Medical and Dental Service Pilots.

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

(5) Figures may not sum due rounding

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

Figure 3.5 compares net expenditure on the NHS in 2001-02 with the planned expenditure figures for 2001-02 published in last year's report.

Figure 3.5: Comparison of Net NHS Expenditure Plans for 2001-2002 with those in last year's Departmental Report (Cm 5103)

£ million

	Departmental Report 2002 Figure 3.4	Departmental Report 2001 Cm 5103 Figure 3.8	2001-2002 difference
HCHS revenue	42,499	42,002	497
HCHS capital	1,699	1,949	-250
FHS non discretionary	4,190	3,829	361
Central Health and Miscellaneous Services	1,018	972	46
NHS Total	49,406	48,752	654

1 Totals may not sum due to rounding

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

Figure 3.6: Main Areas of Change (£10 million or over) to the Spending Plans presented in last year's Departmental Report (Cm 5103)

2001-2002	Difference		
HCHS current	497 including:	330	Take up of End Year Flexibility (EYF)
		320	Transfers from HCHS capital
		-306	Transfers to FHS non discretionary
		240	Reclassification of NHS Trusts Depreciation
		-150	Estimated underspend
		35	Transfers from CHMS
		18	Transfers from PSS
		12	Transfers from Other Government Departments
HCHS capital	-250 including:	-320	Transfer to HCHS revenue
		50	In year addition from Treasury Capital Modernisation Fund.
		95	Take up of EYF
		-75	Estimated underspend
FHS non discretionary	361 including:	306	Transfer from HCHS revenue
		56	Take up of EYF
CHMS	29 including:	35	Take up of EYF
		30	In year addition from HM Treasury
		-35	Transfers to HCHS revenue

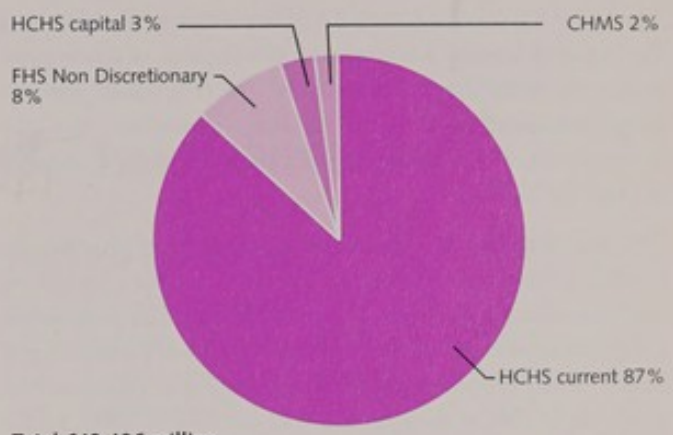
1 Totals may not sum because only those changes over £10 million are included.

NHS Expenditure Trends

NHS Net Expenditure in 2001-02 is estimated to be over £49 billion, an increase of 8.9 per cent in real terms (measured by the GDP deflator) over 2000-01.

The largest part of NHS spending is on Hospital and Community Health Services, discretionary family health services and related services. For 2001-02 the estimated outturn position in net current expenditure is forecast to be £42.5 billion and £1.7 billion on net capital expenditure. Within overall NHS net expenditure, the total for non-discretionary FHS is expected to account for £4.2 billion in 2001-02. The remainder will be spent on Central Health and Miscellaneous Services. **Figure 3.7** contains the breakdown of NHS Net Expenditure for 2001-02 (Estimated Outturn).

Figure 3.7: NHS Net Expenditure, 2001-2002 (estimated outturn)



Total £49,406 million

Personal Social Services (PSS) Expenditure

3.4 The Department of Health provides resources for the delivery of high quality social care through local authorities and other agencies. The resources provided for PSS from the Department's public expenditure programme are shown in Chapter 6, section 6.11 which give details on PSS revenue provision.

Figure 3.8 shows total local authority current and capital expenditure on PSS. Between 1991-92 and 2001-02 local authority PSS net current expenditure has increased by 84 per cent in real terms.

Figure 3.8: Expenditure on Local Authority Personal Social Services

£ million

	1991-92 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 outturn[3]	2000-02 budget
Current expenditure							
gross[1]	5,127	9,263	9,984	10,847	12,048	12,848	–
charges[1]	-506	-1,320	-1,530	-1,788	-1,998	-2,152	–
net							
cash	4,622	7,943	8,454	9,059	10,050	10,699	11,076
real terms[2]	5,950	8,991	9,284	9,677	10,483	10,699	11,076
Capital expenditure							
gross	166	180	150	140	134	170	–
income	-34	-44	-43	-53	-51	-57	–
net	132	136	107	87	83	113	–
Total local authority expenditure							
gross	5,293	9,443	10,134	10,987	12,182	13,018	–
charges/income	-540	-1,364	-1,573	-1,841	-2,049	-2,209	–
net	4,753	8,079	8,561	9,146	10,133	10,809	–

Source: PSS EX1, RO and RA LAs Returns

(1) Gross current expenditure, income from charges and capital figures are not available for 2001-02

(2) At 2001-02 prices using the GDP deflator.

(3) The 2000-01 outturn figures in this table are taken from form PSS EX1 which is returned to the Department annually by local authorities. This form was introduced in 2000-01. The 2000-01 outturn figures in Fig 3.1 are derived from form RO3 returned by local authorities to the Department of Transport Local Government and the Regions. Hence, there is a discrepancy of around £3m between the two figures.

Complementary Sources of Funding

New Opportunities Fund

3.5 *The National Lottery Act*[3.2] 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 has been three tranches of funding released for NOF.

The first tranche, was launched in January 1999 with the Healthy Living Centre initiative. The initiative has a budget of, £232.5 million in England (£300 million UK). The programme targets areas and groups that represent the most disadvantaged sectors of the population and it is expected that HLCs will be accessible to 20% of the population by the close of 2002. HLCs influence the wider determinants of health, such as social exclusion, poor access to services, and social and economic aspects of deprivation which can contribute to health inequalities. Projects cover a range of activities including, for example, smoking cessation, dietary advice, physical activity and training and skills schemes. Local communities and users are involved in all aspects of design and delivery of a project. All of the funding has to be committed by the close of 2002 for projects which can last up to 2007.

By mid May 2002 140 HLCs in England had been approved and announced by NOF totalling just over £109.6 million. All funding will be committed by Autumn 2002. New HLCs are announced regularly and these can be found on NOF's web-site at: www.nof.org.uk

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 is being used to fund the purchase of cancer equipment such as linear accelerators and MRI scanners (see also section 5.5 in Chapter 5).

The third tranche of £232.5 million was announced last year, to boost the fight againt cancer, coronary heart disease, and stroke. It will also be used to provide palliative care for adults and children. The CHD funding from the third tranche includes £65m to purchase diagnostic angiography equipment over the next three years. The first wave of recipients was announced in November 2001, enabling 29 new and 8 replacement angiography and catheterisation laboratories to be purchased which will speed up diagnosis. This first wave of funding will enable the NHS to carry out up to 14,000 extra angiograms each year. Recipients of the second and third waves will be announced during the forthcoming year. The CHD money will also be used to buy ambulance equipment and defibrillators, and to improve cardiac rehabilitation and heart failure services. There will also be £52 million to fund nutritional projects to reduce heart disease and cancer. Of this, £10 million will be used to expand the five-a-day initiative, and £42 million will be used to bring forward the targets of the National School Fruit Scheme. There will be 50-60 pilot projects for the School Fruit Scheme, based in PCTs with the highest levels of deprivation. In addition, £48 million will be used to improve palliative care for children, and £22 million will be used to improve community palliative care for adults.

4. Investment

THIS CHAPTER COVERS:

Policy context

4.1 Investment continues to play a pivotal role in the modernisation of the NHS to produce faster, fairer services that deliver better health and tackle health inequalities. The *NHS Plan*[4.1] and *Departmental Investment Strategy*[4.2] set out a planned programme of investment in the NHS. During 2002-03 that programme will be taken forward to focus on delivery of key priority investment areas covering:

- Tackling cancer, cadiovascular disease, mental health, and narrowing the health gap by improving services;
- Cutting waiting times and improving emergency care;
- Improving the patient experience;
- Improving older people's care;
- Modernising primary care; and,
- Strengthening frontline capacity.

To meet these investment challenges, NHS capital investment is set to rise to over £3.3 billion in 2002-03 including land sale receipts and investment generated through the Private Finance Initiative.

Figure 4.1 summarises the Department's capital expenditure plans to 2003-04. **Figure 4.2** shows the disposition of 2002-03 capital resources.

Figure 4.1: NHS Capital Spending 2001-02 to 2003-04 (Resources)

	£ million		
	2001-2002 Forecast Outturn	2002-2003 Plan	2003-2004 Plan
Government Spending	1,745	2,401	2,898
Percentage Real Terms Growth		*34.2*	*42.7*
Receipts from Land Sales	491	355	270
Percentage Real Terms Growth		*-29.5*	*-25.8*
PFI Investment	723	783	934
Percentage Real Terms Growth		*5.7*	*16.4*
Total	**2,959**	**3,539**	**4,102**
Percentage Real Terms Growth		*16.7*	*28.3*

Real Terms Growth calculated using GDP deflator of 2.5 per cent.

Figure 4.2: Disposition of 2002-03 Capital Resources

		£ million
Total NHS Capital Investment		**3,539**
Less: PFI Investment		-783
Gross NHS Capital		**2,756**
Less:		
Costs associated with the retained estate	30	
NHS Trust receipts	55	
Transfer to revenue for Primary Care	66	
Other NHS Capital	34	-185
HCHS Capital available for allocation		**2,571**
To be allocated as follows:		
Central Budgets		**86**
NHS Trusts/Health Authorities/ Primary Care Trusts		
General Allocations	1,352	
Local Capital Modernisation Funds	110	
Secure Hospitals – Fallon Enquiry	9	
Renal Services	9	
Additional Medical Students	26	
Cancer	71	
Coronary Heart Disease	114	
Waiting Lists – Action on Programmes	41	
On Site Nurseries	15	
Ante-natal and Child Screening	3	
Mental Health	62	
Junior Doctor Working Hours	2	
Older People	41	
Looked After Children	10	
Decontamination and Sterilisation facilities	150	
Maternity	50	
Elimination of Nightingale Wards	40	
Learning Disablity Development Fund	20	
Performance Fund	50	
Genetics	3	
Pharmaceutical Manufacturing	4	
Clinical Assessment System	16	
Diagnostic and Treatment Centres	15	
Primary Care Access – NHS LIFT	60	
To be allocated later	212	
Total to NHS Trusts/Health Authorities/ Primary Care Trusts		**2,485**

Priorities for Capital Investment in 2002-03

4.2 Examples of investment targeted at specific health areas in 2002-03 are:

Cancer – £71 million is available in 2002-03. This will go into expanding the breast screening service to extend routine invitations to women aged up to 70 from which 400,000 women will benefit each year. The funding will also buy new and replacement equipment to improve detection and treatment of cancer in line with the *NHS Cancer Plan*[4.3] launched in September 2000.

ON THE GROUND:

Cancer patients in Lincolnshire are to benefit from significantly shorter waiting times following the arrival of a third new linear accelerator (machines used for treating cancer).

A £22 million centre for molecular imaging, the most advanced of its kind in the world, is to be built in Manchester. It will enable specialist research into the biology of cancer and the way that anti-cancer drugs work.

Coronary Heart Disease – £114 million is available in 2002-03. Funding will go into revascularisation schemes to expand cardiac services with around 12 additional cardiac theatres and 380 extra beds. This investment will reduce waiting times for heart surgery patients in the areas served by the units receiving funding. Capital will also be targeted at expanding diagnostic angiography to reduce waiting times for tests and inpatient admissions. The expansion of revascularisation services will be underpinned by long-term capacity building. The Department of Health has announced a modernisation and expansion programme for eight cardiac centres at a cost of £170m over four years, bringing the number of centres undergoing major improvements up to 12 costing £251m. Treasury Capital Modernisation Fund money will provide CHD equipment for Primary Care. This money (totalling £35m) will also fund cardiac rehabilitation and treatment of heart failure.

ON THE GROUND:

Before patients suffering a heart attack in Dorset would have to wait until arrival at hospital before their ECG readings could be interpreted and the correct treatment given. But using telemetry an ECG taken in the ambulance can now be faxed to the heart unit where a diagnosis and appropriate arrangements for treatment can be made as soon as the patient arrives. This means thrombolysis (clot-busting drugs) can be administered much quicker than before.

Mental Health – £62 million is available in 2002-03. Funding will be targeted at improving security at the three high security psychiatric hospitals and for the transfer of some patients into more appropriate care settings. There will also be funding for the refurbishment of acute psychiatric wards to provide a better environment for patients to receive treatment.

Decontamination and Sterilisation Facilities – £150 million is available in 2002-03. This investment will underpin a major overhaul to provide the NHS with the most up-to-date decontamination equipment. It will modernise sterile service departments, providing new fully automated state-of-the-art sterilisers and washer disinfectors.

Maternity – £50 million available in 2002-03. This funding represents the second tranche of a two-year £100 million programme of investment announced last year to modernise and improve facilities at over 209 maternity units across England. The investment will cover areas such as major refurbishments, facilities for fathers and families, modernisation of antenatal units and provision of better bereavement facilities.

Primary Care Access – NHS LIFT – £60 million available in 2002-03. Further information on this initiative is given in paragraph 4.8.

Empowerment of Clinical Teams – £110 million is earmarked from general capital allocations in 2002-03 for Local Capital Modernisation Funds. This will continue the initiative started in 2001-02 to enable doctors, nurses, and other clinical staff in acute hospitals in England to decide top priorities for investment. This funding can be spent on large, expensive pieces of equipment (such as kidney dialysis machines), smaller equipment, or a mixture of the two.

Diagnostic and Treatment Centre Programme

4.3 The NHS Plan included a commitment to develop 20 diagnostic and treatment centres by 2004 with eight fully operational by then. In February 2001 the Department announced 26 proposed schemes. In February 2002 a further eight early proposals were announced. These centres will be receiving patients by the end of the year and will provide over 20,000 extra treatments a year, making an impact on waiting times in some of the most pressured parts of the country. It is planned to accelerate the DTC programme further.

DTCs will insulate routine, booked hospital appointments from the unpredictable peaks and troughs of emergency cases meaning that there will be fewer cancellations, a more convenient service and quicker treatment. DTCs will take a range of innovative approaches to providing fast and convenient care, in partnership with public and private organisations, in primary care and in hospitals. DTCs will ensure effective use of day surgery and process re-design to maximise efficiency.

Maximisation of Block Capital

4.4 The use of block capital is again to be maximised in 2002-03 to bring about smaller scale improvements across the NHS rather than expenditure being focused on a few larger projects. Regional Offices must 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 no less than their previous year's block allocation (a definition of block capital is contained in the glossary).

Restrictions on Capital to Revenue Transfers

4.5 As in previous years, a limit has been set on capital to revenue transfers in 2002-03 to control the amount of capital which can be transferred to support revenue expenditure. This will ensure that capital resources are expended on capital investment as intended.

Treasury Capital Modernisation Fund

4.6 There is £168 million available from the Treasury's Capital Modernisation Fund (TCMF) in 2002-03 to support innovative capital investment projects. The funds available from TCMF are shown in **Figure 4.3.**

Figure 4.3: Treasury Capital Modernisation Fund 2002-03

	1999-2000	2000-01	2001-02	2002-03	2003-04
					£ million
A&E Modernisation	85	35			
Coronary Heart Disease			70	10	20
Decontamination		5		100	
Reducing Waiting Times				31	37
Looked After Children				10	10
Chlamydia				2	3
Primary Care of which:					
Walk in Centres	15	40			
Dental Access		15	50		
Modernising Premises		15	30		
NHS Direct	14		20		
NHS LIFT				10	10
Joint ventures with private sector			50		
Cataract Treatment		12	8		
Total	**114**	**122**	**228**	**163**	**80**

Capital Prioritisation

4.7 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 £7.7 billion have been given the go-ahead. Thirteen of these developments are already completed and operational, and a further 15 are already under construction. **Figure 4.4** lists all major schemes given the go-ahead since May 1997.

Public Private Partnerships

4.8 The Private Finance Initiative (PFI) continues to help us deliver the largest hospital building programme in the history of the NHS. On current plans, PFI will provide nearly £800 million capital for 2002-03. This represents 28.4 per cent of total NHS capital spending in this year.

A further eight of the 'first wave' of major PFI schemes finish construction and become operational (Greenwich, Calderdale, North Durham, South Manchester, Norfolk & Norwich, Hereford, Barnet & Chase Farm and Worcestershire) making a total of eleven in the past two years. Two more are expected to be completed by the end of the 2002.

In February 2001 a further 29 new hospitals, each with a capital value of over £20 million, were given the go-ahead under the PFI procurement procedure. Several of these are timetabled to go out to tender during 2002.

As well as the programme for major acute schemes the PFI model continues to successfully deliver a number of small and medium sized mental health and community schemes. Over seventy such schemes worth approximately £350 million have now reached financial close or are further advanced.

One of the newly established Public Private Partnerships (PPPs) outlined in the NHS Plan is NHS Local Improvement Finance Trust (NHS LIFT). At a national level a 50:50 joint venture company has been established with Partnerships UK (PUK). The company – 'Partnerships for Health (PfH) – will support the development of local NHS LIFT schemes (e.g. developing and implementing a standard approach to procurement) as well as providing some equity investment into local LIFTs. The Department and PUK have both agreed to provide an initial £5 million equity investment.

Local LIFTs will be set up as a limited company with the local NHS, PfH and the private sector as shareholders. Priority for investment will be to those parts of the country, such as inner cities, where primary care premises are in most need of expansion. NHS LIFT will empower and assist the regeneration of local communities by providing better healthcare facilities, involving local businesses to deliver local solutions.

Six NHS LIFT areas were given the go-ahead in the 1st Wave in February 2001: Newcastle and North Tyneside; Barnsley; Manchester, Salford & Trafford; Sandwell; Camden & Islington; East London & City.

Another twelve were given the go-ahead in a 2nd Wave in January 2002: Barking & Havering; Birmingham & Solihull; Bradford; Cornwall & Isle of Scilly; Coventry; East Lancashire; Hull; Leicester; Liverpool and Sefton; West Kent (Medway); North Staffordshire; Redbridge & Waltham Forest.

Another new form of PPP is the Electronic Staff Record (Human Resources and National Payroll System) initiative which aims to introduce standardisation and investment in modern systems to the quality of management information supporting all NHS staff. A consortia was selected on 5 December 2001 to deliver a state-of-the-art electronic staff record system to all NHS Trusts in England and Wales.

ON THE GROUND:

Worthing Hospital opened an 11-bed private patients' suite in May 2001. It has to date treated nearly 400 patients and raised income for the NHS of £161,000. This has helped to pay for new staff for the cancer service as well as education and training for medical staff. It has also helped to fund the continuation of the paediatric outreach service.

Asset Disposal

4.9 The *Sold on Health report*[4.9] 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 strategy, 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:

Figure 4.4: Major Capital Schemes approved since 1 May 1997, in the UK

Scheme	£ million Capital Value
PFI Schemes:	
PFI Schemes reached Financial Close which are completed:	
Dartford & Gravesham NHS Trust	94
North Cumbria Acute Hospitals NHS Trust	67
South Buckinghamshire NHS Trust	45
Queen Elizabeth Hospital NHS Trust	93
Calderdale & Huddersfield NHS Trust	65
North Durham Health Care NHS Trust	61
South Manchester University Hospitals NHS Trust	66
Norfolk & Norwich NHS Trust	158
Hereford Hospitals NHS Trust	64
Worcester Acute Hospitals NHS Trust	87
Barnet and Chase Farm Hospitals NHS Trust	54
Total PFI Schemes at Financial Close which are completed (11)	**854**
PFI Schemes reached Financial Close with work started on site:	
Bromley Healthcare NHS Trust	118
South Durham Healthcare NHS Trust	48
South Tees Acute Hospitals NHS Trust	122
Swindon & Marlborough NHS Trust	96
King's Healthcare NHS Trust	64
Leeds Community NHS Trust	47
St George's 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
Dudley Group of Hospitals NHS Trust	137
West Berkshire Priority Care NHS Trust	30
Gloucestershire Royal NHS Trust	32
Total PFI Schemes reached Financial Close with work started on site (13)	**1,229**
Total PFI Schemes reached Financial Close with work started on site or completed (23)	**2,083**
PFI Schemes approved but not reached financial close:	
Wave 1A:	
Bart's & The London NHS Trust	620
Total Wave 1A Schemes (1)	**620**
2nd Wave Schemes Prioritised:	
Central Manchester Healthcare/Manchester Children's Hospitals NHS Trusts	199
Newcastle Upon Tyne Hospitals NHS Trust	124
Walsgrave Hospitals/Coventry Healthcare NHS Trusts	178
Total 2nd Wave schemes Prioritised (3)	**501**
3rd Wave Schemes Prioritised [1] [2]:	
Leeds Teaching Hospitals NHS Trust	125
Oxford Radcliffe Hospitals NHS Trust	96
Barking, Havering and Redbridge Hospitals NHS Trust	156
Portsmouth Hospitals NHS Trust	120
Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust	73
Southern Derbyshire Acute Hospitals NHS Trust	177
Total 3rd Wave schemes Prioritised (6)	**747**
4th Wave Schemes Prioritised [1] [2]:	
University Hospital Birmingham/South Birmingham Mental Health NHS Trusts	291
Bradford Hospitals NHS Trust	116
Avon & Western Wiltshire Mental Health 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

Scheme	£ million Capital Value
4th Wave Schemes Prioritised (continued):	
Peterborough Hospitals NHS Trust	135
Salford Royal Hospitals NHS Trusts	102
Maidstone & Tunbridge Wells/Invicta Community Care NHS Trusts	189
Pinderfield & Pontefract Hospitals/Wakefield & Pontefract Community/Dewsbury Health Care NHS Trusts	164
Whipps Cross Hospitals NHS Trust	184
Total 4th Wave Schemes Prioritised (12)	**1,737**
5th Wave Schemes Prioritised [1] [2]:	
Brighton Health Care NHS Trust	28
United Bristol Healthcare NHS Trust	104
Sherwood Forest Hospitals 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 NHS Trusts	224
Plymouth Hospitals NHS Trust	101
St Helens & Knowsley Hospitals NHS Trust	211
Walsall Hospitals/Walsall Community Health NHS Trusts	43
Paddington Basin	460
Royal Wolverhampton Hospitals NHS Trust	110
Total 5th Wave Schemes Prioritised (14)	**1,659**
6th Wave Schemes Prioritised [1] [2]:	
Oxford Radcliffe Hospitals NHS Trust	28
Southampton University Hospitals NHS Trust	52
South Devon Healthcare NHS Trust	65
Tameside & Glossop Acute Services NHS Trust	47
Total Prioritised Schemes	**192**
Total PFI (64)	**7,539**
Publicly Funded Schemes:	
Publicly Funded Schemes which are completed:	
Rochdale Healthcare NHS Trust	24
Central Sheffield University Hospitals NHS Trust	24
Total Publicly Funded schemes which are completed (2)	**48**
Publicly Funded Schemes with work started on site:	
Royal Berkshire & Battle Hospital NHS Trust	74
Guys & St.Thomas NHS Trust	50
Total Publicly Funded schemes with work started on site (2)	**124**
Total Publicly Funded schemes with work started on site or completed (4)	**172**
Total Major Capital Investment given go ahead (68)	**7,711**

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, bank due diligence fees, banks' lawyers' fees and third party equity costs.*
3. *As PFI procures a service, capital values shown are necessarily estimates.*

- A national framework and regional overviews for the procurement, operation and disposal of the NHS estate. A document has been completed and is currently being tested prior to being formally implemented;
- A corporate approach to the disposal of surplus estate and the achievement of best value. NHS Estates now act as the informed client for all disposals by NHS trusts;
- 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. Earned autonomy has now been introduced;
- A programme for better capital procurement including new partnering relationships with the private sector to structure the process and deliver better value for money. *NHS ProCure 21*[4.5] has been launched. It includes four key elements partnering, enabling the NHS to be best client, promoting design quality on NHS schemes (HRH Prince Charles has agreed to be a Design Champion for the NHS) and benchmarking and cost intelligence; and,
- An acceleration of the disposal of surplus land and buildings, reducing costs and releasing additional funds for the NHS. Over 100 properties have been sold by auction (£12 million+ realised). NHS estates is now pursuing a sale of over 120 properties with an estimated value of around £400 million by means of a Public Private Partnership.

Pooled Budget Arrangements

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

4.10 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.

By providing more assistance towards the cost of innovative projects, which may need up front 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.

Rounds 1 – 3

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 coastguard services.

In Round 2 the invitation to submit bids to the Invest to Save Budget was extended to local authorities and health authorities. 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.

In Round 3 The Department of Health were awarded a total of £5.26 million. 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.

Round 4

In Round 4 of ISB the priorities will again be to support projects, which involve the electronic delivery of transactional services, have a citizen-focused approach or which seek to tackle the root causes of social problems.

£60 million is available across Government Departments and The Department of Health has submitted 31 Bids of which 3 have been successful in securing funds.

