**Departmental report : 2007 / Department of Health ; presented to Parliament by the Secretary of State for Health and the Chief Secretary to the Treasury.**

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### Publication/Creation

London : H.M.S.O 2007

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DH Department of Health

# Department of Health

*Departmental Report 2007*

**Departmental Report**

The Health and Personal Social Services Programmes

This document is part of a series of Departmental Reports (Cm 7091 to Cm 7117) which, along with the Main Estimates 2007-08, the document Public Expenditure Statistical Analyses 2007 and the Supplementary Budgetary Information 2007-08, present the Government's expenditure plans for 2007-08, and comparative outturn data for prior years.


# Departmental Report 2007

# Department of Health

DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health
by Command of Her Majesty
May 2007

London: The Stationery Office

Cm 7093

£32.50

# Contents

ANNEXES



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

This report and those of 1998 to 2006 are available on the Internet at: www.dh.gov.uk.

The Department also has a Public Enquiry Office which deals with general queries, 020 7210 4850.

# Foreword by the Secretary of State

This annual report, the Department's seventeenth, provides an overview of the impressive improvements in health and social care services delivered during the last year. These achievements are thanks to the dedication and commitment of all those working across public services.

The record level of investment we have made in the NHS since 2002 has made these improvements possible. By 2008, we will have nearly trebled spending on the NHS to over £90 billion. In social care too, there has been substantial increases in funding so that by 2008, the Government will be providing £12.5 billion to local councils for adult social services.

But it is investment alongside our reform programme that will deliver our long-term vision for health and social care. Rightly, people want more convenient access to more personalised care and they want to know that they are receiving the best possible treatment for their condition. Our reforms will help us deliver this vision, ensuring that we get maximum benefit from the additional funding and provide world-class services.

We have already made substantial progress of which we can all be justifiably proud:

- giving patients faster access to NHS services than ever before, with waiting times at an historic low;
- saving over 50,000 more lives, with mortality rates from cancer falling;
- introducing new services such as NHS Direct and NHS walk-in centres to give people easier access to care;
- opening over 80 new hospitals and investing in primary care infrastructure through NHS Local Improvement Finance Trust;
- employing some 300,000 more staff, better paid than ever before;
- modernising the way the NHS uses information, through the National Programme for IT; and
- supporting more older people to live at home.

Through our programme of reform, we are also:

- giving people more opportunity to choose, with their professional and supported by comparable information, the care appropriate for their needs;
- personalising social care by giving people more control through direct payments and individual budgets;
- strengthening commissioners to work with partners to get the best value within available resources;
- introducing new freedoms for a more diverse range of providers to innovate and improve services; and
- rolling out a financial framework that incentivises improvements in care and promotes financial responsibility.

Quality is at the heart of our reforms. Underpinned by robust, effective regulation that assures national

core standards, front-line clinical staff will have the support and freedom to improve the quality of clinical care and develop services that are responsive to people's needs.

It has not always been easy. The transparency of our new financial framework highlighted the deficits in a minority of NHS organisations. Last year, I said we would have the NHS back in balance by the end of this year and I know some organisations have had to take difficult decisions to return to good financial health. The most recent figures from Quarter 3, published in February 2007, show that the NHS is on track to break even, in line with the financial targets agreed at the beginning of the year. This impressive achievement by NHS staff leaves the NHS well placed to enter 2007-08 when we will be investing over an additional £8 billion.

In this next year, delivering the lasting and ambitious vision we set out in *Our Health, Our Care, Our Say* becomes a reality. This means reforming and improving our community services to create health and social care services that:

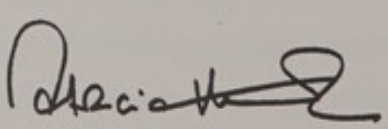
- genuinely focus on prevention and promotion of health and well-being;
- deliver care in more local settings;
- promote the health of all, not just of a privileged few; and
- deliver services that are flexible, integrated and responsive to people's needs and wishes.

We will build on our achievements to deliver continuous improvements in care. In particular, we will:

- focus on delivering our ambitious waiting times target so that by the end of 2008, patients will be able to expect a maximum wait of 18 weeks from GP referral to first hospital treatment. Most people will be treated more quickly, a significant improvement in people's experience of care;
- implement the comprehensive smoke-free legislation we introduced so that by July 2007, virtually every enclosed public place and workplace will be smoke free, a major step forward for improving public health;
- take forward our manifesto commitment to provide high-quality, safe and accessible maternity care, giving women choice in where and how they have their baby and what pain relief they use;
- continue to make progress with the 13 pilots of individual budgets in adult social care, which hold the promise of an improved life, with more independence, by increasing their choice and control over services; and
- we will introduce legislation to modernise the regulation of healthcare professionals, in response to the Shipman inquiries. This includes measures to ensure that healthcare professionals are objectively revalidated throughout their career and remain up to date with clinical best practice.

Looking ahead to this autumn, the Chancellor will announce the outcome of the Comprehensive Spending Review, which will set spending levels for 2008-09 to 2010-11. Following such record levels of investment, it is right that the NHS should return to a more sustained level of growth. This means that we must focus on ensuring maximum value for money from this additional investment, to release resources to meet new priorities and challenges in the decade ahead.

The fundamental values of the NHS, providing care free to all at the point of need, must not change as these values are as relevant to us now as they were when it was founded sixty years ago. Through investment and reform, we are creating a health and social care system that is true to these values but is relevant to our modern society, can stand comparison with international standards and can meet the challenges of the future.



Rt Hon Patricia Hewitt
Secretary of State for Health

# Ministerial Responsibilities

## Rt Hon Patricia Hewitt MP

### Secretary of State

Overall responsibility for the work of the Department with particular responsibility for: NHS and social care delivery and system reforms; finance and resources; and strategic communication.

## Rt Hon Rosie Winterton MP

### Minister of State for Health Services, MS (HS)

Responsibilities include: international and EU business; emergency preparedness (including pandemic flu); counter fraud; cancer services; cardiac services; diabetes services; renal services; mental health (including Mental Health Bill); prison healthcare; dentistry; patient and public involvement; equality and diversity issues; optical services; assisted dying; and chronic diseases.

## Andy Burnham MP

### Minister of State for Delivery and Reform, MS (DR)

Responsibilities include: strategic finance (including allocations and Comprehensive Spending Review); financial recovery; NHS efficiency and productivity; capital development; system reform; reconfigurations; delivery of targets (including 18-weeks); primary care; unscheduled and emergency care; and statistics.

## Lord Hunt

### Minister of State for Quality, MS (Q)

Responsibilities include: safety and quality; research, pharmacy and healthcare products; system regulation; professional regulation; NHS IT and Connecting for Health; and NHS workforce and departmental management.

## Caroline Flint MP

### Minister of State for Public Health, MS (PH)

Responsibilities include: Public Health White Paper implementation (including Health Bill); health inequalities; drugs; tobacco and smoking; alcohol; physical activity; diet and nutrition; communicable disease; immunisation; sexual health; Human Fertilisation and Embryology Authority and Food Standards Agency; sustainable development; and cross-government initiatives.

## Ivan Lewis MP

### Parliamentary Under Secretary of State for Care Services, PS (CS)

Responsibilities include: social care finance, performance and workforce issues; social care inspection (Commission for Social Care Inspection and Social Care Institute for Excellence); children's health; maternity services; Child and Adolescent Mental Health Services; older people's services; physical and learning disabilities; fluoridation; allied health professionals; voluntary sector; *Our health, our care, our say* White Paper (care lead); and Arms Length Bodies review implementation.

# Department of Health Organisation Chart

**Chief Medical Officer**
**Sir Liam Donaldson**

- Healthcare Quality
  **Martin Marshall***
- Health Improvement
  **Fiona Adshead***
- Research & Development
  **Sally Davies***
- Health Protection, International Health & Scientific Development
  **David Harper***
- Clinical Programmes
  **Bill Kirkup***
- 9 Regional Public Health Groups/ Directors of Public Health

**Permanent Secretary**
**Hugh Taylor**

- Policy & Strategy
  **Bill McCarthy***
- Social Care
  **David Behan***
- Departmental Management
  **Alan Doran***
- Communications
  **Matt Tee (interim)***
- Health Care Partnerships
  **Antony Sheehan***
- Equality and Human Rights
  Surinder Sharma

**NHS Chief Executive**
**David Nicholson**

- Finance & Investment
  **Richard Douglas***
- Chief Nursing Officer
  Experience/Involvement
  Professional Leadership
  **Chris Beasley***
- Commissioning
  **Duncan Selbie***
- Provider Development
  **Andrew Cash***
- Workforce
  **Clare Chapman***
- NHS Connecting for Health/NPAT
  **Richard Granger***
- Commercial
  **Mike Seitz (Acting)***

*Directors General

# 1 Introduction

## Introduction

1.1 This report, the Department of Health's seventeenth annual report, plays a key role in the Department's accountability to Parliament for its management of the public money invested in health and social care.

1.2 It provides a comprehensive overview of spending and investment programmes and of the system reforms accompanying this investment. It focuses on the continuous improvements being delivered for people using health and social care services and on the Department's progress against its Public Service Agreements (PSAs).

1.3 The report also sets out the Department's plans for future years. In particular, it focuses on activities and improvements planned for 2007-08. The announcement of the 2007 Comprehensive Spending Review (CSR) in the autumn will set the future financial context for health and social care.

1.4 This report was produced and published under the reporting framework issued by HM Treasury.

## Department of Health

1.5 The Department is responsible for the stewardship of over £90 billion of public funds. It advises ministers on how best to use this funding to achieve and inform their decisions and carry out their objectives. Its staff are responsible for leading and driving forward change in the NHS and social care, as well as improving standards in public health.

1.6 The Department is accountable to the public and the Government for the overall performance of the NHS, adult personal social services (PSS) and the work of the Department itself.

1.7 Health and social care services are delivered through the NHS, local authorities, arm's length bodies and other public and private sector organisations.

### The Department's aims

1.8 The Department's overall aim is to improve the health and well-being of the people of England. Its work includes setting national standards and shaping the direction of the NHS and social care services; and promoting healthier living.

1.9 The Department has three distinct but inter-related roles:

- it is the major Department of State for a broad and complex range of governmental activity;
- it is the effective national headquarters of the NHS; and
- it is responsible for setting policy on public health, adult social care and a swathe of related topics from genetics to international work.

1.10 The shape of the Department has changed to help it improve the way it fulfils these roles, makes key decisions and meets its top priorities.

1.11 Ministers and the then joint DH Permanent Secretary and NHS Chief Executive commissioned a high-level review of the Department, supported by consultants McKinsey & Co in December 2005. This reported in January 2006, with recommendations for an expanded Departmental Management Board and for significant structural changes, including the creation of new directorates and the dismantling of the former business group structure. The changes to the Board and the main adjustments in directorate structure and associated senior appointments were completed in summer 2006.

1.12 Sir Nigel Crisp, joint DH Permanent Secretary and NHS Chief Executive, decided to retire in March 2006. Sir Ian Carruthers was appointed as Acting NHS Chief Executive and Hugh Taylor as Acting DH Permanent Secretary.

1.13 It was subsequently decided to split the role permanently. The transitional arrangements continued through 2006, with David Nicholson

taking up post as NHS Chief Executive in September 2006 and Hugh Taylor being appointed as DH Permanent Secretary in December 2006.

1.14 More information on this high-level review and the subsequent structure of the Department is included in chapter 11.

### The Department's objectives

1.15 The Department's objectives, derived from its PSAs with the Treasury, are:

- to lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people;
- to enhance the quality and safety of health and social care services, providing faster access and better patient and user choice and control;
- to deliver an improved care experience for patients and users, including those with long-term conditions;
- to improve the capacity, capability and efficiency of the health and social care system;
- to ensure that system reform, service modernisation, IT investment and new staff contracts deliver improved quality and value for money;
- to improve the service we provide as a Department of State to – and on behalf of – ministers and the public, nationally and internationally; and
- to develop departmental capability and efficiency and cement our reputation as an organisation that is a good place to do business with, and a good place to work.

## National Health Service (NHS)

1.16 The Department is responsible for the provision of health services through the NHS. Services are delivered locally by 1.3 million staff in 361 organisations and through 8,500 GP practices, as well as other primary care services. These services are in contact every day with over 1.5 million patients and their families.

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

1.18 NHS funding will increase by an average of 7.0 per cent a year over and above inflation for the three-year period of the 2004 Spending Review (2005-06 to 2007-08). This will take NHS expenditure from £69.1 billion in 2004-05 to £90.7 billion in 2007-08.

## Personal Social Services (PSS)

1.19 The Department also sets the strategic framework for adult social care. It gives advice and guidance to local authorities, whose responsibility it is to manage social care funding according to local priorities and the principles of local accountability. Almost 1 million staff work in the social care sector, providing services to 1.7 million users, most of whom are elderly, through 31,000 social care providers, of which the great majority are small, independent sector organisations.

1.20 In the 2004 Spending Review, the Government allowed for continued, substantial growth in PSS resources in England.

1.21 Over the three years, 2005-06 to 2007-08, there will be an average real terms increase in funding of 2.7 per cent over and above inflation. This compares with the 6 per cent average annual growth from 2003-04 to 2005-06.

1.22 In total, government funding for adult social care currently stands at around £12.5 billion each year, with the majority administered by the Department for Communities and Local Government (DCLG) through the formula grant. The Department of Health sets the overall policy for delivery of adult social care, while also contributing £1.6 billion in direct local authority allocations for specific grant funding.

## Content summary

1.23 The following chapters in this report provide Parliament and the public with an account of how the Department has spent the resources allocated to it, as well as its future plans. It also describes our policies and programmes and gives a breakdown of spending within these programmes.

### Chapter 2 (Health Promotion and Protection)

This chapter reports progress against the ambitious agenda set out in *Choosing Health: Making Healthy Choices Easier* (DH, November 2004) to tackle inequalities in health and to engage people in looking after their own health. It also provides an update on the work of the Department to protect people's health through the National Vaccination Programme and the preparations for a possible influenza pandemic, and on offender health.

### Chapter 3 (Improving Health Services for NHS Patients)

One of the Department's objectives is to deliver an improved care experience for patients and users, including those with long-term conditions. This is being achieved through a range of programmes and policies reflected throughout this report. This chapter focuses specifically on improving people's access to care, their experience of that care, and improving quality within specific service areas, for example cancer care, children's services and mental health.

### Chapter 4 (System Reforms in Health and Social Care)

*Our health, Our Care, Our Say: A New Direction for Community Services* (DH, January 2006) set out a strategic vision for community health and social care services. This chapter includes an update on the progress to deliver that vision. It also provides a comprehensive overview of the programme of health reform which aims to deliver better care, better patient experience and better value for money. Finally, it provides an update on the recommendations for service improvement and on *The NHS in England: The Operating Framework for 2007-08* (DH, December 2006).

### Chapter 5 (Improving Social Care Services)

This chapter summarises the role of the new Directorate for Social Care. It aims to improve the quality of people's lives by enabling people to live as independently as possible and to exercise choice and control over the support they receive, and by promoting high-quality, safe services. It outlines the work programmes supporting prevention and early intervention, individualisation of services and the life chances of disabled people. It also includes performance against the PSA target for older people.

### Chapter 6 (Research and Development)

This chapter provides an overview of the programme of health research funded by the Department. In particular, it includes a progress report on implementation of the Government's health research strategy *Best Research for Best Health: A New National Health Research Strategy* (DH, January 2007). It also looks forward to the implementation of the Chancellor's commitment to create a single, ring-fenced budget for health research and to the implementation of Sir David Cooksey's review into health research funding.

### Chapter 7 (Workforce)

The Department continues to play a central role in securing the right number of appropriately trained and motivated staff to deliver high-quality care for patients and people who access services. This chapter includes information on both the health and social care workforce and, among other issues, it addresses: modernising education and training; modernising the regulation of healthcare workers; and pay and pensions in the NHS, including for primary medical care contractors.

### Chapter 8 (National Programme for IT)

NHS Connecting for Health is responsible for delivering the National Programme for IT, which is using new technology and information systems to give patients more choice, and health professionals more efficient access to information thereby enabling them to deliver better patient care. It provides an overview of the main deliverables for the National Programme, including the NHS Care Record Service, Choose and Book, Electronic Prescription Service, Picture Archiving and Communications System (PACS), N3 network and NHSmail.

### Chapter 9 (Revenue Finance)

This chapter addresses NHS and PSS revenue finance and NHS efficiency. It details the level of investment in both PSS and the NHS and how these funds have been spent across the various programmes. It also highlights the improvements in NHS productivity and efficiency.

### Chapter 10 (Capital Finance)

This chapter highlights the priorities within NHS capital investment. Investment continues to play a pivotal role in the modernisation of the NHS. *The NHS Plan: a plan for investment, a plan for reform* (DH, July 2000) set out a planned programme of investment in the NHS.

### Chapter 11 (Managing the Department of Health and Developing Policy)

This chapter is concerned with the management of the Department and its development of policy. It outlines the running costs, staffing, recruitment policy and senior civil service salaries of the Department. It also describes how well the Department manages risk, handles correspondence from the public, and the environment in which it operates.

### Annexes

The annexes provide the spending and administrative core data tables; the Department's current PSA targets and operating standards, along with progress reports on each; and a list of the agencies that help the Department discharge its functions. There is also a note of the Public Accounts Committee (PAC) reports in 2006, an account of the Department's spend on publicity and advertising, and a list of sponsorship received.

# 2 Health Promotion and Protection

## Introduction

2.1 This chapter reports progress against the ambitious agenda set out to tackle inequalities in health and to engage people in looking after their own health. It also provides an update on the work of the Department to protect people's health through the National Vaccination Programme and the preparations for a possible influenza pandemic, and on offender health.

## Choosing Health

2.2 Good health and well-being are everyone's responsibility – individuals, communities, business, public services and government. *Choosing Health: Making Healthy Choices Easier* (DH, November 2004) set out an ambitious agenda for new thinking and practical action to tackle inequalities in health and to engage people in looking after their own health. Of 190 commitments in *Choosing Health*, 135 have already been achieved.

2.3 Over the past two years, we have learnt more about people's expectations around health and how we can build effectively on successes, learning from the experience of the new approaches that have developed. *Health Challenge England – Next Steps for Choosing Health* (DH, October 2006) set out the next steps in our strategy to support the changes we all need to make in our lives in order to enjoy the best possible health.

2.4 The main elements of the *Health Challenge England* approach are:

- providing strong leadership across government at national and local levels and joining up policy;
- developing a stronger focus on understanding people;
- forging new partnerships with industry, the voluntary sector and communities and providing better information and opportunities for positive health choices;
- personalising support in improving health;
- providing protection where needed, such as legislating to ensure smoke-free public and work places;
- focusing on key priorities for delivery; and
- ensuring system reform is aligned to improve health and tackle inequalities.