- **Birmingham Health Authority (£393,000)** – To develop a network of supported housing placements, complemented by a fully qualified staff team, to provide care and accommodation for people with learning disabilities with forensic needs, i.e. who commit criminal offences/and are at risk of offending, but who do not require the level of physical security offered in a hospital unit.
- **North Nottinghamshire Health Authority (£150,000)** – Development of innovative approaches to involve young people within an area of high deprivation in order to re-engineer services relevant to them through: a Service Modernisation Fund; a Health Improvement & Modernisation Post for Young People aged 10 to 15 years; effective marketing and enhanced information systems.
- **North Cumbria Health Authority (£99,267)** – Development of online delivery of supported distance learning specialist course (BSc(Hons) Nurse Practitioner) which is in increasing demand by the NHS. Responds to need in primary and secondary care and builds on partnerships.

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

THIS CHAPTER COVERS:

Summary of 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.

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

The NHS Plan set the direction of modernisation and reform. It 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.

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.

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

What does the Plan aim to achieve?

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.

The extra resources provided by the 2002 Budget will allow the Government to go further in tackling the major capacity constraints suffered by the NHS. The Government will use this extra investment to:

- Recruit and retain increasing numbers of key staff. By 2008 the NHS is expected to have net increases over the September 2001 census (latest available headcount figures) of at least:
  - 15,000 consultants and GPs
  - 35,000 nurses, midwives and health visitors
  - 30,000 therapists and scientists
- Expand and make better use of hospital capacity through a combination of measures. By 2008, it is expected that the NHS will have:
  - increased the number of operations carried out as same day cases to over 75 per cent of all operations – the equivalent of adding an extra 1,700 general and acute beds in hospitals
  - opened 42 additional major hospital schemes mostly delivered through the PFI with 13 more major schemes under construction
  - additional fully operational Diagnostic and Treatment Centres – the new generation of fast-track surgery centres which separate routine from emergency surgery
- Modernise the way services are delivered in order to expand the choices available to patients. For example:
  - establishing around 750 primary care one-stop centres across the country to offer a broader range of services, backed by more primary care nurses and specialist GPs, pharmacists, therapists and diagnostic services.
  - expanding the capacity of NHS Direct from 7.5 million callers per year to 30 million callers per year to provide advice, and direct patients to the most appropriate service for their needs

– electronic booking of all appointments across the NHS by 2005 and electronic patient records in all Primary Care Trusts by 2008

Further details about the additional facilities and staff that will now become available following the Budget announcement will be published over forthcoming months. However, this investment has to be accompanied by reform. To secure the best use of resources, the reform programme outlined in the NHS Plan will now need to be driven forward to redesign the NHS around the needs of the patient.

Implementing Reform

5.2 The Health Act 1999 introduced a statutory duty of quality on NHS Trusts, Primary Care Trusts and Health Authorities, which requires them to put and keep in place arrangements for monitoring and improving the quality of the health care they provide. Clinical governance, as the central framework enabling NHS organisations to fulfil this statutory duty, puts in place mechanisms that will improve the quality and safety of clinical services throughout the NHS. All NHS Trusts are expected to complete, implement and update their clinical governance development plans for 2002-03, and to report on clinical governance within their 2001-2002 Annual Reports.

Clinical Governance reporting and performance monitoring processes are currently under review following publication of *Shifting the Balance of Power*. A new framework for Clinical Governance reporting and Board assurance processes is being developed, with the aim of ensuring that all clinical governance reports can be more closely linked to the work of the Commission for Health Improvement – further guidance will be issued in due course.

The Commission for Health Improvement (CHI) was established as an executive NDPB under the Health Act 1999. Since April 2000, when it began its programme of work, CHI has been an independent watchdog for the NHS, carrying out local clinical governance reviews, investigations, and national service reviews. CHI has completed over 100 clinical governance reviews of NHS Trusts, including acute and mental health Trusts, and of a number of health authorities (covering primary care).

The Bristol Royal Infirmary Inquiry recommended that the number of bodies inspecting and regulating health and social care should be rationalised. At present, the Audit Commission, the National Care Standards Commission and the Commission for Health Improvement all play an important and effective role in regulating and assessing health care performance. The Government has announced plans to establish an independent new health inspectorate which will bring together the health value for money work of the Audit Commission, the work of the Commission for Health Improvement and the private health care role of the National Care Standards Commission. Legislation will be introduced to establish the new body as soon as Parliamentary time allows.

The National Institute for Clinical Excellence (NICE) has been created to help ensure that every NHS patient in England and Wales gets fair access to quality treatment by identifying best practice, and spreading it quickly. NICE will promote the uptake of successful innovations and help end the lottery of post-code prescribing by identifying which new developments most improve patient care, and which do not.

The National Patient Safety Agency (NPSA) was established in July 2001. The core function of the organisation is specifically to improve the safety of NHS patient care by promoting a culture of reporting and learning from adverse incidents and professional errors, and to manage the national reporting system to support this function. Following on from piloting, which ended in March 2002, the reporting system will be implemented across the NHS from later in 2002.

2001-02 was the first year of operation for the NHS Performance Fund. The fund provides resource to fund locally developed and designed incentive schemes tailored to the particular needs of each area and aimed at supporting implementation of the NHS Plan.

In September 2001 all non-specialist acute NHS Trusts were issued with performance ratings (stars) reflecting their performance during 2000-01. The star status assigned to organisations is based upon delivery of national targets and overall performance as measured against a balanced scorecard reflecting staff, patient and clinical focus.

The Health Act Partnership Arrangements[5.2] are helping to break down the barriers between services provided within healthcare and community sectors by removing existing constraints in the system. The Department of Health has been notified of over 100 projects using the Health Act Partnership arrangements, with £1 billion now invested in this way. Projects include services for older people, intermediate care child and adolescent healthcare, nursing home places, learning disability services, mental health services, equipment, and interim care arrangements for winter pressures.

The introduction of Care Trusts (single organisations that may commission and/or provide health and social care services) is a real opportunity to deliver improved, integrated health and social care. The first four Care Trusts were established on April 1 2002, in Bradford, Camden and Islington, Manchester and Northumberland. The first three are based on an NHS Trust model and focus on mental health services (Bradford includes its learning disability services). Northumberland Care Trust combines the services formerly provided by four Primary Care Groups with the whole of adult social services delegated from the Council.

The extra resources provided by the 2002 Budget will allow the Government to meet the NHS Plan's commitment to 'liberating the potential of staff'. Further steps on reform will change working practices and help put frontline staff in charge of making improvements happen at all levels of the NHS.

The NHS Confederation is negotiating with the BMA to introduce a modern GMS contract for GPs and primary care staff. A framework was published in April 2002, which envisages more

flexible contracts between PCTs and practices that better reward high quality clinical and organisational standards. The responsibilities of practices will be defined more clearly, and they will be able to seek to provide new services in primary care. By October 2001, 18 per cent of GPs had chosen to move onto local PMS contracts and this proportion continues to grow.

The Department of Health, alongside other UK Health Departments, has agreed a framework for a new consultants' contract with the British Medical Association. The new contract will allow the NHS to make better use of consultant time, increasing the time spent on direct clinical care and extending consultant delivered services for NHS patients. The contract will provide a more effective system of planning and timetabling consultants' duties, with job plans clearly setting out commitments and objectives. Pay progression will depend on maintaining consistent standards of performance and commitment to the NHS throughout a consultant career. There will be a more robust framework for recognising on-call and out-of hours work, with greater rewards for those who make the greatest contribution. Consultants wishing to undertake additional clinical work outside the contract will first have to offer the NHS additional work, and there will be a new set of rules to prevent conflicts of interest between private practice and NHS work. The new contract will be implemented from April 2003.

Good progress has also been made in talks to modernise the NHS pay system following publication of the White Paper, – Agenda for Change. There has been considerable work done in preparing a NHS job evaluation system and Knowledge and Skills Framework to underpin the proposed new pay system. The aim is to complete negotiations later this year with a view to starting implementation at the earliest possible opportunity.

A modern framework of pay and conditions of service will ensure fair pay and help managers and staff to develop improved patient services.

Investment in NHS staff and development of traditional roles has continued. We have begun to remove the glass ceiling constraining clinical careers and to strengthen clinical leadership with over 730 nurse, midwife and health visitor consultant posts established to date. Following consultation nurse prescribing is being extended with more nurses and midwives beginning to extend their involvement in post-natal care to 6 weeks. In addition, ward sisters have been given annual £5000 budgets to improve the ward environment and nearly 1900 modern matrons have been introduced, each accountable for a group of wards, easily identifiable to patients and with the authority necessary to resolve problems quickly and ensure high standards of care.

The Patients voice is being strengthened at every level of the health service including primary care where 70 per cent of patients receive their care.

- There will be a Patient Advice and Liaison Service (PALS) and Patients' Forum for every trust, including Primary Care Trusts;
- We will reform the NHS Complaints procedure to make it more responsive to the needs of patients and support people in making a complaint through a new Independent Complaints Advocacy Service (ICAS);
- Patients will have direct representation on all trust and PCT boards, bringing the patients' perspective into the decision-making process;
- A new Commission for Patient and Public Involvement in Health (CPPIH) and Patients' Forums will be established to represent the views of patients and the public in the delivery of NHS services, primarily through the new arrangements;
- The Health and Social Care Act 2001 provides for the Overview and Scrutiny Committees of local authorities to have the power to scrutinise the local NHS;
- The Health and Social Care Act 2001 places a duty on NHS trusts, Primary Care trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public service planning and operations and in the development of proposals for changes;
- Patient experience will be measured through locally-audited surveys and linked to the overall performance assessment process; and,
- A patient prospectus will be delivered to every household informing citizens about local health services and their performance.

Special effort will be focused on reducing waiting times for treatment since this is the public's principal concern about the NHS; the resources from the 2002 budget allow this programme to be driven forward in the years to 2008. The main improvements patients will see include:

- By 2005 a reduction in waiting times for an outpatient appointment to a maximum of 3 months;
- By 2005 a reduction in the maximum wait for a hospital operation to 6 months, then falling to a maximum of 3 months by 2008 (with an average wait of half this time);
- A reduction in maximum waiting times in A&E departments to 4 hours by 2004 with average waits reduced to 75 minutes. There will be further progressive reductions in this maximum waiting time; and,
- A reduction in waiting to see a GP so that by 2004 patients are seen within 48 hours or seen by another primary care professional within 24 hours.

Implementation of the NHS Plan

5.3 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?

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

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 5.4).

In December 2000 the *NHS Plan Implementation Programme* [5.3] 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*[5.4], 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.

The funding increase announced in the 2002 Budget will enable the Government to take forward the next phase of the NHS Plan. The next steps for investment and reform have recently been published in *Delivering the NHS Plan* (April 2002); this document outlines what the public can expect to see in improved services as the Plan is implemented, and how these improvements will be secured. The document emphasises that historic problems can not be solved by extra investment alone: it is essential to reform the way the NHS works in order to get maximum benefit from the Budget increases. Significant reforms include:

- **Stronger incentives** for providers to treat more patients to higher standards.
- **Continued decentralisation** 'Foundation Trusts' will have more freedom to operate, and the 'NHS Bank' will take over existing brokerage arrangements.
- **Funding and incentives for social care** – to reduce delayed discharges and stabilises the care home market.
- **Two new regulators** for health and social care (the Commission for Health Audit and Inspection and the Commission for Social Care Inspection) replacing a variety of current arrangements.
- **Greater local accountability** – PCTs will provide every household with a patient prospectus detailing their future plans and their past performance.
- **More patient choice** – and a clearer recognition of patients' responsibilities.

Actions Achieved to Date

5.4 Owing to the hard work of managers and frontline staff the NHS is making good progress in delivering the improvements set out in the NHS Plan. Key achievements within each of the taskforce areas include the following:

Access

Improve access to care in line with patients' need.

- NHS Direct advises patients on the most appropriate course of action for their enquiry and on the availability of local NHS services and other voluntary or self-help groups operating in the caller's area. Up to 10 million patients are now able to access out of hours services through NHS Direct.
- 42 NHS walk-in centres are now open, with 1 more to opened later this year. Since they opened they have seen around 1.5 million patients.
- The result of the Quarter 4 Primary Care Access Survey confirmed that the 60 per cent milestone for patients to see a GP within 48 hours had been achieved and that the same milestone to see a healthcare professional within 24 hours had been missed by less than 1 per cent.
- By March 2003, 90 per cent of patients who wish to do so will be able to see a primary care professional within 1 working day and a GP within 2 working days.
- By March 2002, 5 million patients had benefited from the Booked Admissions Programme.
- By the end of March 2002, all but 2 NHS trusts had achieved the reduced maximum 15 month inpatient waiting time.
- By the end of March 2002, all but 1 NHS Trust had achieved the 6 month maximum waiting time for first outpatient appointments.

Cancer

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

- 95.9 per cent of patients referred urgently with suspected cancer were seen within 2 weeks during Q4 2001-02.
- 94.2 per cent of women with breast cancer received their first treatment within one month of diagnosis during January to March 2002.
- 12 per cent of breast screening units are now in place to implement the expansion in 2001-02, ahead of the 10 per cent milestone.
- An estimated 40,000 extra women aged 65-70 were invited for breast screening in 2001-02.
- The Cancer Collaborative is being rolled out across the country, and some projects are already reducing waits for diagnosis and treatment.
- Over 300 PCT clinical leads for cancer are now in post.
- Around 31,000 patients benefiting from cancer drugs approved by NICE.

- New and replacement cancer equipment provided through central programmes includes, up to the middle of June 2002, 32 new MRI Scanners, 47 Linear Accelerators, 96 CT Scanners and over 330 items of breast screening equipment, all delivered since April 2000.

ON THE GROUND:

Suspected cancer patients are all being seen within two weeks by a specialist at New Cross Hospital in Wolverhampton. This is the target set under The NHS Plan. 639 patients were seen within two weeks between October and December last year. This included all cancers, including those of the breast, brain and stomach. Most patients are receiving their treatment within one month.

Capital and Capacity

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

- Total capital investment (including PFI) is set to rise to £3.5 billion this year.
- In 2001-02, the growth available for investment in activity and service development included:

- £450 million for cancer and CHD
- £423 million to tackle waiting times
- £188 million to increase intermediate care services
- £173 million for central investment in IM&T

- Since May 1997, 68 major hospital developments (64 PFI and 4 Public) worth nearly £7.7 billion have been approved to proceed. The latest of these to become operational are located at Hereford, Worcester and Barnet.
- In the last 18 months, over 90 per cent of GP surgeries have been connected to *NHSnet*, providing desktop email, access to the Internet and a communications infrastructure for general practice across the NHS.
- 1098 GP premises had been refurbished or replaced.
- 68 one-stop primary care centres have been established.

Coronary Heart Disease

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

- Death rates from all circulatory diseases have reduced by 13.7 per cent from the 1995-97 baseline (and projections indicate that if the current trend continues the target of a 40 per cent reduction in mortality by 2010 could be achieved by 2008).
- The Primary Care Collaborative is working with over 500 practices to reduce the death rate in patients with established CHD through the rapid implementation of the National Service Framework (NSF).
- 172 Rapid Access Chest Pain Clinics are now open, easily exceeding the Plan target of 100 by March 2002.
- The target of 6000 extra heart operations by April 2003 should be achieved this year. Up to March 2001, the NHS had already performed an extra 4800 operations.
- The target of a maximum 12 month wait for heart operations by the end of March 2002 has been met, although the target was only introduced in November 2001.
- Prescribing of cholesterol-lowering drugs – such as statins – has risen by about one third in just a year. Statin prescribing has a very significant effect in reducing CHD mortality. For example, one Primary Care Group has reported a validated reduction in CHD deaths of 45 per cent in only one year.

ON THE GROUND:

Three out of four patients suffering a heart attack should receive thrombolysis (clot-busting drugs) within 30 minutes of arrival at an A&E department. United Lincolnshire Hospitals expects to reach the target this April. It has already exceeded its interim target of 65 per cent, currenty achieving 67 per cent.

Children

Improve children's health and social care services.

- There has been an increase in the proportion of looked-after children adopted for the third successive year (from 4 per cent in 1998 to 5 per cent in 2000-01), representing an increase of some 940 children.
- The national target of 17.2 per cent for re-registrations on the child protection register has already been met. It is now 14 per cent.
- Child and Adolescent Mental Health Services Innovation Projects (CAMHS) have now been operational for three years; two of these projects have been awarded NHS Beacon status, giving them responsibility for disseminating their practice. Funding has now been agreed for the programme for a further 2 years (subject to parliamentary approval)
- In March 2001, a guidance booklet was published to help local authorities: 'Planning and providing good quality placements for children in care'.
- The SEN and Disability Act received royal assent on July 11th, strengthening the right of children to be educated in mainstream schools and requiring LEAs to provide advice and information to parents.

Mental Health

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

- Currently on track to achieve the NHS plan target to provide 140 high secure places by 2004 (70 at Rampton, 70 at Broadmoor), with 23 beds and 3 community forensic teams for

people with dangerous and severe personality disorders from 2003.

- 'Caring for carers' implementation is underway; carers of people on enhanced Care Programme Approach (CPA) will have their own written care plans.
- A campaign has been launched to tackle the stigma and discrimination faced by people with mental health problems. In all, 200,000 postcards targeting young people in bars and clubs have been distributed.
- A comprehensive review of mental health services has taken place between April and October 2001, co-ordinated by the 126 Local Implementation Teams (LITs) in place.
- A strategy to promote the employment of young people with mental health problems within health and social services has been introduced.

ON THE GROUND:

South Staffordshire Healthcare Trust has transformed a mental health day unit from a traditional hospital-based unit to a modern community-based unit delivering services which make a real difference to patients. An 800 per cent increase in new referrals was achieved by its third year.

Quality

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

- Clinical governance, as the framework enabling NHS organisations to fulfil their statutory duty to continuously improve the quality of their care – and with patient involvement as one of its key principles – is beginning to bed in across the NHS.
- NHS trusts will be reporting on implementation of clinical governance within their 2001-02 Annual Reports.
- CHI has published over 100 clinical governance review reports to date.
- The NHS Modernisation Agency has already supported teams in some 585 NHS organisations through its Clinical Governance Development Programme.
- All hospitals in England now provide a patient environment that is good, or at least acceptably clean.
- By May 2002 all acute NHS trusts will have completed surveys of inpatients. Later this year trusts will be publishing individual patient prospectuses based on the results of these surveys.
- There will be a Patient Advocacy and Liaison Services and Patients' Forum in every trust, including Primary Care Trusts.
- New consent processes – Patient leaflets (setting out patients' rights when their consent is sought, and encouraging them to ask questions and take the time they need to come to a decision) were published in July 2001; guidance plus a new consent form and model consent policy issued November 2001.
- The National Patient Safety Agency, established in July 2001, completed the piloting phase of the new national mandatory reporting system for adverse incidents at the end of March 2002, prior to NHS wide implementation from later in 2002.
- Mixed sex accommodation is expected to be eliminated in 95 per cent of Trusts by December 2002.

Older People

Improve the care provided to older people.

- Almost 2,500 extra intermediate care beds have been created for active recovery and rehabilitation.
- Bids for adapting 233 nightingale wards for older people at a cost of £80 million have been approved. Conversions have begun and will be completed by April 2004.
- 2001 Spring monitoring indicated that 805 of councils have started to make plans for the integration of health and social services community equipment provision.
- 6 Care Direct Pilots have been established extending access to services.
- Pilot schemes for retirement health checks are now underway.

ON THE GROUND:

The NHS has teamed up with two local authorities as well as the voluntary and private sector in Enfield and Haringey to co-ordinate action to reduce the risks of falls and injuries requiring hospital admission. Falls prevention programmes have been set up, pharmacists have reviewed the medicines taken by older people, home safety checks are carried out and social support provided. Safer homes were provided for about 1800 older and disabled people in one year – some work helped to ensure early discharge from hospital in one in five cases work helped to prevent hospital admission or residential care. Physiotherapists have run exercise classes; foot care services have been set up to identify older people at risk with home visits being arranged by a podiatrist.

Inequalities and Public Health

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

- New national targets to reduce inequalities have been set:
  - 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;
  - Starting with health authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.
- A national consultation exercise, *Tackling Health Inequalities* invited views on the implementation of the targets. The results of the consultation are to be published in the spring.

A delivery plan for the implementation of the national targets is due to be published later in the year.

- During the period April and December 2001, around 153,000 people set a quit date through the NHS smoking cessation services, and 79,100 (52 per cent) were successful at the four week follow-up. This is well ahead of the 2001-02 target for 50,000 people to have quit at the four week follow up through smoking cessation services with one quarter remaining.
- During the same period, 2,633 pregnant women set a quit date through the services and 1,306 (50 per cent) had successfully quit based on self report at the four week follow up stage.
- The under-18 conception rate fell by a further 2.4 per cent in 2000, compared to its 1999 level, in line with the 15 per cent reduction target between 1998 and 2004.
- The number of drug users entering treatment in the six months to September 2000 was 33,100. This is an estimated annual increase of 8 per cent from the six month period to September 1998.
- Work is progressing on developing a number of child health and antenatal screening programmes, including newborn hearing and haemoglobinopathies.
- The National School Fruit Scheme will benefit from £42 million from the New Opportunities Fund to support further testing and expansion of the scheme over the next two years. 250,000 children will be receiving a free piece of fruit each day by the end of the summer term.
- Work continues on the Five-a-day programme to increase awareness of, and access to, fruit and vegetables in deprived communities. A further 66 local initiatives are being supported by the New Opportunities Fund over the next two years. Led by PCTs, the initiatives will be based on lessons from five successful pilot initiatives.
- The principal aim of Health Action Zones is to tackle inequalities in health in the most deprived areas of England through health and social service modernisation programmes with opportunities to address other interdependent and wider determinants of health such as housing, education and employment. From April 2002 they will align with local health systems in order to mainstream their way of working.

Workforce

Increase numbers of staff within the service and modernise jobs.

- An increase of 20,740 nurses (9.9 per cent) employed in the NHS between 1999 and 2001. The NHS Plan target has been reached well in advance of the original 2004 target date.
- Between September 2000 and September 2001 the number of qualified nurses employed in the NHS increased by 14,430 or 4.3 per cent.
- In September 2001 there were 9,550 more doctors than in 1997, including 8,250 in the hospital and community sector and 1,290 in general practice.
- There are 2,460 more consultants working in the NHS now than there were in 1999. Since 1997 the number of consultants has increased by 4,320 and there are now 25,690 consultants working in the NHS.
- The number of hospital doctors (excluding GPs working part time in hospitals) has increased by 2,720 in the last year.
- Medical schools are currently in the process of delivering the extra 2,150 medical school places announced between 1999 and 2001, at 57 pr cent the largest increase since the NHS was established. Intakes are already almost 950 places above 1997 levels, a 25 per cent increase, and between 1999 and 2001 over 1,700 extra students have entered English medical schools as a result of this expansion. The remaining places will be created by autumn 2005. Four new medical schools and four new centres of medical education will have opened by autumn 2003.
- By the end of February 2002, 3,763 nurses, midwives and health visitors and 622 allied health professionals and healthcare scientists had returned to the NHS since 1 April 2001.

Delivering the NHS Plan, published in April this year, says that by 2008 we expect the NHS to have net increases over the September 2001 staff census (latest available headcount figures) of at least:

- 15,000 consultants and GPs;
- 35,000 nurses, midwives, and health visitors;
- 30,000 therapists and scientists.

We are also putting more staff in training and *Delivering the NHS Plan* states that:

- compared with 2001/02, by 2008 there will be over 8,000 more nurses each year leaving training – a 60 per cent increase;

Similarly, there will be an extra 1,900 medical school graduates per year – a 54 per cent increase.

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.

- Implementation of a performance ratings system for all acute trusts.
- Development of a performance ratings system for non-acute trusts.
- Development of a framework for intervention in failing trusts.
- Drawing up arrangements for increased freedoms for the best performing trusts-earned autonomy.
- Publication of NHS performance indicators.

Further information on progress towards meeting NHS Plan targets can be found in the Modernisation Board's Annual Report.[5.5]

The NHS Cancer Plan

5.5 The *NHS Cancer Plan*[5.6] was published on 27 September 2000. It provides a comprehensive framework for the development of cancer services over the next five to eight years.

Significant progress being made in cancer care was detailed in *NHS Cancer Plan – Making Progress*[5.7] which was published in December 2001. Progress includes:

- NHS breast screening programme has just started to being extended to include routine invitations to women aged 65 to 70 alongside improvements in the way mammography images are checked. An extra 40,000 women aged 65-70 were invited to be screened in 2001-02 as a result;
- 95.9 per cent of patients referred urgently with suspected cancer were seen within 2 weeks during January to March 2002;
- 94.2 per cent of women with breast cancer received their first treatment within one month of diagnosis during January to March 2002.
- Upgrading and expansion of equipment: 32 new MRI scanners, 96 CT scanners and 47 Linear accelerators and over 330 pieces of equipment for breast screening delivered to the NHS since January 2000. This means 28 per cent of MRI, 45 per cent of CT, and 26 per cent of Linear accelerators now in use in the NHS are new since January 2000;
- 79,100 smokers reported they had successfully quit smoking at their 4 week follow-up during April to December 2001, already ahead of the target of 50,000 quitters for the whole of 2001-02;
- Extra 428 cancer consultants expected to be appointed by April 2002 (compared to April 1999). We are on target to appoint nearly an extra 1000 cancer consultants by 2006 (in addition to extra surgeons, urologists, gastro-enterologists and other specialists involved in cancer care);
- 488 Cancer Services Collaborative projects have begun in the 34 cancer networks across the country, some have already reduced cancer waiting times by weeks or even months;
- 31,000 patients each year will now benefit from new anti-cancer drugs following NICE appraisals;
- From December 2001 patients will have a maximum one month wait from being referred urgently by their GP to treatment, for children's and testicular cancers and acute leukaemia; and,
- Over 10,000 district nurses are receiving training over the next three years to help them support people with cancer at home for as long as possible during their illness.

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

Prevention

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.

Diet plays an important part in cancer prevention. The Government launched the National Fruit Scheme in 2000 to increase fruit consumption. 80,000 children in 27 areas and over 500 schools now receive a free piece of fruit each school day. The scheme is being rolled out over the next two years to reach all school children aged between four and six years old

Screening and early detection

The breast screening programme is being 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.

New screening technologies are being piloted to the cervical screening programme.

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.

£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 stomach cancers.

Treatment

New and challenging 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.

£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. This initiative will be in place across the country by 2002.

Together with Macmillan Cancer Relief £3 million is being 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

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

The New Opportunities Fund have also committed £45 million to improve access to adult palliative care particularly for disadvantaged groups in inner cities and rural groups.

Working with Macmillan Cancer Relief and Marie Curie Cancer Care, £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

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.

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

32 MRI scanners, 96 CT scanners and 47 linear accelerators which are used to diagnose, plan and treat cancer as well as over 330 pieces of equipment for the NHS breast screening programme have been delivered under central investment programmes over the last two years. A further 56 MRI scanners, 90 CT scanners and 56 linear accelerators will be delivered to the NHS over the next two years.

The first two years of pathology modernisation, from 1999 to 2001, directed £20 million to 35 local initiatives, to support local rationalisation and technology upgrade projects. This year, almost £8 million has been invested in four large-scale pilot projects aimed at re-configuring and rationalising pathology services.

ON THE GROUND:

Worthing Hospital's breast screening unit is testing more than 20,000 women each year in three mobile units which tour West Sussex. Over 80 per cent of women diagnosed with breast cancer have an operation within three weeks.

Eastbourne Hospitals NHS Trust has introduced a fast-track referral pathway for cancer scans which has cut waits for scans from 14 days to as low as five days. Before gynaecologists would have to request scans verbally on good will but a formal booking process has been set up in the gynaecology cancer clinic for patients who require further investigation.

Pathology Modernisation

5.6 The Government's 10-year programme to modernise and reconfigure NHS pathology services recognises the vital role pathology plays in delivering the NHS Plan and Cancer Plan, meeting National Service Framework targets and protecting public health – up to 70 per cent of diagnosis depends on pathology.

The Government has already invested £20 million in 35 projects, and in 2001-02, the Secretary of State for Health announced almost £8 million investment in four large-scale pilot projects at Teesside, Lincolnshire, Leeds/Bradford and London, aimed at re-configuring and rationalising pathology services. In line with the NHS Plan commitment that 'the NHS will explore with the private sector the potential for investment in services – such as pathology and imaging and dialysis,' (11.10), the Teesside and Lincolnshire initiatives will involve joint venture partnerships being formed with private companies, to enable the NHS to better manage services for patients, improve computer systems, update clinical equipment and modernise outdated buildings. This will provide faster, higher quality, more efficient care for patients. Both sites are currently in discussions with private companies to look at setting up the partnerships, which will be subject to a tendering process.

The Department of Health is also working with pathology experts across the NHS to develop a planning guide to drive pathology modernisation forward. Following consultation, this guidance will be issued in the Summer.

A Strategy for NHS Dentistry

5.7 The Government remains committed to the Prime Minister's pledge that after September 2001 everyone would be able to locate an NHS dentist simply by phoning NHS Direct. It is also working with the profession to identify means of modernising and improving NHS dental care and standards of oral health.

In 2001-02 the Department made £6 million Dentistry Action Plan fund money available to help dentists expand their practices and treat more NHS patients. The value of the commitment scheme, introduced in 2000-01 to reward dentists who are committed to GDS dentistry, was increased to £20 million in 2001-02. The government has also invested £35 million to modernise NHS dental practices and equipment.

The extra investment has met with a measure of success, though the Government is aware that more work is required. The number of General Dental practitioners continues to increase and the systems are now in place to enable patients to access NHS dental treatment through NHS Direct.

The Government has continued exploring alternative ways of providing NHS dentistry and by mid 2002, 49 dental access centres, operating from over 100 sites, will have been established. By the end of 2001-02 DACs, together with other Personal Dental Services pilot schemes, are expected to be able to treat about 500,000 patients per annum.

Pharmacy in the Future

5.8 The Department's programme for pharmacy was published in *Pharmacy in the Future – Implementing the NHS Plan* (September 2000)[5.8]. That set an ambitious programme for the role of pharmacy in the NHS, including measures to improve access to medicines, to promote high quality pharmacy services, and to reduce waste by promoting better use of medicines within the NHS.

During 2001-02, NHS Trusts assessed the state of their hospital pharmacy services and, where necessary, put in place action plans

to improve performance. In the community, a Project Team has been set up to support the development of services to help people make better use of their medicines. The first two waves of collaborative schemes are now under way. Also, the *Health and Social Care Act 2001*[5.9] laid the foundations for a new and more flexible way of providing pharmaceutical services in the community. The first pilots of the new arrangements, to be known as Local Pharmaceutical Services (LPS), will begin in 2002. Other developments planned for 2002-03 include the start of the roll out of repeat dispensing, which will mean that patients will be able to get their medicines supplied in instalments from their pharmacy, without having to go back to their GP's surgery each time they need a new prescription.

The National Beds Inquiry

5.9 The National Beds Inquiry concluded that more, rather than fewer beds are needed to meet the needs of patients in the 21st century NHS. Steps have been taken to make this happen. 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)*[5.10]. The guidance required each health authority, in partnership with councils and other partners in the local health and social care economy, to develop clear action plans to implement change. During the summer, NHS organisations, in partnership with local councils, carried out a performance and modernisation audit and proposed 3-5 year service plans. An important part of the audit was to ensure that the NHS meets the specific objectives of increasing the numbers of general and acute beds and intermediate care beds by 2004. Published figures for 2000-01 show an increase of 714 general and acute beds, one third of the way towards the 2004 target. Plans for increases in intermediate care beds are also progressing well. The results of a recent survey on intermediate care show that by the end of March 2001 there will be an additional 2,400 intermediate care beds.

In developing their proposals, health authorities were invited to use a planning tool. The original version of this analytical tool 'Modelshire' was mainly concerned with planning acute services. Subsequently an expanded version was produced to assist planning of residential and nursing home care as part of a 'whole system' incorporating the latest (1999-2000) Hospital Episodes Statistics Data. Modelshire II is now available to the NHS through the Department of Health website www.doh.gov.uk/nbi

Next Steps

5.10 During 2001 health and social care communities have conducted Local Modernisation Reviews to plan change. These have confirmed that the three major priority areas are:

- delivering emergency services when and where they are needed;
- reducing waiting times and delays throughout the system; and,
- improving quality of service and outcomes in the clinical priority areas of cancer, heart disease, mental health and services for older people.

In all of these areas attention needs to be given to addressing inequalities in access to services and health outcomes with special efforts made to reach the most disadvantaged in society.

The way these priorities will be achieved will be determined locally. However, it will clearly depend on continuing progress being made in developing primary care and Primary Care Trusts (PCTs), recruiting, retaining and involving staff, improving the environment for care and developing information management and technology (IM&T). Funding is earmarked for IM&T to ensure there is investment in all parts of the country in line with Local Information Strategies.

Treating NHS Patients in the UK Independent Sector and Overseas

Plurality and Diversity in the Provision of NHS Services

5.11 *Delivering the NHS Plan* set out the Government's intention to make greater use of UK private sector and overseas providers to treat NHS patients and to bring about greater diversity and pluralism in the provision of NHS services.

Greater diversity will in future be underpinned by common standards and a common system of inspection for different providers. And, wherever they are treated, NHS patients will receive care according to NHS principles, free and available according to need, not ability to pay.

The development of diversity in provision builds on the Concordat agreed between the NHS and the independent healthcare provider sector in October 2000. The NHS has increasingly made use of spare independent sector capacity to help with progress to get waiting times down. According to data collected from independent healthcare providers by the Independent Healthcare Association, between April 2001 and March 2002, at least 73,000 daycases, outpatient appointments and inpatient treatments were carried out in the independent sector for NHS patients. We estimate that in future up to 150,000 operations a year might be bought in this way.

Some NHS patients have also received treatment in other EU Member States. Following judgements of the European Court of Justice in July 2001 the NHS is now legally able to commission care from countries in the European Economic Area. The department worked with three NHS pilot sites (East Kent, Portsmouth/Isle of Wight and West Sussex/East Surrey) to arrange treatment abroad for NHS patients waiting in those areas. Between January and the end of April 2002 190 NHS patients were treated in France and Germany under the pilot scheme. Treatment abroad will remain an option for commissioners.

The Department now intends to build on this by inviting the UK independent sector and overseas healthcare providers to provide elective care specifically for NHS patients, in the UK, on a

sustained basis and on a significant scale. As a first step, one of the NHS Diagnostic and Treatment Centres (DTCs) due to begin treating patients this year, at Redwood in Surrey, will be run by BUPA, subject to completion of detailed negotiations. The Department is developing arrangements for overseas clinical teams to work within the UK, treating NHS patients from within NHS facilities. It will also develop a framework under which overseas providers of healthcare will establish and manage new DTCs, with services provided principally by overseas clinical teams.

Independent Reconfiguration Panel (IRP)

5.12 The NHS Plan stated that decisions on the outcome of major health service reorganisations would in future be based on the recommendations of an independent panel. The Plan stressed that the current system, under which the Secretary of State makes decisions on contested proposals, is insensitive, opaque and not sufficiently independent. Too little attention is paid to the impact on the total health care system.

From autumn 2002, a new independent panel will provide advice to the Secretary of State on major changes. The Independent Reconfiguration Panel will assess changes against clear criteria, and will explicitly take account of the rigour of the local consultation process. The Panel will operate openly, publish its recommendations, the reasons for its conclusions, and the evidence it considered.

Dr Peter Barrett, a practising GP, has been appointed as Chair. Membership of the panel will be drawn from health care professionals, health service managers and patients' and citizens' representatives.

Modernisation Agency

5.13 The NHS Plan set out the vision of where we want to be – a vision of the sort of healthcare system we all want to see in the 21st century.

That requires investment: more staff; more beds; new buildings; better technology. Repeated calls for new investment are being met but money alone is not enough.

It must be accompanied by reform and reform that always puts the patient at the centre of the service.

The NHS Modernisation Agency was formed in April 2001 to support the NHS to make the radical and sustainable changes required.

The Agency's role is supporting the transformation required in the service but the real drive for change comes from the NHS itself. From the nurses, porters, therapists, clerks, doctors and all the other staff who deliver NHS services.

The Agency's work programme for its first year focuses on the NHS Plan targets, improving organisational performance and the drive for improved quality.

Priority tasks for the year have been to:

- Highlight and record the growing number of examples of improvement as seen through the eyes of patients and front line staff;
- Support the NHS to deliver the improvements necessary to achieve key national targets; and,
- Help to create long-term capacity, capability and networks for continuous improvement in the NHS, beyond the current life span of the NHS Plan.

The Agency brought together individuals and teams from the NHS with established reputations for modernising services and developing leadership.

Some of the results so far include:

- 1,000 clinical teams making tangible changes across improvement programmes;
- 60,000 NHS staff trained in redesign skills for access improvement;
- 370 clinical teams and more than 100 Boards taking part in clinical governance development programme;
- more than 30,000 staff receiving leadership development;
- 40 changing workforce pilots in year one; and,
- by March 2002, more than 2,000 NHS staff trained in capacity and demand management to remove bottlenecks and improve patient flow.

This work has led to:

- saving more than 400 years of patient waiting time in the Cancer Services Collaborative (CSC) pilot programme;
- 90 per cent of CSC projects hit the 2004 booking targets by March 2001;
- waiting times reduced by more than 50 per cent with the Coronary Heart Disease Collaborative; and
- all practices within the first and second wave of the Primary Care Collaborative achieving 48 hour access.

The ongoing challenge for the Agency is to work with the NHS to move modernisation from rhetoric to reality. Success will depend upon three sets of changes: the three Rs of Modernisation:

- Renewal – more modern buildings and facilities, new equipment and information technology, more and better trained staff;
- Redesign – services delivered in radically different ways with a much greater use of clinical networks to better co-ordinate services around the patient; and
- Respect – a culture of mutual respect between politicians and the NHS, between different groups of staff and, crucially, between the NHS and those we serve.

6. Breakdown of spending programme

THIS CHAPTER COVERS:

Hospital and Community Health Services

HCHS Resources by Sector

6.1 **Figure 6.1** shows the breakdown by service sector of health authority gross current expenditure on the Hospital and Community Health Services (HCHS) in 1999-2000, 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 3.4.**

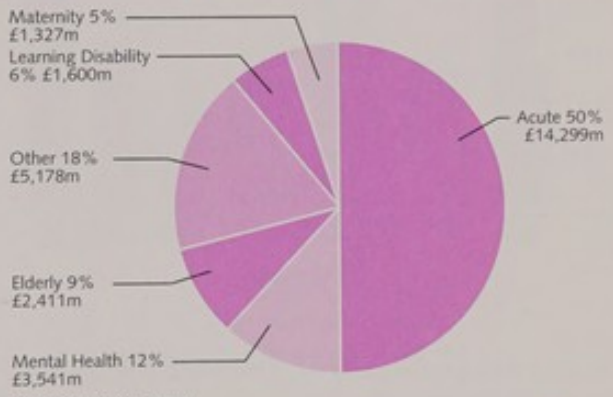
The Proportion of HCHS expenditure by programme of care is as follows:

- Acute services 50 per cent;
- Mental health 12 per cent;
- Services intended primarily for the elderly 9 per cent;
- Learning disabilities 6 per cent;
- Maternity 5 per cent; and,
- Other services 18 per cent.

The predominance of spending in the acute hospital sector reflects the demand for emergency treatment, and the continuing emphasis on reducing waiting lists and waiting times.

The proportion of community health services has continued to increase, rising to approximately 18 per cent in 1999-2000. This has risen from about 13 per cent in 1989-90 and reflects the changing patterns in care.

Figure 6.1: Hospital and Community Health Services Gross Current Expenditure by Sector, 1999-2000



HCHS Current Resources by Age Group

6.2 **Figure 6.2** shows that in 1999-2000 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 44 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, 1999-2000

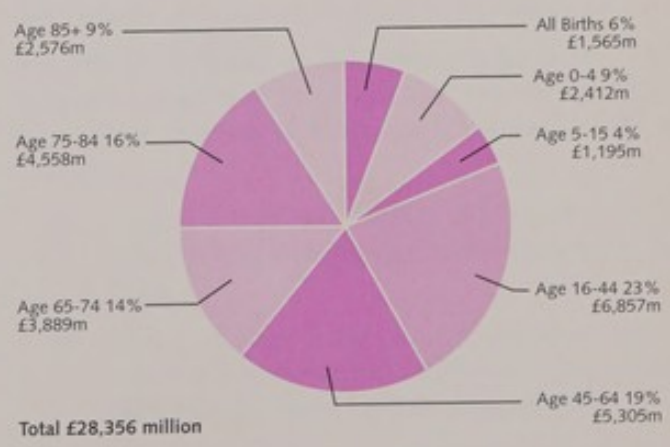
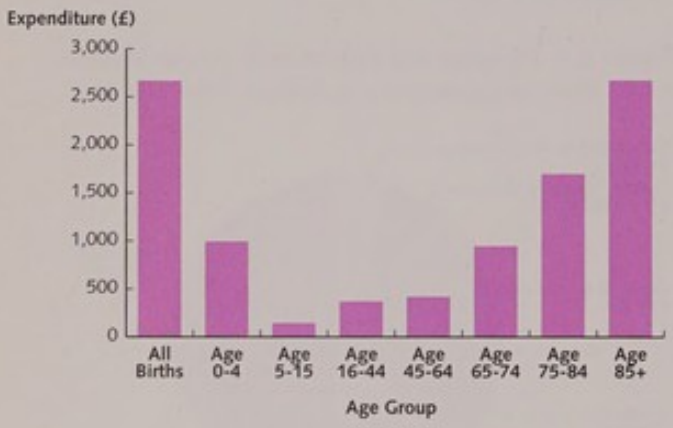


Figure 6.3 shows the estimated expenditure in 1999-2000 on HCHS for each age group, expressed as a cost per head of the population. High costs are associated with each birth, but costs per head then falls steeply, remaining low through young and middle age groups, before rising sharply from age 65. This reflects the greater use of health services by elderly people.

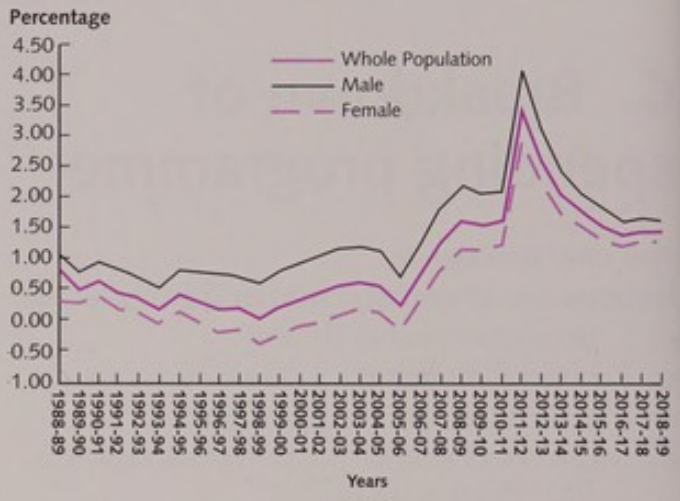
Figure 6.3: Hospital and Community Health Services Gross Current Expenditure per head of population 1999-2000



The changing demographic make up of the population affects the demand for NHS care. The elderly, in particular, have an impact. Although the number of elderly women is currently falling, the total number of elderly people in the population is still growing and is expected to grow more quickly in the next 10 years than in the previous decade.

Figure 6.4 shows that the increase in the population, aged 65 and over, averaged 0.3 per cent per year between 1988-89 and 1999-2000. Over the next 10 years, to 2009-10, the expected effect averages 0.7 per cent per year. Over the next 20 years, the growth rate becomes more pronounced at 1.4 per cent per year. To date the NHS has been able to manage the increase in the use of its services caused by an ageing population. But the pattern of service delivery may need to change in the future.

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

6.3 Revenue allocations to Health Authorities for 2002-03 were announced in December 2001. More details of the allocations can be found in *2002-03 Health Authority Revenue Resource Limits Exposition Book*[6.1].

The sum available for HCFHS current for 2002-03 is £46,168 million.

Figure 6.5 summarises the way in which national HCFHS revenue translates into Health Authority allocations.

Figure 6.5: Distribution of Revenue Resources, 2002-03

	2002-03 £ million	Percentage increase over previous year
HCFHS current	**41,168**	
Capital charges and other funding adjustments	1,697	
Total available	**47,865**	
Deployed as:		
CFISSA [1]	**6,397**	
Total for Health Authorities	**41,468**	**9.9**

1 Centrally Funded Initiatives and Services and Special Allocations.

Centrally Funded Initiatives and Services and Special Allocations (CFISSA)

6.4 The CFISSA programme provides central funding to implement the NHS Plan and other initiatives. **Figure 6.6** provides details of the central budget programme for 2002-03.

Figure 6.6: Centrally Funded Initiatives and Services and Special Allocations (CFISSA), 2002-03

Budgets	Amounts (£000s)
Multi-Professional Education and Training	2,947,316
R&D	514,135
Public Health	390,232
HR	280,269
Access and Waiting	221,240
Children and Older People	167,404
IM&T	153,872
Medicines and Pharmacy	199,808
Clinical Priorities (includes funding for cancer, coronary heart disease, mental health, dentistry and disability)	168,402
Primary Care	103,479
Clinical Audit and Quality	74,207
Modernisation Agency	59,811
Public Involvement	36,654
Screening	16,260
Patient Environment	13,000
Other Central Budgets	1,050,403
GRAND TOTAL	**6,396,492**

Unified Allocations

6.5 £41,468 million has been distributed to Health Authorities as unified allocations. The range of Health Authority percentage increases was from 9.31 per cent to 11.68 per cent, with an average of 9.88 per cent.

Figure 6.7 shows the distribution of increases by Health Authority.

Figure 6.7: Unified Allocations – Distribution of Increases, 2002-03

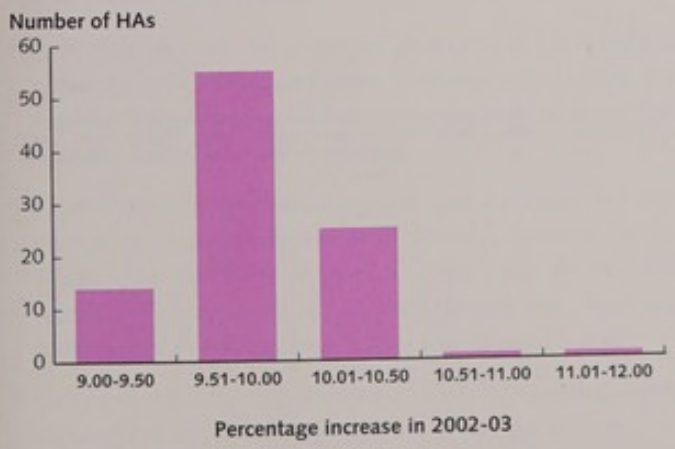
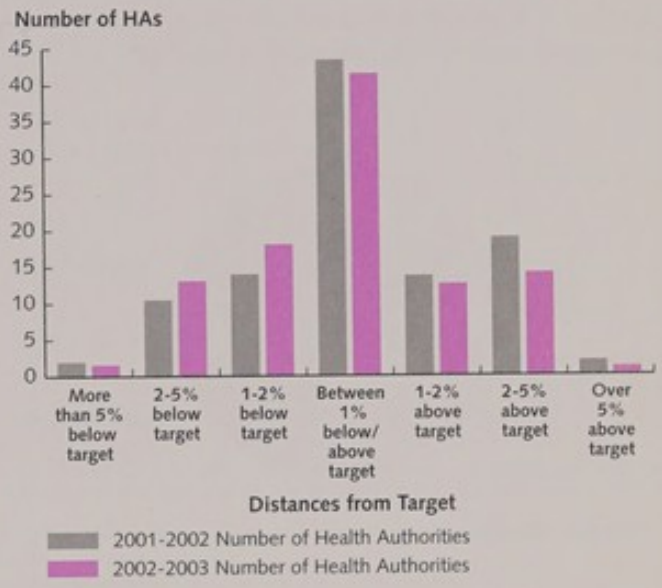


Figure 6.8 shows Health Authorities':

- 2001-02 distances from unified target
- 2002-03 distances from unified target

Figure 6.8: Health Authorities' Distance from Unified Target (DFT), 2001-02 and 2002-03



Review of Resource Allocation

6.6 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.

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.

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

For 2001-02, following ACRA's recommendation, the health inequalities adjustment was introduced. For 2002-03 ACRA recommended three changes which have been introduced into the formula:

(a) a General Medical Services Non Cash Limited (GMSNCL) component has been introduced in the formula;

(b) the way additional need (ie over and above age) is measured in the General Medical Services Cash Limited (GMSCL) component has been changed; and,

(c) the staff Market Forces Factor has been updated.

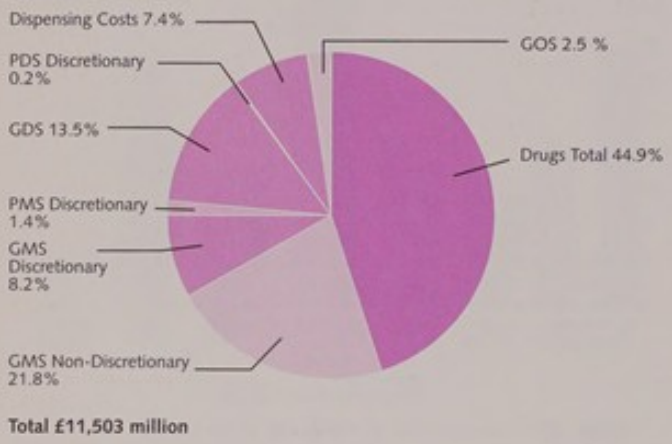
The intention is that, following the review, the new formula will be ready for 2003-04 allocations.

Family Health Services

Family Health and Personal Medical and Dental Services Resources

6.7 Figure 6.9 shows the distribution of gross expenditure on FHS of £11,503 million in 2000-01 among the constituent Family Health Services.

Figure 6.9: Family Health and Personal Medical and Dental Services Gross Expenditure, 1999-2000



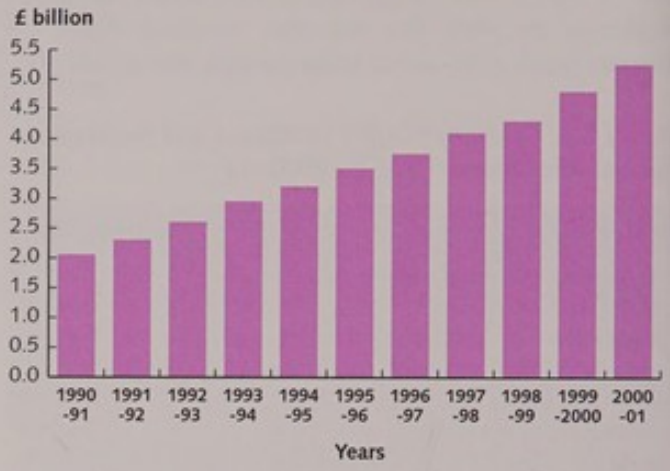
Total £11,503 million

Drugs Bill

6.8 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 2000-01 FHS drugs bill outturn was £5,161 million in cash terms, this represents a 6.5 per cent increase on the previous year. This was lower than the average increase of 8.1 per cent over the previous five years. This increase appears low due to a higher than average growth in 1999-2000, which was due to increases to generic drug prices. Other reasons for the low outturn in 2000-01 are:

- The Maximum Price Scheme which was introduced after the instability of the generic drugs market in 1999, 2000-01 has been the first full year of savings. This scheme has been rolled forward for a further year and continues to achieve pre-1999 prices for the department; and,
- The 4.5 per cent price cut achieved through the 1999 PPRS has delivered in excess of some £200m in 1999-2000. 2000-01 has been the first full year of savings.