2.5 The new approach to public health builds on a reformed NHS and the ambitions people have for their own health and that of their family. It recognises the vast changes in lifestyles and attitudes in modern society and involves every adult in safeguarding their health and well-being and that of their dependents. Public health messages have become part of the every day vocabulary of society; from food labelling and '5 A Day' to the enactment of smoke-free legislation, no individual will be untouched by the actions taken to improve the health and well-being of the whole population.

## Health Challenge England – into action

### Providing strong leadership across government at national and local levels and joining up policy

#### Tackling obesity

2.6 Tackling obesity is a complex issue. There are no quick fixes. Obesity is increasing across the developed and developing world, and nowhere has yet managed to reduce increases in obesity.

2.7 Obesity is linked to increased risk of heart disease, type 2 diabetes and some cancers, and obese people are more likely to suffer from social and psychological problems. Obesity impacts on health inequalities. The 2004 *Health Survey for England* (DH, December 2005) suggests that obesity remains highest in the lower socio-economic groups and in more deprived areas. Obesity also has serious economic costs. It has been estimated that the cost of obesity to the NHS is approximately £1 billion

per year, with an additional £2.3 billion to £2.6 billion per year to the economy as a whole.

2.8 In 2004, the Government set a Public Service Agreement (PSA) specifically on obesity, which is jointly owned by the Department of Health, Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS), to:

> halt the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.

2.9 The PSA target will be delivered using a tiered approach. This will mean action to create a climate for success by working in partnership to make healthier choices easier, for example by restricting the promotion of foods high in salt, sugar and fat to children, and improving front-of-pack food labelling. The Department will work to ensure that existing interventions, such as the Healthy Schools Programme, and School Sport Strategy, focus on tackling obesity as part of their work; and we will ensure that, at a local level, targeted interventions are available to help overweight and obese children and families.

2.10 Three underpinning work streams support this approach:

- raising awareness of the importance of healthy weight and the risks of obesity to children and parents;
- working with local partners to ensure obesity is seen as a key concern for local services and practitioners; and
- developing our knowledge about what works to tackle obesity.

### Using social marketing to tackle obesity

2.11 The Department has used social marketing to identify different groups of families and their susceptibility to the risk of obesity. It has discovered that reasons for these susceptibilities vary across the different 'family groups'. Working with external partners, the Department has identified the changes in behaviour that need to be supported, and the practical and emotional barriers to change that need to be understood. The Department has built a coalition of 150 public and private sector organisations to develop the means of support for families to lead healthier lifestyles.

2.12 A programme of activity resulting from this work commenced in spring 2007. It includes work with key workforce groups and stakeholders, and public-facing campaigns, such as Top Tips for Top Mums, a campaign to help families get more fruit and vegetables into their children's diets.

### Measurement of obesity in children

2.13 The Department has introduced an annual national weighing and measuring exercise to record the heights and weights of pupils in Reception and Year 6 in primary schools.

2.14 The data from this exercise will enable the Department to get a better understanding of children's needs in this area and will enable schools, PCTs, local authorities and other partners to target resources and interventions where they are most needed. In areas where there is effective engagement between PCTs and schools, the Department has seen that the exercise in itself can galvanise local activity on tackling obesity.

### Supporting local delivery

2.15 The National Institute for Health and Clinical Excellence (NICE) published *Obesity: Guidance on the Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children* (NICE clinical guideline 43, December 2006). The Department is working in partnership across different sectors to ensure implementation of the wide-ranging advice issued by NICE on obesity.

2.16 PCTs are working with local authorities through children's trusts to coordinate activities to improve children's health and other outcomes. The PCT Development Plans and the local authority Children and Young People's Plans are vehicles for agreeing shared priorities to tackle child obesity, feeding into Local Area Agreements (LAAs).

2.17 Recognising that there is a wider and longer-term strategic context to tackle obesity in the population, the Department will be commissioning further research to build on the evidence base and will work in partnership with the Government's Foresight Project, which has been commissioned to 'produce a long-term vision of how we can deliver a sustainable response to obesity in the UK over the next 40 years'.

### Physical activity

2.18 The *Choosing Health* White Paper in November 2004 and the *Choosing Activity: A Physical Activity Action Plan* (DH, March 2005) set out a series of projects aimed at increasing levels of physical activity.

2.19 In April 2006, the Prime Minister asked the Minister of State for Public Health to lead a cross-government group to look at what had been achieved since publication of *Choosing Activity*, and to develop plans to achieve a fitter nation in the run-up to the 2012 Olympic Games.

2.20 Key achievements in the past year include the following:

- All maintained schools are now in a schools sports partnership. 80 per cent of pupils are now participating in at least two hours of high-quality physical education (PE) and sport in a typical week.
- 40 per cent of schools in England have active travel plans, which are helping more children to walk or cycle safely to school.
- The evaluation findings of the Local Exercise Action Pilots, a joint venture with Sport England and Natural England, were launched at a national conference to help guide development of local initiatives to promote physical activity.
- The *General Practice Physical Activity Questionnaire* (DH, December 2006) was published, which will help health professionals decide when advice and interventions to increase physical activity might be appropriate for their patients.
- A national school pedometer programme was announced, which will see 250 schools in deprived areas given around 40,000 pedometers, to encourage children to become more active.
- The Health and 2012 national and London delivery plans were published, setting out how the Department and the NHS will deliver a healthy Olympic Games in 2012, and use the Games to promote a healthier and fitter population.
- 4,000 primary care health professionals, across 220 PCTs (pre-reconfiguration) have been trained in motivational behaviour change as part of the National Step-O-Meter Programme launched in 2006.

### Alcohol harm reduction strategy

2.21 The Government's *Alcohol Harm Reduction Strategy for England* (Cabinet Office, March 2004) was subsequently reinforced in the Public Health White Paper, *Choosing Health: Making Healthy Choices Easier*. There are four main themes of the cross-government Alcohol Harm Reduction Strategy:

- improving health and treatment;
- education and communication;
- tackling crime and disorder; and
- working with the drinks industry.

2.22 The Department and the Home Office are jointly leading a cross-government programme of work, together with DfES and DCMS to tackle a range of alcohol-related harms, including binge drinking and improving treatment for dependent

drinkers through the Alcohol Harm Reduction Programme.

2.23 Work on tackling alcohol misuse contributes to the Department's PSAs on reducing mortality rates from major killers where alcohol may be a contributing factor (e.g. cancer, cardiovascular disease, liver disease and mental health). Some £217 million is currently being spent by PCTs on alcohol treatment, with around 63,000 people receiving treatment. A further £15 million is being allocated to PCTs for alcohol interventions for 2007-08.

2.24 The Government continues to work in close partnership with the alcoholic drinks and retail industries and with the health and voluntary sectors. Significant progress has been made in this regard during 2006:

- Sensible drinking messages and labelling have been introduced to standardise and strengthen unit information that appears on alcoholic drinks labels.
- The Drink-aware Trust has been established with a Memorandum of Understanding between the Government, the devolved administrations and The Portman Group. The Trust is an independent UK-wide, public-facing body, with the objective of positively changing public behaviour and the national drinking culture. It will become fully operational in 2007.
- The Department has welcomed the development and publication of a national Principles and Standards document for producers and retailers, which covers issues like clear protocols around seeking proof of age.
- The Government launched its Know Your Limits Campaign in October 2006, which is the first national campaign regarding alcohol and focuses on young people who binge drink.

2.25 The Department has launched *Alcohol Misuse Interventions: Guidance on Developing a Local Programme of Improvement* (DH, November 2005), which is aimed at local health organisations, local authorities and others seeking to work with the NHS to tackle alcohol misuse.

2.26 *Models of Care for Alcohol Misuse Services* (MoCAM) provides guidance setting out a framework for commissioning and providing interventions and treatment for adults affected by alcohol misuse and provides best practice guidance on commissioning alcohol services.

### Local Area Agreements

2.27 LAAs are three-year compacts, based on local Sustainable Community Strategies that set out the priorities for a local area. They are agreed between central Government (represented by the Government Office) and a local area represented by the lead local authority and other key partners through Local Strategic Partnerships. They have been shown to have great potential in delivering improvements in health and social care outcomes and have proved an important catalyst for improved partnership working. 2006 saw LAAs developed and come into force with health inequalities now being a mandatory target within these frameworks from April 2007, by which date, every area in England will have their own LAA.

### Jointly appointed Directors of Public Health

2.28 The reconfiguration of the NHS in 2006 has led to a reduction in the number of PCTs and appointment processes for Directors of Public Health to the new boards. Over 70 per cent of these appointments have been joint between the PCT and the local authority.

### Guidance on health and strategic environmental assessment

2.29 Directive 2001/42/EC, known as the Strategic Environmental Assessment (SEA) Directive, requires environmental assessment of certain plans and programmes that are likely to have a significant effect on the environment, including on population and human health.

2.30 The Department has published draft guidance on health in SEA, to assist responsible authorities (plan makers) in meeting these obligations. Regional and local Directors of Public Health will be consulted at the same time as statutory consultation bodies, to give an opinion on the effects of implementing the plan or programme on the population's health and well-being.

2.31 This will be a major contribution to prevention, as SEA will be applied systematically to around 300 to 400 plans each year and programmes covering spatial, transport, housing, waste and river basin plans in England and will support joint work and communication between health and planners.

### Health impact assessment across government

2.32 The Council for Science and Technology (CST) report *Health Impacts – A Strategy Across Government* (CST, December 2006) sets out the framework for supporting health impact assessment across the main government departments. It recommends a joint approach between the Department and other government departments on commissioning evidence; joining up databases to strengthen evidenced-based policy-making; making health more visible in the impact assessment process in government; training for policy-makers on the wider determinants of health; involvement of stakeholders in the early stages of policy-making; and creative forms of consultation. This places the population's health at the centre of government policy-making.

### National Institute for Health and Clinical Excellence

2.33 In March 2006, ministers announced a change in the NHS Standards that clarifies the status of NICE public health guidance for implementation in the NHS, and enables the Healthcare Commission to assess the progress of NHS organisations in implementing NICE public health guidance from 2007-08. In July 2006, ministers agreed public health and clinical topic selection criteria for NICE guidance that mainstream the reduction of health inequalities for the first time. NICE's forward public health programme, comprising 11 new guidance topics, was announced by ministers in August 2006.

### Actions for a Safer Europe

2.34 The European Commission has initiated proposals for a communication on Actions for a Safer Europe and a Council Recommendation on the prevention of injury and the promotion of safety. Member states have had the opportunity to comment on the proposals and on suggested amendments by the European Parliament to the draft Council Recommendation, which now awaits consideration by the Health Council. The Department has been involved in consulting and inputting views from across government on the proposals.

2.35 The draft Council Recommendation looks to the combined efforts of the Commission and member states in taking forward Actions for a Safer Europe and provides a framework for action, including recommending that member states and the Commission:

- develop a national injury surveillance system;
- set up national plans for preventing accidents and injuries;
- ensure that injury prevention and safety promotion are included in the vocational training of healthcare professionals;
- establish both a community-wide surveillance system for collecting injury data and a mechanism for the exchange of information on good practice; and
- support the development of good practice and policy actions.

## Developing a stronger focus on understanding people

### Social marketing for health

2.36 Health-related social marketing is the systematic application of marketing alongside other concepts and techniques to achieve specific behavioural goals, to improve health and reduce inequalities. A key commitment of the *Choosing Health* and *Our Health, Our Care, Our Say* White Papers was to develop a comprehensive social marketing strategy for health in England. The first phase of the programme was the *It's Our Health* review published by the National Consumer Council in June 2006. In December 2006, the National Social Marketing Centre was launched by Caroline Flint, the Minister for Public Health.

2.37 Key findings of the independent review were as follows.

- Applying social marketing more systematically will increase the impact of our health promotion efforts.
- There is a need to develop understanding and application of social marketing and to embed social marketing as a standard operating approach for health promotion.
- The impact of health promotion interventions can be enhanced when they are driven by deep understanding of what moves and motivates people to change and what does not. An approach that focuses on people and how they live their lives, and at what point they are in their life, can enhance approaches that focus on single diseases or health behaviours.

2.38 The publication of *Health Challenge England* signalled the integration of social marketing as a core operating model of the Department's future health promotion efforts. Four of the seven *Health Challenge England* principles (providing strong leadership and joining up policy, developing a stronger focus on understanding people, forging new partnerships, and personalising support) are underpinned by the application of a social marketing approach.

2.39 Key milestones during the year included:

- completion of the *Choosing Health* commitment to undertake a national review of social marketing. Publication of the *It's Our Health* (NCC, June 2006 ) review and supporting 12 research reports;
- establishment of the Ethics Advisory Group, an academic network linked to the Public Health Academic forum;
- joint development of social marketing planning tools and approach, as part of the Government's strategic communication programme Engage;
- establishment of a national social marketing associates and advisers scheme;
- the first national social marketing conference and master class held in Newcastle in September 2006;
- establishment of a national learning forum for social marketing;
- a wide range of national and regional events, with over 5,000 NHS and local authority staff receiving introductory training in social marketing;
- establishment of ten demonstration sites; and
- production of a social marketing website and resources.

## Forging new partnerships with industry, the voluntary sector and communities and providing better information and opportunities for positive health choices

### Clubs That Count

2.40 Clubs That Count is an initiative run by Business in the Community in partnership with the Department. The initiative is based on measuring current corporate social responsibility activities in football and rugby clubs, and then giving them a score with accompanying advice on how to improve. It also provides a forum to share best practice.

2.41 The initiative has been running for 18 months. Twenty-six clubs participated in the first year, exceeding the minimum target of 20:

- 9 Premier Rugby clubs;
- 8 Premier League football clubs;
- 7 Football League clubs;
- 1 Rugby League club; and
- 1 Welsh Premier football club.

2.42 First-year findings demonstrate that clubs are tackling a wide range of social and environmental issues in unique and innovative ways and are conduits to promote healthy lifestyles.

### Health Profile of England

2.43 The Department published the *Health Profile of England* (DH, October 2006) to support *Health Challenge England*, and in fulfilment of a *Choosing Health* White Paper commitment. It is a collection of national and regional data and provides a yardstick against which to compare national data with that in the Local Authority Health Profiles. The *Health Profile of England* focuses on the six priority areas identified in *Choosing Health*: health inequalities; smoking; obesity, diet and nutrition; sexual health; mental health and well-being; and alcohol. Snapshot data and a chart book provide a broad picture of health and the determinants of health and health inequalities.

### Local Authority Health Profiles

2.44 The Local Authority Health Profiles were successfully launched, together with the *Health Profile of England*, in October 2006. High-profile media attention on the BBC's '10 O'Clock News' led to over 6,500 downloads of the *Health Profile of England* and over 300,000 downloads of individual local profiles (see www.communityhealthprofiles.info). The profiles provide a consistent, concise and comparable overview of the health of the community. Local government and the NHS can use the profiles for needs assessment, policy development and commissioning, in order to improve health and reduce health inequalities locally.

2.45 The profiles contain a wide range of indicators of health inequality, including life expectancy, infant mortality, educational achievement and the environment, all of which are known to impact on people's health and quality of life. An evaluation of content, format and availability of the profiles was overwhelmingly positive. Health profiles have already been used for targeted local partnership action to reduce health inequalities. The download statistics show that there is great public interest and demand for such information being made available.

### Informing Healthier Choices

2.46 Informing Healthier Choices is the information and intelligence strategy for improving public health, a *Choosing Health* commitment. Following an extensive consultation exercise, the overall direction of travel was supported. The strategy will support the developing commissioning function of PCTs and local authority partners, which requires them to produce joint strategic needs assessments for local communities.

2.47 An extensive set of deliverables have been identified, but key outputs in the coming year will be:

- Local Authority Health Profiles 2;
- analyses of public lifestyle behaviour from general practice data;
- example guidance on data sharing across public services; and
- production of at least three local authority and PCT-level prevalence models.

### The Communities for Health Programme

2.48 This has been piloted in 25 areas throughout England and promotes action across local organisations on a locally chosen priority for health. The pilots have implemented over 100 local activities to engage their local communities in

improving their physical and mental health. The programme will be rolled out to a further 56 areas to ensure coverage across all spearhead areas.

### Health and work

2.49 The Royal College of Physicians has been commissioned as the preferred bidder to establish the NHS Plus Clinical Effectiveness Unit. The initial focus will be the production of relevant evidence-based guidelines for the practice of occupational health, and designing and implementing two national audits of current occupational health practice based on similar audits of other clinical services in the NHS.

2.50 Professor Dame Carol Black has been appointed as the first National Director for Health and Work. Since her appointment in August 2006, she has met with over 30 key national stakeholders, including the Disability Rights Commission, Boots the Chemist, Royal Mail and Cadbury Schweppes.

2.51 The dedicated NHS Plus Project website (www.nhsplus.nhs.uk) was launched in October 2006 together with an online feedback service.

2.52 The Department is working with the Royal College of Physicians to identify a number of projects which can be developed as part of *Health, Work and Well-being – Caring for Our Future: A Strategy for the Health and Well-being of Working Age People* (DH, DWP and HSE, October 2005), where the greatest impact can be made on sickness absence and return to work in the shortest time.

### Healthy Schools

2.53 Fifty-five per cent of the nation's schools achieved the original Healthy Schools standards. Eighty per cent of schools nationally are participating in the programme and we are on track to achieve the *Choosing Health* commitment to have all schools gaining or working towards Healthy Schools status by 2009. To accelerate the mainstreaming of Healthy Schools, we commissioned an independent review of the programme in early 2007, which is due to report in the spring.

## Personalising support in improving health

### Health trainers

2.54 Nearly half of the NHS has signed up to the Health Trainers Scheme, and there has also been considerable interest from third-party organisations:

- Prisons have made great strides with their health trainer programme, with currently in the region of 50 health trainers.
- The Army expects to have trained 450 physical training instructors (PTIs) by December 2007.
- Royal Mail is considering training some of its first aid staff.
- The programme is also working with organisations such as Asda, Marks & Spencer, National Pharmacies and the Football Foundation.

### LifeCheck

2.55 February 2007 saw the Secretary of State for Health launch the LifeCheck Programme, which is aimed at providing individuals with the opportunity to assess key aspects of their health and well-being and empowering them to manage their personal health. There are three strands of LifeCheck: early years, teenage and mid life. All three will be piloted in the coming year. The Teenage LifeCheck went live in early February 2007 and is being extensively trialled in our four groundbreaking teenage health demonstration sites and on the Teenage Health Freak website. For more details see chapter 3.

### Skilled for Health

2.56 This health literacy programme is a partnership between DH and DfES and the health and education charity ContinYou. Launched in 2003, the programme is designing, testing and marketing health education resources and packages under the national Skills for Life umbrella. In 2006, phase one was completed with the publication of

learning resources on health and well-being and on services and self-care.