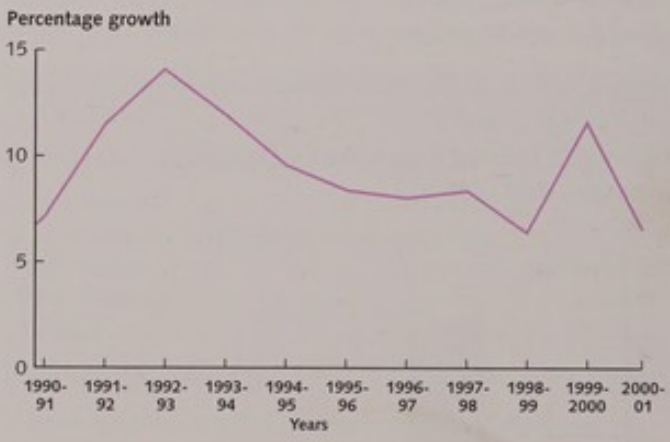
Figure 6.10: Family Health Services Drugs Bill (Cash), 1990-91 to 2000-01



Important factors in the 2000-01 bill include:

- The Maximum Price Scheme which was introduced after the instability of the generic drugs market in 1999 has been rolled forward for a further year and continues to achieve pre-1999 prices for the department; and,
- The 4.5 per cent price cut achieved through the 1999 PPRS has delivered in excess of some £200m in 1999-2000. Annual savings for 2001 are expected to be of this order.

Figure 6.11: Family Health Services Drugs Bill – Percentage Growth (Cash), 1990-91 to 2000-01



FHS Gross Expenditure

6.9 **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 (Cash), 1990-91 to 2000-01

£ million

	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	% 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**	**5,168**	**85.4**
GMS Non-Discretionary	1,484	1,656	1,768	1,840	1,902	1,965	2,073	2,198	2,243	2,451	2,510	26.9
GMS Discretionary[5]	464	600	686	715	723	754	800	835	878	885	940	51.9
Total GMS	**1,948**	**2,256**	**2,454**	**2,555**	**2,625**	**2,719**	**2,873**	**3,033**	**3,121**	**3,336**	**3,449**	**32.8**
PMS (discretionary)[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	37	84	161	
GDS[3]	1,041	1,248	1,308	1,223	1,281	1,292	1,325	1,349	1,439	1,479	1,556	12.1
PDS (discretionary)[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	12	21	
Dispensing Costs	561	603	658	677	679	706	746	768	781	808	856	14.5
GOS[4]	111	141	172	192	213	223	237	241	240	281	292	97.8
Total	**5,752**	**6,583**	**7,243**	**7,627**	**8,050**	**8,446**	**8,989**	**9,498**	**9,978**	**10,852**	**11,503**	**50.0**

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 Gross GDS costs 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 the relevant Appropriation Accounts apart from PMS and PDS data which is drawn from HAs' I&E accounts.

- With the move to unified allocations, all drugs expenditure is now within Health Authority cash limits.

Central Health and Miscellaneous Services

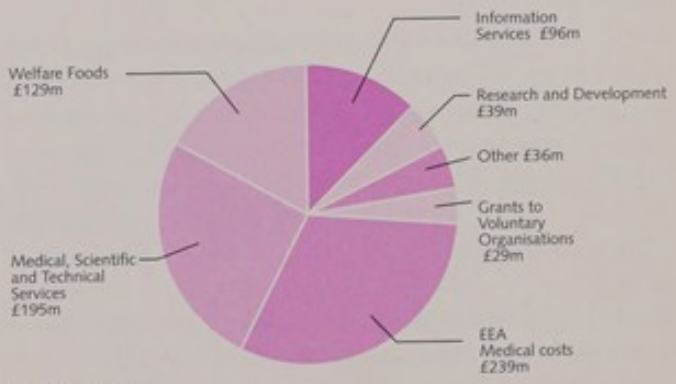
Central Health and Miscellaneous Services Resources

6.10 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**) and,
- Grants to voluntary organisations, mainly at a national level, across the spectrum of health and social services activity.

Figure 6.13 provides details of gross expenditure on Central Health and Miscellaneous Services for 2002-03

Figure 6.13: Central Health and Miscellaneous Services Gross Expenditure, 2002-03 (Main Estimate)



Total £763 million
(Total may not sum due to rounding)

Personal Social Services

Personal Social Services Revenue Provision

6.11 In 2002-03, £11,169 million will be available for social services, 6.2 per cent more than in 2001-02. The majority of these resources will be distributed to local councils through the Revenue Support Grant, while the remainder will be distributed as grants. **Figure 6.14** below sets out the resources available for social services in 2002-03.

Figure 6.14: Personal Social Services Revenue Provision 2002-03

	£ million
Total PSS Provision	**11,169.00**
of which:	
Standard Spending Assessments	9,230.99
Revenue Grants Total	**1,937.96**
of which:	
Preserved Rights	614.00
Children's Services	452.00
Building Care Capacity	200.00
Promoting Independence	155.00
Mental Health	154.44
Residential Allowance	93.00
Carers	85.00
Training Support Programme	57.50
Performance Fund	50.00
Deferred Payment	30.00
AIDS Support	16.50
Teenage Pregnancy Local Implementation	16.00
Care Direct	10.00
Young People's Substance Misuse	4.50

Personal Social Services Capital Resources (Credit Approvals)

6.12 The Government provides capital resources for personal social services by means of credit approvals (permission to borrow) and cash grants. Credit approvals may be used either for any local authority service (basic credit approvals – BCAs) or are targeted on particular services or projects (supplementary credit approvals – SCAs). From 2002-03 BCAs will be allocated by DTLR through a single capital pot of which 95 per cent will be allocated on a formula basis. The remaining 5 per cent will be discretionary and based on the quality of councils' Capital Strategies and Asset Management Plans.

Councils can 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.

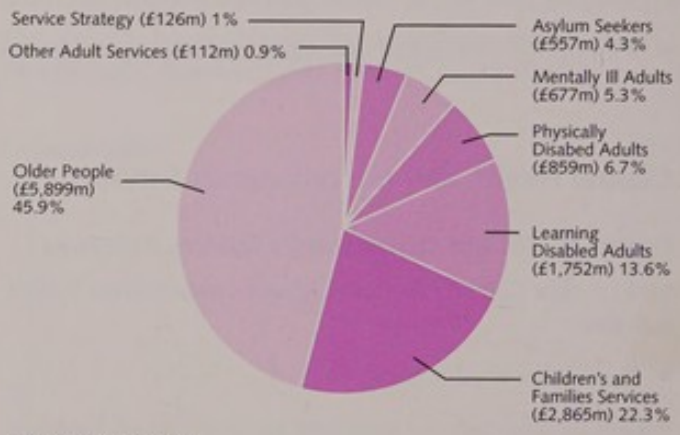
In 2002-03 BCAs for personal social services will total £37 million. Annual capital guidelines (ACGs) of £42.2 million will be distributed to councils with personal social services responsibilities. (ACGs will comprise 95 per cent of BCAs plus receipts taken into account.) SCAs will be available for mental health services (£15.6 million) and AIDS/HIV services (£3.1 million).

How the Resources are Used

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 2000-2001. **Figure 6.15** shows gross expenditure by client group in 2000-2001. **Figure 6.16** displays the breakdown by type of provision.

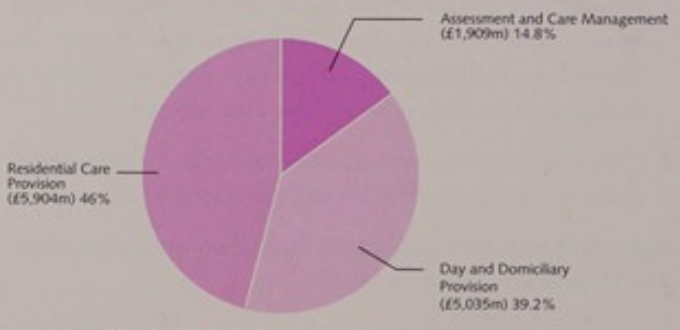
In 2000-2001, gross expenditure in England on personal social services was just under £13 billion. Local authorities' expenditure on services for older people and children accounted for over two-thirds of this spend. The largest items of expenditure were for residential care (46 per cent) and day and domiciliary care (39 per cent). Within spending on residential care, most was spent on residential and nursing home care provided by the independent sector.

Figure 6.15: Local Authority Personal Social Services Gross Expenditure by Client Group, 1999-2000



Total £12,848 million

Figure 6.16: Local Authority Personal Social Services Gross Expenditure by Type of Service, 1999-2000



Total £12,848 million

7. Activity, performance and efficiency

THIS CHAPTER COVERS:

Figure 7.1: Hospital Activity Trends, 1990-91 to 2000-01

	1990-91 (1)	1996-97 (1)	1997-98 (1)	1997-98 (2)	1998-99 (2)	1999-2000 (2)	2000-01 (2)	% change (2) 1999-00 to 2000-01
Ordinary admissions[3] (thousands)								
General and acute[4]	5,685	6,395	6,514	6,996	7,030	7,085	7,152	1.0%
Geriatrics	468	545	524	542	542	531	525	-1.1%
Maternity[5]	947	1,108	1,096	780	815	813	819	0.8%
All specialties[6]	7,524	8,369	8,459	8,541	8,563	8,588	8,636	0.6%
Day cases (thousands)								
General and acute[4]	1,251	2,869	3,036	3,029	3,377	3,542	3,588	1.3%
All specialties[6]	1,261	2,907	3,071	3,086	3,421	3,580	3,629	1.4%
All finished consultant episodes (thousands)								
General and acute [4]	6,936	9,264	9,549	10,025	10,407	10,627	10,741	1.1%
All specialties[6]	8,785	11,275	11,530	11,627	11,984	12,168	12,265	0.8%
New outpatients (first attendances) (thousands)								
General and acute[4]	7,593	10,415	10,643		10,919	11,294	11,637	3.0%
Geriatrics	72	110	107		108	113	114	0.5%
Maternity[8]	695	588	590		565	554	537	-3.2%
Mental Health	211	285	290		287	282	285	1.2%
Learning disabilities	3	6	6		6	7	7	7.3%
All specialties[6]	8,502	11,294	11,529		11,778	12,136	12,466	2.7%
New A&E (first attenders) (thousands)	11,204	12,484	12,794		12,811	13,167	12,953	-1.6%
Ward attenders[7]	981	1,026	1,034		1,068	1,073	1,078	0.4%
Average length of episode (ordinary admissions) (days)								
General and acute[4]	–	6.3	6.0		5.9	5.8	5.9	–
Geriatrics	–	18.9	18.1		17.4	16.8	17.4	–

1 Consultant episode data from the Department of Health return KP70.
2 Consultant episode data for 1997-98 to 2000-01 are derived from Hospital Episode Statistics (grossed for 1997-98). 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 consistently report activity according to the speciality of the consultant involved. Some Trusts report KP70 data for some specialties according to the specialty of treatment.
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.

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 1999-2000 and 2000-01 for first outpatient attendances was 2.7 per cent. Over the last ten years, the number of first outpatient attendances for all specialties grew by 46.6 per cent;
- The percentage increase between 1999-2000 and 2000-01 for total FCEs was 0.8 per cent. Total FCEs for the last ten years grew by 38.4 per cent.
  - percentage increase for ordinary admissions between 1999-2000 and 2000-01 was 0.6 per cent. Total ordinary admissions over the last ten years have grown by 13.7 per cent
  - percentage increase for day case admissions between 1999-2000 and 2000-01 was 1.4 per cent. Total day case admissions over the last ten years have grown by 186.4 per cent.
- The percentage increase between 1999-2000 and 2000-01 for total general and acute FCEs was 1.1 per cent. Total general and acute FCEs for the last ten years grew by 47.5 per cent, during this period day case FCEs grew by 187.4 per cent.

In-Patient and Out-Patient Waiting

7.2 In line with the NHS Plan, inpatient waiting times will fall on a staged basis from 15 months now through to 12, 9 and down to 6 months by 2005. As a result, we expect the average time patients wait for inpatient treatment to fall from three months to seven weeks.

As a first step towards this, the maximum waiting time for an inpatient appointment from April 2002 is15 months. By the end of December 2001 68 per cent of NHS Trusts had achieved the target of having no 15 month waiters. By the end of March 2002 this had increased to 99 per cent. At the end of March 2002 the number of patients waiting more than 15 months for in-patient treatment was at the lowest level on record. In addition the number of patients waiting more than 12 months for in-patient treatment is at its lowest level since 1996. The number of patients waiting more than 15 months for in-patient treatment is at the lowest level on record. There was only one patient waiting more than 15 months for in-patient treatment in the whole of the rest of the NHS, but up to 280 at RUH Bath. The number of patients waiting more than 12 months for in-patient treatment is at its lowest level since 1996.

There has been a substantial investment to help those health organisations facing the toughest challenges to accelerate progress towards meeting waiting and access targets. An additional £30m has been invested to ensure the delivery of the 15 months maximum inpatient waiting time and £40m was allocated to fund operations in the private sector.

There are also targets to reduce the number of people waiting for over 13 weeks for outpatient appointments and to implement a maximum six months wait by March 2002. Action plans have been drawn up in areas facing difficulties to help them meet the deadline.

The number of patients waiting more than 26 weeks for an initial outpatient appointment at the end of March 2002 is the lowest since records began. This is also the case for those waiting more than 13 weeks. There were 831 patients waiting more than 26 weeks for an initial out-patient appointment in the whole of the rest of the NHS, but 337 at RUH Bath.

- To read more about inpatient and outpatient waiting times visit – www.doh.gov.uk/waitingtimes

ON THE GROUND:

Waiting times for cataract operations in Peterborough have been cut from 12 months to as little as four weeks.
This follows the introduction of a one-stop service, which has reduced the number of hospital visits for patients from nine to just two.
Opticians can now refer patients directly to the hospital for surgery, cutting out visits to GPs and outpatient clinics. The improvement has been made at no extra cost.
Previously patients who went to their GP would have to wait six months for an outpatients appointment to see a consultant and then another six weeks for surgery.
Since the project got underway in October 1999, 420 patients have gone through the new system, which has also had the benefit of freeing up outpatient appointments for other patients.
There has been a very favourable response from the patients. One patient who responded to the questionnaire said: 'I couldn't believe it. I went into my optician and I was given a time and a date there and then for my cataract operation.'

Booked admissions

All NHS inpatient and outpatient appointments should be pre-booked by 2005. This will give all patients a choice of a convenient date and time within a guaranteed period and help to reduce waiting times.

By the end of March 2002, more than five million patients had booked their appointment at a date and time of their choice. The aim is for **all** appointments to be pre-booked by 2005. The NHS Modernisation Agency has worked with health organisations all over the country in achieving this target.

The programme achieved its first target in March 2001 when every acute NHS trust was able to offer booking for some patients in at least two specialties.

Just over 50 hospitals are able to facilitate electronic booking either within the hospital or between the GP and hospital, or both.

The fourth stage of the programme, which aims to involve all acute trusts, although not all specialties, by March 2003, started in September 2001.

- To read more about booked admissions visit – www.doh.gov.uk/bookedadmissions/overview.htm

ON THE GROUND:

At Heatherwood and Wexham Park Hospitals Trust in Slough, 100 per cent of day case surgery patients now have pre-booked appointments.

The rates of people who do not attend their appointments have been reduced from 4.8 to 2.6 per cent as a result.

The day case pre-booked appointment system has improved patient satisfaction from 45 to 81 per cent.

One patient responding to a satisfaction questionnaire said: 'The appointment person had my referral form from my GP and knew all about me and gave me an appointment that was convenient for me. It was much more reassuring than waiting for a letter to come.'

Staff faced many challenges setting up the project and say the lessons learned included the importance of the active involvement of line managers and listening to patients and acting upon what they say.

Emergency Care – Working to Improve Emergency Services

The IDEA Programme

7.3 The Ideal Design of Emergency Access (IDEA) programme seeks to develop new ways of delivering emergency care. The programme has three objectives: to reduce patient journey time, improve patient and carer experience, and reduce variation.

There are a number of key features to the programme that will enable it to achieve its objectives:

- The application of modern operations management practices, such as 'lean thinking', to emergency care systems. Lean thinking concepts involve novel operations management and design and control concepts.
- A whole systems approach, involving primary care, ambulance services, NHS Direct, out of hours services, walk-in centres, A&E, MAU, acute admissions, social services, community care.

There are two 'test bed' sites (Lewisham and North Cheshire) where the primary testing of new ways of working is taking place. There are also eight first wave sites involved in the programme that will ensure that the changes developed in the test bed sites are transferable across the NHS.

Identifying flows –Each of the project teams are identifying the key process flows within their high volume group of patients. Each group is now beginning to design operations that will improve each of these flows through the emergency care system. A particular challenge for the IDEA programme has been to develop a whole systems approach to understanding flows. Multi-agency teams, with staff from NHS Direct, ambulance service, primary care, social services, out of hours services and voluntary groups are working together to improve patient journeys.

Minor injuries – There are now five sites that have implemented or are implementing the 'treat and complete' system for dealing with minor injuries. This is a radical new way of delivering care that has removed the need for triage and has dramatically cut waiting times.

Warwick Report – Warwick Business School, who have particular expertise in modern operations management practices, have undertaken an analysis of the two test bed sites. This has identified some key principles for improvement within emergency care. A summary version of this report has been produced and widely distributed.

Patient, Carer and Staff Experience – The programme is encouraging innovation in the way that patients and carers are involved in the development of service provision. Video cameras in A&E, games to obtain the views of children and diaries for patients with chronic conditions are just some of the

Figure 7.2: Community Nursing, Dental and Cross-Sector Therapy Services Activity

Thousands

Number of episodes [1] [2]	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01
Health visiting	3,700	3,700	3,700	3,700	3,700	3,700	3,600	3,600	3,400	3,300
Community nursing services (total)	2,700	2,800	2,800	2,900	3,000	3,000	2,900	3,000	2,900	2,800
District nursing	2,200	2,200	2,200	2,300	2,300	2,300	2,200	2,300	2,200	2,100
Community psychiatric nursing	270	300	340	360	380	380	370	360	350	330
Community learning disability nursing	21	21	22	23	24	26	26	29	26	26
Specialist care nursing	220	270	270	260[3]	280	280	310	320	330	320
Chiropody services	940	970	1,010	980	950	980	940	900	860	830
Clinical psychology	150	160	170	180	190	200	200	190	190	190
Occupational therapy	840	880	940	1,020	1,100	1,130	1,150	1,160	1,190	1,200
Physiotherapy	3,300	3,400	3,500	3,900	4,100	4,100	4,100	4,200	4,200	4,200
Speech and language therapy	250	270	290	300	300	320	330	330	330	330
Community dental services[4]	1,251	1,259	1,221	1,212	1,153	1,132	1,096	967	869	747

1 Number of new episodes commenced in the year except health visiting (number of different persons seen at least once in a year) and community dental services (number of episodes of care commenced in year).

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

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

4 Includes a small number of discontinued episodes of care.

ideas that are currently being tested. A separate measure has been developed for staff experience, to ensure that changes are made to improve the working environment for this important group of front line staff.

Trolley Wait Programme

Worked with 13 challenged organisations (16 A&E departments) to eliminate 12-hour trolley waits between summer of 2000 and March 2001.

Stage two involved publication of the Steps guide, 'improving the flow of emergency admissions – Key questions and action steps'.

Achievements - Reduced over 12-hour trolley waits in all participating Trusts.

Produced a step-by-step guide for the NHS – disseminated November 2001.

Regional conferences and seminars carried out throughout summer of 2001.

Future Directions – Working closely with the IDEA programme to ensure implementation of the steps guide in the IDEA sites.

Supporting other NHS organisations to implement the steps and reduce trolley waits. Working with WEST and other organisations to support the NHS.

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

	1990-91	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	% Change 1990-91 to 2000-01	% Change 1999-2000 to 2000-01
Staffing											
Number of General Medical Practitioners [1]	25,622	26,289	26,567	26,702	26,855	27,099	27,392	27,591	27,704	8.1%	0.4%
Number of GP practice staff (WTE) [1] [2]	45,333	53,952	51,833	59,255	59,318	60,579	61,331	63,087	62,583	38.1%	-0.8%
Number of practice nurses (WTE) [1] [2] included in practice staff	7,738	9,605	9,099	9,745	9,821	10,082	10,358	10,689	10,711	38.4%	0.2%
Organisation											
Number of practices [1]	n/a	9,142	9,100	9,062	8,999	9,003	8,994	8,944	8,878	n/a	n/a
Average list size at 1 October each year [1] [3]	1,942	1,902	1,900	1,887	1,885	1,878	1,866	1,845	1,853	-4.6%	0.4%
Consultations											
Total number of consultations (millions) [4] [5] [6]	237	261	265	265	270	*	251	*	258	n/a	n/a
Total number of consultations per GMP [4] [5] [6]	9,240	9,920	10,000	9,920	10,100	*	9,150	*	9,040	n/a	n/a
Expenditure											
Total General Medical Service (£000s) [7]											
Discretionary (Cash limited) [8] [9]	464	715	723	754	800	835	878	885	940	102.6%	6.2%
Non-discretionary (Non-cash limited)	1,484	1,840	1,902	1,965	2,073	2,198	2,243	2,451	2,510	69.1%	2.4%
Total	1,948	2,555	2,625	2,719	2,873	3,033	3,121	3,336	3,450	77.1%	3.4%
Expenditure											
Total Personal Medical Services (£000s)	n/a	n/a	n/a	n/a	n/a	n/a	38	84	161	n/a	91.7%
Total General Medical Services per GMP (£ cash)	76,028	97,189	98,807	101,828	106,982	111,923	113,938	120,909	124,531	63.8%	3.0%
Total General Services per GMP at real terms 2000-2001 prices (£)	83,859	107,199	107,443	107,591	109,656	118,862	121,003	129,373	133,871	59.6%	3.5%
Discretionary (Cash limited) expenditure per GMP (£ cash)	18,109	27,198	27,214	28,238	29,790	30,813	32,053	32,076	33,930	n/a	5.8%
Discretionary (Cash limited) expenditure per GMP at real terms 1999-2000 prices (£)	19,991	30,024	29,593	29,836	30,534	32,723	34,040	34,321	36,475	n/a	6.3%
Real terms expenditure per consultation (2000-2001 prices) (£)	9.07	10.80	10.77	10.84	10.91	n/a	12.75	n/a	n/a	n/a	n/a

1 Source: GMS Census 1 October. Data refers to unrestricted principals and 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, 2a to 2b only.

ON THE GROUND:

Surrey Ambulance services have devised the only system in the UK to use 'live-time information' to refer patients to the nearest point of care and provide appropriate information to GPs and ambulance staff. This means that staff can routinely refer people to the professional best able to deliver their needs in the shortest possible time. Before, activity levels at different hospitals varied as much as 80 per cent – so one hospital could be very busy while another had spare capacity. Since this new system was introduced the pressures have been shared across Surrey and not a single A&E has had to close or divert ambulances.

Community Nursing, Dental and Cross Sector Therapy Services Activity

7.4 Statistics on community nursing services and on cross sector therapy services over the period 1991-92 to 2000-01 are shown in **Figure 7.2**. Activity increased slightly in most areas of community nursing until 1996-97 since then there has been a slight decline. Activity for most therapy and Allied Health Professions services has increased slightly over the period. Community Dental Service episodes of care have been reduced by the transfer of some CDS work to the Personal Dental Service which began in October 1998.

General and Personal Medical Services (GPMS)

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

Personal Medical Services

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.

Up to 2000-01, 248 PMS schemes have been established since the introduction of PMS in April 1998. 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.

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

Pharmaceutical Services[1]		1990-91	1996-97	1997-98	1998-99	1999-2000	2000-01	% Change 1990-91 to 2000-01	% Change 1999-00 to 2000-01
Prescriptions (millions)[2]		396.6	498.3	510.3	524.6	542.6	570.2	43.8	5.1
Number of contracting pharmacies[3, 4]		9,714	9,775	9,785	9,782	9,767	9,765	0.5	0.0
Average number of prescriptions dispensed by pharmacy and applicance contractors		35,739	45,329	46,297	47,759	49,641	52,066	45.7	4.9
Cost of pharmaceutical services per prescription in real terms (1999-2000 prices) £[2, 5]	*Gross*	8.91	10.09	10.23	10.20	10.61	10.57	18.6	-0.4
	Drug	7.03	8.44	8.62	8.65	9.10	9.06	28.9	-0.4
	Remuneration	1.88	1.65	1.61	1.55	1.51	1.51	-19.7	0.0
Cost of drugs and appliances in real terms (1999-2000 prices) (£m)[2, 6]		2,771	4,167	4,376	4,521	4,918	5,161	86.3	4.9
Percentage of all prescription items which attracted a charge[7]		21.6	14.4	14.6	14.6	14.9	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 1990-91 refers to 31 December. Figures for subsequent years refer to 31 March (eg 1996-97 is number as at 31 March 1997).

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.

Pharmaceutical Services

Figure 7.4 provides information on pharmaceutical services.