2.57 The second phase, which is a *Choosing Health* commitment, began in 2006 and involved working with partners in specific sectors designing and testing packages to meet their corporate needs and those of their learners. These include employees in business (Royal Mail), local government (Nottingham City Council), people in prison (Care Services Improvement Partnership), and users of libraries (London Libraries and Museum Agency). These sectors offer the prospect of tens of thousands of learners. In addition, the 'early adopter' approach used for the Health Trainers Scheme will be used for developing networks and hubs for wider dissemination and learning in communities.

2.58 Skilled for Health is a model for the engagement of the non-governmental organisation (NGO) sector. The programme has grown from small beginnings with a grant to ContinYou by the Department, to the stage where ContinYou is now poised to move from being one of three equal partners in this work to being the national delivery agency for the programme leading new developments.

### Concept development of NHS Health Direct digital healthy living service

2.59 It is estimated that four out of five deaths in people under 75 could be delayed by changes in individual behaviour such as smoking, alcohol consumption and exercise. However, DH-commissioned research concludes that many consumers are confused about where to go for support and which information they should trust. The *Choosing Health* White Paper and Labour Party manifesto commitments outlined plans for a new, multi-channel digital healthy living support service, NHS Health Direct. By the end of 2006, the initial design concept, content strategy and consumer and market research to support procurement for the information, advice and interactive elements of the online portal, SMS text service and interactive TV service were complete.

2.60 The NHS Health Direct concept and research are now helping to shape the development of NHS Choices. This is the leading NHS programme to harness the power of new media technologies to help those who are most disadvantaged, and the health and community professionals who support them, make more informed choices about healthcare treatment, choice of provider, and take steps to sustain a healthier lifestyle. It is proposed that the NHS Choices website, scheduled to launch in summer 2007, will incorporate an interactive assessment tool that allows users to assess the impact of their lifestyle on their health and set goals to improve it, as well as a search and signposting service to improve individual access to the local health improvement services that can best support them.

## Providing protection where needed, such as legislating to ensure smoke-free public places and workplaces

### New smoke-free laws – the Health Act 2006

2.61 In July 2006, the *Health Act 2006* received Royal Assent. The Act contains provisions for the prohibition of smoking in virtually all enclosed and substantially enclosed public places and workplaces. The new smoke-free law is being introduced to provide protection from the risks to health from exposure to second-hand smoke. Smoke-free regulations have been made under powers in the *Health Act 2006* that set out detailed legislative arrangements following a full public consultation run by the Department from July 2006.

2.62 The Department is working to assist local authorities, businesses and the general public to be prepared for the implementation of the new law on 1 July 2007. Under powers in the *Health Act 2006*, legislation has been passed to raise the age of sale for

tobacco products from 16 to 18 years. These provisions are due to come into force on 1 October 2007.

## Focusing on key priorities for delivery

### Public Health National Support Teams

2.63 Over the last year, four Public Health National Support Teams (NSTs) have been established on a phased timetable as part of the delivery arrangements for implementing *Choosing Health*. Their purpose is to provide intensive support to those health partnerships most challenged in meeting one or more public health deliverables relating to PSAs. The four teams focus on wider sexual health (including access to genito-urinary medicine (GUM) clinics), tobacco control, health inequalities and teenage pregnancy. An obesity NST will be established in 2007-08.

2.64 The NSTs draw expertise from the NHS, local government and the voluntary sector, to ensure a credible professional team with expertise in relevant clinical areas, service management, change management, commissioning and public health. Areas for support are identified principally on performance in relation to targets and key indicators, and in agreement with relevant policy teams, the Recovery and Support Unit, Government Offices and SHAs. The NST approach starts with an initial intensive visit over a number of days, followed by an agreed package of support over a period of time.

2.65 The Sexual Health NST was established in February 2006 and undertook 21 visits up to the end of March 2007. The team has also developed a self-assessment tool. The Tobacco Control NST was established in October 2006 and piloted its approach over three areas, two of which are spearheads. The team provides support in relation to performance against the quit target, but uses a holistic model of tobacco control. The Health Inequalities NST recently established and piloted its approach in three places in 2006-07. The team is focused on delivery of the life expectancy target in spearhead areas, particularly concentrating on the key contributors to the health inequalities gap and the interventions that will make the difference by 2010. The Teenage Pregnancy NST has only been established since the beginning of 2007, in conjunction with DfES and the National Teenage Pregnancy Unit, and is focused on the 22 areas with high and increasing rates of teenage pregnancy. The team undertook intensive visits to two areas before the end of 2006-07.

2.66 Over 80 intensive visits are planned for 2007-08, with further visits to be piloted for the Obesity NST by summer 2007. In addition, the teams provide more generic advice and guidance to all areas in England, including the development of toolkits and models to support improvement in delivery against PSAs, and will be contributing to national, regional and local conferences and learning events.

2.67 The NST programme has been very well received by local areas. Early indications are that the teams provide a real catalyst for change in local areas, with evidence of improved performance following visits and with the agreed packages of support.

### Progress on health inequalities

2.68 Health inequalities are a top priority for the Government. The most comprehensive programme ever in this country has been put in place to address them. A key element in the Government's strategy to tackle health inequalities is the 2010 PSA target:

> by 2010 to reduce health inequalities by 10 per cent as measured by infant mortality and life expectancy at birth.

2.69 Nationally, while infant mortality rates in the routine and manual group are continuing to improve, the gap between this group and England as a whole has widened. Life expectancy is

increasing for both men and women, including in the spearhead areas. But it is increasing more slowly there, so the gap continues to widen. This means the long-term trend at a national level has been a widening of the inequalities gap, but there are some early signs of progress.

2.70 Three-fifths of spearhead areas are on track to narrow their life expectancy along with England as a whole, by 10 per cent by 2010 compared with baseline, for either males or females, or both. Latest figures indicate that the infant mortality gap between lower socio-economic groups and the population as a whole may have stopped widening.

2.71 There have been continued improvements in cardiovascular disease (CVD) and cancer mortality inequalities, with a 27.9 per cent reduction in the absolute CVD inequality gap, and a 12.7 per cent reduction in the absolute cancer inequality gap, since the baseline.

2.72 The *Review of the Health Inequalities Infant Mortality PSA Target* (DH, February 2007) identified four evidence-based interventions that have the biggest contribution to reducing the gap. These accounted for 70 per cent of the required reduction in the gap:

- reducing teenage pregnancies;
- targeted interventions to reduce sudden unexpected deaths in infancy;
- reducing smoking in the routine and manual group; and
- reducing obesity in the routine and manual group.

2.73 Evidence shows that the interventions that could have the most impact on life expectancy in spearhead areas are:

- smoking cessation;
- effective control of blood pressure; and
- effective control of cholesterol.

2.74 These could help narrow some 9 to 10 per cent of the gap. In addition, effective interventions to treat diabetes and other long-term conditions, respiratory and alcohol-related diseases will also contribute. Underpinning these interventions are good access to primary care, embedding health inequalities within planning and commissioning as set out in the *Commissioning Framework for Health and Well-being* (DH, March 2007) and using effective communication to raise aspirations to better health for people living in deprived areas.

### Reducing the number of people who smoke

2.75 Smoking is the main cause of premature death in England. It kills around 86,500 people (one in five of all deaths) a year, who lose 16 years of life on average. Smoking contributes significantly to inequalities in life expectancy between areas and population groups. Reducing smoking in routine and manual groups will have a major impact on cancer, CHD and respiratory disease, and will narrow the health gap.

2.76 The 2004 PSA target (SR 2004, target 3) on smoking is to:

> reduce adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less.

2.77 The latest figures, published in 2006, showed that there were some 1.6 million fewer smokers in England in 2005 when compared with smoking rates in 1998. Smoking rates in 2005 for all adults stood at 24 per cent. However, routine and manual groups still lagged behind at 31 per cent.

2.78 Figures published in 2006 showed that the Department was ahead of its target set in the *Smoking Kills* White Paper (DH, November 2006). This means smoking in pregnancy has reduced from 23 per cent in 1995 to 17 per cent in 2005.

2.79 The Department's comprehensive tobacco control strategy has six strands, each of which has a measurable impact on reducing smoking prevalence:

- highly successful media and education campaigns, which have proved to be the single most important factor triggering smokers' decisions to quit;
- restrictions on advertising, promotion and sponsorship: a comprehensive advertising ban has been in place since February 2003, and has now been extended to point of sale, sports sponsorship and the internet;
- supply reduction: our tobacco products are highly taxed – our cigarettes are the most expensive in the EU – and more is being done to reduce the supply of cheap smuggled tobacco (this strand is owned by HM Revenue and Customs and HM Treasury);
- an extensive network of NHS stop smoking services and a national quitline, through which skilled advisers can help people of all ages to stop smoking;
- measures to make smoke-free environments the norm at work and leisure; and
- regulation of tobacco products, including pack health warnings.

2.80 NHS stop smoking services have continued to provide high-quality support to smokers who want to stop, in an increasing number of settings. During the period October 2005 to June 2006, 461,987 people set a quit date through the services and 253,015 (55 per cent) were successful at the four-week follow-up.

2.81 The Healthcare Commission report on *Tobacco Control* (Healthcare Commission, January 2007) found that overall PCT performance in tobacco control was good, with 33 per cent of PCTs scoring as, 'excellent', 56 per cent as 'good' and 11 per cent as 'fair'. The report showed that tobacco control performance was higher in more deprived areas and concluded that this has made a positive contribution to the health inequalities agenda.

2.82 The Department's education campaigns continued throughout 2005, with significant presence across the media. Among a number of initiatives in the last year, the Department has launched a new campaign to highlight the poisons in tobacco smoke with Cancer Research UK. In 2006, these media and education campaigns remained the principal reason why smokers said they tried to quit.

2.83 The UK's far-reaching ban on tobacco advertising was extended in 2006, with major restrictions on tobacco advertising where tobacco is sold and a ban on tobacco advertising on the internet from sites that originate in the UK or EU. This means that the UK now has among the most comprehensive tobacco advertising and sponsorship bans worldwide.

2.84 Major progress was made by the World Health Organization (WHO) *Framework Convention on Tobacco Control* (FCTC), the first-ever global health treaty. As of February 2007, 141 parties had ratified the treaty. The second conference of the parties is to be held in June 2007. Working groups set up to take forward work on protocols on illicit trade and cross-border advertising, and guidelines on tobacco ingredients and smoke-free environments, produced detailed preliminary reports which will be the basis of future coordinated action in these areas.

2.85 A comprehensive audit of European countries published in 2006 placed the UK second only to Ireland in implementing effective tobacco control policies. With smoke-free legislation covering the whole country from summer 2007, this will put the UK comfortably top of the list.

### Sexual health

2.86 Significant progress has been made in taking forward the commitments for sexual health in Choosing Health. Improving access to GUM clinics is identified as a key priority for NHS delivery in

the 2006-07 and 2007-08 NHS operating frameworks for these years. Good progress has been made towards the target: The latest Health Protection Agency (HPA) quarterly survey data showed that 65 per cent of patients are now seen, and 69 per cent are offered an appointment to be seen, within 48 hours.

2.87 To improve data quality and performance management, the Department introduced a new monthly continuous data collection genito-urinary medicine access monthly monitoring (GUMAMM). More than 92 per cent of clinics are now returning data (December 2006 return). The Department continues to work closely with clinics and software suppliers in order to address all outstanding IT issues, thus enabling full returns. Provisional results from GUMAMM for December shows that 67 per cent of patients are seen, and 71 per cent of patients are offered an appointment, within 48 hours.

2.88 In November 2006, the Department launched a new sexual health campaign, Condom Essential Wear, to tackle the five major acute sexually transmitted infections (STIs) – chlamydia, syphilis, gonorrhoea, genital warts and herpes – as well as HIV. It aims to raise awareness about the prevalence and invisibility of STIs, while promoting condom use among sexually active young adults. The campaign includes TV, press and radio advertising, digital and online advertising, public relations and partnership work with commercial stakeholders.

2.89 Progress continues to be made in rolling out the National Chlamydia Screening Programme (NCSP). The operational management for the programme has now been transferred to the HPA, who have recruited a strengthened national and regional team to support implementation. The deferred local delivery plans for chlamydia will come into play for 2007-08 and every PCT has been asked to plan to screen at least 15 per cent of the target population.

2.90 On HIV, the Department has continued to provide considerable funding to the voluntary sector to support HIV and STI prevention work. The National Strategy for Sexual Health and HIV identified tackling stigma and discrimination for those with HIV as a key area for action. In early 2006, we consulted on a draft Stigma Action Plan which identified several actions for the Department and others to take forward. A final version of the plan will be published shortly. A conference was held in November 2006 to highlight the considerable work undertaken by the Department and voluntary sector partners around HIV prevention and health promotion.

2.91 The Department also undertook a consultation to clarify policy on patient confidentiality and disclosure of information on STIs, including HIV. This is a complex and sensitive area and many health professionals have sought clarification of the circumstances when they may need to disclose confidential information, including about a patient's HIV status, both with and without the patient's consent. The results of the consultation and way forward will be published in 2007.

2.92 Approximately 4 million people use NHS contraception services each year. Roughly, three-quarters see a GP, and the remainder attend specialist community contraception services (family planning clinics). During 2006, the Department undertook a baseline review of contraception provision, to which 82 per cent of PCTs responded. The Department will shortly publish the results of this review which maps PCT provision of contraception and will help determine how best to meet gaps in local services. The Department will also publish *Best Practice Guidance on Reproductive Healthcare* during 2007.

### Teenage pregnancy

2.93 The Government's Teenage Pregnancy Strategy represents the first coordinated attempt to

tackle both the causes and consequences of teenage pregnancy. It has two targets:

- to halve the under-18 conception rate by 2010, and establish a firm downward trend in the under-16 rate; and
- to increase the proportion of teenage parents in education, training or employment to 60 per cent by 2010, to reduce their risk of long-term social exclusion.

2.94 Local delivery is supported by two national media campaigns: RU Thinking, aimed at younger teenagers, promoting messages on delaying first sex and avoiding peer pressure; and Want Respect: Use a Condom, aimed at sexually active young people, promoting condom use by associating using condoms with behaviour that will earn young people respect from their peers. The strategy also provides support for parents to talk to their children about sex and relationship issues, through the Time to Talk initiative delivered by Parentline Plus.

2.95 *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies* (DH, July 2006) sets out what is known about effective delivery of local teenage pregnancy strategies, based on in-depth reviews carried out in a number of areas with differing levels of success in reducing under-18 conception rates. It also includes new analysis on the underlying factors that affect young people's sexual behaviour and subsequent outcomes, to help areas target their strategies on young people at greatest risk of early pregnancy.

2.96 The guidance asks local areas to reassess their strategies in the light of the review findings and new analysis, and reflect them in their forward plans. It also sets out what support will be provided nationally to support local delivery.

2.97 *Teenage Pregnancy: Accelerating the Strategy to 2010* (DfES, September 2006) sets out how the strategy needs to develop to take account of the growing body of evidence of what is working in areas with sharply declining rates, and to reflect new analysis on the underlying causes of teenage pregnancy. It also sets out how the Government will focus support on areas with high and increasing rates.

2.98 A resource toolkit, *Teenage Pregnancy: Working Towards 2010 – Good Practice and Self-Assessment* (DfES, October 2006), provides local areas with more detailed guidance on the key ingredients that need to be in place locally to reduce under-18 conception rates, building on the guidance provided in *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies.* It also provides a self-assessment form for areas to use when reviewing their local strategies, to help them identify those aspects of their local strategies where further action is required to accelerate progress.

### Drug treatment

2.99 In September 2006, data from the National Drug Treatment Monitoring Service showed that the treatment element of our PSA target (SR 2004, target 6) had been met two years early. Figures showed that over 181,000 people received specialist, structured drug treatment in England during 2005-06, well in excess of the 170,000 required to meet our PSA target.

2.100 The other element of the target that was introduced in 2002, regarding a higher proportion of drug users being retained in treatment year-on-year, is also currently on target. In March 2006, 78 per cent of all clients in treatment either successfully completed or were retained in treatment, compared with 75 per cent in March 2005.

2.101 The other element of the PSA target concerns the effectiveness of drug treatment. This is measured by a proxy indicator that reports the percentage of individuals who are retained in treatment for more than 12 weeks. Year-on-year

increases are being achieved, but continued work to improve the effectiveness of drug treatment remains central to our policy objectives.

**2.102** To support the programme of improvements, DH and the Home Office established the pooled drug treatment budget, which has risen from £129 million in 2001-02 to £375 million in 2006-07. Nearly £400 million will be invested in 2007-08.

**2.103** Further investment has been made of £54 million capital in in-patient and residential rehabilitation (collectively Tier 4) over the next two years. Funding will be issued to SHAs with recommendations for spend based upon the outcome of a strategic bidding process, the outcome of which was announced on 23 February 2007.

**2.104** This significant additional funding will both increase the capacity and improve the outcomes of Tier 4 treatment. In-patient and residential rehabilitation services are effective in the treatment of substance misusers with complex needs. The expansion and improvement of this sector is an important part of the DH and National Treatment Agency's (NTA)Treatment Effectiveness Strategy launched last year.

**2.105** As well as the Department's PSA target, treatment is crucial to the delivery of PSAs owned by other government departments, in particular the Home Office target of 1,000 offenders a week entering treatment by March 2008. Treatment services are currently meeting this demand. Research suggests that for every £1 spent on drug treatment there are an associated £9.50 savings to crime and health costs. We work closely with the Home Office on the delivery of this target.

**2.106** A number of initiatives have been undertaken to support the improvements in the effectiveness of treatment. Among the key initiatives to support this are a *Models of Care for Treatment of Adult Drug Misusers* (NTA, July 2006) guidance document to support the treatment of adult drug misusers; a project on benchmarked unit costs, run jointly with the NTA and the Audit Commission; and a Treatment Outcome Profile (TOP) Monitoring Project, due to be available for use by services around April 2007. Prepared by the NTA, the TOP project is intended to provide consistent outcome data to assist service users, practitioners, local service providers and local commissioners in reviewing progress and in local performance monitoring. At local partnership and Drug Action Team (DAT) level, this will provide additional information for assessing the effectiveness of local systems of care.

### UK Focal Point on Drugs

**2.107** The Focal Point submitted its annual report on the UK drugs situation to the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) together with an extensive set of statistical tables. These include improved and more up-to-date coverage. There was also progress in integrating information from the devolved administrations, enabling a more comprehensive picture of the situation across the whole of the UK to be provided.

## Ensuring system reform is aligned to improve health and tackle inequalities

**2.108** System reform is a key enabler to the improvement in health and the reduction in health inequalities, for example through commissioning for health and well-being. System reform issues are covered in more detail in chapter 4.

## Health protection

### Pandemic influenza

**2.109** The appointment of Professor Lindsey Davies as the Department's first National Director of Pandemic Influenza Preparedness in April 2006 brought new impetus to work to prepare for a potential influenza pandemic.

2.110 Work has been undertaken to expand and update the *UK Health Departments' Influenza Pandemic Contingency Plan* (DH, October 2005) in order to develop a cross-government framework for the response to pandemic influenza. This will be supported by a range of guidance for care in a community setting, acute hospitals, social care and ambulance services, each of which has been developed with the assistance of steering groups involving key stakeholders.

2.111 Following the Chief Medical Officer's recommendation that a national committee be set up to examine the wide range of ethical issues that pandemic influenza might raise, the Committee on Ethical Aspects of Pandemic Influenza was established. It met for the first time in September 2006 under the chairmanship of the Very Reverend Graham Forbes. The committee has prepared an ethical framework to support decision-making that will be issued with the revised contingency plan. Although primarily aimed at planners and strategic policy-makers, it may also be useful to others involved in responding to an influenza pandemic.

2.112 The UK has purchased sufficient antiviral medication to treat 25 per cent of the population during a pandemic; the stockpile was completed in 2006. In 2006, the Department also purchased and received 2.6 million doses of H5N1 vaccine which will be used for research and, if appropriate, offered to front-line healthcare workers in England during a pandemic. The devolved administrations, with whom the Department works closely on pandemic influenza preparedness, are making similar arrangements.

2.113 Good hygiene habits are important during a pandemic, and are also valuable in limiting the spread of infections at other times. In 2006, the Department initiated a public campaign to promote good hygiene habits, including hand washing and respiratory hygiene.

2.114 The Department continued to keep scientific developments in this field under close review through its Scientific Advisory Group and to work with WHO and other international partners as part of the global effort to prepare for pandemic influenza.

### The national immunisation programme

2.115 Vaccines are recognised as one of the most cost-effective health interventions. Vaccines, along with clean water, are recognised by WHO as having had the greatest impact on the world's health.

2.116 The national immunisation programme aims to prevent illness and deaths caused by vaccine-preventable disease. It is easy to forget the difference that vaccines have made to health in this country, because many diseases that used to be commonplace are now rare, or not seen at all. This is due to the success of the national immunisation programme.

2.117 Parents no longer see children in this country crippled by polio, because this disease has been eliminated from the UK and most of the world. Before measles vaccines were introduced, there were as many as three-quarters of a million cases of measles in the UK during epidemic years. About one in every 2,500 to 5,000 children with measles would die.

2.118 Until 1999, meningitis C was a much-feared disease that killed young children and teenagers. Introduction of the meningitis C conjugate vaccine has resulted in cases of meningitis C disease falling by over 95 per cent in all age groups.

2.119 In developing and maintaining a successful immunisation programme, it is essential to ensure that:

- vaccination policy is based on the best available scientific and medical evidence;
- the NHS has the support required to implement vaccination programmes effectively;

- information materials for parents and health professionals are clear, evidence-based, and meet the needs of the target audience;
- the national immunisation programme is closely monitored, performance is reviewed, and improvements made where possible; and
- horizon scanning anticipates future challenges.

2.120 Key priorities for 2006-07 have included:

- the introduction of the pneumococcal vaccine into the routine childhood immunisation programme; and
- completion of the independent review of seasonal influenza.

## Introduction of pneumococcal conjugate vaccine (PCV) to the routine childhood immunisation schedule

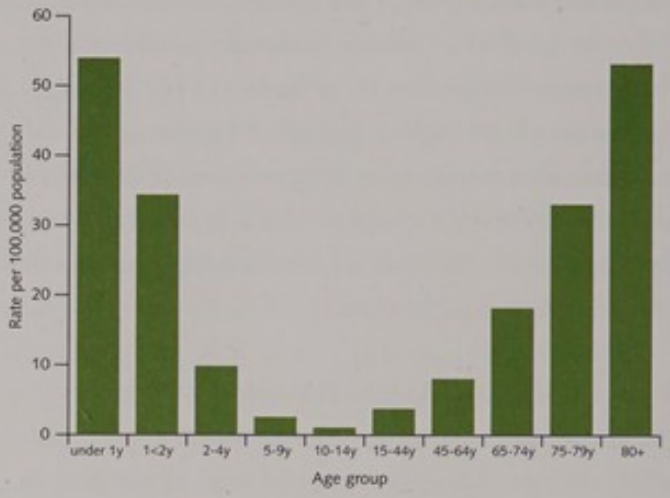
### Background

2.121 In September 2006, pneumococcal conjugate vaccine (PCV) was added to the national immunisation programme. The vaccine protects against the seven most common strains of *Streptococcus pneumoniae.*

2.122 Pneumococcal infection can cause invasive pneumococcal disease (IPD) presenting as meningitis, septicaemia and severe pneumonia, as well as less serious diseases, such as milder pneumonia and bronchitis.

2.123 Younger children, particularly those under one year of age, are particularly vulnerable to pneumococcal infection. **Figure 2.1** illustrates that the incidence of disease declines as children become older.

**Figure 2.1: IPD rates by age per 100,000 population – 2003-04 epidemiological year**




2.124 Before the introduction of PCV vaccine, there were around 5,000 cases of IPD in England and Wales each year, around 530 of these in children under two years of age. Around 50 children under two years of age died from IPD each year and two-thirds of these deaths were from pneumococcal meningitis. Up to half of those who survive pneumococcal meningitis will be left with permanent disabilities, including deafness, cerebral palsy or blindness.

2.125 From September 2006, all children under two years of age were offered pneumococcal vaccine.

### Expected impact of the pneumococcal immunisation programme

2.126 The Department expects to see the rate of pneumococcal infections in young children decline significantly, and it is monitoring this very closely. The Department expects to see cases of pneumococcal infection in older people also declining – this is because fewer children will be carrying the bacteria.

## Seasonal influenza vaccination programme

### Background

2.127 Seasonal influenza can be a serious illness for certain groups of the population, such as older people, and for people with, for example, chronic

lung conditions. During severe epidemics, over an additional 20,000 deaths may be caused by this virus.

2.128 Since 2000, all those aged 65 years and over, and those in clinical risk groups, are offered seasonal influenza vaccine every year. As well as reducing illness in these groups, the seasonal influenza vaccination programme plays an important part in reducing winter pressures on the NHS.

## Review of the seasonal influenza vaccination programme

2.129 On 22 November 2005, the Health Secretary announced in the House of Commons a review of the arrangements currently in place for the seasonal influenza programme in England. This review was completed and published on 8 March 2007. The review details the current vaccine supply system and provides a range of recommendations to strengthen the management of the programme. The main recommendations are:

- high coverage achieved so far should be sustained;
- communications need to be strengthened – advisory letters to the NHS need to be issued earlier to support local planning, and relationships with key stakeholders improved;
- uptake among occupational health groups needs improving;
- stronger performance management is needed – the role of influenza coordinators should be improved and there should be better national, regional and local coordination and contingency planning;
- the full range of delivery mechanisms available to the NHS through the different contract types should be explored; and
- future options for the purchase, supply and delivery of vaccine should be considered.

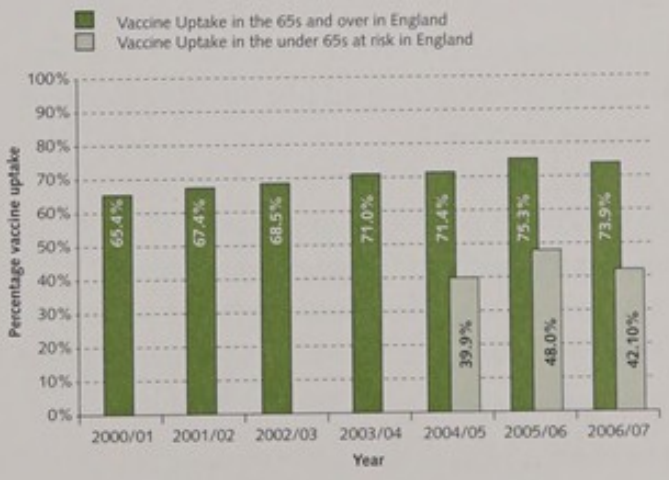
2.130 The Department is currently considering the recommendations from the review.

## Influenza programme 2006-07

2.131 Despite reported delays to the distribution of influenza vaccine at the start of the programme, by the middle of December 2006, 14.6 million doses of vaccine had been distributed in the UK. This is 900,000 more doses than were used in the previous year.

2.132 Final vaccine uptake data collected by the HPA on behalf of the Department shows that vaccine uptake in England in those aged 65 and over was 74 per cent, which is similar to the level of 75 per cent achieved in the previous year. This compares with the WHO target for 2010 of 75 per cent, making England one of the highest achievers so far on record in Europe. Vaccine uptake in those under 65 in an at-risk group was 42 per cent compared with 48 per cent at the same time last year. **Figure 2.2** shows influenza vaccine uptake in those aged 65 and over in England since 2000-01.

### Figure 2.2: Vaccine uptake in the 65s and over and in the under 65s at-risk, England




## Poultry workers

2.133 In January 2007, the Department introduced a new programme to offer seasonal influenza vaccine to those who work in close contact with poultry. Poultry workers would be at greater risk of exposure to avian influenza ('bird flu') virus if this were to occur in poultry in this country. By protecting poultry workers against human influenza, the very slight risk that the worker could

catch human influenza and avian (bird) influenza at the same time would be reduced. This is a precautionary measure which reduces any very low-risk of a pandemic influenza virus emerging in the UK from a mixing of the avian and seasonal influenza viruses. The programme was concluded by 31 March 2007.

## Offender health

2.134 People in prison have generally poorer health than the population at large. This is reflected in strong evidence of health inequalities, unhealthy lifestyles and social exclusion – for example, 90 per cent of prisoners have a mental health problem, a substance misuse problem, or both, and 80 per cent of prisoners smoke.

2.135 Budgetary and commissioning responsibilities for health services in all publicly run prison establishments in England and Wales transferred to the NHS on 1 April 2006 – in England to PCTs. This completed the staged transfer process that had started in 2003, making 2006 the year when health services for prisoners finally became a part of the NHS for the first time. Prison health services should be broadly equivalent to the wider NHS.

2.136 Prisons provide an opportunity to offer health promotion and harm minimisation programmes. *Choosing Health* applies in prisons. Initiatives to improve the health of people in prison have built on earlier successes and include:

- smoking – prisons have been working in partnership with the NHS on smoking cessation projects, with NHS support available for all prisons. Prevention of smoking in prison communal areas will begin in 2007;
- drug misuse – the Integrated Drug Treatment System introduced in 17 prisons in 2006 will provide:

– improved clinical management with greater use of maintenance presenting;
– intensive psycho-social support during the first 28 days of clinical management; and
– greater integration of clinical and psycho-social treatment services with renewed emphasis on through-care; and

- hepatitis B – in October 2006, 1,500 prisoners completed a course of hepatitis B vaccinations – 40 per cent of those intravenous drug users in the wider community who reported receiving one or more hepatitis B vaccinations received them in prison.

### Prison mental health

2.137 Suicide rates in prison remain higher than in the general population, although there was a welcome decline in actual numbers, from 78 apparent self-inflicted deaths in 2005 to 67 in 2006, the lowest figure for ten years. Suicide prevention measures have continued across the prison estate following collaboration between Prison Health (DH), the Care Services Improvement Partnership (CSIP), the Safer Custody Group (part of the National Offender Management Service) and the Prison Service. Forty-one prisons have implemented a new care-planning system – Assessment, Care in Custody and Teamwork (ACCT) – for at-risk prisoners. ACCT will be extended to all prisons across the estate by mid 2007.

2.138 Three hundred and sixty prison in-reach workers now provide mental health services for people with severe mental illness in 102 prisons. A project that aims to reduce waiting times and provide seamless transfers to hospital for those prisoners with a severe mental illness started in April 2005. A waiting time standard of 14 days for these transfers is being piloted until summer 2007. There has been a reduction in the number of such prisoners waiting over 12 weeks for a transfer to hospital – in the quarter ending December 2006, 38 prisoners were waiting, down from 62 prisoners waiting in the quarter ending June 2005.

2.139 The number of people transferred from prison to hospital under sections 47 and 48 of the

*Mental Health Act 1983* (DH, March 2003) rose from 721 people in 2003 to 941 in 2006.

**2.140** A mental health awareness training package has been developed and produced specifically for Prison Service staff. A comprehensive support pack is included and has been sent to all prison mental health leads. It is particularly targeted towards meeting the training need of prison discipline staff, especially those involved with escort and reception duties.

### Secure mental health services

**2.141** Local commissioning capacity plans are now in place for medium secure services in each region. These capacity plans incorporate the provision of services for different groups, including women and patients with personality disorder. In addition, the new purpose-built building for the National Women's Service at Rampton High Secure Hospital opened in November 2006, in order to provide specialist gender-sensitive services for women in high secure care. Broadmoor's and Rampton's Dangerous and Severe Personality Disorder pilot units are working towards full capacity and the majority of wards are now open.

# 3 Improving Health Services for NHS Patients

## Introduction

3.1 This chapter provides an overview of the policies and programmes that are delivering improvements in patients' access to and experience of the care they receive from the NHS. This includes improvements within specific clinical areas.

## Improving the patient experience

3.2 The patient experience is becoming increasingly integral to commissioning and delivering services. The Public Service Agreement (PSA) for 2005 to 2008 has set the Department the goal to:

> secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider, as measured by independently validated surveys (SR 2004, target 7).

3.3 Within the PSA target, 'patient experience' comprises five distinct themes:

- improving access and waiting;
- providing safe, high-quality coordinated care;
- building closer relationships;
- providing a clean, comfortable and friendly environment; and
- better information, more choice.

3.4 The target is to secure an improved experience for patients overall across these five domains, and success is measured by the NHS National Patient Survey Programme, developed in conjunction with the Healthcare Commission. This programme is one of (if not the) largest survey programmes in existence; since 2002, over 1.2 million patients have taken part in 16 surveys across seven different settings. Surveys are conducted by all NHS organisations that provide care in each of the settings covered by the programme, so they provide a highly robust and powerful local, regional and national insight into the experience of patients across the country.

3.5 At a national level, the surveys show that a vast majority of patients report a good experience of healthcare services. *State of Healthcare 2006* (Healthcare Commission, October 2006) made it clear that the quality of patient care and experience has improved in many areas. These conclusions are reflected in the results of a wide range of survey questions that probe patients on different aspects of their recent experiences, including, for example:

- the overall quality of care provided by NHS organisations;
- improved waiting times for treatment;
- confidence and trust in staff;
- being treated with respect and dignity; and
- being given the levels of privacy they individually require.

3.6 However, national survey results do also highlight a number of areas where patients are less positive and where they want to see improvements, including, for example:

- the cleanliness of wards, toilets and bathrooms;
- the quality of hospital food, and help eating food;
- staff communication, for example being given inconsistent information and talking in front of patients;
- being involved in decisions about care and treatment; and
- information for patients, for example information about treatment or condition, being informed about the side effects of medication and danger signals to look for after discharge.

3.7 Analysis of survey results also shows that, even on questions where the national picture is positive, there are often wide variations in the experience of patients treated by different organisations.

3.8 The Healthcare Commission's website provides further information on the National Patient Survey Programme and the results of recent surveys (see www.healthcarecommission.org.uk).

## Primary care

3.9 Some 90 per cent of all patient contact with the NHS happens in primary care, with around 314 million consultations a year. Improving access to primary care is therefore a key part of improving patients' experience of the NHS.

### 24/48-hour access

3.10 NHS patients are now experiencing shorter waits to see a family doctor, and access to primary medical care is improving. Our annual patient survey shows that almost nine in ten patients (88 per cent) now report having the opportunity to see a GP within 48 hours.

3.11 Although access to GPs has improved, the target to ensure that everyone has the opportunity to consult a primary care professional within 24 hours or a GP within 48 hours has had some unintended consequences. In particular, some practices have not allowed patients to book appointments more than one or two days in advance, and some patients report problems in contacting their practice by telephone.

3.12 The GP contract for 2006-07 includes a new incentive to encourage practices to offer better access, including advance booking and responsive telephone systems. For the first time, payments are based on what patients say about their experiences of their GP. Five million questionnaires have been sent to patients, and results will be published in May 2007.

3.13 The same survey asks patients what opening hours they would like their practice to offer. GP opening hours were highlighted by the *Your Health, Your Care, Your Say* consultation (DH, July 2005) as an area where some people say they would like to see change. While the PCT Patient Survey reported that 70 per cent of patients say they are happy with existing hours, some patients would like evening and weekend opening, and Saturday opening in particular (even at the cost of some closures during existing opening hours). Only a minority of practices now offer these appointments. All patients have access to PCT out-of-hours medical services for urgent problems.

3.14 The Improvement Foundation (a not-for-profit company, formerly the National Primary Care Development Team) is helping practices to develop appointment systems that are sensitive to patients' preferences and has so far worked with over 5,000 practices (of the 8,000+ in England) responsible for over 32 million patients.

### Registration with a general practice

3.15 In the White Paper *Our Health, Our Care, Our Say* (DH, January 2006), the Department made a commitment to ensuring that the right to register as an NHS patient with a GP practice becomes a reality for all.

3.16 The Department is working towards guaranteed acceptance at every practice with an open list, simplifying both the handling of closed lists and the process of registration. The Department is bringing an end to 'open but full' practice lists so that all patients will be able to register with their practice of choice – the one which is most convenient and offers the range of services and the opening times that best meet their needs.

3.17 The Department is also clarifying the rules on eligibility to register and making access to GP services more transparent. Alongside this, it is making it easier for patients to access the information they need to choose a practice.

### Fairness in primary care

3.18 The opportunity for people to register with a practice is affected particularly by variations in primary medical care capacity in different localities.

*Our Health, Our Care, Our Say* highlighted the two-fold variation in successful registration between the PCTs with most and fewest GPs for their population. This variation is longstanding, and the White Paper committed the Department to working closely with the 30 PCTs with fewest GPs to take systematic action to address this.

3.19 The Fairness in Primary Care (FPC) programme offers PCTs the opportunity to draw on national expertise to attract new providers with innovative solutions to fill gaps in primary care provision within their area using the new Alternative Provider Medical Services (APMS) contract.

3.20 Under an earlier pilot programme intended to highlight the potential of APMS, two PCTs (Barking and Dagenham PCT and City and Hackney Teaching PCT) signed government-brokered (APMS) contracts with new independent sector providers. Since summer 2006, local patients have been benefiting from extended GP opening hours, including evening and Saturday morning surgeries and NHS walk-in centres that are open seven days a week.

3.21 The first four PCT advertisements under the FPC programme were placed in early April, with more expected in June 2007. The first contracts are expected to be awarded in summer 2007 and new services to commence in early 2008.

### NHS walk-in centres

3.22 NHS walk-in centres are nurse-led first contact centres which provide access to treatment and advice without requiring patients to register or make an appointment first. They offer access to healthcare in the evenings and at weekends, increasing choice and convenience for patients. About 80 NHS walk-in centres are now in operation in England. They see around a quarter of a million patients a month, an average of 120 patients a day at each centre, which is about the same as the average general practice. Some of the busier centres see over 200 patients a day.