General Dental Services

Recent Trends

The overall volume of activity was broadly stable in 2000-01. The number of general dental practitioners continues to increase, by 2 per cent in the year to September 2000 and by 17 per cent in the last 10 years. Patient registrations have been stable since 1998, following the reduction caused by the shortening of the registration period to 15 months from September 1996. There were over 26 million courses of treatment for adults during 2000-01, 2 per cent higher than in 1999-2000 and 17 per cent higher than in 1990-91. An adult course of treatment cost an average of £40 in 2000-01, the same in real terms as in the previous year. The reduction of 15 per cent since 1990-91 reflects a reduction in the amount of complex or advanced treatments. The introduction of the Personal Dental Service in October 1998 has replaced some GDS activity. Key activity measures are set out in **Figure 7.5**.

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

General Dental Services[1][2]	1990-91	1996-97	1997-98	1998-99[3]	1999-2000[3]	2000-01[3]	% Change 1990-91 to 2000-01	% Change 1999-00 to 2000-01
Number of general dental practitioners[3]	15,480	16,336	16,728	17,247	17,721	18,049	17	2
Adult courses of treatment (thousands)	22,559	24,580	25,268	26,171	25,915	26,353	17	2
Adults registered into continuing care (thousands)[4][5]	n/a	19,524	19,383	16,721	16,649	16,813	n/a	1
Children registered into capitation (thousands)[4][5]	n/a	7,270	7,367	6,775	6,821	6,845	n/a	0
Average gross cost of an adult course of treatment (1999-2000 prices) (£)[6]	47	42	40	39	40	40	-15	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 The introduction of the Personal Dental Service in October 1998 has affected some General Dental Service activity.
3 Principals, assistants and vocational trainees at 30 September.
4 Number of patients registered as at 30 September. Registrations 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.
5 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.
6 From 1996-97 onwards, costs are based on item of service fees and adult continuing care payments. For 1990-91, the cost covers item of service fees only. Average gross costs are converted to 2000/01 prices using the GDP deflator. Changes in the average cost are affected by changes in the dental work carried out in a course of treatment.

General Ophthalmic Services

The number of sight tests increased by 2 per cent in 2000-01 over the previous year. There was a large increase (about 34 per cent) between 1998-99 and 1999-2000 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. NHS optical vouchers reimbursed by health authorities fell by 2 per cent between 1999-2000 and 2000-01 following a decrease in the number of people on income support, although the number issued in 2000-01 still represented a 47 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	1996-97	1997-98	1998-99	1999-2000	2000-01	% Change 1990-91 to 2000-01	% Change 1999-00 to 2000-01
NHS sight tests (thousands)[1]	4,154	6,808	6,991	6,992	9,399	9,567	130	2
Optical vouchers (thousands)[2]	2,432	3,967	3,935	3,777	3,662	3,575	47	-2
Number of opticians[3]	6,431	6,939	7,091	7,305	7,517	7,824	22	4

1 From 1 April 1999, eligibilty for NHS sight tests was extended to all patients aged 60 and over. Figures show the number of sight tests paid for by FHSAs/HAs in the year.
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

7.6 The *NHS Performance Assessment Framework* (PAF)[7.1] was published in April 1999, following a period of consultation, and is based on the balanced scorecard approach. The use of the balanced scorecard allows organisations to get a more rounded view of performance by identifying different key elements of performance and understanding how changes in them may have implications for others.

The NHS Plan endorsed the PAF as a single system for measuring, assessing and rewarding NHS performance. The Health Authority based PAF highlights six areas of performance which, taken together, give a balanced view of the performance of the NHS:

(a) Health improvement;

(b) Fair access;

(c) Effective delivery of appropriate health care;

(d) Efficiency;

(e) Patient/carer experience; and

(f) Health outcomes of NHS care.

Performance Indicators

The PAF is supported by a set of national headline *NHS Performance Indicators*. An annual development cycle was instigated in 2001 to improve the coverage of indicators across each area. The cycle includes a wide-ranging consultation process, and a regular series of meetings with policy leads across the Department (tri-laterals). This year's cycle laid the foundation for the first full set of specific acute NHS trust-based indicators, published in February 2002[7.2], to complement the health authority set. This will enable trusts to assess and benchmark their performance against the full range of PAF areas. The trust-based PAF will be similar to the HA version but will have four areas:

- Clinical Effectiveness and Health Outcomes;
- Patient and Carer Experience;
- Efficiency; and a new area,
- Capacity & Capability.

This reflects the central importance of infrastructure issues, such as human resources, capital and information technology, to trust performance. Trust indicators will build on the existing clinical indicators and will also include specific information on quality of care, the workforce, resources and efficiency.

Increasingly health and social services must work together to improve the care that people receive. In such cases, where both the NHS and Personal Social Services have a part to play, neither can be held wholly responsible for the outcome. Instead, the NHS and PSS are jointly responsible. To reflect this, a number of 'interface' indicators are included in both the indicator sets of the NHS PAF and the equivalent PSS PAF. Both health authorities and councils with social services responsibilities will be held accountable for performance against these indicators.

It is our intention to develop a full set of primary and community based indicators for publication in the summer of 2002.

A bigger set of benchmarking performance indicators is also being developed to enable NHS organisations to analyse their performance against their peers, identify poor performance and make improvements.

NHS Performance Ratings

In July 2000 the Government set out, in the NHS Plan, a blueprint for the modernisation and reform of the NHS over the next ten years. It made clear the determination to deliver a convenient and high quality service that fully meets the needs of patients. The Department also made a commitment to provide both patients and the general public with more comprehensive, easily understandable information on the performance of their local health services. In September 2001 all non-specialist acute NHS trusts were issued with performance ratings (stars), reflecting their performance during 2000-01.

The star status assigned to organisations is based upon delivery of national targets and overall performance as measured against a balanced scorecard reflecting staff, patient and clinical focus. Trusts with the highest level of performance have been awarded a rating of **three stars**. Those that are performing well overall, but have not reached the same consistently high standards, received **two stars**. Trusts giving some cause for concern were awarded only **one star**. Trusts that have shown the poorest levels of performance against key targets have received **zero stars**. A poor performance rating does not necessarily mean that trusts are failing to provide a good standard of care to their patients but that the overall patient experience is poor.

All zero rated trusts are required to produce a Performance Action Plan detailing specific action the trust will be taking to address its areas of poor performance. These plans are to be agreed with the Modernisation Agency and the trust's DH Regional Office.

A second set of performance ratings will be issued during 2002-03 covering all NHS organisations' performance in 2001-02.

Earned Autonomy

Depending on a trusts performance rating they will expect to receive different levels of earned autonomy. The best performing trusts can expect :

- less frequent monitoring from the centre;
- fewer inspections by the Commission for Health Improvement;
- retention of more of the proceeds of local land sales for re-investment in local services;
- extra resources for taking over and turning round persistently failing Trusts;

- be able to establish private companies; and,
- have the opportunity to shape national policy.

Foundation Trusts

Top performing Trusts will have the option to become Foundaton trusts. They will have freedom to develop their board and governance structures to ensure more effective involvement of patients, staff, the local community and other key stakeholders. Further powers will include full control over all assets and retention of land sales. We are exploring options to increase freedoms to access finance for capital investment through either a prudential borrowing regime modelled on similar principles to that being developed for local government. We are committed to decentralisation in the NHS and devolving power towards the frontline. Foundation Trusts will be a potent symbol of this commitment and will be at the leading edge of reform and innovation driven at a local level.

NHS Performance Fund

While the performance rating system provides a national driver for performance improvement at organisational level, the NHS Performance Fund provides a lever for Chief Executives to incentivise improvement at local level. The fund provides resource to fund locally developed and designed incentive schemes tailored to the particular needs of each area and aimed at supporting implementation of the NHS Plan. Performance ratings will determine the level of discretion allowed in the use of the NHS Performance Fund.

Local health economies have as much autonomy as possible so that the fund can be used in ways which best suit local circumstances, but the degree of freedom will vary according to performance rating. All organisations will receive a share of the fund regardless of their performance rating.

ON THE GROUND:

The vascular radiology team at Manchester Royal Infirmary has been named team of the year by Hospital Doctor *for diagnostic imaging. The team has changed working practices with a progressive shift towards outpatient and day case care together with extended roles for nurses and radiographers who are now routinely performing diagnostic angiography. In addition to traditional angiography, the team is using ultrasound, CT and MRI scanning as an increasing element of vascular diagnostic imaging. An outreach team at Doncaster Royal Infirmary introduced an early warning scoring system on five wards (acute and surgical) in Jan 2001. It has since been rolled out to another five wards. The mortality rate on the intensive care unit has been consistently 25 per cent for the previous seven years but since the scoring system was introduced the mortality rate has dropped to 20 per cent.*

Management Costs

7.7 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 and through organisational mergers, pooling and sharing services locally.

Over the four years from 1997-98 to 2000-01 £848 million that would otherwise have gone on bureaucracy has been freed up for patient care. This means that we are well on course to achieve the £1 billion target. Audited figures for 2001-2002 are not yet available.

As part of the work on implementing *Shifting the Balance of Power* and *Delivering the NHS Plan* the Department is reviewing policy on management costs.

Financial Performance of Health Authorities

7.8 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.

Health authorities were responsible for spending £38.9 billion on patient care in 2000-01 (the comparable figure for 1999-2000 being £37.5 billion).

As was reported in the 2001 Departmental Report, 1999-2000 was the last year in which health authorities would report their financial results in terms of income and expenditure. Commencing 2000-01 the income and expenditure statement of health authorities has been replaced with an Operating Cost Statement. The new statement more accurately reflecting the funding arrangements of public sector bodies like health authorities which receive the majority of their income direct from the Department. This is consistent with the legislation that aims to place the whole of Government finances under a resource accounting regime.

Whilst still subject to cash limit control, new financial duties have been placed on health authorities. They must contain their annual expenditure (measured on an accruals basis) within an approved limit set by the Department; and they must also achieve 'operational financial balance'.

In 2000-01 all health authorities achieved their statutory financial duty to remain within resource and cash limits. With the exception of one health authority, all others achieved 'operational finance balance', reporting an overall underspend of £50 million.

The continued improvement in the financial position of health authorities is indicative of the NHS benefiting from the Government's new spending plans. In particular through the injection of significantly extra resources – part of which are aimed at ensuring that the NHS operates on a sound financial footing.

Primary Care Trusts

Primary Care Trusts came into existence in April 2000. They are responsible for the commissioning of health care on behalf of their resident population and some PCTs are also responsible for providing community services to their population. PCTs are accountable to the health authority who provides the majority of their income.

In the same way as health authorities, PCTs are subject to resource and cash limit control and have a financial duty to achieve financial balance in resource terms.

In 2000-01 (the first year in which they were established) all PCTs achieved their statutory financial duty to remain within resource and cash limits – reporting in total an 'operational finance balance' underspend of £4 million.

Financial Performance of NHS Trusts

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

There were 356 operational NHS trusts in 2000-01.

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 the 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 and every year, there may be reasons for the 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.

In 2000-01 NHS trusts reported an income and expenditure surplus, on an accruals basis, of £56 million, compared to a £76 million[1] deficit in 1999-2000. Whilst a small number of NHS trusts did report a deficit in 2000-01, none breached their statutory financial duty to break-even 'taking one financial year with another' (see previous paragraph).

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 this should not be at the expense of proper service provision.

1 After national accounting adjustment agreed with National Audit Office.

Payment of Bills by NHS Trusts and Health Authorities

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

Performance has improved over the years, and a large number of NHS trusts and health authorities are prompt payers. However, further improvement is still required before the current target of 95 per cent is attained. The national average is a little under 85 per cent of bills paid on time.

Fraud and Corruption

7.11 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.

There are two PSA targets relating to fraud and these are referred to both below and in Chapter 2 of this report.

The Strategy

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*[7.3] published in December 1998. The NHS Counter Fraud Service (NHS CFS – formerly known as the Directorate of Counter Fraud Services (DCFS)) is the specialist organisation 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.

Identifying the problem

The NHS CFS 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 National Audit Office have pronounced themselves satisfied that the methodology provides a sound basis for estimating the likely levels of fraud and incorrectness

Creating an effective structure

The NHS CFS has created an effective structure to implement the strategy. There is a Central Unit based in the Department which directs and manages the entire service. The NHS CFS Operational Service now has eight regional teams, one national proactive team and a specialist pharmaceutical fraud team. The manager and staff have been recruited for a new dental fraud team

and it is envisaged that after receving specialist training the team will be operational by September 2002. Almost 400 Local Counter Fraud Specialists (LCFS) cover every NHS health body. All staff are required to be fully trained at the NHS CFS Training Services centre, undergoing specialist, professional training accredited by the Institute of Criminal Justice Studies at Portsmouth University.

Taking action in all key areas

Much progress has been made towards achievement of NHS Counter Fraud Service objectives. Work has been carried out in the following generic areas:

- **Creation of an anti-fraud culture**

  The development and implementation of Counter Fraud Charter agreements with NHS stakeholders has continued to show our joint commitment to tackle fraud and corruption through partnerships with other key organisations. The *Counter Fraud Charter*[7.4] originally published in December 1999, has now been signed by professional representative associations representing over 400,000 NHS staff and contractors.

  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. Altogether over 590 fraud awareness presentations have been delivered since the NHS Counter Fraud Service was established.

  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. PCT LCFSs are now being put in place.

- **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. Since the creation of the NHS counter fraud service in 1999, there has been a steady increase in the number of positive articles and reports in the media in relation to countering fraud, with a total of 368 positive articles up to March 2002.

- **Successful prevention of fraud**

  The NHS CFS Central Unit is specifically oriented to revising policies and processes to ensure that weaknesses that have allowed fraud to take place are removed so that fraud does not recur. For example, claims by contractors in the dental services concerning Recalled Attendance fell from £14.2 million in 1999-2000 to £12.3 million in 2000-01 and are projected to fall to £10 million in 2001-02. Similar reductions for claims for Domiciliary Visits from £10.6 million to a projected £9 million are also expected. Both these reductions follow the introduction of changes to legislation to prevent and deter fraud. Comprehensive Action Plans – drawing on all the experience of the first three years of counter fraud work in the NHS – are under development to revise policy and processes to prevent fraud across each area of the NHS.

  The NHS CFS Central Unit 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.

  Under the Health and Social Care Act 2001, health authorities will be able to remove a practitioner from a list or refuse admission to any NHS list on the grounds of fraud and unsuitability as well as inefficiency. The Act includes powers to introduce new rules requiring practitioners to declare financial interests.

- **Prompt detection of fraud**

  A new confidential Fraud and Corruption Reporting Line, the first of its type to exist within the NHS, became operational in 2001. This allows 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 with confidentially.

  A new Central Intelligence Unit has been established, and further refinements to the NHS fraud database introduced to maximise sharing of information on fraud activities.

- **Professional investigation of all fraud that is detected**

  NHS 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. As of June 2002, almost 500 counter fraud staff have received this specialist training to become Accredited Counter Fraud specialists. It is expected that all Directors of Finance will have received training by the autumn of 2002.

  Specialist, professional training is reinforced by guidance in the NHS Fraud and Corruption Manual issued to all accredited counter fraud specialists and Finance Directors.

- **Consistent use of appropriate legal action, sanctions and redress**

  It is the policy of the NHS CFS to seek to combine the application of disciplinary, civil and criminal sanctions where fraud is found – to dismiss an employee or suspend or de-register a professional, to obtain civil law orders to freeze assets and recover funds and to impose a criminal sentence.

  As at the end of March 2002 action has resulted in 115 successful prosecutions (a 99 per cent success record), with a further 32 cases awaiting court hearings. A further 159 civil and disciplinary cases had been successfully completed by this time and there were 451 ongoing investigations.

The new Penalty Charge, introduced under *The Health Act 1999*[7.5], for patient evasion of NHS charges was implemented with effect from 1 December 2000. The first penalty charges were imposed in August 2001. As at 31 January 2002, over 23,000 Penalty Notices had been issued to patients incorrectly claiming exemption from prescription charges.

A key aspect of the NHS CFS's work has been to ensure that fraud losses are recovered so that the resources can be spent on patient care. By the end of November 2001, the level of recoveries for 2001-02 were already running at five times the figure for the whole of 1998-99 and a total of £9 million had been recovered.

Meeting targets and making savings

The end result of all this work is to meet targets and make savings.

The first two measurement exercises on patient prescription charge fraud, comparing figures from 1998-1999 and 1999-2000, indicate that since the introduction of the strategy, losses in this area have already been reduced by £48 million or around 41 per cent, from £117 million to £69 million. This represents good progress towards the first PSA target of *'A 50 per cent reduction in prescription charge evasion (compared to 1998 levels) by the end of 2002-03'.*

On pharmaceutical contractor fraud, results of the baseline measurement exercise in pharmaceutical services will be announced in 2002. The results of the first ever optical patient and contractor fraud measurement exercises will also be announced during 2002. The dental patient and contractor fraud measurement exercises have now been completed this data is being analysed and should be available by the time this report is published.

The second PSA target concerned *'£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'.*

To date £7.47 million has been recovered from action on contractor fraud together with £9.3 million in prevention savings, thereby meeting the target.

Wales

A partnership has been established between the National Assembly for Wales and the NHS CFS to counter fraud and corruption in the NHS in Wales. A common strategy will now be implemented across Wales and England. The strategy document for Wales was published in September 2001. The Welsh NHS CFS Operational Service team was in place by June 2001 and directions have been issued to Welsh health bodies on countering fraud and corruption. Fraud awareness presentations to Welsh health bodies were completed in November 2001. Measurement exercises relating to Wales are being developed and additional policy changes considered, with policy support from within the NHS Counter Fraud Service. For example, penalty charges were introduced in Wales in September 2001.

Conclusion

2001-02 has seen major progress in countering fraud and corruption in the NHS. A structure now exists, covering every part of the NHS, which can take appropriate action. Significant results have already been achieved in reduced losses, a developing anti-fraud culture, many prosecutions, and a big increase in recoveries. 2002-03 should see further progress.

Efficiency

NHS Efficiency

7.12 The *Reference Costs 2001*[7.6] publication details the average cost across the NHS for a range of treatments and procedures for the 2000-01 financial year. The publication gives details of the unit costs from relatively straightforward tests such as x-rays to more complex treatments such as lung transplants. It also gives cost information for treatments carried out in the local community including patients' own homes.

This information now covers 83 per cent of annual expenditure on hospital and community based health services. For the first time some services have been provided by primary care trusts and these are also covered. The 2001 publication covers £21 billion of NHS expenditure compared to approximately £14 billion in 2000. It includes a wider range of community-based services as well as giving more detail on some specialist acute services in addition to standard inpatient, day case, accident and emergency and outpatient treatments and appointments.

With the increased coverage, reference costs have been used for the setting of efficiency targets. This is only one strand in the overall approach to NHS performance. There are a number of indicators used to assess overall performance that are detailed in the NHS Plan.

HCHS Cost Weighted Activity Index

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.

Figure 7.7 shows the overall activity levels, which have increased by approximately 32 per cent, in the ten year period between 1989-90 and 1999-2000. 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 around 28 per cent.

The difference between the two measures reflects the increase in efficiency within the HCHS over the past ten years, in this case 3 per cent.

Expenditure in real terms (i.e. after allowing for GDP inflation) increased by approximately 45 per cent over the ten year period from 1989-90. This is greater than the rise in overall HCHS activity (32 per cent). This is due to a greater increase in expenditure over the last few years in order to improve quality. This has, therefore, not resulted in an increase in activity of the same magnitude.

Figure 7.7: HCHS Cost Weighted Activity Index

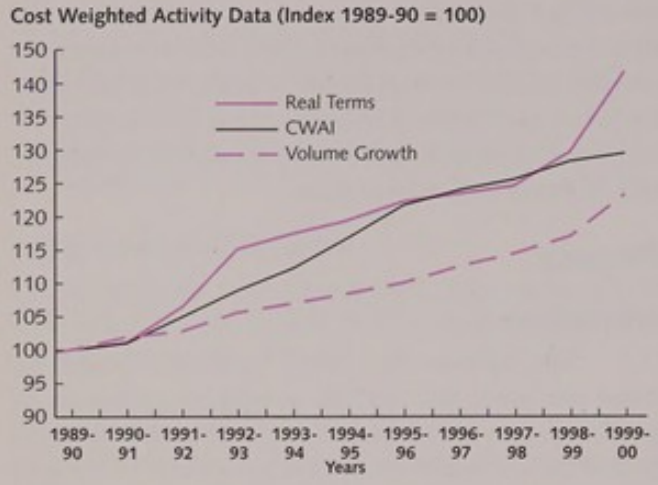
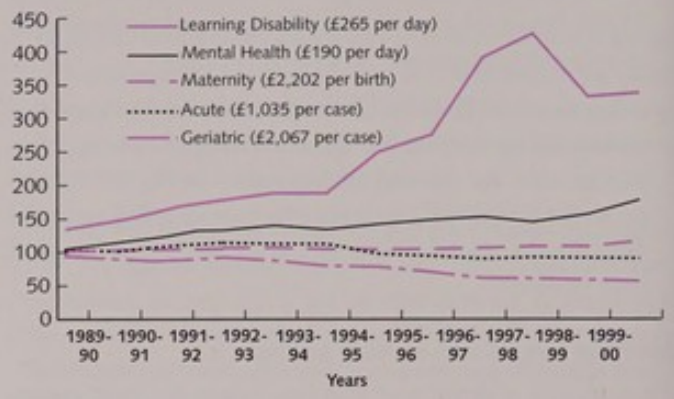


Figure 7.8: Average unit costs by category of care 1989-90 to 1999-2000 (Index 1989-90 = 100)



Unit Costs

Some data required for the 1999-2000 Programme Budget was not available at the necessary level of detail. For this reason, estimations based on expenditure ratios at 1998-99 were used to calculate the 1999-2000 expenditure, hence it is only possible to compare unit costs up to 1998-99. Overall unit costs in the hospital sector have tended to rise in real terms in the last ten years, most markedly in Learning Disabilities. However, the position varies depending on the category of care being delivered. These differences between categories of care in 1998-99 has 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 geriatric patients shows 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.

Personal Social Services

Children's Services Activity

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

Key points are that:

- the number of children looked after by local authorities at any time during the year was fairly constant from 1994-95 to 1998-99, since when it has risen by 3 per cent;
- the number of care days provided per child has steadily risen over the years 1994-95 to 2000-01, and is now 16 per cent higher than at the beginning of the period;
- the number of children looked after at 31 March has increased to 58,900, however, the rate of increase is less marked than in recent years;
- the proportion of children looked after aged under 10 has shown a slight decrease compared with 1999-2000;
- there has been a small decrease in the percentage of children looked after with three or more placements, 16 per cent in 2000-01 compared with 18 per cent in 1999-2000;

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	2000-01
Number of children looked after by local authorities at any time during the year	79,100	79,200	78,200	79,300	79,400	82,200	81,700
Average number of care days provided per child	226	230	237	240	248	253	262
Children looked after by local authorities at 31 March	49,500	50,500	51,000	53,300	55,500	58,100	58,900
% aged under 10	37	39	40	42	43	43	42
% in foster care	65	65	65	66	65	65	65
% in children's homes	14	13	12	12	11	11	11
% with three or more placements during year	20	21	20	20	19	18	16[1]
Registrations to child protection register during year	30,400	28,300	29,200	30,000	30,100	29,300	27,000
% whose reason was sexual abuse	24	22	21	20	19	17	16
% that were re-registrations	16	18	19	19	15	14	14
All adoptions during year	5,500	5,400	4,600	4,000	4,400	4,800	4,900
adopted from care	2,000	1,900	1,900	2,100	2,200	2,700	3,100

1 *Provisional*

- the number of children placed on the child protection register during 2000-01 has fallen by 8 per cent since 1999-2000 and by 11 per cent since 1994-95; and,
- there has been further increase in the number of children adopted from care with 3,100 'looked after children' adopted in 2000-01, an increase of nearly 40 per cent over 1998-99.

Adults' Services Activity

7.14 **Figure 7.10** gives a summary of Personal Social Services provided to adults. Adults' services include all services provided to individuals aged 18 or over. The users range from those who have just reached adulthood to the most elderly of 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	2000-01[4]
All adults aged 18 or over								
Households receiving home care	514,600	538,900	512,400	491,100	479,100	447,200	424,000	398,000
of which, percentage receiving fairly intensive home care[1]	12	15	21	25	28	33[R]	34	36
of which, percentage receiving intensive home care[1a]					12	15	16	18
People supported in residential care	119,200	137,500	153,200	170,300	176,500	181,200	185,200[R]	183,500
People supported in nursing care	25,200	43,200	57,200	66,100	72,900	73,500	73,900[R]	71,800
People aged 18-64								
with physical/sensory disabilities								
helped to live at home per 1000 pop[2]				2.2	2.3	2.0		
helped to live at home per 1000 pop[3]						3.5	3.7[R]	3.7
supported in residential care	6,300	7,100	6,700	7,200	5,900	5,900	6,200	6,100
supported in nursing care	1,500	2,300	2,700	3,200	2,800	3,200	3,400	3,400
with mental health problems								
helped to live at home per 1000 pop[2]				1.2	1.2	1.2		
helped to live at home per 1000 pop[3]						1.7	2.2[R]	2.6
supported in residential care	4,200	5,200	6,500	6,800	7,900	8,700	8,800	9,200
supported in nursing care	270	600	850	1,130	1,370	1,500	1,620	1,720
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	2.3[R]	2.4
supported in residential care	17,500	20,300	22,200	24,800	25,100	26,900	28.300	28,600
supported in nursing care	190	300	640	690	930	930	1,010	990
in other groups								
supported in residential care	1,400	1,800	1,700	2,100	2,300	2,000	1,800	1,700
supported in nursing care	140	190	230	280	340	300	260	270
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	85[R]	84
supported in residential care	89,800	103,100	116,100	129,400	135,300	137,800	140,100[R]	138,100
supported in nursing care	23,100	39,900	52,800	60,800	67,500	67,500	67,600[R]	65,500

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 in September/October.
1a Intensive is defined here as receiving more than 10 hours of home care and 6 or more visits during a survey week in September/October.
2 Helped to live at home by means of home care, day care and meals services. This is an Audit Commission indicator. For 1997-98 and earlier years England figures are based on an unweighted average of authority figures.
3 Helped to live at home by means of any service recorded on Referrals, Assessments and Packages of Care (RAP) return P2s. This includes planned short term breaks, direct payments, professional support, transport and equipment and adaptations as well as home care, day care and meals services. Data for 1998-99 on this basis are estimated as are data for 1999-2000 for around a quarter of the 150 local authorities.
4 The total number of households is calculated differently for 2000-01 than in previous years.
R – Figure has been revised.