3.23 Most NHS walk-in centres are open 365 days a year early until late and allow local people quick and easy access to a range of NHS services. The centres help to improve access for specific groups with particular needs, including young people, homeless people, students, economic migrants, refugees and asylum seekers.

3.24 NHS walk-in centres provide a quality service at a comparatively low cost. The current Walk-in Centre Funding Review, to be published later in 2007, has found that many PCTs have reported that a consultation at their NHS walk-in centre costs them less than £20.

### NHS 'commuter' walk-in centres

3.25 Six of the seven NHS walk-in centres designed particularly to meet the needs of commuters and procured from the independent sector have now opened in Leeds, London, Manchester and Newcastle. Their opening hours are tailored to the needs of commuters, but the service is also available to local residents. PCTs are able to commission additional services for local patients or longer opening hours if they wish.

## NHS Direct

3.26 NHS Direct is a world-class provider of health information, advice and guidance round the clock. It aims to be the preferred NHS partner in delivering value for money in unscheduled and managed healthcare.

3.27 Core services can be accessed in three ways:

- by calling 0845 4647 and speaking to health professionals 24 hours a day, 365 days a year. As at December 2006, NHS Direct had handled almost 40 million calls since the service was launched and currently receives over half a million calls a month;

- by logging on to the website www.nhsdirect.nhs.uk. With more than 1.5 million visits every month, it is thought to be the most used health website in the UK. The online service was successfully re-launched at the end of October 2006 with a new look and easier-to-use interface; and
- by viewing on digital TV. NHS Direct Interactive on the Sky digital TV platform was launched in December 2004 and is available to 8.4 million UK households. It contains over 3,000 pages of information on around 500 health topics, making it one of the largest interactive digital TV services of its kind. In addition, NHS Direct Interactive was launched on the Freeview digital TV platform in December 2006, making the digital TV service available to around 60 per cent (14.8 million) of UK homes.

3.28 NHS Direct nurses are highly qualified and, supported by state-of-the-art decision software, they are able to provide patients with the same high-quality, safe level of service across the country. The expanding role of NHS Direct Online and the launch of the NHS Direct Freeview digital TV service also support people to self-care. Nearly 40 per cent of all calls to NHS Direct are completed without onward referral to any other service and nearly 70 per cent of all calls are completed either by NHS Direct or with referral to routine in-hours services.

3.29 In addition, NHS Direct:

- provides out-of-hours dental call-handling to around a third of PCTs, covering a population of almost 14 million;
- gives people access to local providers of out-of-hours services. In addition, PCTs are able to commission NHS Direct to provide integrated out-of-hours enhanced services;
- can refer people, where appropriate, to help from their local pharmacy;
- is an active player in the provision of support for individuals with long-term conditions; and
- has worked with the Department to provide a public helpline in the event of health alerts.

## Emergency care

3.30 In recent years, numerous improvements have been made to deliver fast, responsive and effective emergency care services, which continue to be maintained effectively for the benefit of NHS staff and patients.

### Urgent care

3.31 Through the consultations *Independence, Well-being and Choice* (DH, March 2005) and *Your Health, Your Care, Your Say*, people said that they want more convenient local health and social care services. In particular, they want the different services to be more closely integrated to meet their needs, with better information provided to service users.

3.32 The White Paper *Our Health, Our Care, Our Say* commits the Department to developing a strategy on urgent care. Lord Warner launched the discussion document *Direction of Travel for Urgent Care* (DH, October 2006) at a national stakeholder event on 4 October 2006. The responses from the consultation will be used to inform a new strategy for urgent and emergency care which is being developed through discussion with stakeholders, users and carers.

### Out-of-hours services

3.33 Under the new primary care contract, GP practices are able to transfer responsibility for providing out-of-hours services to PCTs. The transfer of responsibility is improving the lives of GPs and recruitment and retention.

3.34 PCTs now have a responsibility to ensure that they provide, or secure the provision of, a high-quality, sustainable GP out-of-hours service to meet the needs of their local population.

The Department's aim is to ensure that all patients can be assured of high-quality, responsive and consistent out-of-hours services wherever they live. For this reason, the Department has put in place a set of quality requirements to set the standards for the delivery of out-of-hours care. Where a provider is failing to meet the quality requirements, the PCT and the strategic health authority (SHA) must work together with the provider to improve performance.

3.35 The report *The Provision of Out-of-Hours Care in England* (National Audit Office (NAO), May 2006) confirms that the Department is on the right track towards providing quality round-the-clock GP out-of-hours services. Patient experiences of out-of-hours services are generally positive, with eight out of ten patients being satisfied with the service and six out of ten rating the service as excellent or good.

3.36 While some PCTs need to improve both their performance and that of their service providers to achieve compliance with the standards set out in the quality requirements, the NAO report found no evidence of risk to patient safety.

3.37 The Department commissioned a new *Out of Hours Clinical Audit Toolkit* (Royal College of General Practitioners, March 2007). The Royal College of General Practitioners developed the toolkit to help out-of-hours service providers to carry out audits more effectively.

## Accident and emergency services

3.38 The *NHS Plan* (DH, July 2000) set the initial target of reducing the total amount of time people spend in accident and emergency (A&E) departments from arrival to admission, transfer or discharge to four hours. Subsequently, this was translated to providers being performance-managed against 98 per cent of patients being seen, diagnosed and treated within four hours to allow for the minority of patients who clinically require more than four hours in A&E. The target became an operational standard during 2005.

3.39 It is now the second full financial year during which the NHS has needed to deliver against the operational standard. Following the excellent performance of NHS trusts in 2005-06, where 98.2 per cent of patients were seen, diagnosed and treated within four hours of their arrival at A&E, a high level of performance has been maintained during 2006-07. The first three quarters of this financial year were all above the 98 per cent operational standard. Such sustained performance against the operational standard suggests that access to services in A&E departments really has been transformed.

3.40 Quarterly statistics on A&E performance are available at:
www.performance.doh.gov.uk/hospitalactivity/data_requests

## Ambulance services

3.41 The past year has been a challenging one for ambulance trusts, with demand continuing to increase (6 per cent higher in 2005-06 than in 2004-05), reconfiguration of ambulance trusts, and implementation of *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* (DH, June 2005).

3.42 Nonetheless, ambulance trusts reached 25 per cent more category A (immediately life-threatened) patients within eight minutes in 2005-06 (over 1.2 million compared with just under 1 million in 2004-05). On 1 July 2006, the number of ambulance trusts reduced from 31 to 12, with separate management arrangements for the Isle of Wight. This change, while not affecting the number of front-line ambulance staff or vehicles, should realise efficiencies for ambulance trusts and provide them with the capacity and capability necessary to build world-class ambulance services and to deliver the step change in provision and quality envisaged in *Taking Healthcare to the Patient.*

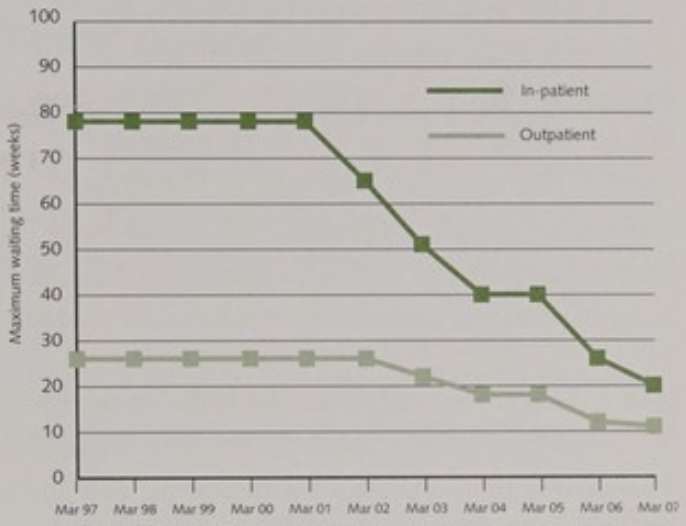
3.43 During 2006, the Department began to review implementation by establishing a range of stakeholder groups to improve collaborative working, coordinate activity and provide strategic direction. Long-term workforce plans are being developed to ensure that ambulance staff have the knowledge and skills to deliver the vision of treating more people over the telephone, in their homes or in their local community. Finally, work is being taken forward to build leadership capacity and capability and increase collaborative procurement of vehicles, equipment and services to improve efficiency and improve targeting of ambulance resources.

## Secondary care

### Elective care waiting times

3.44 Fewer patients are waiting and thousands of patients are benefiting from earlier treatment. This is shown in **Figure 3.1**.

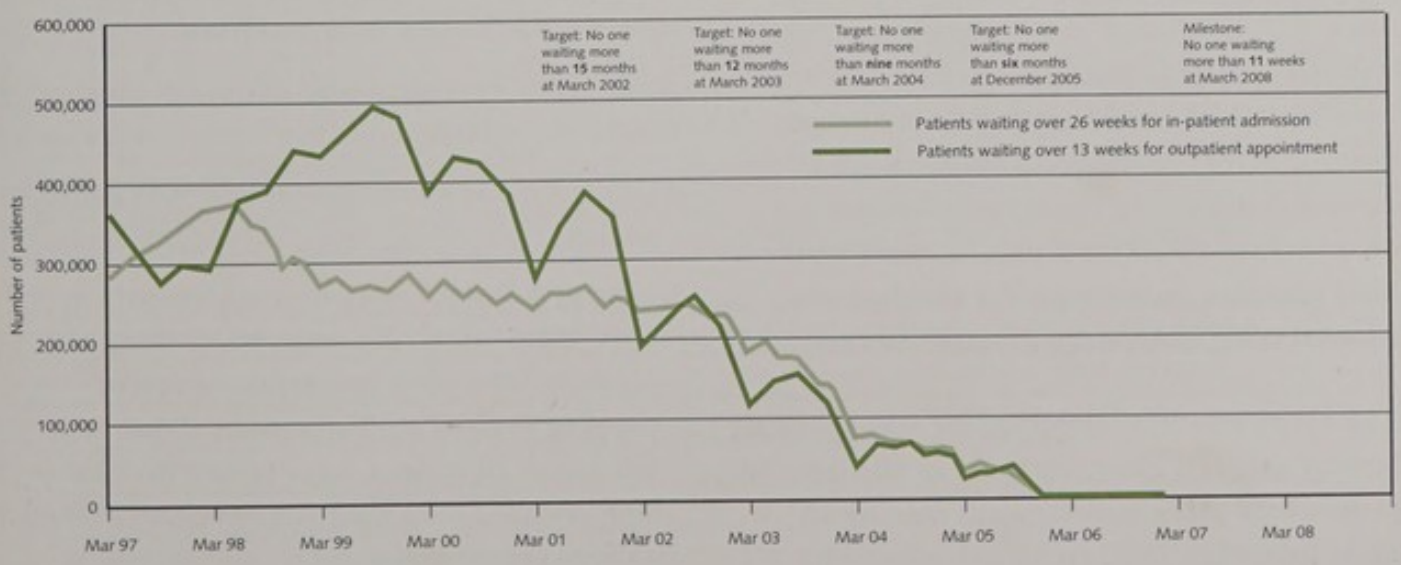
**Figure 3.1: Reduction in in-patient and outpatient maximum waiting times**




3.45 Today, patients can expect to wait no more than 13 weeks for their first outpatient appointment. Ten years ago, waits of over six months were not uncommon.

3.46 Patients who need an operation can now expect to be admitted within a maximum of 26 weeks, compared with waits of often two years, ten years ago. Most patients are admitted much sooner. This is shown in **Figure 3.2**.

**Figure 3.2: Reduction in number of over 13-week outpatient waits and 26-week in-patient waits since 1997**



## The 18 Weeks waiting-time target

3.47 Over the next 18 months, the NHS will go even further to shorten waits for patients. By December 2008, patients referred for non-emergency surgical or medical consultant-led care will be offered treatment within 18 weeks of referral. The majority of patients will be treated much more quickly. In practice, this means every patient being treated without unnecessary delay, just as cancer patients are now.

3.48 This is very ambitious. An initial assessment in 2006 suggested that about 35 per cent of patients who needed to be admitted for treatment, and 70 to 80 percent of patients who did not, received the treatment they needed within 18 weeks. However, this is a good base on which to build, and the NHS is planning to make the necessary progress towards the ultimate objective in 2007-08.

3.49 Very significant changes are required in the way care is organised. Working with key NHS stakeholders, the Department is supporting this by developing good practice commissioning pathways for each of the highest volume specialties.

3.50 In January 2007, a new data collection was introduced to enable the NHS to measure the time that each patient waits for treatment from the point of referral. This enables the NHS for the first time to track and manage patients through their care pathway without unnecessary delay.

3.51 The NHS is also piloting better tracking of individual patient's waits, as they move through their pathway from referral to treatment. The experience in reducing cancer waits was that effective patient tracking stimulated much more rapid reductions in waiting times than had been achieved using retrospective monthly data only.

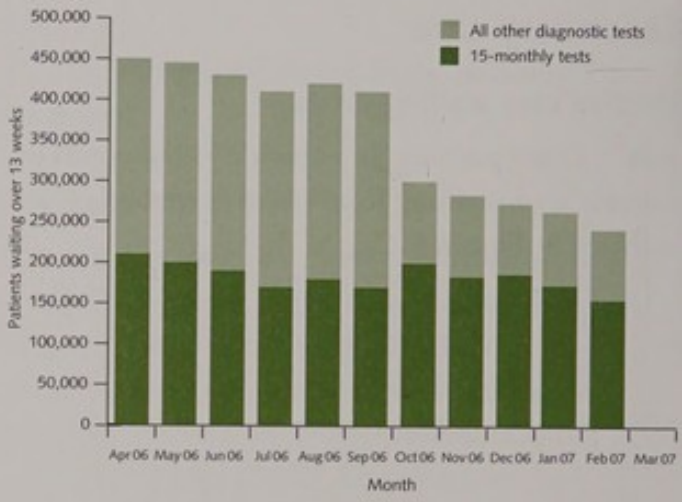
3.52 The new NHS Contracts for Acute Hospital Services gives NHS commissioners an effective tool to drive local performance towards meeting 18 weeks from April 2007, enshrining agreements between commissioners and providers about how many and how quickly patients will be treated.

## Diagnostic waiting times

3.53 Reducing waits for diagnostic tests is central to delivering a maximum 18-week wait.

3.54 To help the NHS understand how long patients are waiting now for diagnostic tests, and to be able to measure progress in reducing them, the NHS began measuring diagnostic waits for the first time from January 2006 (See **Figure 3.3**).

### Figure 3.3: Diagnostic over 13-week waiters




3.55 The diagnostic stage of treatment is undoubtedly the most challenging because it has received little or no attention until recently. Long waits have fallen substantially since the NHS started reporting diagnostic waiting times in January 2006. However, this remains an area of focus.

3.56 The Department will continue to monitor this closely and take action by:

- supporting and encouraging the NHS to redesign services;
- using performance measures and incentives to drive improvements. For example, in 2006-07, 'choice of scan' offers patients the option of choosing to go to another provider if their wait will exceed 20 weeks. Choice of scan has now been extended from April 2007 to patients whose waits exceed 13 weeks; and,

- working with SHAs to ensure that there is enough additional diagnostic capacity from 2007-08, both from within the NHS and from the independent sector (IS). The Department expects that the additional diagnostic activity being procured centrally from the IS will equate to around 8.5 million tests over five years, of which around 40 per cent will be magnetic resonance imaging (MRI) and ultrasound scans.

### Activity trends

3.57 **Figure 3.4** gives details of hospital activity levels for each of the main sectors. 2005-06 saw an increase of 2.2 percent since 2004-05 for general and acute elective hospital admissions and 3.8 percent for first outpatient attendances.

## Dental services

### Reform of primary dental care services

3.58 The Government's high-level objectives for dental services and dental public health are to support the NHS and the professions to:

- reduce oral health inequalities;
- improve access to NHS dental services; and
- promote high-quality NHS dental services.

**Figure 3.4: Hospital activity trends, 1992–93 to 2005–06**

| | 1992-93 | 1997-98 | 1998-99 | 1999-2000 | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 | 2005-06 | % change 2004-05 over 2003-04 | % change 2005-06 over 2004-05 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **General and acute (thousands of episodes)** | | | | | | | | | | | | |
| Elective admissions[1] | 4,066 | 4,450 | 4,869 | 4,934 | 5,045 | 5,080 | 5,308 | 5,492 | 5,607 | 5,732 | 2.1% | 2.2% |
| Emergency and other admissions (non-elective admissions)[1] | 3,532 | 3,736 | 3,855 | 3,893 | 3,949 | 3,968 | 4,014 | 4,282 | 4,504 | 4,700 | 5.2% | 4.3% |
| Total admissions (first finished consultant episodes)[1] | 7,598 | 8,186 | 8,724 | 8,827 | 8,994 | 9,048 | 9,322 | 9,774 | 10,111 | 10,432 | 3.5% | 3.2% |
| **Geriatrics (thousands of episodes)** | | | | | | | | | | | | |
| Total admissions (first finished consultant episodes)[2] | 459 | 401 | 399 | 383 | 359 | 347 | 357 | 357 | 368 | 361 | 3.1% | −1.9% |
| **Maternity (thousands of episodes)** | | | | | | | | | | | | |
| Total admissions (first finished consultant episodes)[2] | 905 | 827 | 880 | 884 | 896 | 877 | 924 | 970 | 1,000 | 1,038 | 3.1% | 3.8% |
| **New outpatients (first attendances) (thousands)** | | | | | | | | | | | | |
| General and acute[3] | 8,488 | 10,643 | 10,919 | 11,294 | 11,637 | 11,838 | 12,080 | 12,650 | 12,617 | 13,094 | −0.3% | 3.8% |
| – of which, geriatrics[3] | 77 | 107 | 108 | 113 | 114 | 115 | 115 | 125 | 122 | 131 | −2.4% | 7.0% |
| Maternity[3][5] | 612 | 590 | 565 | 554 | 537 | 504 | 522 | 505 | 482 | 465 | −4.7% | −3.6% |
| Mental illness[3] | 238 | 290 | 287 | 282 | 285 | 263 | 271 | 267 | 264 | 239 | −1.0% | −9.4% |
| Learning disabilities[3] | 4 | 6 | 6 | 7 | 7 | 8 | 7 | 8 | 8 | 7 | −1.8% | −11.8% |
| All specialties[3][5] | 9,342 | 11,529 | 11,778 | 12,136 | 12,466 | 12,613 | 12,879 | 13,431 | 13,370 | 13,805 | −0.4% | 3.2% |
| **New A&E (first attenders) (thousands)[4]** | 10,993 | 12,794 | 12,811 | 13,167 | 12,953 | 12,901 | 13,253 | 15,313 | 16,712 | 17,775 | 9.1% | 6.4% |
| **Average length of spell (ordinary admissions) (days)** | | | | | | | | | | | | |
| General and acute[2] | 7.9 | 7.0 | 6.8 | 6.7 | 6.9 | 7.1 | 7.0 | 6.8 | 6.3 | 5.9 | −7.4% | −6.2% |
| – of which, geriatrics[2] | 26.9 | 22.7 | 22.2 | 21.8 | 23.3 | 23.4 | 23.1 | 21.7 | 20.1 | 19.0 | −7.4% | −5.5% |

*Notes:*
*(1) Source: SaFFR quarterly monitoring and current monthly monitoring. Figures are for admissions purchased by the NHS. Figures prior to 2005-06 have been re-based to allow direct comparison. General and acute specialties do not include mental health, learning disabilities or maternity. From 30 June 1998 activity is calculated on the basis of first finished consultant episodes. Elective activity includes waiting-list, booked and planned admissions. A corresponding figure for 1992-93 is not available, so the figure in the table is estimated from the Hospital Episode Statistics for the number of admissions to NHS hospitals in England. For 1992-93, admissions where the method of admission is unknown are included in the emergency and other admission category. Note that some unknown cases may be elective cases. Figures prior to 2001-02 are from health authorities. With the abolition of health authorities, figures for 2001-02 are based on returns from NHS trusts. Data is presented for financial years and are not adjusted for the differing number of working days per year. There were three more working days (255) in 2005-06 compared with 2004-05 (251).*
*(2) Source: Hospital Episode Statistics. Figures are for admissions to NHS hospitals in England. Figures are grossed for coverage, except for 2002-03, 2003-04, 2004-05 and 2005-06 which are not yet adjusted for shortfalls.*
*(3) Source: KH09 and QMOP. Figures for 2001-02 and onwards are sourced from QMOP.*
*(4) Source: QMAE and KH09. From 2003-04, attendances at walk-in centres are included. A large proportion of the 15.5 per cent growth in A&E attendances seen between 2002-03 and 2003-04 is due to the inclusion of NHS walk-in centre activity for the first time in 2003-04.*
*(5) Q1 2005-06 data for Maternity has been estimated to obtain the 2005-06 total as it was not available.*

3.59 In support of these objectives, the Government introduced a new framework for primary dental care services from 1 April 2006. Responsibility for commissioning dental services was devolved to PCTs, in conjunction with new contractual arrangements for dentists and a simpler system of patient charges. The budgets devolved to PCTs represent around £2.4 billion of gross expenditure (including assumed income from patient charges) – one-third higher than expenditure three years ago (£1.8 billion in 2003-04) or about a 20 per cent increase after adjusting for increases in dental remuneration.

3.60 In recent years, targeted investment and workforce initiatives have improved access in areas of the country that suffered from poor access to NHS dentistry. The reforms introduced in April 2006 now provide a much more stable platform for supporting further improvements. PCTs are already using the reforms to commission new dental services for their areas and to match services more closely to local needs.

3.61 The early priority in the run-up to the reforms in April 2006 was to agree contracts with existing dentists or dental practices. The new contracts signed by these dentists and practices initially represented around 96 per cent of previous service levels. However, the additional services commissioned by PCTs since April 2006 already exceed the 4 per cent of capacity temporarily lost through dentists choosing not to take up the new contracts. The level of services commissioned by PCTs has continued to grow steadily throughout 2006-07.

3.62 The Department has established an Implementation Review Group to monitor the impact of the reforms and identify any changes that may be needed to maximise their benefits for patients, the NHS and the profession.

3.63 In May 2006, the Government announced a two-year £100 million capital investment programme to improve and modernise dental practices across the country.

## General and personal dental services (GDS and PDS)

3.64 **Figure 3.5** provides key information on general dental services (GDS) and personal dental services (PDS) in England. The most significant feature over the period 2004-05 to 2005-06 was the acceleration in the move to PDS pilots. This was consistent with the Department's aim that at least 25 per cent of dental practices should be operating within PDS pilots by April 2005, where they and their patients could benefit from new ways of working under locally commissioned contracts. Reductions in GDS activity and numbers of dentists in 2005-06 were counter-balanced by significant growth in PDS activity. The key points are as follows:

- The overall volume of activity was broadly stable in 2005-06, taking into account that new ways of working generally result in more preventative care and less intensive throughput of patients.
- The number of dental practitioners working in GDS and PDS increased by 6 per cent in the year to September 2005 and by 31 per cent in the period from 1995 to 2005, reflecting in part the drive to recruit additional dentists in areas with access difficulties. Between April 2004 and October 2005, the Department and the NHS exceeded the Project 1,000 target by recruiting the equivalent of over 1,450 full-time NHS dentists.
- The equivalent of patient registrations across GDS and PDS increased in 2005-06, helping to rebuild the patient base after the access difficulties of earlier years.
- There were nearly 26 million courses of treatment for adults during 2005-06 across GDS and PDS. This represents a small reduction compared with the number in 2004-05, reflecting the new ways of working in PDS, but more than 4 per cent higher than in 1995-96.
- The average cost of an adult course of treatment within GDS was £46 in 2005-06, an increase of

4 per cent in real terms compared with the previous year. The average cost has fallen in real terms over the last decade by 4 per cent, reflecting a reduction in complex or advanced treatments. No equivalent figure can be calculated for PDS as remuneration cannot be similarly itemised and attributed to specific categories of patient.

- At 30 September 2005, 7,089 dentists were working in PDS, 5,149 of whom were not also working in GDS. PDS dentists include both salaried dentists working mainly in dental access centres and independent contractors working in high-street dental surgeries.

## Eye care services

### Review of general ophthalmic services

3.65 The Department has recently completed a review of general ophthalmic services, the main outcome of which is a toolkit to support PCTs and practice-based commissioners in developing a wider range of community-based eye care services appropriate for their local populations. This supports our overall objectives of developing more community-based services and giving patients greater choice and voice.

### General Ophthalmic Services

3.66 **Figure 3.6** provides key information on general ophthalmic services in England. The key points are as follows:

- The number of NHS sight tests has risen substantially by some 59 per cent over the ten years from 1995-96 to 2005-06, driven mainly by the Government's decision to extend eligibility for free NHS sight tests from 1 April 1999 to everyone aged 60 and over. Since April 1999, the underlying trend has been for an average annual increase of about 1.6 per cent in the volume of tests.

### Figure 3.5: Family Health Services – Key Statistics on General and Personal Dental Services, England

| | 1995-96 | 2001-02[2] | 2002-03[2] | 2003-04[2] | 2004-05[2] | 2005-06[2] | % change 1995-96 to 2005-06 | % change 2004-05 to 2005-06 |
|---|---|---|---|---|---|---|---|---|
| **General dental services**[1,4,5] | | | | | | | | |
| Number of general dental practitioners[3] | 15,951 | 18,354 | 18,400 | 18,537 | 17,865 | 15,741 | −1% | −12% |
| Adult courses of treatment (thousands) | 24,752 | 26,318 | 26,284 | 26,507 | 23,826 | 17,019 | −31% | −29% |
| Average gross cost of an adult course of treatment (2005-06 prices) (£)[4,5] | 48 | 46 | 45 | 45 | 44 | 46 | −4% | 4% |
| **Personal dental services**[2] | | | | | | | | |
| Number of personal dental practitioners[6] | n/a | 707 | 997 | 1,190 | 2,699 | 7,089 | n/a | 163% |
| Number of personal dental practitioners not working in the general dental service[6] | n/a | 467 | 656 | 802 | 1,857 | 5,149 | n/a | 177% |
| Adult courses of treatment (thousands) | n/a | 319 | 442 | 542 | 2,662 | 8,825 | n/a | 232% |
| Child courses of treatment (thousands) | n/a | 161 | 217 | 257 | 945 | 2,945 | n/a | 212% |
| **Total dental services** | | | | | | | | |
| Number of general and personal dental practitioners | 15,951 | 18,821 | 19,056 | 19,339 | 19,722 | 20,890 | 31% | 6% |
| Numbers of adults registered (thousands)[7] | 19,994 | 17,281 | 17,064 | 17,374 | 17,237 | 17,670 | −12% | 3% |
| Numbers of children registered (thousands)[7] | 7,292 | 6,982 | 6,841 | 6,964 | 6,891 | 7,044 | −3% | 2% |

*Notes:*
*(1) General Dental Services are the care and treatment provided by independent high street dentists who provide services under NHS arrangements.*
*(2) The introduction of the Personal Dental Services pilots in October 1998 and their subsequent growth has progressively affected General Dental Services activity.*
*(3) Principals, assistants and vocational trainees at 30 September.*
*(4) Based on item of service fees and adult continuing care payments. Average gross costs are converted to 2005/06 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.*
*(5) Data on courses of treatment represents completed treatment claims processed by the Dental Practice Board within the relevent year, rather than only courses of treatment conducted within the year.*
*(6) Number of PDS practitioners at 30 September.*
*(7) In 1995-96, adult registrations lasted 24 months and child registrations lasted until the end of the following calendar year. The percentage change between 1995-96 and 2005-06 is distorted by the shorter GDS registration period of 15 months for both adults and children introduced in September 1996, which forms the basis for the figures from 2000-01 onwards. For the period since September 2003, registrations for PDS pilots (which had varying registration periods) are estimated using 'proxy registrations', namely the number of patients seen in the previous 15 months; for the period before September 2003, actual PDS registrations are used. The 1995-96 figure shows patients registered at 30 September; the figures for 2001-02 onwards show patients registered at 31 March.*

- The number of reimbursed NHS optical vouchers has decreased slightly over the past ten years, averaging out as a fall of 0.4 per cent per year. However, there have also been some moderate fluctuations year on year, reflecting changes in factors such as the number of adults claiming Income Support and income based Jobseeker's Allowance (the main category of people who qualify for vouchers). The fact that the number of reimbursed vouchers in 2005-06 was 1 per cent higher than in 2004-05, and yet was 4 per cent lower than ten years ago, reflects these fluctuations.
- Activity levels can be affected by two factors: variations in the size of the population groups eligible for NHS sight tests and optical vouchers, and variations in the take-up rates for sight tests and vouchers.
- the number of opticians in 2005-06 showed no significant change over the previous year, but the total of 8,467 represented an increase of 25 per cent over the number in 1995-96.

## Pharmacy

3.67 *A Vision for Pharmacy in the New NHS* (DH, July 2003) was instrumental in enabling pharmacy services to deliver greater choice, better access and higher quality for all patients. Since then, *Our Health, Our Care, Our Say* has signified a fundamental shift in the direction and delivery of NHS services in future. Community pharmacy, with its tradition of easy and convenient access for all and high public confidence in the services, advice and support available, is well placed to develop services tailored locally to patients' needs, in convenient settings, close to or in the home.

### Community pharmacy contractual framework

3.68 The contractual framework for community pharmacy, introduced on 1 April 2005, has improved the quality and range of services that pharmacists can offer to patients and makes better use of pharmacists' skills and expertise. This includes:

- continuing progress on the repeat dispensing of prescriptions. Over 600,000 items had been dispensed by repeat dispensing by November 2006;
- pharmacists can now provide up to 400 medicines-use reviews in a year. Over 500,000 were undertaken by the end of December 2006; and
- a total of 17,745 local enhanced services, such as stop smoking services or needle and syringe exchange services, were commissioned by PCTs and provided by community pharmacy contractors in 2005-06.

3.69 Twenty-eight PCTs from each of the SHAs took part in the Community Pharmacy Framework Collaborative (CPFC) to support the implementation of the new contractual framework and improve NHS pharmaceutical services provided from community pharmacies.

3.70 From 1 April 2006, the Local Pharmaceutical Service (LPS) scheme was established as a mainstream mechanism for primary care commissioning and provides PCTs with the

**Figure 3.6: Family health services – key statistics on general ophthalmic services, England**

| | 1995-96 | 2001-02 | 2002-03 | 2003-04 | 2004-05 | 2005-06 | % change 1995-96 to 2005-06 | % change 2004-05 to 2005-06 |
|---|---|---|---|---|---|---|---|---|
| NHS sight tests (thousands)[1] | 6,512 | 9,807 | 9,662 | 9,845 | 10,149 | 10,355 | 59% | 2% |
| Optical vouchers (thousands)[2] | 3,815 | 3,607 | 3,472 | 3,520 | 3,624 | 3,678 | −4% | 1% |
| Number of opticians[3] | 6,778 | 8,103 | 8,096 | 8,331 | 8,472 | 8,467 | 25% | 0% |

*Notes:*
*(1) From 1 April 1999, the eligibilty criteria for NHS sight tests were extended to include all patients aged 60 and over. Figures are based on the number of sight test claims where the date of payment fell within the financial year, rather than the date the sight test was conducted.*
*(2) The voucher scheme was introduced on 1 July 1986 to help certain priority groups with the provision of spectacles. Figures are based on the number of vouchers reimbursed to practitioners in the year, including payments for complex appliances, rather than the date when the vouchers were exchanged by patients for spectacles.*
*(3) Optometrists and ophthalmic medical practitioners at 31 December.*

flexibility to commission services that address specific local priorities and needs as well as general situations not covered by the national community pharmacy contractual framework.

## Control of entry

3.71 Following the Government's response in July 2003 to the Office of Fair Trading (OFT) report *The Control of Entry Regulations and Retail Pharmacy Services in the UK* (OFT, January 2003), which had recommended total deregulation, a balanced package of reform measures to the NHS regulatory system known as 'control of entry' was introduced in April 2005.

3.72 Fulfilling a commitment originally made in 2003, the Department undertook a review of these reforms in 2006 and published the results in the report *Review of Progress on Reforms in England to the "Control of Entry" System for NHS Pharmaceutical Contractors* (DH, January 2007). On the evidence so far, the balanced package of reform measures has achieved the goal of opening up the market, but the impact has been uneven.

3.73 However, the report also identified certain shortcomings. Ministers therefore decided to review what action is needed to allow PCTs to have more powers to commission as necessary to secure adequate service provision to meet local health needs. Anne Galbraith, former Chair of the Prescription Pricing Authority, chaired this review, which reported in March 2007. Ministers are considering her findings prior to formal consultation on any proposed changes.

## Hospital pharmacy

3.74 The Healthcare Commission published its national findings about medicines management in acute and specialist trusts in the report *The Best Medicine: Medicines Management in Acute and Specialist Trusts* (Healthcare Commission, January 2007). The Commission noted many positive developments since the last review by the Audit Commission in 2002. However, more work is needed to ensure that pharmacy services in all trusts reach the standards of the very best.

3.75 At the same time, the Healthcare Commission published the parallel report *Talking About Medicines: Medicines Management in Mental Health Trusts* (Healthcare Commission, January 2007). Although the methodology used was experimental and did not provide a complete survey of mental health trusts, the report did helpfully highlight issues requiring further consideration, which will feed into the Department's review of the way care of mental health patients is planned, managed and coordinated.

3.76 The Department has published guidance to support the introduction of the new consultant pharmacist role, and the first posts have been approved in specialties that include critical care, adult mental health and HIV.

## Pharmacy and public health

3.77 Pharmacies have a very important contribution to make to improving health and reducing health inequalities, as they are ideally placed in the heart of the communities they serve to impart healthy lifestyle messages both to people who are well and to those who are not. *Choosing Health Through Pharmacy – A Programme for Pharmaceutical Public Health 2005–2015* (DH, April 2005) aims to maximise the contribution of pharmacy to public health.

3.78 An Implementation Advisory Group has been established with a wide range of stakeholders from both the public health and the pharmacy communities to provide leadership and support for implementation of the strategy. This group has led the development of a range of educational tools and resources to help pharmacists and their teams provide brief advice and interventions in key areas such as stopping smoking, weight management, alcohol reduction, improved nutrition and diet and increased physical activity. These tools and resources

were launched in February 2007, and further information can be found at www.pharmacymeetspublichealth.org

### Pharmacy workforce

3.79 The *Health Act 2006* enables pharmacists and pharmacy owners to make better and more flexible use of all staff working in pharmacies. It clarifies the responsibilities of the pharmacist in charge of the pharmacy and makes clear how the pharmacist is to discharge his or her supervisory responsibilities.

3.80 These changes will allow highly trained pharmacists to provide a wider range of services, such as providing professional advice on the safe and most effective use of medicines and health improvement services. The changes will enable the 44,000 pharmacy technicians and other support staff to make a much greater contribution to pharmacy services. The Department is consulting with all interested parties on the details of the responsible pharmacist changes, which are expected to be set out in regulations, later in 2007.

3.81 *Implementing Care Closer to Home – Providing Convenient Quality Care for Patients: A National Framework for Pharmacists with Special Interests* (DH, September 2006), designed for pharmacists and commissioners, was launched in 2006.

### Utilising IT

3.82 *Delivering 21st Century IT Support for the NHS: National Strategic Programme* (DH, June 2002) states that a national electronic prescription service will be available by the end of 2007. The Electronic Prescription Service (EPS) is being developed and supported by NHS Connecting for Health.

3.83 In order to be able to carry out their wider roles safely and effectively, the Department is also committed to ensuring that community pharmacists have appropriate access to healthcare records through the NHS Care Record Service. The Department will be consulting on what information should be available to community pharmacy staff through this service.

3.84 Further information on both the EPS and the NHS Care Record Service is included in chapter 8.

### Pharmaceutical services – key facts

3.85 **Figure 3.7** provides key information on pharmaceutical services in England. In particular, it highlights the following:

- Both the volume of prescriptions and the average number of prescriptions dispensed by pharmacy and appliance contractors continue to increase. The year-on-year growth in the number of prescriptions per pharmacy in 2005 was 5.4 per cent; in comparison, there was growth of 5.7 per cent in 2004.
- The gross cost per prescription decreased by 7.0 per cent in 2005. This was partly due to the requirement under the 2005 Pharmaceutical Price Regulation Scheme (PPRS) that all companies that sell more than £1 million worth of branded medicines to the NHS reduce prices by 7 per cent and partly due to the introduction of new pricing arrangements for many generic drugs from April 2005.
- The percentage of prescriptions that attract a charge has shown a consistent downward trend over recent years, from 14.9 per cent in 2000 to 12.4 per cent in 2005.

### Prescription charge review

3.86 During 2006, the Health Select Committee conducted an inquiry into NHS charges (including prescription charges). The Government responded to the committee's report in October 2006.

This response ruled out the abolition of charges in England as this would reduce, by some £430 million, the money available to deliver health priorities.

**3.87** The Government is undertaking a review of prescription charges and will report on the outcome of this review by the summer recess 2007. This review includes options to:

- revise the list of medical exemptions to prescription charges;
- introduce a flat-rate prescription charge with no exemptions; and
- base exemption to prescription charges solely on income.

**3.88** These options will be considered on the basis that any changes to prescription charge exemptions, if implemented, will be cost-neutral for the NHS.