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 continues to fall, and the proportion of these households receiving 'fairly intensive' home care continues to increase (as the total number of contact hours of home care increases). There is also evidence that in 2000-01 there were more people helped to live at home by means of services wider than home care;
- around 72,100 households (18 per cent of households received intensive home help/home care in 2000 defined as more than 10 contact hours and 6 or more visits during the week). This represents a 5 per cent increase of the 1999 figure of 68,700; and,
- except for the latest year the number of people supported by councils in residential or nursing care has continued to increase 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.

ON THE GROUND:

After revising admission and discharge policies and developing a link working system with social services, East Kent Community no longer has a waiting list for outpatient appointments in older people's services. Before, there was a 24-week wait.

At Winchester and Eastleigh Healthcare NHS Trust a Preventing Dependency Team is offering patients short-term intensive rehabilitation support in their own homes rather than in hospital. Intervention by the team is rapid so allowing the patient to either leave hospital earlier than normal or to prevent then being admitted to hospital at all. The team comprises nurses, physios, occupational therapists, rehabilitation assistants and care managers. The team is now expanding to help more patients. As part of the move towards single assessment, the team is already setting short-term plans combining rehabilitiation and social care, with a maximum of four visits a day to the patient's home.

PSS Performance and Performance Assessment

7.15 The PSS performance assessment system is designed to improve the services 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 councils work effectively with the NHS, 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 councils that are performing poorly and ensuring that they take action to improve; and,
- providing service users and the general public with readily understandable information about the performance of their council.

The White Paper *Modernising Social Services*[7.7] 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 (see box). 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 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 rounded 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 child care, 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; and,
- **Monitoring** – the SSI regions 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.

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). This helps the Department each year to collate all the available information and assess the overall performance of each council. SSI regions 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.

In addition, from Spring 2002 an additional output of the performance assessment process will be performance 'star' ratings for each council. SSI regions, having assessed all the available evidence, will categorise current performance and prospects for improvement on four point scales. This will be done separately for adult and children services. These judgements will then be combined into an overall rating of zero to three stars, which will allow the general public and service users to know, for the first time, what SSI's view of their council's social services is. This presentation is already familiar from the star rating introduced for NHS trusts in September 2001.

Recent Performance

In May 2002 the first social services performance 'star' ratings were published. These presented each council's performance on social services as from zero to three stars, just as NHS performance ratings had previously done for NHS trusts. The social services star ratings are based on an overall assessment of all the available evidence from performance indicators, inspections and monitoring.

The Social Services Inspectorate came to a judgement for each council as to current performance on children's services and adult services, and also on their prospects for improvement for each of these. These in turn were combined into the single overall rating.

Eight councils received three stars, the best rating, and a further 50 received two stars also showing good performance. These councils were spread across the country, showing that councils of all types are able to achieve good performance. Most councils (82) received one star, and ten councils received zero stars. These councils are on 'special measures', meaning that the Social Services Inspectorate monitor their performance intensively and agree with the council a performance improvement plan.

The ratings show that performance is likely to improve. Almost seven in ten (69%) were judged to have good or excellent prospects for improvement. Even at the one star level more than half of councils had good or excellent prospects.

In general, the judgements for children's services were better than for adult services.

The performance star ratings are consistent with the various sources of performance evidence, because all that evidence is used to inform the stars. The evidence comes from:

- Various inspections, for the most part summarised (alongside other performance information) in the Chief Inspector's annual report *Modern Social Services – a commitment to deliver (August 2001)*[7.8];
- The performance indicators published in October 2001 in *Social Services Performance Assessment Framework Indicators, 2000-2001*[7.9]; and,
- Monitoring information from Autumn 2001.

The Chief Inspector's annual report noted the following key messages on performance:

- Despite clear evidence of commitment from all councils to modernisation, progress is slow in many areas of service delivery;
- Obstacles to improvement exist, such as recruitment and retention of appropriately qualified staff, these are getting in the way of achieving the national objectives for the service;
- Whilst there is positive improvement in joint work between councils and the NHS, there is some way to go before the integrated services envisaged in the NHS Plan are realised; and,
- The concerns about social services in London, especially in children's social services.

The performance indicators, published since that report, paint a similar picture of progress that is not consistent across the country:

- At an England level there was an improvement in performance for the second year running (of the indicators that can be compared, 18 showed an improvement between 1999-2000 and 2000-01, 3 worsened and 2 remained at their previously high

level);

- Performance still varies between councils for many of the indicators but the variation reduced for the second successive year; and,
- Data quality improved but there is room for further improvement.

The messages from the Autumn 2001 monitoring round are consistent with the above, in that improvements are happening but often slowly:

- On children's services, inspectors judged that 51 per cent of councils were making some progress, but only 39 per cent were making significant progress; and,
- On adult services, inspectors judged that 55 per cent of councils were making some progress, with 42 per cent making significant progress.

In more detail, the following messages are drawn from monitoring and indicator information.

Children's services – detailed performance messages

- Steady progress has been made towards a number of objectives, especially those concerned with stability of placements for looked after children, and aspects of child protection.
- However review procedures for child protection cases need to improve further as only 25 per cent of councils reviewed all their cases and one in eight reviews did not take place when it should.
- Indicators on life chances for looked after children continue to cause concern. The number of children leaving care with at least one GCSE increased from 31 per cent to 37 per cent, below the target of 50 per cent for 2000-01. Looked after children are three times as likely to receive a final warning or conviction than children in general, and no consistent improvement is forecast by councils.
- Councils and their partner agencies are progressing a wide range of service initiatives to deliver reductions in teenage pregnancy.
- There was a further large increase in the proportion of looked after children adopted. Since the Quality Protects initiative began in 1998-99 the number has increased by almost 40 per cent, to 3,100 in 2000-01. However, there are more children waiting to be adopted than there are approved adopters waiting for a match;
- a quarter of looked after children are placed outside their council area, and half of these are placed 20 miles or more outside. Councils are planning to reduce this number by 25 per cent by 2003-04.

Adult services – detailed performance messages

- there is some success in promoting independence, with the numbers of people helped to live at home rising slowly, and the numbers of people entering residential care falling.
- The extension of Direct Payments to older people has accelerated rapidly since Autumn 2000, although overall numbers remain small.
- The proportion of discharges from hospital that were delayed fell slightly to 11.3 per cent, just above the target of 11 per cent. The most frequent causes of delay are waits for residential or nursing home placements or for public funding.
- There are signs of continuing difficulty in establishing effective partnerships with NHS bodies as a result of continued local reorganisation, although these are seen mainly as temporary setbacks. Two indicators at the interface between health and social services show targets either met (emergency admissions of older people) or progress being made towards target (emergency psychiatric re-admissions).
- a high proportion of users (84 per cent) said that they got help quickly, with the figure reaching over 90 per cent for one fifth of councils.
- a third of users placed for residential drug misuse rehabilitation programmes fail to complete.

Further information can be found at: www.doh.gov.uk/pssratings

Efficiency in Social Services

7.16 The Public Service Agreement (PSA) 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'*. Similarly the Service Delivery Agreement (SDA) underpinning the PSA includes an expectation that there will be year-on-year efficiency gains of 2.5 per cent in future.

The available evidence shows that the national efficiency target was missed but only by a very small margin. The estimated efficiency gains for the three years of the PSA targets were 2.1 per cent, 2.3 per cent and 2.5 per cent. This means that the total estimated efficiency gain for the PSA period was 7.1 per cent, compared with the total target for the three years of 7.2 per cent.

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.

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;
- 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; and,
- Further work is to be undertaken to develop new measures of cost effectiveness, covering cost together with quality and outcomes.

Future developments

The introduction of performance 'star' ratings has been mentioned above. In addition there are a number of other developments coming.

- The PSS Performance Fund will incentivise local performance improvement, with every council getting their fair share but the freedom to use the fund dependent on the star rating;
- Other 'freedoms' will be developed that will be dependent on star rating, which may include for example a lighter touch inspection regime;
- There will be a reduction in the number of plans that councils are required to submit to the Department of Health; and,
- The local government white paper, *Strong Local Leadership—Quality Public Services*[7.10], picks up on many of these themes and extends them to all local government services.

The performance indicators will continue to be developed via a PSS PAF Development Group, which includes council representatives.

8. Managing the Department of Health

THIS CHAPTER COVERS:

Running Costs and Staffing Tables

8.1 The Department comprises 11 directorates dealing with various aspects of the organisation's work (e.g. Policy, NHS Human Resources, and Public Health & Clinical Quality) and 8 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.

The provisions for the administration of the Department appear, for past years, in Annex A of the 2001-02 Departmental Report[8.1] and, for 2002-03, they form part of the Request for Resources 2 in the 2002-03 *Main Estimates*[8.2]. As part of the 2000 Spending Review, the Department agreed with Treasury a profile of administration costs over the period 2001-02 to 2003-04 which is level in real terms compared to 2000-01.

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**.

No maladministration payments were made in 2001.

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

8.2 The Department's quangos are all operating under measures introduced by the Government in 1998[8.3] designed to increase public accountability and confidence in these bodies. The Department's 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 undergo formal reviews at least

Figure 8.1: Department of Health Administration Costs

£ million

	1998-99 outturn	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 Plan	2003-04 Plan
Gross Administration Costs:						
Paybill	140	148	168	175		
Other	168	162	166	169		
Total gross administration costs	**308**	**310**	**334**	**344**	**347**	**360**
Related administration cost receipts	-11	-5	-7	-9	-13	-11
Total net administration costs	**298**	**278**	**327**	**336**	**334**	**349**
of which						
Departmental Expenditure Limit (DEL)	277	258	299	317	313	323
Non-cash AME	21	20	28	19	21	26
Total Net Administration Costs by activity						
Central department	268	277	277	290	288	305
Medical Devices Agency	6	7	7	7	8	8
NHS Pensions Agency[1,2]	19	17	20	20	19	16
NHS Purchasing and Supply Agency[1,2]	0	0	18	18	19	20
Youth Treatment Service[1,2]	4	4	5	0	0	0
Total Net Administration Costs	**297**	**305**	**327**	**335**	**334**	**349**
Controls and limits						
Administration Costs limits for gross controlled areas						
Central department	255	260	254	273	272	
Medical Devices Agency	10	7	7	8	8	
NHS Pensions Agency	18	17	20	19	19	
NHS Purchasing and Supply Agency	0	0	18	19	19	
Youth Treatment Service	4	4	5	0	0	
Total administration Costs limits for gross controlled areas	**287**	**289**	**304**	**318**	**319**	

1 A Next Steps Executive Agency.
2 These figures are included in the Department of Health figures above.

Figure 8.2: Staff Numbers

Staff-years

	1995-96 outturn	1996-97 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 plan	2003-04 plan
Department of Health (Gross Control Area)									
Civil Servants (full-time equivalents)	3,801	4,309	4,091	4,081	4,200	4,448	4,636	4,243	4,218
Overtime	43	40	40	40	40	0	0	0	0
Casuals	239	137	116	98	101	63	79	66	66
Total	**4,083**	**4,486**	**4,247**	**4,219**	**4,341**	**4,511**	**4,715**	**4,309**	**4,284**
NHS Estates Agency (Net Control Area)[1]									
Civil Servants (full-time equivalents)	101	138	142	236	263	306	427	143	143
Overtime	2	0	0	0	0	0	0	0	0
Casuals	1	1	2	6	7	20	8	17	17
Total	**104**	**139**	**144**	**242**	**270**	**326**	**435**	**160**	**160**
Medicines Control Agency [2]									
Civil Servants (full-time equivalents)	356	378	413	492	490	436	574	574	574
Total Department of Health	**4,543**	**5,003**	**4,804**	**4,953**	**5,101**	**5,273**	**5,724**	**5,043**	**5,018**

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.

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 follows Cabinet Office guidance[8.4] on their conduct. The Department's emerging infectious disease strategy proposes new health protection arrangements which are likely to involve changes to the pattern of the Department's executive NDPBs.

The Department's approach to the management of the performance of its arm's length bodies (NDPBs, Agencies and special health authorities) 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 involves structural improvements, mainly in the form of guidance which is available both to the bodies themselves and their sponsor branches 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. 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 approach will concentrate on the performance management of arm's length bodies. The Department's new internal corporate development initiative will further strengthen these moves.

The Department has five executive Agencies:

- The Medical Devices Agency (MDA) – the MDA is widely regarded as a world leader in its field;
- The Medicines Control Agency (MCA) – the MCA is also regarded as a world leader in its field and continues to play a major role in the development of public health and Britain's pharmaceutical industry;
- NHS Estates (NHSE) – following a quinquennial review in 2000, the Agency's strategic focus on the *NHS Plan* has been reinforced. The Agency will shortly be procuring a private sector partner for its trading arm;
- NHS Pensions Agency (NHSPA) – work has been completed to implement recommendations from a five yearly review, in particular procurement of a private sector partner to contractorise the Agency's non-core services; and,
- 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 in time become the centre of expertise on purchasing and supply for the NHS. The Agency is also a leading player in e-commerce in the NHS.

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 Agencies can be found in **Annex B**.

Public Appointments

8.3 All appointments to NHS bodies, Executive NDPBs and Advisory NDPBs which are sponsored by the Department are made according to a Code of Practice laid down by the Commissioner for Public Appointments. The Code requires that all appointments are made on merit, after an open and transparent recruitment and selection process involving independent assessors.

Appointments to the boards of NHS Trusts, Health Authorities and Primary Care Trusts are now undertaken by the NHS Appointments Commission. The Commission was established as a Special Health Authority on 1 April 2001. It is chaired by Sir William Wells, who is supported by eight Regional Commissioners. The Secretary of State determines the criteria against which all candidates are judged by the Commission, as well as setting equal opportunities goals and objectives to ensure that NHS boards are representative of the communities they serve. This apart, he no longer has any direct role in the

appointments process to local NHS boards.

Progress has been maintained in improving the gender and ethnic balance of the boards for which the Department is responsible, as well as increasing the recruitment of disabled people. As at 1 January 2002, the position was as follows:

Figure 8.3: Public Appointments Sponsored by the Department at 1 January 2002

Type of Body	Chairs	Members	Total
Health Authorities	89	477	566
NHS Trusts	299	1,503	1,802
Primary Care Trusts	188	823	1,011
Special Health Authorities	17	261	278
Advisory Non-Departmental Public Bodies	22	339	361
Executive Non-Departmental Public Bodies	9	104	113
Other Public Bodies	2	14	16
Total	**626**	**3,521**	**4,147**

The Department is responsible for public appointments to a wide range of bodies, as detailed in **Figure 8.3**.

More comprehensive information on appointments made to individual bodies is included in the Department's Public Appointments Annual Report, a copy of which can be obtained from:

Department of Health
Public Appointments Unit
HRD-HRB
Quarry House
Quarry Hill
Leeds
LS2 7UE

Tel: 0113 254 6348
Email: christine.l.hope@doh.gsi.gov.uk

Figure 8.4: Public Appointments – Progress by Gender and Ethnic Balance

	NHS Trusts, Health Authorities and Primary Care Trusts	Special Health Authorities and Non-Departmental Public Bodies
% board members who are women	48.80	38.10
% chairs who are women	41.30	36.8*
% board members from ethnic minorities	12.10	15.70
% board members who are disabled	3.70	2.80

** Also includes vice chairs.*

Recruitment

8.4 Until 1 October 2001 external recruitment was centrally managed within Personnel/HR sections of the Agencies and Regional Offices. After that date responsibility was devolved from the central personnel function to HR sections within Directorates. Procedures for recruitment by Agencies and Regional Offices remain the same. Well-established systems are in place to 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*. The Department introduced recruitment controls on 3 December 2001. This involved the introduction of a revised procedure for filling posts and was designed to support financial control of administrative expenditure, and critically to support colleagues whose posts may be displaced by organisational change. These controls will remain in place until 30 June 2002 in the first instance.

The number of successful candidates in external competitions is shown in **Figure 8.5** (overleaf) 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:

- 92 secondments;
- 2 short term senior appointments where highly specialised skills required; and,
- 93 conversions of Fixed Term and Casual appointments to permanency;

The review of the internal selection mechanism for non-Senior Civil Service staff is now complete and Fairer Job Specific Selection rolled out across the Department on 7 January 2002. The new procedures have been endorsed by the Departmental Board and the Change Management Group and have been agreed by the Departmental Trade Union Side. Fairer Job Specific Selection has been designed as part of the Departmental review and links closely with the New Understanding and Diversity Action Plans. It also reflects the most recent employment law changes and best practice.

Senior Civil Service Salaries

8.5 Details of Senior Civil Service salaries in the Department of Health are given in **Figure 8.6**.

Figure 8.6: Salaries in the Department of Health for Senior Civil Service staff in post as at 1 April 2001

Payband (per annum)	Number of Staff
£40,000 – £44,999	4
£45,000 – £49,999	15
£50,000 – £54,999	60
£55,000 – £59,999	52
£60,000 – £64,999	76
£65,000 – £69,999	75
£70,000 – £74,999	34
£75,000 – £79,999	25
£80,000 – £84,999	26
£85,000 – £89,999	13
£90,000 – £94,999	20
£95,000 - £99,999	7
Over £100,000	30
Total	**437**

A Healthier Workplace

8.6 The Department remains committed to achieving its targets agreed last year with Cabinet Office and the Treasury for reducing its levels of sickness absence as part of a Civil Service-wide initiative.

The Department continues to meet its legal obligations to safeguard the health and safety of its staff and in 2000-01 appointed a new occupational health supplier to help manage its sickness absence.

New guidance is currently being developed 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 respective roles and responsibilities for managers and individual members of staff in relation to managing attendance.

Work is also being undertaken to look at a range of management information systems including information on sickness absence.

Accommodation

8.7 There has been no significant change to Departmental buildings during the year. All the main Departmental buildings continue to operate at or near capacity with the Victoria Climbie Inquiry making cost effective use of the space vacated by parts of the Food Standards Agency on their move to their new headquarters building. The *Shifting the Balance of Power* initiative will result in a major reduction of the Department's buildings outside London and Leeds and plans are being put in place for the disposal of the resulting surplus property.

The Environment

8.8 The Department continues to raise the profile of its sustainable development strategy in line with Government policy (see Chapter 2, section 2.14). This strategy is wide-ranging, encompassing sustainable development, environmental appraisal and operational environmental management, building on work undertaken to identify significant environmental impacts and the development of strategies to improve the Department's environmental performance.

A review of the Department's policy on Environmental Management, including waste and energy management has continued in the programme of re-tendering support services. Provision for meeting (and exceeding) the Department's waste target has successfully been incorporated into the new cleaning and waste contract (April 2001) and improved energy and emissions management from June 2001. The Department has introduced the purchase of 100 per cent renewable 'green' electricity in five of its London Estate buildings from November 2001, exceeding the 5 per cent target. This energy is Climate Change Levy (CCL) exempt. Environmental aspects are a mandatory element of any contract being re-tendered. The Department actively continues to pursue EMS accreditation under ISO 14001.

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 8.5: Recruitment into the Department of Health, 2001

	Total	Male	Female	Ethnic Minorities	Disabled
Permanent Staff joining during 2001 who are still employed by the Department of Health					
Senior Civil Service	24	15	9	0	0
Fast Stream	21	9	12	0	0
Posts at former UG6 and below	658	225	398	31	4
Total	**703**	**249**	**419**	**31**	**4**
Permanent Staff joining during 2001 who are no longer employed by the Department of Health					
Senior Civil Service	8	3	1	0	4
Fast Stream	0	0	0	0	0
Posts at former UG6 and below	254	44	82	2	126
Total	**262**	**47**	**83**	**2**	**130**
All Permanent Staff joining during 2001					
Senior Civil Service	32	18	10	0	4
Fast Stream	21	9	12	0	0
Posts at former UG6 and below	912	269	480	33	130
Total	**965**	**296**	**502**	**33**	**134**

List of Annexes

ANNEX A1

Total Capital Employed by the Department

£ million

	1998-99 outturn	1999-00 outturn	2000-01 outturn[6]	2001-02 estimated outturn	2002-03 plan	2003-04 plan
Within the Departmental Account[1][2]	17,896	15,813	15,146	15,524	15,912	16,310
Investment outside Accounting Boundary[3][4][5][6]	15,853	22,529	23,005	23,580	24,169	24,774
Total Capital Employed	33,749	38,342	38,150	39,104	40,082	41,084

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

2 Source: DH consolidated resource accounts. For 2001-02 and beyond figures are based on projected growth.

3 Figures from 1999-2000 onwards include the NHS Litigation Authority which moved inside the accounting boundary in 2000-01.

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

5 Source: NHS Trusts summarisation schedules, and accounts of other organisations. For 2001-02 and beyond figures are based on projected growth.

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

7 These are provisional figures.

ANNEX A2

Department of Health Resource Budget

£ million

	1998-99[1] outturn	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 plan	2003-04[2] plan
Consumer of Resources by activity						
National Health Service (NHS)	**39,794**	**41,313**	**44,374**	**50,300**	**53,958**	**58,857**
of which						
Hospital and Community Health Services	**34,879**	**36,269**	**39,154**	**45,144**	**49,329**	**52,542**
of which						
Health Authorities unified budget and central allocations and grants to local authorities	34,879	36,269	39,154	45,144	49,329	52,542
Family Health Services	**4,223**	**4,237**	**4,337**	**4,157**	**3,650**	**5,276**
of which:						
General dental services	1,004	1,060	1,097	1,165	1,170	not available
General medical services	2,212	2,458	2,479	2,221	1,700	not available
General ophthalmic services	236	286	290	301	305	not available
Pharmaceutical services	1,113	803	855	877	903	not available
Prescription charges income	-343	-371	-384	-407	-428	not available
Central Health and Miscellaneous Services	**396**	**498**	**558**	**645**	**624**	**670**
of which						
Welfare Foods DEL	295	101	106	106	120	120
EEA Medical Costs	-62	137	164	197	200	241
Other Central Health and Miscellaneous Services	163	259	289	342	304	309
Departmental Administration including agencies	296	310	324	354	355	370
Personal Social Services (PSS)	711	631	654	1,062	1,927	2,194
of which						
Personal Social Services	32	34	43	69	191	193
Local Authority personal social services grants	679	597	610	993	1,736	2,001
of which						
Training Support programme for social services staff	35	39	43	48	58	70
Grants for adults	618	436	446	558	1,173	1,223
Grants for children	26	122	120	386	456	609
Grants funded from the invest to save fund	0	0	2	1	0	0
Performance fund	0	0	0	0	50	100
Pensions						
of which						
NHS - Superannuations – E&W	623	455	522	172	-50	-51
Total Department of Health Resource Budget	41,128	42,400	45,550	51,535	55,834	61,000
of which						
Departmental Expenditure Limit (DEL)	38,242	39,939	43,506	48,724	53,268	58,358
Non-cash items in AME	2,263	2,005	1,522	2,638	2,616	2,694
of which						
Depreciation	155	365	398	432	333	402
Cost of Capital Charges	1,346	1,408	1,259	1,138	1,266	1,468
Changes in provisions & Other changes	763	232	-135	1,068	1,017	824
Other spending in AME (NHS Pensions)	623	455	522	172	-50	-51

1 Figures for 1998-99 are taken from the Department's 1998-99 Resource Account which did 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 From 2003-04 budgets are set on a stage 2 resource budgeting basis. These stage 1 resource budgeting figures are therefore indicative for that year and include Budget 2002 additions on a stage 1 resource budgeting basis.

3 Figures may not sum due to rounding

ANNEX A3

Department of Health Capital Budget

£ million

	1998-99[1] outturn	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 plan	2003-04[2] plan
National Health Service – (NHS)	**700**	**908**	**1,318**	**1,745**	**2,401**	**2,898**
of which						
Hospital and Community Health Services	**700**	**871**	**1,288**	**1,699**	**2,367**	**2,867**
of which						
Health Authorities unified budget and central allocations and grants to local authorities	700	871	1,288	1,699	2,367	2,867
Central Health and Miscellaneous Services	**0**	**15**	**16**	**18**	**15**	**11**
Departmental Administration including agencies	**#**	**22**	**14**	**28**	**19**	**20**
Personal Social Services (PSS)	**60**	**61**	**59**	**112**	**97**	**97**
of which						
Personal Social Services	55	57	57	108	81	81
Local Authority Personal Social Services Grants	5	4	2	4	16	16
of which						
Grants for Children	5	4	2	4	16	16
Grants funded from the Invest to Save Fund	0	0	1	#	0	0
Total Department of Health Capital Budget	**760**	**969**	**1,377**	**1,857**	**2,498**	**2,995**
of which						
Departmental Expenditure Limit (DEL)	760	969	1,377	1,857	2,498	2,995

1 Figures for 1998-99 are taken from the Department's 1998-99 Resource Account which did 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 From 2003-04 budgets are set on a stage 2 resource budgeting basis. These stage 1 resource budgeting figures are therefore indicative for that year and include Budget 2002 additions on a stage 1 resource budgeting basis.

3 Figures may not sum due to rounding.

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

ANNEX A4

United Kingdom

National Health Service – By Area of Expenditure (resources)

£ million

	1999-00 outturn	2000-01 outturn	2001-02 estimated outturn	2002-03 plan	2003-04[2] 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	44,089	48,323	53,982	58,849	63,171
Charges and receipts	-2,064	-2,170	-2,179	-2,340	-2,499
Net	42,025	46,153	51,803	56,509	60,672
Capital expenditure[1]					
Gross	1,978	2,353	2,696	3,175	3,656
Charges and receipts	-755	-764	-551	-369	-284
Net	1,223	1,589	2,145	2,806	3,372
Total					
Gross	46,067	50,676	56,678	62,024	66,826
Charges and receipts	-2,819	-2,934	-2,730	-2,709	-2,783
Net	43,248	47,742	53,948	59,315	64,043
National Health Service family health services (non-discretionary)[3]					
Current expenditure					
Gross	6,137	6,358	6,260	5,889	7,589
Charges and receipts	-907	-952	-1,001	-1,005	-1,007
Net	5,230	5,406	5,259	4,885	6,583
Central health and miscellaneous services[4]					
Current expenditure					
Gross	1,185	1,212	1,446	1,515	1,597
Charges and receipts	-156	-138	-180	-127	-134
Net	1,029	1,073	1,266	1,388	1,463
Capital expenditure					
Gross	40	34	46	34	31
Charges and receipts	-3	-4	#	#	#
Net	37	31	46	34	31
Total					
Gross	1,225	1,246	1,491	1,549	1,628
Charges and receipts	-159	-142	-180	-127	-134
Net	1,066	1,104	1,311	1,422	1,494
Total National Health Service					
Current expenditure					
Gross	51,411	55,892	61,687	66,254	72,358
Charges and receipts	-3,126	-3,260	-3,360	-3,471	-3,640
Net	48,284	52,632	58,327	62,782	68,718
Capital expenditure					
Gross	2,018	2,387	2,742	3,209	3,686
Charges and receipts	-758	-768	-551	-369	-284
Net	1,260	1,619	2,191	2,840	3,402
Total					
Gross	53,429	58,279	64,430	69,462	76,044
Charges and receipts	-3,885	-4,028	-3,911	-3,840	-3,924
Net	49,544	54,251	60,518	65,622	72,120
Net percentage real terms change(%)	-	7.5	8.6	5.8	7.2
GDP as at 17 April 2002	98.2	100.0	102.8	105.3	108.0

1 Includes Departmental Unallocated Provision (DUP) for 2002-03 and 2003-04.

2 From 2003-04 budgets are set on a stage 2 resource budgeting basis. These stage 1 resource budgeting figures are therefore indicative for that year and include Budget 2002 additions on a stage 1 resource budgeting basis. UK figures are subject to the decisions of the devolved administrations.

3 Figures for FHS non-discretionary expenditure between 1999-2000 and 2003-04 are not comparable because of transfers to FHS discretionary principally to fund successive waves of Personal Medical and Dental Service Pilots.

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

5 Figures may not sum due rounding

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

ANNEX B

Executive Agencies of the Department of Health

NHS Estates Agency

B.1 NHS Estates was established as an Executive Agency in April 1999. The Agency's task is to support Ministers, the Department of Health and the NHS in the management of the estate and patient environment. It employs approximately 400 staff and its turnover is in excess of £20 million.

The main objective of the Agency is to help the NHS to improve patient care through better use of NHS estates and enhancing the patient environment by taking a responsive approach to providing healthcare services. NHS Estates is supporting Ministers and the NHS through policy development and implementation on estates, facilities and capital management issues including:

- creating a better patient environment;
- the more efficient use of assets;
- improving capital procurement;
- delivering asset solutions in acute and primary care;
- property policy, planning and management;
- design excellence;
- key guidance and standards; and,
- delivering better hospital food

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.

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 2000-2001. Copies are available from the Information Centre, NHS Estates, 1 Trevelyan Square, Leeds LS1 6AE; 0113 254 7070. The website address is www.nhsestates.gov.uk

Medicines Control Agency

B.2 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, post-marketing surveillance and information provision.

The Agency employs over 500 staff and has gross running costs of £37 million derived from fees charged to the pharmaceutical industry and other users of its services. These fees wholly cover the Agency's costs.

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. The MCA continues to contribute to the NHS Plan and to building a safer NHS for patients.

The Agency's forward plans and targets are set out in the Annual Report which can be purchased from the Stationery Office, price £16.70 and the Business Plan, which can be obtained by writing to the office of the Chief Executive, Room 16-208, Market Towers, 1 Nine Elms Lane, London SW8 5NQ, or from the MCA website at www.mca.gov.uk

Medical Devices Agency

B.3 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 £9.0 million offset by income of £0.4 million.

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 and help Trusts in their work to implement the NHS Plan. 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.

In 2001-02 the Agency concentrated specifically on working with its European partners to promote amendments to the main Directive and a more consistent implementation of it across the EU, promoting better practice amongst users of medical devices, and working more closely with partners such as the Commission for Health Improvement and the emerging National Patient Safety Agency. It established a new Committee on the Safety of Devices to advise the Agency, held its first annual Stakeholder Meeting and Conference, and introduced online reporting of adverse incidents through its new website.

In 2002-03 the Agency faces a significant increase in its workload, particularly in the receipt of adverse incident reports and in compliance and enforcement cases. It will review its priorities and procedures to meet increased demands within a reduced budget. Working with key organisations concerned with the education of health care professionals, it will encourage the development of course materials on safe use of medical devices. Committed to working in partnership with the medical devices industry, it will further speed up its assessment of clinical investigation notifications for new products. Continuing to improve its external communications, it will exploit new media for the transmission of information. Above all, the Agency will put patients at the centre of its activities, developing new dialogues with patient groups.

Further details can be found in the Agency's Annual Report and its Corporate and Business Plans, available on the Agency's website at www.medical-devices.gov.uk, or by phoning 020 7972 8000.

NHS Pensions Agency

B.4 The NHS Pensions Agency is responsible for the administration of the NHS Pension Scheme and the NHS Injury Benefit Scheme for England and Wales. The Pension Scheme has 1.8 million members and pensioners and receives pension contributions totalling £2.3 billion per annum and pays benefits of £2.8 billion per annum. In administering the Scheme, the Agency employs some 480 staff and incurred net expenditure of £17.1 million for 2000-2001.

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 for the scheme are commercially competitive.

More information about the Agency's activities, progress towards its objectives and associated key targets, can be found in its Annual Report and Accounts for 2000 – 2001, which is available from the NHS Pensions Agency, Hesketh House, 200-220 Broadway, Fleetwood FY7 8LG; 01253 774774 and at the Agency's website at www.nhspa.gov.uk

NHS Purchasing and Supply Agency

B.5 The NHS Purchasing and Supply Agency was launched as an executive agency on 1 April 2000. It acts as the centre of advice and expertise on matters of purchasing and supply for the NHS for the benefit of patients and the public. The Agency is an advisory and co-ordinating body and also an active participant in the ongoing modernisation of purchasing and supply in the health service. The Agency ensures that purchasing and supply issues are taken into account when determining national healthcare policies. The Agency also provides advice to individual NHS bodies and negotiates contracts for goods and services on behalf of the NHS. The Agency employs over 300 people and its gross running costs from 1 April 2000 to 31 March 2001 were £19.5 million.

Key achievements for 2001-02 include:

- achieved purchasing savings of £130 million for the NHS;
- co-ordinated procurement nationally for cancer equipment for the NHS under the New Opportunities Fund;
- delivered 1,000 days of purchasing and supply training to NHS trust staff; and,
- contributed significantly to the 'Better Hospital Food' initiative.

In 2002-03 the Agency aims to:

- work to raise the standard of purchasing and supply in the NHS, making sure that all purchasing decisions are subject to good procurement practice;
- contribute to the delivery of fast, responsive care built around the needs of patients;
- achieve purchasing savings of at least 5 per cent of contract value; and,
- play a leading role in the purchasing and supply implications of approximately 40 projects in the NHS Plan

Further details can be found in the Agency's Business Plan 2002-03, which can be obtained by writing to the Communications Department, Premier House, 60 Caversham Road, Reading RG1 7EB, and is available on their website at www.pasa.doh.gov.uk

ANNEX C

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

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. CCETSW's provisional gross expenditure was £37.4 million in 2000-2001 with a total staff of 156 whole time equivalents. The Department of Health's net grant was £29.5 million in 2000-01. CCETSW functions transferred to the General Social Care Council, a new Executive NDPB with a wider remit, which was established in England, in October 2001. The functions of CCETSW in the other three countries passed to their equivalent Councils. For more information on the GSCC contact www.doh.gov.uk/gscc or The General Social Care Council, Goldings House, 2 Hays Lane, London SE1 2HB or telephone 020 7397 5100.

Human Fertilisation and Embryology Authority

C.2 The Authority was established by the Human Fertilisation and Embryology Act 1990 and began its work in August 1991. Its main responsibilities are to license and monitor those clinics which carry out IVF and donor insemination, and to license research projects involving the creation of embryos in vitro, or the keeping or use of embryos. It also regulates the storage of gametes and embryos. It has 21 members (including the Chairman and Deputy Chairman) and has 35 staff.

The Authority's gross expenditure in 2000-2001 was £1,772,910. 70 per cent of the Authority's income was raised from licensing income, with the remaining 30 per cent from the Department of Health. Particular issues considered by the Authority were cloning, intracytoplasmic sperm injection (ICSI) and the use of pre-implantation genetic diagnosis. Further information about the work of the Authority and its accounts can be found in its Annual Report and Accounts, which is available on the HFEA's website www.hfea.gov.uk. Otherwise, information can be obtained form Mr Ted Webb at the Department of Health, Room 654C, Skipton House, 80 London Road, London SE1 6LH; (020 7972 5863).

The Commission for Health Improvement (CHI)

C.3 The Commission for Health Improvement was set up under the Health Act 1999 with the aim of raising the quality of NHS care. CHI's main role is to carry out a programme of reviews of all NHS bodies in England and Wales (known as clinical governance reviews) in order to assess the standard of care being provided to patients. It also has the power to investigate local service problems and review the implementation of national standards set for specific clinical services or care groups. To date, CHI has published over 100 reviews of local NHS services, six investigation reports and, jointly with the Audit Commission, a report on NHS cancer care in England and Wales.

In the coming year, CHI will publish over 100 clinical governance review reports and begin a national study into the implementation of the National Service Framework for Coronary Heart Disease. CHI will also begin to use new powers set out in the NHS Health Reform and Health Care Professions Bill which is currently before parliament. This legislation will enable CHI to carry out inspections of NHS services against published standards and recommend special measures where it identifies unacceptably poor services. CHI will also publish an independent annual report on the quality of services to NHS patients and establish an Office for Information on Health Care Performance.

CHI is currently funded by a grant from the Department and the National Assembly for Wales and its gross expenditure in 2000-01 was £14 million.

The Chief Executive, Dr Peter Homa, may be contacted at 1st Floor, Finsbury Tower, 103-105 Bunhill Row, London EC1Y 8TG; tel 020 7448 9200. Further information can be obtained from CHI's website at www.chi.nhs.uk or by emailing information@chi.nhs.uk

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

C.4 The Board's main statutory responsibility under the Nurses, Midwives and Health Visitors Act 1997 is to approve educational institutions in England to provide 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 2000-2001 was £7.8 million, of which £5.9 million was a Government Grant. The Board employs 99 staff. Legislation to replace the ENB, the UKCC and the other National Boards with a new Nursing and Midwifery Council from 1 April 2002 was approved by Parliament at the end of 2001. The ENB will cease to exist after 31 March 2002.

Medical Practices Committee (MPC)

C.5 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 2000-2001 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. The Committee will be abolished on 31 March 2002 with the commencement of Section 14 of the Health and Social Care Act 2001. For more information on the Committee contact www.doh.gov.uk/mpc or Keith Baggs, HRD-WD, Room 2W24, Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 5731.

National Biological Standards Board (NBSB)

C.6 The NBSB, set up in 1976, 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 2000-2001 was £14.5 million of which £10 million was funded by the Government. It employs 279 staff. NBSB's corporate aims and strategy together and its performance against key targets can be found in the Annual Report and Accounts. For more information about the NBSB contact Ed Davis, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 1644 or see the NIBSC's website at www.nibsc.ac.uk.

National Radiological Protection Board (NRPB)

C.7 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 2000-2001 was £14.6 million of which £6.65 million is provided by the Government (£6.34 million by DH and £0.31 million by The Scottish Executive). NRPB employs 311 staff.

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 Yemi Fagun, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5027, or NRPB's website at www.nrpb.org

Public Health Laboratory Service (PHLS)

C.8 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 eight 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 2000-2001 was £135.9 million of which £58.4 million was directly funded by Government. PHLS employs 3,296 staff.

PHLS's corporate aims and strategy with performance against key targets can be found in their Annual Report and Accounts. (See also Figure C1.) For more information about the PHLS, see their website at www.phls.co.uk or contact Brian Bradley Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5304.

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

£ million

	1997-98	1998-99	1999-2000	2000-01	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

Dental Vocational Training Authority

C.9 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 2000-2001 was £116,574. The Authority is entirely funded by Government. From October 1999 to March 2001 the DVTA issued 1,605 vocational training numbers. 116 applications for a vocational number 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.

NHS Appointments Commission

C.10 The NHS Appointments Commission was established in April 2001 following an announcement in the NHS Plan charged with ensuring that health authorities, NHS trusts and primary care trusts have the highest quality non-executive leadership. It achieves this by appointing the chairs and non-executive directors of these bodies, ensuring that annual appraisals are carried out in line with national procedures and that they are supported with appropriate training and development opportunities. Between July 2001 and January 2002 it made over 1,000 appointment decisions. Details of the appointment process adopted by the Commission were published in October 2001. A range of training initiatives was launched in January 2001. The national appraisal process will be available by the end of March 2002. The Commission comprises the Chair, eight Regional Commissioners and the Chief Executive.

For further information, contact Dr Roger Moore at the Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 5611.

National Clinical Assessment Authority (NCAA)

C.11 The NCAA is a SHA established in April 2001 to provide a support services to health authorities and NHS Trusts who are faced with concerns over the performance of an individual doctor. It was established to provide support to doctors and to boost patient confidence in the NHS.

In order to help doctors in difficulty, the NCAA will provide advice, take referrals and carry out targeted assessments where it is deemed necessary. The NCAA's assessment will involve trained medical and lay assessors. Once an objective assessment has been carried out, the NCAA will advise Trusts and Health Authorities on the appropriate course of action. The NCAA is established as an advisory body and the NHS employer organisations remain responsible for resolving the problem once the NCAA has produced its assessment.

The NCAA has recruited a staff of 25 people and its senior management team is well established. The NCAA has made progress in the following areas of its work programme since it was launched. It has:

- Undertaken detailed consultation with the medical profession, NHS managers, patients' groups and other stakeholders to ensure the process and procedures it develops are fair, robust, transparent and effective. This includes the development of a performance assessment framework;
- Published detailed guidance on the role of the Authority and how health authorities and NHS Trusts can refer a doctor to the NCAA for assessment; and,
- Commenced developing and evaluating prototype systems for dealing with referrals concerning individual medical practice, arising from ill-health conduct or competence.

The NCAA's work programme for 2002 includes beginning work on 20 prototype assessments by 31 March 2002.

The NCAA's revenue expenditure was £1.9 million. It also had capital costs of £660,000 in 2001-02.

For further information on the NCAA contact Nick Samuels at nsamuels@ncaa.nhs.uk. Useful information on the role of the NCAA can also be found on the NCAA website which can be found at www.ncaa.nhs.uk. You can also write to the NCAA at its office which are located on the 9th Floor, Market Towers, 1 Nine Elms Lane, London SW8 5NQ.

High Security Hospital Authority (HSHA)

C.12 The Ashworth Hospital Authority manages the Ashworth high security hospital, which is a Special Health Authority (SHA). The high security hospital provides care treatment and rehabilitation for mentally disordered individuals in one of the most secure hospital setting available in the NHS. Virtually all 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.

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 hospital 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.

The NHS Act approved the legislative framework to enable the hospital to be integrated into an existing NHS trust. Ashworth Hospital will become part of the Mersey Care NHS Trust from April 2002.

Ashworth Hospital Authority

C.13 Ashworth Hospital Authority manages 408 beds; 259 for Mental Health, 101 Personality Disorder and 48 Women. Its revenue expenditure in 2000-2001 was £61,643 million, its

income from health authorities £52,439 million and Government funding of £7,358 million and other miscellaneous income of £1,372 million. The Authority employs 1,527 staff. For further information contact Angela Anderson, Director of Communications, Ashworth Hospital Authority, Parkbourn, Maghull, Liverpool L31 1HQ; 0151 471 2397.

National Blood Authority (NBA)

C.14 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.

The Authority's gross expenditure in 2000-2001 was £321 million which was largely recouped through blood handling charges to hospitals and through sales of BPL products. It employs around 5,500 staff. The Authority collected over 2.9 million units of blood in 2000–2001 and supplied over 300 hospitals.

Further information, including summary financial statements, are included in the NBA's 2001 Annual Report which is available from the National Blood Authority, Oak House, Reeds Crescent, Watford WD1 1QA; 01923 486800. Website www.blood.co.uk

National Treatment Agency (NTA)

C.15 The National Treatment Agency for Substance Misuse was established on 1 April 2001 as a Special Health Authority and is the result of joint working between the Department of Health and the Home Office. The NTA's main role is to increase the capacity, and improve the quality and effectiveness, of drug treatment in England. In carrying out this role the NTA will consult and collaborate with parties that have an interest in substance misuse treatment.

The NTA will oversee a pooled national treatment budget of £195.7 million (for 2002) which will bring together money currently being spent on drug misuse treatment by the Department of Health, the Home Office and other funders. This pooled budget comprises the more readily identifiable mainstream expenditure on drug treatment services, along with the significant additions from the Spending Review 2000.

There are several key themes to the NTA's work: performance management and development; development of a knowledge base; and policy management and development. Each will contribute to the Government's drug strategy and its treatment and crime reduction targets by increasing the numbers of clients treated and improving the effectiveness of their treatment.

Prescription Pricing Authority (PPA)

C.16 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 appliance contractors, and calculate amounts due to GPs for supplying drugs and appliances prescribed under the NHS (577 million prescriptions were processed in 2000-2001);
- to produce information for health authorities, primary care groups/trusts, general practitioners, the Department of Health and other NHS stakeholders about prescribing trends and spending on medicines;
- to produce the monthly Drug Tariff containing the reimbursement prices of a range of prescribable items and other remuneration rules;
- to recover unpaid charges and penalty charge payments from those who have incorrectly claimed exemption;
- to administer the NHS Low Income Scheme (LIS). The PPA processed some 0.94 million claims for the remission of NHS charges in respect of prescription, dental and other chargeable services in 2000-2001; and,
- to administer the Pharmacy Reward Scheme.

The Authority's gross expenditure in 2000-2001 was £62.34 million of which £58.159 million was funded by the Department.

As at 31 March 2001 the Authority employed approximately 3,485 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 visit the PPA website www.ppa.org.uk

The Mental Health Act Commission (MHAC)

C.17 The Commission was set up in 1983 as an SHA with responsibility under the Mental Health Act 1983 for keeping under review the exercise of powers and discharge of duties conferred or imposed by the Act in respect of detained patients. It therefore seeks to safeguard the interests of all people detained under the Mental Health Act 1983. Commissioners visit all hospital and mental nursing homes where patients are detained to make sure that the powers of the Act are being used properly, and to meet with detained patients to discuss their concerns. The Commission reports on its visits to hospital managers and requires follow-up action on issues of concern.

The Commission's complaints remit allows it to investigate complaints made by or about detained patients where it feels this is appropriate. In general, the Commission helps patients and other to make their complaints through the NHS complaints procedure, and monitors the progress of such complaints.

The Commission is notified of the deaths of all detained patients and will often attend inquests as an interested party. The Commission has collated its finding in relation so such deaths over recent years and published a report *Deaths of Detained Patients in England and Wales*[C1] in February 2001.

On behalf of the Secretary of State, the Commission administers the provision of Second Opinion Appointed Doctors (SOADs), whose authorisation is required for the administration of certain treatments without consent. It also receives and monitors reports on SOADs work. The Commission arranges over 7,000 SOAD visits each year.

The Commission advises the Secretary of State on changes to be made in the Mental Health Act Code of Practice and is an important source of general and specific guidance on the operation of the powers of the 1983 Act. It publishes Practice and Guidance Notes on specific issues and answers many queries from patients and practitioners. The Commission 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.

There is a statutory duty on the Commission to publish a Biennial Report on its activities. The last such report was the Ninth Biennial report, covering the period 1999 – 2001 and was published in December 2001. Details of the Commission's functions, 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.

The Department of Health directly funds the Commission. Its budget in 2001-02 was £3.25 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 email address is chief.executive@mhac.trent.nhs.uk and its website address is www.mhac.trent.nhs.uk

Family Health Services Appeal Authority Special Health Authority (FHSAA)

C.18 The Family Health Services Appeal Authority SHA was established as an SHA on 1 April 1995. In 2000-2001, the Authority received £754,000 Government funding, and gross expenditure was £754,000. 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 NHS (Service Committee and Tribunal) (Amendment) Regulations. From 14 December 2001, the FHSAA (SHA) also provides support to the Family Health Services Appeal Authority which was introduced by the Health and Social Care Act 2001.

For further information contact Jenny Smith, Department of Health, Room 7E15, Quarry House, Leeds LS2 7UE; 0113 254 5825, or from the website at www.fhsaa.nhs.uk

Health Development Agency (HDA)

C.19 The Health Development Agency was established as an SHA in January 2000 and became fully operational from 1 April 2000. The HDA's remit is to establish and maintain an evidence base of what works in public health practice; provide advice on developing and setting standards; and develop the capacity and capability of the public health workforce.

The Agency's gross expenditure in 2000-2001 was £12.4 million of which £12 million was from the Department of Health. The Agency employed 122 staff in 2000-2001. More information about the HDA can be obtained from Holborn Gate, 330 High Holborn, London WC1V 7BA; telephone: 020 7430 0850. Website: www.hda-online.org.uk

NHS Information Authority (NHSIA)

C.20 The NHS Information Authority was established as a SHA 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.

The Board of the NHSIA consists of a Chair, Chief Executive, three executive officers and four non-executive members. The Authority had 699 WTE staff as at 31 December 2001. Its gross operating cost in 2000-2001 was £75 million of which the Department of Health funded £70 million.

Details of the Authority's key achievements are contained in its 2000-2001 Annual Report. This report, together with more information about the Authority's activities, is available from the Authority's website at www.nhsia.nhs.uk or by contacting Steven Harrison, Head of Corporate Affairs, NHS Information Authority, Aqueous II, Waterlinks, Aston Cross, Rocky Lane, Birmingham B6 5RQ. Telephone 0121 333 0120, fax 0121 333 0334 or e-mail: steven.harrison@nhsia.nhs.uk

The Retained Organs Commission

C.21 The Retained Organs Commission was established in shadow form on 30 January 2001 and formally established on 1 April 2001, following a recommendation by the Chief Medical Officer, Sir Liam Donaldson in his advice to the Government, *The Removal, Retention and Use of Human Organs and Tissue from Post-mortem Examination*, following the interim report of the Bristol Royal Infirmary Inquiry (Kennedy Report) and the Royal Liverpool Children's Inquiry report (Redfern Report).

Sir Liam called for the establishment of an independent Commission to oversee the proper return of retained organs and tissue to families who request it and to address the question of historical and archived collections obtained from post-mortem collections. The new Commission would:

- Ensure that there are accurate records and catalogues before any returns to families are made (to avoid multiple funerals);
- ensure that NHS trusts and universities work together to provide a complete record of retentions identifiable to a particular family;
- ensure that families are involved in agreeing with NHS trusts procedures for dignified return or disposal;
- provide an advocacy service for families experiencing difficulties obtaining information from their local NHS trust; and,
- provide advice (after consultation) to the Government and to NHS trusts and universities on the return, retention, further use or disposal of archive and museum collections, some of which are of international medical importance.

Since April 2001 the Commission's free-phone help-line has handled some 3,000 calls. The Commission has held meetings in public in six separate venues around the country (up to the end of January 2002) and issued comprehensive guidance to NHS Trusts on a wide range of issues relating to organ retention. It has prepared, or is preparing, leaflets on several areas of public interest involving organ retention. The Commission's core expenditure for 2001-02 was £1 million.

For further information on the Commission see the Commissions website at www.nhs.uk/retainedorgans/ or contact The Director of Operations, Dennis Copeman@doh.gsi.gov.uk.

Microbiological Research Authority (MRA)

C.22 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 2000–2001 was £26 million (£22 million revenue and £4 million capital) of which £9 million was funded by the Department of Health (£5 million research and £4 million capital). CAMR employs 383 staff. 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 www.camr.org.uk

NHS Litigation Authority

C.23 The National Health Service Litigation Authority ('the Authority') is a Special Health Authority set up under Section 11 of the NHS Act 1977. Its date of commencement was 21 November 1995.