## Non-medical prescribing by nurses, pharmacists and other health professionals

**3.89** The Non-medical Prescribing Programme is expanding prescribing by nurses, pharmacists, optometrists and some allied health professionals. It aims to give patients improved and quicker access to the medicines that they need. Non-medical prescribers only prescribe where they are qualified and competent to do so, and clinical governance procedures at PCT and NHS trust level help ensure patient safety.

**3.90** From May 2006, qualified nurse independent prescribers and pharmacist independent prescribers were able to prescribe any licensed medicine for any medical condition within their competence, including, for nurses, some controlled drugs. Over 9,000 nurse independent prescribers are now trained to prescribe, an increase of over 40 per cent since early 2006. The first pharmacist independent prescriber qualified in December 2006.

**3.91** Over 750 pharmacists in England are now qualified as supplementary prescribers, prescribing long-term conditions in partnership with a doctor. In addition, smaller numbers of physiotherapists, podiatrists, chiropodists and optometrists have trained to prescribe as supplementary prescribers.

### Figure 3.7: Key statistics on pharmaceutical services, England

| | 1995-96 | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 | 2005-06 | % change 1995-96 to 2005-06 | % change 2004-05 to 2005-06 |
|---|---|---|---|---|---|---|---|---|---|
| | Cash | | Resource | | | | | | |
| **Pharmaceutical Services**[1] | | | | | | | | | |
| Prescription fees (millions)[2] | 440.2 | 520.5 | 549.7 | 580.3 | 611.8 | 641.5 | 679.3 | 54.3% | 5.9% |
| Number of contracting pharmacies[3, 4] | 9,787 | 9,765 | 9,756 | 9,748 | 9,759 | 9,736 | 9,782 | -0.1% | 0.5% |
| Average number of prescription fees per pharmacy dispensed by pharmacy and appliance contractors | 44,978 | 53,303 | 56,345 | 59,530 | 62,691 | 65,889 | 69,444 | 54.4% | 5.4% |
| Average net ingredient cost per fee (£)[5] | 7.65 | 9.73 | 10.27 | 10.87 | 11.23 | 11.29 | 10.50 | 37.3% | −7.0% |
| Percentage of all prescription items which attracted a charge[5] | 16.2 | 14.9 | 14.6 | 14.3 | 13.8 | 13.1 | 12.4 | | |

*Notes:*
*(1) Pharmaceutical services are mainly the supply of drugs, medicines and appliances prescribed by NHS practitioners.*
*(2) Includes prescriptions dispensed by community pharmacists and appliance contractors; excludes those dispensed by dispensing doctors.*
*(3) Includes appliance contractors; excludes dispensing doctors.*
*(4) Figures refer to 31 March (for example number for 2004-05 is as at 31 March 2005).*
*(5) 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 Prescription Pricing Division of the Business Services Authority in the calendar year. Prior to 2001, the analysis is based on prescriptions submitted by community pharmacists and appliance contractors only; from 2001 onwards it also includes dispensing doctors.*
*(6) Cost are shown in cash for 1995-06 and 2000-01 and in resource from 2001-02 onwards. This reflects the move to resource accounting in DH accounts from 2000-01.*

### Modernising the home oxygen service

3.92 The introduction of a modern NHS home oxygen service saw 79,000 patients transferred to the new arrangements from 1 February 2006. Patients can now get all their home oxygen needs from the single supplier for their home oxygen area. This includes a wider range of modern equipment that can help them better manage their symptoms and improve their quality of life. A number of service problems emerged during the transition to the new service. For the most part these have been addressed, but work continues to ensure delivery of a better service.

## Modernising pathology services

3.93 In the last year, the Department has continued to support key initiatives to modernise NHS pathology services, including:

- a National Pathology Service Improvement Programme using lean principles and a national Pathology Action Learning Programme;
- a National Pathology Workforce Re-profiling Project as part of the wider programme of workforce reform in healthcare science;
- support for modernisation of the pathology accreditation system;
- development of a national project to provide decision support and electronic test requesting in primary care;
- development of a national clinical benchmarking system; and
- publication of good practice guidance for NHS mortuary staff, *Care and Respect in Death* (DH, August 2006).

3.94 In September 2005, as part of the Modernising Pathology Programme, the Department announced an independent review of pathology services, chaired by Lord Carter of Coles, to determine the feasibility of and benefits from wide-scale service reconfiguration and modernisation. *Report of the Review of NHS Pathology Services in England* (DH, August 2006) found that pathology services in England are generally of high quality and are reliable. It also identified a lack of robust data about activity and costs. The Department accepted the report's key recommendation to test and refine the review's findings through a programme of pilots. As a result, 12 pilot sites, running from January to September 2007, are collecting data on activity and costs which will provide an evidence base for service reconfiguration and recommendations for NHS implementation from April 2008.

## Healthcare-associated infections

3.95 Over the last year, tackling healthcare-associated infections (HCAIs) has continued to be a priority for the Government and the NHS. *The NHS in England: Operating Framework for 2007-08* (DH, December 2006) makes clear that tackling infections is one of only four top priorities.

3.96 The statutory *Code of Practice for the Prevention and Control of Health Care Associated Infections* (DH, October 2006) requires NHS bodies to have appropriate management and clinical governance systems in place to deliver effective infection control. The Healthcare Commission will assess compliance with the code.

3.97 The Department of Health commissioned updated national guidance for preventing all HCAIs in hospitals; *Epic 2: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England* was published as a supplement to the *Journal of Hospital Infection* in February 2007.

3.98 The latest HCAI data is available via the Health Protection Agency (see www.hpa.org.uk).

### MRSA

3.99 Latest MRSA data (published in January 2007) shows our progress towards meeting the target to halve the number of MRSA bloodstream

infections by 2008. In particular, the most recent six-monthly total of MRSA bloodstream infections (April to September 2006) is the lowest ever since mandatory recording began in 2001. However, the pace of reduction needs to increase in order to deliver the target and we shall continue to build upon the key activities of the past year, which include:

- developing the toolkit *Saving Lives: A Delivery Programme to Reduce Healthcare Associated Infection Including MRSA* (DH, June 2005), an evidence-based delivery programme for best practice in acute settings, supplemented by *Essential Steps to Safe, Clean Care: Reducing Healthcare-associated Infections* (DH, June 2005), which focused on non-acute settings;
- activities to engage chief executives and medical directors, for example *Going Further Faster* (DH, May 2006), which brings together current learning on reducing MRSA/HCAIs;
- implementing a programme of targeted support and performance management for trusts with the most challenging rates;
- publishing enhanced advice in November 2006 on screening at-risk patients prior to their admission;
- publishing a root cause analysis tool (NPSA, September 2006) to help trusts investigate and understand better how and why MRSA bloodstream infections occur; and
- publishing specific toolkits: *Safer Practice in Renal Medicine* (DH, November 2006) and *Infection Prevention and Control in Adult Critical Care – Reducing the Risk of Infection Through Best Practice* (DH, December 2006).

**3.100** We are also about to commission a project to investigate the prevalence of new community-acquired strains of MRSA. These are genetically distinct from the strains normally found in hospitals and tend to affect younger, previously healthy people.

**3.101** The updated *Choosing Your Hospital* booklet has again included information on trusts' progress in tackling MRSA (as judged by the Healthcare Commission). This means that patients have the information required to choose hospitals that are cleaner and have lower infection rates.

### Clostridium Difficile disease

**3.102** Against a background of a continued rise in reports over the past decade, since April 2007 PCTs and trusts have had to set a local target to significantly reduce *C. difficile* cases, using the most recent data.

**3.103** While *C. difficile* has different characteristics to MRSA, the established HCAI programme should impact on this disease, although we are also putting in place additional initiatives that specifically target *C. difficile* reduction. We have written to all hospitals, setting out new operational guidance on the management of *C. difficile*-associated disease, and have added a *C. difficile* 'high impact intervention' to the *Saving Lives* toolkit.

### Other activity to tackle HCAIs

**3.104** The Department made an additional £50 million available to tackle infections via the Capital Challenge Fund. This has enabled trusts to deliver infrastructure improvements such as additional single rooms within wards (to facilitate treatment in isolation) and the installation of additional hand-wash basins on wards.

**3.105** It is acknowledged that hospital cleanliness and related issues such as the wearing of staff uniforms remain an important element of the public's confidence in hospital care (although there is little evidence of a direct link between hospital cleanliness and reduced infection rates).

**3.106** Every year since 2000, the NHS has carried out inspections of cleanliness using Patient Environment Action Teams (PEAT). At the outset, one-third of all hospitals were rated as 'poor' or 'unacceptable'. The latest PEAT inspections indicate that almost two-thirds are being rated as 'excellent' or 'good'.

3.107 A review of current policy on uniforms has been taking place by a multi-disciplinary team. Its forthcoming findings will clarify expectations about wearing, changing and laundering of uniforms, and a review of relevant NHS technical guidance on laundry management will follow.

## Support for people with long-term conditions

3.108 Strong general practice, social services, community nursing and hospital outreach services are at the heart of high-quality services for people with long-term conditions.

3.109 *The NHS and Social Care Long-Term Conditions Model* (DH, January 2005) set out a structured approach to help health and social care communities embed locally more effective systematic approaches for the care and management of their chronically ill population. This includes the infrastructure needed to promote different interventions for users with different degrees of need, namely:

- supported self-care – for the majority of patients with a long-term condition who, given the knowledge, skills and confidence, can care for themselves and their condition effectively;
- disease-specific care management – for patients who have a complex single need or multiple conditions which require responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways such as the National Service Frameworks (NSFs) and the Quality and Outcomes Framework of the nGMS contract; and
- case management – for the most vulnerable people, who have highly complex, single or multiple long-term conditions. This requires organisations to identify proactively the patients with complex needs who are most at risk of unplanned admission and provide high-quality personalised services by community matrons or other case managers.

### PSA target

3.110 The long-term conditions PSA target focuses on improving health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk and reducing emergency bed days by 5 per cent by 2008, through improved care in primary and community settings. The emergency bed day element has now been met – between 2003-04 and 2005-06 the number of emergency bed days decreased by 5.4 per cent. See **Figure 3.8** for numbers of emergency bed day reductions.

### The Combined Predictive Risk Model

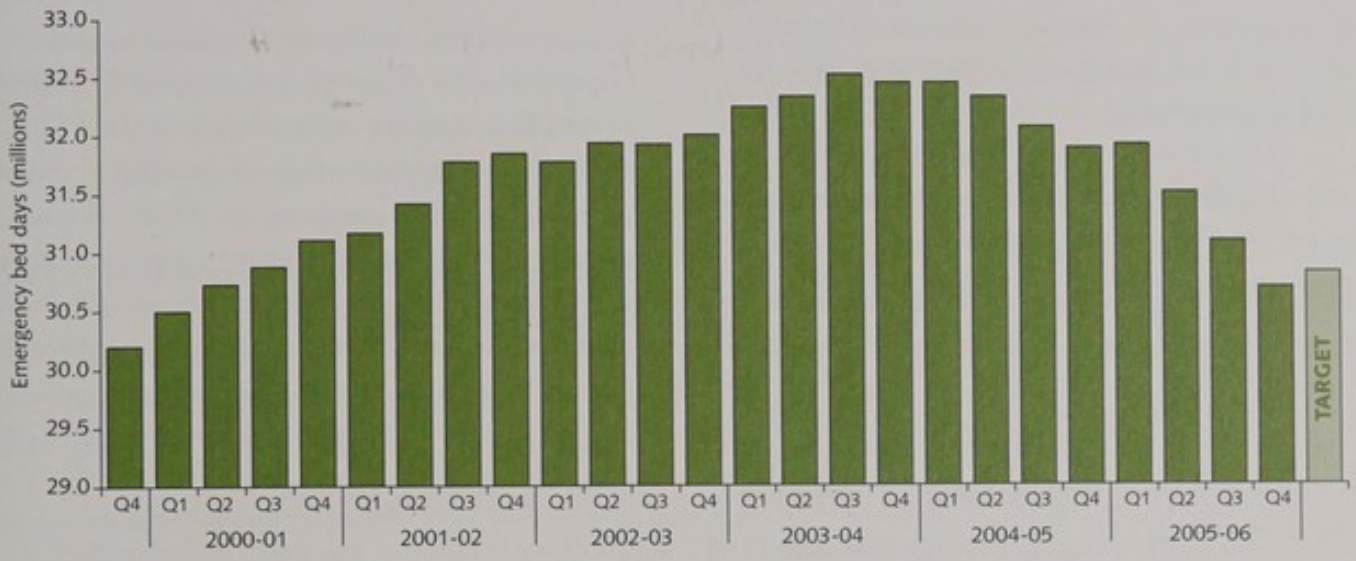
3.111 The Department launched the Combined Predictive Risk Model in December 2006. This is the final phase of the work around risk predictions commissioned from the King's Fund in partnership with Health Dialog Analytical Services and New York University. The Combined Predictive Risk Model uses a combination of hospital in-patient, outpatient, A&E and general practice data to provide a rich information source. The model allows PCTs to identify high-risk individuals in most need of case management, medium-risk patients in need of disease management and low-risk individuals who may require self-care support.

### Self-care

3.112 With regard to self-care, the Department is taking forward work to create a self-care competency framework for staff and embed key elements, including values and behaviours around assessment and support in continuing professional development requirements.

3.113 Work is under way to develop a common core of principles for NHS and social care staff to support self-care. Skills for Health and Skills for Care have been instrumental in developing this, with support from the voluntary sector and user and carer organisations.

Figure 3.8: Emergency bed day reductions




3.114 The Department has also arranged a programme of engagements with the medical Royal Colleges and faculties and medical regulatory bodies to discuss and raise the profile of self-care and agree ways in which to embed self-care in core curricula. A separate programme of work is also starting with non-medical professional bodies.

## Expert Patient Programme

3.115 The Expert Patient Programme (EPP) is a lay-led self-management programme for people living with long-term conditions. The programme supports people to increase their confidence, improve their quality of life and manage their condition better.

3.116 *Our Health, Our Care, Our Say* made a commitment to increase EPP capacity from 12,000 course places a year to 100,000 by 2012 and to establish a community interest company to market and deliver self-management courses. The EPP Community Interest Company was incorporated on 12 October 2006 and went live on 1 April 2007.

3.117 Internal evaluation data from approximately 1,000 EPP participants who completed the course between January 2003 and January 2005 indicates that the programme is achieving improved health outcomes for patients and reducing the degree to which they use healthcare services. The results of a randomised controlled trial into the effectiveness and cost-effectiveness of the EPP were published in the *Journal of Epidemiology and Community Health* in March 2007.

## Care planning

3.118 *Our Health, Our Care, Our Say* commits the Department to offering personalised care plans to those with both long-term health and care needs by 2008 and to everyone with a long-term condition by 2010. An expert reference group on personalised and integrated care planning took place in May 2006 to identify the key principles of person-centred planning, potential barriers and how to address them. Building on these discussions, a policy collaborative is working with the Department to help shape and develop guidance on person-centred and integrated care planning, to be published in the summer of 2007.

## Whole-system LTC demonstrators

3.119 The Department published proposals in *Our Health, Our Care, Our Say* to establish demonstrators that will test the benefits of integrated care supported by advanced assistive technology. The demonstrators will support individuals with longer-term and complex health and social care needs through the creation of multi-

disciplinary teams at PCT and local authority level providing comprehensive and integrated care. Where appropriate, advanced assistive technology will be deployed in individuals' homes to support the provision of care.

3.120 The focus will be on two patient user groups:

- people of any age who are at risk of current or future hospital admission because of chronic heart disease, COPD or type 2 diabetes; and
- the frail elderly who are at risk of current or future hospital admission, who have complex health and social care needs.

3.121 The demonstrators will collectively serve a resident population of at least 1 million from a variety of demographic and geographical contexts. Applications have been received from a number of PCT and local authority partnerships and are currently being considered through a rigorous assessment process.

### National Service Framework for Long-term Conditions

3.122 The *National Service Framework for Long-term Conditions* (DH, March 2005) provides a neurological focus for the long-term conditions strategy by aiming to improve services for people with neurological conditions while also drawing out lessons that could be applied to other long-term conditions.

3.123 Over the last year, the Department has continued to engage a wide range of stakeholders to raise awareness of the NSF for Long-term Conditions and to promote and support local and national implementation. It has also:

- produced guidance to improve commissioning of services for long-term neurological conditions;
- provided £1.5 million of funding for a research initiative for long-term neurological conditions, which will provide the baseline data needed to assess the impact of the NSF for Long-term Conditions;
- worked with the Healthcare Commission and Commission for Social Care Inspection to identify ways of including the *NSF for Long-term Conditions* in national service review and improvement programmes; and
- developed a set of clinical indicators as part of the Better Metrics Programme.

3.124 Over the next year the Department will continue its work to embed the NSF for Long-term Conditions. This will include:

- producing a range of guidance, including how to identify 'quick wins' to start improving neurological services; improving vocational rehabilitation services for people with long-term neurological conditions; and promoting the development of neuroscience clinical networks;
- developing a neurological workforce strategy;
- developing a neurological minimum dataset;
- reviewing and updating an online self-assessment tool for health and social services; and
- developing care pathways for neurological conditions as part of the End-of-Life Care Strategy.

## Cancer

3.125 The *NHS Cancer Plan: A Plan for Investment, A Plan for Reform* (DH, September 2000) was the first comprehensive strategy to tackle cancer. It set out a programme of investment and reform to improve cancer services.

3.126 In December 2006, the Department commenced work on the Cancer Reform Strategy (CRS), which will build on the progress made since the publication of the *NHS Cancer Plan* and take account of challenges and opportunities, including the predicted rise in incidence and the likely availability of new technologies. It is expected that

the strategy will be published towards the end of 2007.

### Awareness

3.127 Early diagnosis greatly increases a patient's chance of survival. We are investing in a campaign to raise awareness of the signs and symptoms of breast, lung and bowel cancer, to encourage people with symptoms to seek help earlier than they currently do. This campaign is being run by the Healthy Communities Collaborative in 20 spearhead areas over the next two years.

### Breast cancer screening

3.128 The NHS Breast Cancer Screening Programme targets, of introducing two-view mammography and extending the screening age to 70, were completed in March 2006. Following calls for the upper age range to be further extended, research in this area was commissioned on behalf of the Advisory Committee on Breast Cancer Screening (ACBCS). A final report on this research is due in mid 2007 and, based on this, the ACBCS will advise on a way forward.

### Cervical screening

3.129 The national roll-out of liquid-based cytology (LBC) has continued. It will speed up the reporting of results and provide a more reliable test. When fully implemented, LBC will mean that 300,000 women a year will not have to undergo repeat tests. The retraining of staff and installation of new equipment is a major undertaking, and we do not expect full implementation until the end of 2008. By the end of March 2007, 83 per cent of laboratories will have converted to LBC.