The principal task of the Authority is to administer schemes set up under Section 21 of the National Health Service and Community Care Act 1990. This enables the Secretary of State to set up one or more schemes to help NHS bodies pool the costs of any 'loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of [their] functions'. There are currently five schemes:

- the Clinical Negligence Scheme for Trusts (CNST) covering liabilities for alleged clinical negligence where the original incident occurred on or after 1 April 1995;
- the Existing Liabilities Scheme (ELS) covering liabilities for clinical negligence incidents which occurred before 1 April 1995;
- the Ex RHA Scheme where the NHSLA acts as defendant covering the outstanding liabilities for clinical negligence in respect of the former Regional Health Authorities when they were abolished in April 1996;
- the Liability to Third Party Scheme (LTPS) relating to any liability to any third party where the original incident occurred on or after 1 April 1999; and,
- the Property Expenses Scheme (PES) relating to any expenses incurred from any loss or damage to property where the original loss occurred on or after 1 April 1999.

As well as overseeing the schemes in such a way as to ensure that public money is used appropriately, the Authority is expected to promote the highest possible standards of patient care and to minimise suffering resulting from those adverse incidents which do nevertheless occur.

The Authority has taken firmer control of the litigation process by establishing, by tender, a panel of legal advisers to be instructed on all future CNST claims. From the 100 firms dealing with cases in 1996, there are now only 15 highly specialist panel teams now appointed to act for the Authority. In April 2001 the Authority took over the handling and financial management of all cases under the ELS. A similar exercise has begun for all claims under the CNST and is expected to be completed by April 2002.

The Authority's administration costs for 2000-2001 amounted to £8.5 million. At 31 March 2001 it employed 101 staff. For further information on the NHSLA contact David Towns, Head of Communications, NHS Litigation Authority, Napier House, 24 High Holborn, London WC1V 6AZ; 020 7430 8700.

NHS Logistics Authority

C.24 The NHS Logistics Authority was set up as a Special Health Authority on 1 April 2000. As the key service provider within the NHS for consumable healthcare products, the Authority's aim is to provide a quality range of supply chain services for the benefit of the NHS. The Authority works in partnership with NHS trusts to help them to develop efficient supply channels; to maximise the use of their own consolidated supply route; to realise efficiencies and to make cost savings. The NHS Logistics Authority's gross expenditure in 2000-01 was £697 million. The Authority employs around 1,500 staff.

In 2000-01 The Authority:

- reduced its prices to the NHS by 0.8 per cent; and,
- expanded the range of products stocked by 6,000 lines.

Details of the NHS Logistics Authority's other key achievements can be found in its 2000-01 Annual Report. This report, together with more information about the Authority's activities, is available by visiting www.logistics.nhs.uk

Further information can be obtained by writing to the Corporate Communications Manager, NHS Logistics Authority, West Way, Cotes Park Industrial Estate, Alfreton DE55 4QJ; telephone 01773 724261, or by email to carole.appleby@logistics.nhs.uk

Dental Practice Board

C.25 The DPB is an independent statutory body supporting dentistry in England and Wales. Its main tasks are to handle payment claims and remunerate dentists providing General Dental Services and Personal Dental Services under the NHS. It provides an important check to detect and prevent potential fraud or abuse of the dental payments system. It also manages the Dental Reference Service, which provides independent professional dental patient examinations. At the end of 2000-2001 the DPB employed 416 staff, and during the year approved fees amounting to almost £1.6 billion to an average 19,081 dentists, at a gross administration cost of £22.8 million. For further information contact the Chief Executive, Dental Practice Board, Compton Place Road, Eastbourne BN20 8AD; 01323 417000 or www.dpb.nhs.uk

The National Patient Safety Agency (NPSA)

C.26 The National Patient Safety Agency was established on 2 July 2001 under the NHS Act 1977. Its main functions are to devise and implement a national system for reporting, analysing and learning from adverse events and near misses for the purpose of promoting patient safety. The NPSA will collect and analyse data on reported adverse incidents to: identify trends and patterns of avoidable adverse events; provide feedback to NHS organisations to enable them to change their working practices; help develop models of good practice and systems solutions at national level; and support ongoing education and learning at local level.

The NPSA is funded by a grant from the Department, and has been allocated £6.5 million in its first year. Sue Osborn and Susan Williams are the joint Chief Executive of the Agency and may be contacted at Marble Arch Tower, 55 Bryanston Street, London W1H 7AT; Tel 020 7868 2203. Further information about the work of the NPSA can be obtained from its website at www.npsa.org.uk

United Kingdom Transplant (UKT)

C.27 UK Transplant was formed on 12 July 2000 as a result of the Quinquennial Review of the former United Kingdom Transplant Support Service Authority (UKTSSA) which was established in April 1991. 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 117 WTE staff. Its gross expenditure in 2000-01 was £6.296 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 nicole.sutherland@uktransplant.nhs.uk or the Communications Directorate, UK Transplant, Fox Den Road, Stoke Gifford, Bristol BS34 8RR – Tel: 0117 975 7575.

National Institute for Clinical Excellence (NICE)

C.28 NICE is a SHA which was formally established in February1999 to provide guidance on best clinical practice to the NHS, patients and their carers. 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).

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 progress against its work programme. NICE completed 31 technology appraisals and four Clinical Guidelines from its inception from its inception to 31 December 2001.

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 has set 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.

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 www.nice.org.uk

Other NHS Bodies

Tribunal Non-Departmental Public Bodies

The National Health Service Medicines (Control of Prices and Profits) Appeal Tribunal

C.29 The Tribunal is an independent body with judicial powers derived from the Health Service Medicines (Price Control Appeals) Regulations 2000 as amended. It is supervised by the Council on Tribunals. Its purpose is to determine appeals from suppliers or manufacturers of NHS medicines against decisions made by the Secretary of State pursuant to sections 33 to 37 of the Health Act 1999 which:

- require a specific manufacturer or supplier to provide information to him;
- limit, in respect of any specific manufacturer or supplier, any price or profit;
- refuse to give his approval to a price increase made by a specific manufacturer or supplier; and,
- require a specific manufacturer or supplier to pay any amount (including an amount by way of penalty) to him.

The Tribunal has one permanent employee, the Clerk to the Tribunal, who is paid an annual retainer of £3,000. There have been no appeals to the Tribunal.

For further information contact Mat Otton-Goulder, Room 138, Richmond House, 79 Whitehall, London SW1A 2NS.

Family Health Services Appeal Authority

C.30 The FHSAA is an independent tribunal established on 1 October 2001. The Lord Chancellor appoints its President and members and makes the rules under which it operates.

The FHSAA deals with:

- appeals from practitioners against HA discretionary decisions to refuse to admit them to a list, to remove them from a list, to set conditions on their admission to a list, or to contingently remove them from a list;
- applications from HAs that practitioners removed from a list should be disqualified nationally from all HA lists (When considering an appeal from a practitioner the FHSAA can decide itself to disqualify nationally);
- representations that PMS doctors seeking to exercise their preferential right of return to GMS should be prevented from so doing;
- requests from HAs to extend certain suspensions beyond six months; and,
- requests to review its earlier decisions or earlier decisions of the NHS Tribunal.

The FHSAA hears appeals and applications from practitioners and health authorities in England only. A practitioner may appeal on a point of law to the Court against a FHSAA decision. For further information contact Jenny Smith, Department of Health, Room 7E15, Quarry House, Leeds LS2 7UE; 0113 254 5825.

Mental Health Review Tribunals (MHRTs)

C.31 MHRTs are independent judicial bodies and their role is to review the continued compulsory detention of patients under the Mental Health Act 1983. Members of the Tribunal are appointed by the Lord Chancellor. There is a legally qualified Tribunal chairman for each of the four 'Tribunal Regions' in England. They are responsible for the members within their region. There is a Tribunal office in each of the these regions. The office of the national secretariat is in London. The MHRT employs a total of 69 Department of Health staff who arrange hearings in hospitals and units throughout England. Staff at local and national level provided also provide administrative support to the regional chairmen. In 2000-2001 there were 19,962 applications and 11,243 hearings. Administrative running costs, including salaries were £1.7 million. The costs for the membership were £9.7 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 4577/4503.

The Protection of Children Act Tribunal

C.32 The Protection of Children Act Tribunal is an independent judicial body which became operational from 2 October 2000. It considers appeals in England and Wales against decisions of the Secretary of State to include an individual's name, 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 provides a suite of rooms which can accommodate public hearings. The secretariat itself comprises a small number of staff seconded from the Department of Health.

The Tribunal will, from 1 April 2002, be subsumed by new tribunal arrangements as a result of the Care Standards Act 2000. The Care Standards Act provides for a new system of regulation of social care services and provides for the Protection of Children Act Tribunal to assume additional functions in order to hear appeals from organisations and individuals falling within the new regulatory regime. See below for further details of the Care Standards Tribunal

Registered Home Tribunal

C.33 The Registered Homes tribunal is an independent judicial body set up under the Registered Homes Act 1984 to hear appeals from independent sector residential care homes, nursing

homes and children's home proprietors against a decision by the registering authority to refuse, cancel or vary the registration conditions for the home. The tribunal operates under the Registered Homes Act 1984 and the Children Act 1989.

Legal members are appointed by the Lord Chancellor and expert members by the Privy Council. The Department of Health currently provides the secretariat for the Tribunal.

The RHT will cease to exist some time after April 2002 when the extended Protection of Children Act Tribunal will take on the function of hearing appeals relating to the registration of care homes and children's homes.

The Care Standards Tribunal

C.34 The Care Standards Act 2002 provides for appeals against decisions brought under that Act to fall to the Tribunal established under the Protection of Children Act 1999(PoCA). Although legally the Tribunal will continue to be The Protection of Children Act Tribunal, it will have extended functions and will operate under the title 'the Care Standards Tribunal'. The Tribunal will hear appeals in relation to: decisions made by the National Care Standards Commission and National Assembly for Wales in respect of establishments and agencies; decisions made by the National Care Standards Commission and National Assembly for Wales in respect of refusal to waive disqualification from running or being concerned with or employed in a children's home; decisions of the Chief Inspector of Schools in England and the National Assembly for Wales in respect of the registration of early years provision; decisions of the Secretary of State for Health in respect of inclusion on the list of those considered unsuitable to work with children; decisions of the Secretary of Health in respect of inclusion on the list of those considered unsuitable to work with vulnerable adults.

In addition, it will consider appeals against: decisions of the General Social Care Council in England and the National Assembly for Wales in respect of the registration of social workers and social care workers; decisions of the Chief Inspector of Schools in respect of the registration of early years inspectors in England; applications for removal from the PoCA and PoVA list, review of disqualification orders issued by the Independent Schools Tribunal and; revocation of disqualification orders issued by the Courts barring individuals convicted of certain offences from working with children.

The Tribunal will have a full time President appointed by the Lord Chancellor. Legal members and lay members for the tribunal will also be appointed by the Lord Chancellor. The Secretariat, which will be seconded from the Department of Health, will be housed in a central London location. This building will also provide a suite of rooms to accommodate public hearings.

The Care Standards Tribunal will become operational from 1 April 2002. For further information contact Barbara Erne, Secretary to the Tribunal, Protection of Children Act Tribunal, 6th Floor, St Christopher House, 90-114 Southwark Street, London SE1 0TE; Tel: 020 7921 1622.

ANNEX D

Public Accounts Committee – Reports Published in 2000

D.1 Two PAC reports have been published in the calendar year of 2001. However, five Treasury Minutes have been produced in the same period (a Treasury Minute is the Government's considered response to a PAC report) because three covered PAC reports published in the latter part of 2000.

The list of PAC reports (with date of publication) covered by Treasury Minutes, in this annex, is as follows:

1.	The Management and Control of Hospital Acquired Infection (HAI) in Acute NHS Trusts in England	23 November 2000
2.	Sir Alan Langlands Valedictory Hearing	18 December 2000
3.	Hip Replacements – Getting it Right	19 December 2000
4.	Inpatient Admissions, Bed Management and Patient Discharge in NHS Acute Hospitals	25 January 2001
5.	The National Blood Service (NBS)	11 July 2001

1. The Management and Control of Hospital Acquired Infection (HAI) in Acute NHS Trusts in England

D.2 The Committee expressed concerns about whether the NHS has a grip on the extent and cost of HAI and that prevention requires a commitment from everyone involved in healthcare.

Action taken on PAC conclusions and recommendations include:

- Compulsory national surveillance of healthcare associated infection undertaken by all acute hospital trusts since April 2001. Data to be published from April 2002;
- Controls Assurance Standard for Acute hospitals revised and strengthened;
- Guidelines for prevention and control of infection in primary care/community commissioned as part of the NICE programme – due for publication in September 2002; and,
- Since April 2001, all hospitals have been required to invest in meeting standards of cleanliness set out in their Cleanliness Action Plan and to routinely monitor patients' views on the cleanliness of hospitals. National Standards of cleanliness will form part of the Performance Assessment Framework and every hospital will be measured against these standards. £62 million has been invested in the last two years on hospital cleanliness and the patient environment.

2. Sir Alan Langlands Valedictory Hearing

D.3 The Committee expressed concerns about the need to improve managerial effectiveness and accountability and to improve clinical excellence, equity and efficiency.

Action taken on PAC conclusions and recommendations include:

- Setting up the Leadership Centre to develop high quality future managers and leaders;
- Placing a statutory duty of quality on all Health Authorities, Primary Care Trusts and NHS Trusts;
- A series of clinical governance inspections by the Commission for Health Improvement;
- The creation of national health inequalities targets 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;
- New ways of working are being supported and rolled out across the NHS by the Modernisation Agency; and,
- Resources are being channelled into IT systems to improve ways of working within the NHS.

3. Hip Replacements – Getting it Right

D.4 The Committee's concerns included the need to implement a national hip register. They also highlighted a lack of key information, including infection rates for hip surgery, which had led to variable practice and efficiency as well as the need to tackle variations in access to treatment, waiting lists and improve best practice.

Action taken on PAC conclusions and recommendations include:

- In July 2001, it was announced that a National Joint Registry would be set up and apply to both the NHS and private sector. Establishing the registry will lead to earlier review of patients with joint replacements and regular monitoring of the performance of these joints;
- The *Information for Health* [DH] strategy has been updated to meet the requirements arising from the NHS plan. The updated Information for Health strategy will ensure the development of an information and IT infrastructure to support patient centred delivery of care. Additional investment is being made for the strategy from 2001 to 2004; and,
- There is clear guidance to the NHS on access to care that states clinical priority must be the main determinant of when patients are seen. The NHS Executive has set up the 'Action on Orthopaedics' programme, where particular attention will be given to hip replacements and the criteria that should be used in formulating and implementing best practice guidance criteria.

4. Inpatient Admissions, Bed Management and Patient Discharge in NHS Acute Hospitals

D.5 The Committee's concerns included the need to reduce the number of operations cancelled at the last minute for non-medical reasons, around 56,000 in 1998-99 and the need to reduce the number of bed days lost, approximately 2 million per year, due to delays in discharging people.

Action taken on PAC conclusions and recommendations:

- In October 2001, the Government issued £100 million to improve emergency care. £50 million of this money will be used to purchase around 20,000 additional operations in the private sector. This will ease bed blocking and capacity issues that are major causes of cancelled operations;
- The 'Theatre Project' has been set up by the NHS Modernisation Agency to look at optimising theatre utilisation and reducing cancelled operations. Pilot sites involved in the project are identifying good practice arrangements to avoid cancellation of operations;
- Additional funds of around £300 million will be allocated to councils for reducing delayed discharge. These funds are being used to address local issues, including stabilising the care home sector where capacity is an issue, and improving assessment processes so that there is less delay in assessing ongoing care needs;
- The NHS Plan announced extra investment of £900 million annually by 2003-04 for intermediate care and related services to promote independence; and,
- Figures for 2000-01 show an increase of 714 general and acute beds (135,794 compared to 1999-2000 baseline of 135,080), one-third of the way towards the 2004 target. Plans for increases in intermediate beds are also progressing well. The results of a recent survey on NHS intermediate care show that by the end of this year there will be an additional 2,400 intermediate care beds (6,974 compared to 1999-2000 baseline of 4,579).

5. The National Blood Service (NBS)

D.6 The Committee's concerns included the need to improve donor care and the safety of blood used in transfusions as well as minimising blood wastage.

Action taken on PAC conclusions and recommendations:

- The Chief Medical Officer has set up a National Blood Transfusion Committee. The Committee met for the first time in December 2001. Its membership is drawn from the Royal Colleges, specialist organisations, patient representatives as well as the NBS and DH. It will build on the work previously done by the National Blood User Group by providing information and guidance to hospitals and the blood service on best practice for blood transfusions, identifying service development needs and addressing donor and patient concerns;
- From 2002, around 20 per cent of blood donors will be able to make appointments. This facility should be available to all donors by 2004. Over the same period NBS plan initiatives to reduce donor waiting times. The first donor attitude and satisfaction survey will take place in 2002 and be repeated every two to three years; and,
- DH and NBS have continued to develop links with research and manufacturers to enable quick responses to be made to new developments and minimise risks of infection in blood transfusions. During 2000 computer systems to control patient sampling and bedside identification were evaluated. In 2001 system piloted in three hospitals.

UK CMOs to hold Conference on Better Blood Transfusion to look at ways to avoid unnecessary use of blood, ways of making blood transfusion safer and giving better information to patients. NBS has set up a group to develop ways to improve blood usage and are developing their Blood Stocks management Scheme to produce six monthly reports.

ANNEX E

Spending on Publicity and Advertising and Income from Sponsorship 2001-02 (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 2001-02 is estimated to be £36 million. The main components included in this total are given below.

New activities in 2001-02 were:

- A new Tobacco Information Campaign aimed at the South Asian community, warning of the dangers of smoking and chewing tobacco with paan;
- *Smokescreen*, involved recruiting five groups of young people (aged 11-18) from different parts of London and Manchester, across a range of socio-economic backgrounds to make short films about the culture of smoking which have been shown on Trouble TV;
- *Mind out for Mental Health* is a sustained programme of activity to tackle the stigma attached to people who experience mental health problems;
- A new campaign to recruit social workers;
- A campaign aimed at the African and African-Caribbean communities designed to increase the number of black organ donors; and,
- Raising awareness amongst students of the service provided by NHS Direct.

Sponsorship

Under Guidelines published by the Cabinet Office in July 2000 government departments are required to disclose sponsorship amounts of more than £5,000 in their departmental annual reports. For these purposes 'Sponsorship' is defined as:

'The payment of a fee or payment in kind by a company in return for the rights to a public association with an activity, item, person or property for mutual commercial benefit.'

The following amounts have been 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
Trouble TV	£800,000	Donated airtime to show Tobacco Information TV programmes aimed at teenagers.
Primesight	£77,200	Donated outdoor poster sites at reduced rate for Organ Donation and Antibiotics – campaigns.
GlaxoSmithKline	£27,000	Funding towards the Hajj Meningitis Campaign.
HBOS plc	£5,000	Funding towards the *Mind Out for Mental Health* Photographic exhibition.

The Association of British Pharmaceutical Industries (ABPI) have been working with the Department on implementing early milestones in the National Service Framework for Older People. An early joint project was a National Conference for Champions of Older People held on 6 March 2002 in London. The ABPI contributed £45,000 towards the cost of the conference.

Figure E1: Departmental Spending on Publicity and Advertising and Sponsorship 2001-02

Campaigns run by the Department	£ million
Smoking (Tobacco Education)	9.9
Workforce	5.5
Teenage Pregnancy	4
Child Immunisation	3
NHS Direct	2.4
Mental Health	1.9
Flu Immunisation	1.7
Quality	1.5
Children's Services	1.4
Social Workers' Recruitment	1.4
Fraud	0.5
Older People (inc Keep Warm, Keep Well)	0.5

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See 2.8

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List of Figures

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).

Block Capital

Block capital is used to maintain the NHS asset base and is available to NHS Trusts for small scale developments, enhancement and overhaul of existing assets, and equipment replacement. Trusts have considerable freedom to decide on how block capital is spent, but will need to demonstrate their spending plans deliver the requirement of *The NHS Plan*.

Discretionary capital is allocated to fund larger capital schemes, often of a strategic nature, that cannot be afforded out of block capital. Access to discretionary capital is controlled by the Regional Office, and allocated on the basis of prioritising business cases for capital investment.

Capital

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if it is in excess of £5,000.

Capital Charges

Capital charges are a way of recognising the costs of ownership and use of capital assets and comprise depreciation and interest/target return on capital. Capital charges are funded through a circular flow of money between HM Treasury, the Department of Health, 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.

Cost of Capital

A charge on the value of assets tied up in an organisation, as a measure of the cost to the economy.

Credit Approvals

Central Government permission for individual Local Authorities to borrow or raise other forms of credit for capital purposes.

Departmental Expenditure Limit (DEL)

The DEL is the annual spending limit imposed on a government department arising from its agreed, longer-term financial settlement with the Treasury. (See also *Annually Managed Expenditure (AME)*)

Depreciation

The measure of the wearing out, consumption or other loss of value of a fixed asset whether arising from use, passage of time or obsolescence through technology, and market changes.

Discretionary

Expenditure subject to cash 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 Department of Health. The EFL represents the difference between the resources a trust can generate internally (principally retained surpluses and depreciation) and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the internal resources are more than the capital spend then the money is used to meet any due repayments of debt principal on the trust's ordinating capital debt and Secretary of State loans, with an excess being invested.

Family Health Services (FHS)

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department of Health following consultation with representatives of the relevant professions, and administered locally by Health Authorities. 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 overall NHS Resources. The exceptions to this are certain reimbursements of practice expenses payable to doctors in general practice (GMS discretionary spending), the costs of administration, and expenditure on drugs by GPs. Funding for these items is included in Health Authorities' (HCHS) discretionary allocations. Responsibility for management of the FHS will pass to Primary Care Trusts in October 2002, subject to parliamentary approval.

General Dental Services (GDS)

The GDS offers patients personal dental care via General Dental Practitioners (GDPs), who work as independent contractors from High Street or local surgeries. Although the GDS is administered by HAs as part of the Family Health Services, GDPs are engaged under a uniform national contract. Funding is provided from a national demand led or non discretionary budget, and is not subject to local resource limits and does not form part of HAs' discretionary allocations.

General Medical Services (GMS)

Contract arrangements agreed at national level for GMS GPs to provide one to one medical services, for example: giving appropriate health promotion advice, offering consultations and physical examinations, offering appropriate examinations and immunisations.

Gross Domestic Product (GDP) Deflator

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms. The series is produced by HM Treasury, and the one used in this report is that published at the April 2002 budget.

Gross/Net

Gross expenditure is the total expenditure on health services, part of which is funded from other income sources, such as charges for services, receipts from land sales and income generation schemes. **Net** expenditure (gross minus income) is the definition of "public expenditure" most commonly used in this report, since it is the part of the total expenditure funded by the Exchequer.

Health 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)

Previously the Health Authority (HA) was responsible 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.On 1 April 2002, 95 HA's was abolished with their responsibilities transferring to PCT's and the 28 new strategic Health Authorities.

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 cash 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 terms.

Personal Dental Services (GDS)

Personal Dental Services offer patients personal dental care equivalent to that provided by General Dental Practitioners within the Family Health Services, but within a more flexible framework of local commissioning. HAs can contract with practitioners or other providers to provide patient services but are free to negotiate and set contract terms which best suit local circumstances and priorities. Funding is subject to local resource limits and forms part of HAs' discretionary allocations.

Personal Medical Services (PMS)

Under the PMS contract which is locally agreed between the commissioner and the provider, GPs are paid for the services and care provided. PMS makes service provision more responsive and equitable and has proved to be very successful in reaching deprived areas where help is often most needed. Many PMS pilots focus on the care of vulnerable groups including homeless, ethnic minorities, mentally ill and travellers.

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.

Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, e.g. estimates for clinical negligence liabilities. Provisions are included in the accounts to comply with the accounting principle of prudence. An estimate of the likely expense is charged to the *income & expenditure* account (for the Department, to the *Operating Cost Statement*) as soon as the issue comes to light, although actual cash payment may not be made for many years, or in some cases never. The expense is matched by a balance sheet provision entry showing the potential *liability* of the organisation.

Real Terms

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

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)

SHAs are health authorities which have been set up to take on a delegated responsibility for providing a national service to the NHS or the public. They can only carry out functions already conferred on SofS. They originate under Section 11 of the NHS Act 1977, which gives SofS the power to establish a special body for the purpose of performing certain specified functions on his behalf.

Specific Grants

Grants (usually for current expenditure) allocated by Central Government to Local Authorities for expenditure on specified services, reflecting Ministerial priorities.

Strategic Health Authority

The term strategic health authority describes the new organisations proposed to be set up in England as part of the Shifting the Balance of Power within the NHS programme. Twenty-eight new health authorities, with a population on average of 1.5 million, related to local and regional government boundaries and roughly aligned with clinical networks, were established on 1 April 2002 when the 95 former health authorities were abolished. The new health authorities are the main link between Department of Health and the NHS and are responsible for ensuring that all NHS organisations work together to deliver the NHS Plan for modernised patient centred services. Their main functions include creating a strategic framework for the delivery of the NHS Plan locally; securing annual agreements with, and performance management of, local NHS bodies; and building capacity and supporting performance improvement. Subject to progress with the NHS Reform and Health Care Professions Bill, the new health authorities are expected to be known as strategic health authorities from October 2002.

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.

Full Contents List

Chapter 5: The NHS Plan – A Plan for Investment; A Plan for Reform 43

NOTES

NOTES

NOTES

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