### NHS Bowel Cancer Screening Programme

3.130 Roll-out of the NHS Bowel Cancer Screening Programme began in April 2006. Men and women aged 60 to 69 are invited to take part using a home testing kit, which they then send off to a laboratory for analysis. Around 2 per cent of those who are screened will test positive and they will be invited for a full colonoscopy (examination of the interior of the bowel).

3.131 Five programme hubs, based across England, have been set up. They provide call and recall services, send out the testing kits, interpret the completed kits and send results out. Sixteen of the local screening centres that provide endoscopy services for the 2 per cent of men and women who have a positive test result are now operational. Roll-out will expand over subsequent years, with anticipated full national coverage in England by 2009.

### NHS Prostate Cancer Programme

3.132 The public awareness pilot programme for prostate cancer, announced by Rosie Winterton in 2004, has now been completed, and the evaluation will be available by mid 2007.

3.133 In November 2006, the Department issued a prostate brachytherapy framework to provide advice to the NHS on developing, providing or commissioning low dose rate prostate brachytherapy services.

3.134 The Prostate Cancer Risk Management Programme, which is designed to help men make an informed choice about being tested for prostate cancer, has been evaluated by the Cancer Research UK Primary Care Education Research Unit at the University of Oxford, and is being reviewed with a view to a relaunch.

3.135 The report *Making Progress on Prostate Cancer* (DH, November 2004) announced plans to develop master classes in surgical procedures for the treatment of prostate cancer. This has been expanded to cover the whole of the multi-disciplinary team. Funding has been secured for the piloting of this multi-disciplinary team training programme, and the training programme is currently being developed.

### Cancer waiting times

3.136 Waiting for a specialist assessment, diagnostic tests and treatment can be a major anxiety for patients with suspected cancer and their families. The NHS Cancer Plan set out key targets for the maximum time cancer patients should wait for assessment and treatment. Over the past year, the NHS has made excellent progress on cancer waiting times, with full achievement of both the 31-day target and the 62-day target.

3.137 The Department will be considering how to improve waiting times further as part of the CRS.

### Cancer treatment

3.138 The series of National Institute for Health and Clinical Excellence (NICE) of reports, *Improving Outcomes*, is now complete. Guidance is now available on 12 tumour groups (breast, colorectal, lung, gynaecological, upper gastrointestinal, urological, haematological and head and neck cancers; skin cancers; sarcomas; brain and central nervous system cancers; and cancers in children and young people), as well as on improving supportive and palliative care for adults with cancer.

3.139 This guidance makes recommendations to the NHS about how health services should be organised to improve outcomes for patients. Implementation is assessed by the National Cancer Peer-review Programme. All cancer networks were peer reviewed over the last three years, and a report summarising the outcome of this programme is expected to be published later in 2007.

3.140 In July 2006, the National Cancer Director's second report on the up-take of NICE-approved cancer drugs showed that a positive NICE appraisal led to increased and more consistent use of these drugs around the country.

3.141 Seventeen cancer drugs have now been approved by NICE for use by the NHS.

3.142 In February 2007, the Department issued a mesothelioma framework setting out advice to the NHS on how best to organise services for mesothelioma patients to improve standards of care across the country.

### End-of-life care

3.143 In recent years, the Government has announced a range of activities to improve the provision of high-quality supportive and palliative care, and to provide people with greater choice at the end of their life.

3.144 Between 2004 and 2007, the £12 million End-of-life Care Programme is providing training to generalist staff in the principles of palliative care, for example through the use of tools such as the Gold Standards Framework, the Liverpool Care Pathway and the Preferred Place of Care initiative. The roll-out of these tools is helping to tackle inequalities and is supporting people at the end of their life to make choices about the treatment they receive and where they die.

3.145 The NHS Cancer Plan commitment to invest an additional £50 million per annum in specialist palliative care has been delivered, and was made recurrent in PCT baseline allocations from 2006-07.

3.146 Action plans, monitored by SHAs, have been developed by the cancer networks to ensure that the NHS implements the recommendations in the NICE guidance *Supportive and Palliative Care* (NICE, 2004).

3.147 Funding of £6 million was provided for an Integrated Cancer Care Programme, which explored models of delivery to help patients get the best quality of care possible, and to find out the most effective ways to use resources. It also supported patient choice by engaging patients more actively in decisions about their care. A final report will be sent to ministers during 2007.

3.148 In September 2006, a £40 million capital fund was created for which adult hospices were able to bid to improve their physical environments.

### End-of-life Care Strategy

3.149 In June 2006, ministers commissioned Professor Mike Richards, with support from all other national clinical directors, to develop an End-of-life Care Strategy for adults. The strategy will deliver increased choice to all adult patients, regardless of their condition, about where they live and die and, within available resources, will provide them with support to make this possible. It is expected that the board, led by Professor Richards, will report to ministers with their recommendations in the autumn of 2007.

### Cancer workforce and training

3.150 An ongoing national training programme for the entire colorectal cancer multi-disciplinary team has been designed as part of the NHS Bowel Cancer Screening Programme, to teach staff about total mesorectal excision. This results in lower rates of local recurrence of bowel cancer, reduces the need for expensive and unpleasant procedures and improves survival rates.

3.151 A national training programme for laparoscopic surgical techniques for bowel cancer is currently being developed and will be piloted with colorectal cancer teams.

3.152 In 2003, more than £9 million was committed over three years to expand endoscopy training capacity. Three national and seven regional training centres have been established to provide multi-disciplinary training in endoscopic procedures, which increases the pool of staff and reduces waiting times.

3.153 A national training programme has been developed for sentinel node biopsy, a new surgical technique for breast cancer patients. It reduces the amount of invasive surgery a patient needs to undergo, lessens the risk of pain and swelling, and reduces the amount of time they need to spend in hospital. The programme is being rolled out through networks and is being run by the Royal College of Surgeons.

3.154 Competency frameworks have been developed by Skills for Health for multi-disciplinary team coordinators; staff working in endoscopy, chemotherapy, supportive and palliative care, cystoscopy, breast assessment and cervical cytology sample taking; new roles relating to flexible sigmoidoscopy; and to scope the competencies relating to urological assessment. These competency frameworks will ensure that skills are recognised, that they are transferable across the UK, and that they can be used to underpin a range of national qualifications and training programmes. Development and implementation of these competencies will continue.

### Cancer equipment

3.155 All funds for the cancer equipment programme have been allocated, and delivery of the equipment is now being monitored. As at 30 January 2007, 1,339 items of diagnostic imaging and radiotherapy equipment had been delivered. A further 83 items of equipment are expected to be delivered by December 2008.

### Positron emission tomography

3.156 To support the implementation of the *National Framework for the Development of Positron Emission Tomography-Computed Tomography (PET-CT) Services in England* (DH, October 2005), £20 million of capital funding has been made available to the NHS over two years (2006 to 2008).

## Vascular disease

3.157 Coronary heart disease, diabetes, kidney disease and stroke are all forms of circulatory disease which relate to blood vessels, or vascular disease. In 2006, the Department brought together national clinical directors and their policy plans for these

areas, to support implementation for the NSFs for diabetes, coronary heart disease and renal disease, and the development of a new national strategy for stoke.

**3.158** The Department is on track to meet the 40 per cent reduction in mortality from cardiovascular diseases in people under-75 well ahead of the 2010 target date. The Department is also on track to meet the 2010 target to reduce the absolute gap in inequalities. This has now reduced by 28 per cent. Further information on Departmental targets can be found in Annex B of this report.

## Diabetes

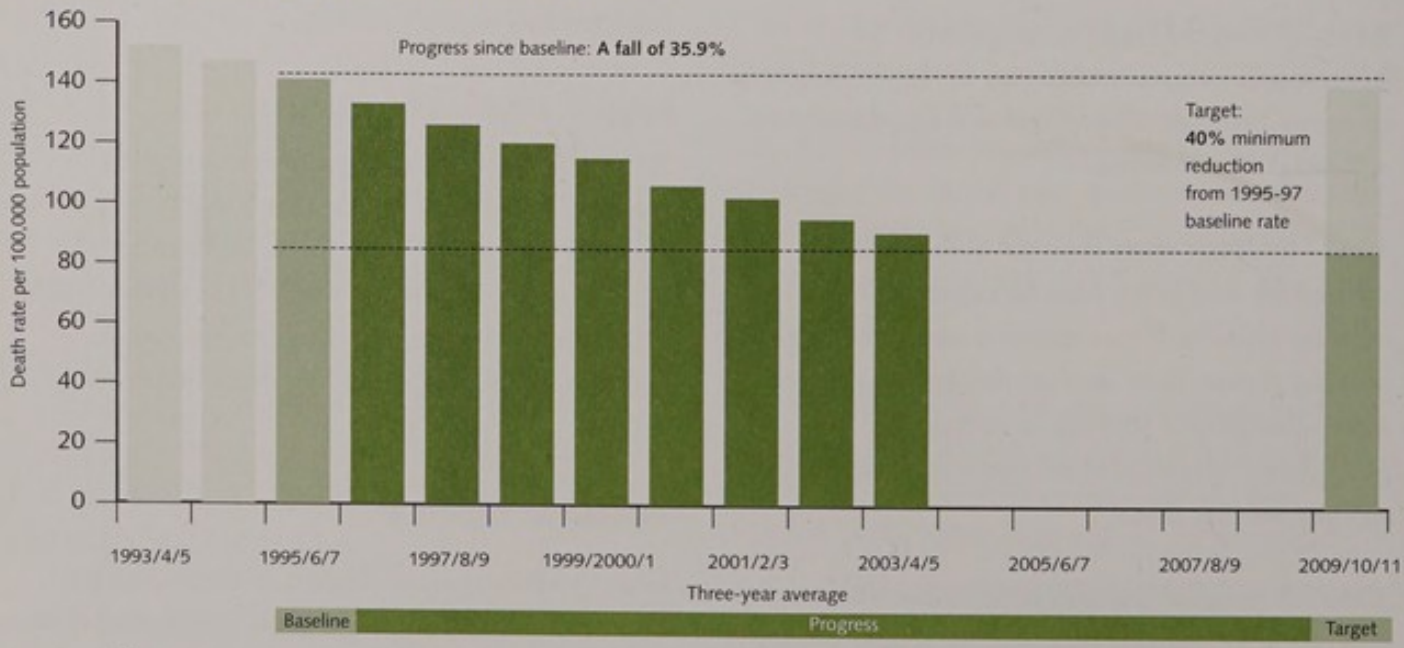
**3.159** Published in March 2007, the fourth NSF progress report contains many examples of good practice and demonstrates that the principle of delivering personalised care is being firmly adopted by the diabetes community.

**3.160** The NSF target of 80 per cent of people with diabetes being offered retinopathy screening, which reduces the risk of sight loss among people with diabetes, was very nearly achieved, and progress continues to be made towards the 2007 target of 100 per cent of people.

**3.161** The Department has just entered into an exciting partnership with Diabetes UK to pilot the Year of Care for diabetes. This describes the ongoing care a person with a long-term condition should expect to receive in a year, decided by the patient in consultation with their clinician. The Department, in collaboration with the National Diabetes Support Team, Diabetes UK, the Primary Care Diabetes Society and the Association of British Clinical Diabetologists, also produced a *Diabetes Commissioning Toolkit* in November 2006.

**3.162** A joint report with Diabetes UK, *Care Planning in Diabetes* (DH and Diabetes UK, December 2006), contains guidance on the care planning process for diabetes services. *How to Assess Structured Diabetes Education: An Improvement Toolkit for Commissioners and Local Diabetes Communities* (DH, August 2006) recognised the key role that people living with diabetes play in managing their condition every day.

### Figure 3.9: Circulatory disease mortality target




*Notes:*
*(1) Rates are calculated using population estimates based on the 2001 census, subsequent to amendments resulting from the Local Authority Population Study (LAPS). Rates are calculated using the European Standard Population to take account of differences in age structure. ICD9 data for 1993-98 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.*
*(2) Source: ONS (ICD9 390-459; ICD10 100-199)*

3.163 The Children and Young People with Diabetes Working Group, set up in October 2005, has now published a report which examines areas for improvement and clarifies standards that need to be met.

## Kidney disease

3.164 In April 2006, the Department took forward two important initiatives to improve renal services: the use of estimated glomerular filtration rate (eGFR) as the standard measurement of kidney function for patients in primary care, and rewarding GPs for diagnosing and treating chronic kidney disease in the Quality and Outcomes Framework. Both initiatives have already helped to identify and treat people at increased risk of dying from cardiovascular disease as a result of undiagnosed chronic kidney disease.

3.165 The Department published *The National Service Framework for Renal Services: Working for Children and Young People* (DH, June 2006), which draws together key guidance for children and young people with kidney disease and makes clear the benefits that can be achieved by adherence to NSF standards and quality requirements.

3.166 January 2007 saw the appointment of Dr Donal O'Donaghue as the first National Director for Kidney Care.

3.167 The Renal NSF Annual Report, *The Way Ahead: The Local Challenge – Improving Diabetes Services: The National Service Framework Four Years On*, was published in March 2007, focusing on the achievements of the year.

## Coronary heart disease

3.168 Professor Roger Boyle, the National Director for Heart Disease and Stroke, published *Mending Hearts and Brains* (DH, December 2006), setting out the clinical case for concentrating professional skills and equipment in specialist centres in order to deliver improved outcomes for patients suffering heart attack and stroke.

3.169 For heart attack, the report set out a vision for delivering angioplasty as a first treatment for heart attack (known as primary angioplasty) in centres which are able offer the appropriate expertise and facilities on a 24-hour, seven-day-a-week basis. For stroke, the report identified that a further 1,000 stroke victims a year would regain independence rather than die or be left dependent on others if they were given clot-busting treatment in specialist centres.

3.170 The Department is working with the British Cardiovascular Society to test the feasibility of offering primary angioplasty countrywide. An interim report will be published in summer 2007, and independent evaluators will publish their report early in 2008, which will include patients' experience and detailed costings.

3.171 Although primary angioplasty services are rapidly being developed, thrombolysis (use of clot-busting drugs) continues to be the main treatment for heart attack. The NSF goal is that eligible heart attack patients should receive thrombolysis within 60 minutes of calling for professional help. This is very challenging in areas where journey times to hospital are lengthy. Use of pre-hospital thrombolysis given by paramedics has delivered significant improvements to times to treatment in some rural areas. The proportion of patients receiving treatment within 60 minutes of calling for professional help is now just under 65 per cent, compared with 24 per cent in 2000 when the NSF was published.

3.172 There have also been improvements in treatment of cardiac arrests. A total of 681 automatic external defibrillators (AEDs) were placed in 110 public places such as railway stations and airports around the country in the first phase of the National Defibrillator Programme, which started in February 2000. A further 2,300 AEDs were procured in September 2004 with funding awarded to the British Heart Foundation by the Big Lottery Fund. Funding was also awarded for community

defibrillation officers in ambulance trusts. Up to January 2007, evidence suggests that 112 lives have been saved through the work of this programme.

3.173 The major Capital Cardiac Programme continues, for which nearly £600 million has been made available. The programme modernises and expands cardiac services at 19 cardiac centres and includes around 27 additional cardiac theatres, critical care capacity, diagnostic services, outpatient facilities and 620 extra beds. To date, 12 schemes have been completed.

3.174 In 2005-06, the NHS performed nearly 75,000 coronary revascularisations (a collective term for coronary bypass operations (21,000) and angioplasty procedures (54,000)) – 5,000 more than in the previous year. There have been radical reductions in the length of time patients wait for treatment. Only a few years ago it was not uncommon for patients to wait over two years for surgery. Now, no one waits over three months, and heart patients are being offered a choice of hospital for their treatment at the time of diagnosis.

### Arrhythmias and sudden cardiac death

3.175 An additional chapter of the *National Service Framework for Coronary Heart Disease* was launched in March 2005, covering arrhythmia and sudden cardiac death. Nationally, the focus areas are improving access to heart rhythm management devices like pacemakers and ICDs, and improving information, support and care for families who have experienced a sudden cardiac death.

### Stroke

3.176 The Department is currently developing a new stroke strategy to improve prevention, treatment and care. Over 110,000 people in England suffer a stroke each year, and it is the main cause of adult disability. All hospitals that treat stroke patients now have specialist services as set out in the *National Service Framework for Older People* (DH, May 2001), but further action is needed to treat stroke as a medical emergency and drive higher standards of care. Both the NAO report *Reducing Brain Damage: Faster Access to Better Stroke Care* (NAO, November 2005) and the response of the Public Accounts Committee have pointed to areas where the Department can support an improvement in stroke services.

3.177 The new strategy is being developed through six multi-disciplinary project groups and will be launched for consultation in summer 2007. In advance of this, the Department has issued new commissioning guidance on stroke, encouraging an integrated approach across health and social care, together with two versions of *'ASSET' – Action on Stroke Services: An Evaluation Toolkit* (DH, May 2006). ASSET won the 2006 Whitehall & Westminster World Civil Service Award for 'Strategic Analysis and Use of Evidence'. It shows PCTs and hospitals how better care will save money in the long run, reduce hospital bed days and save lives.

## Mental health services

### Access to Care

3.178 Since the publication of the *National Service Framework For Mental Health* (DH, September 1999), which sets out a vision for mental health care, mental health services in the community continue to strengthen. There are now over 700 new specialised mental health teams in place to ensure that people with serious mental health problems get the right treatment at the right time.

3.179 As of March 2006, there were around 343 crisis resolution, 252 assertive outreach and 118 early intervention teams established in England. In the first two quarters of the financial year 2006-07, crisis resolution teams provided 50,900 home treatment episodes and achieved 51 per cent of the total target. At 31 December 2006, around 18,000 people had received care from assertive outreach teams, an increase of 6.7 per cent over the previous year.

3.180 In addition, progress has been made in establishing other new workers. Around 1,000 community gateway workers are coordinating and ensuring prompt access to mental health care, and around 720 graduate primary care mental health workers are being appointed to provide first-line treatments within primary care teams.

3.181 In July 2005, we announced an extra £130 million of capital funding to be available from 2006-07, to ensure the continued development of safe and therapeutic in-patient environments in mental health care, and also to ensure that each mental health trust has access to an appropriate place of safety for making assessments under the *Mental Health Act 1983.*

## Suicide rate

3.182 The 2000 PSA target is to reduce the mortality rate from suicide and injury (and poisoning) of undetermined injury by at least 20 per cent by 2010 (PSA SR 2004, target 1). The suicide rate for 2005, the most recent data available, is the lowest recorded level ever and among the lowest in Europe. The target requires a reduction from the 1995 to 1997 baseline of 9.2 deaths per 100,000 population to 7.3 deaths per 100,000 in 2009-2010-2011. The latest suicide monitoring data for the three-year period 2003 to 2005 shows a reduction of 7.4 per cent from the baseline to 8.5 deaths per 100,000.

3.183 In particular, significant progress has also been made in reducing the rates of suicide by mental health in-patients, young men and prisoners. In October 2006, a guide and toolkit, *Guidance on Action to be Taken at Suicide Hotspots* (Care Services Improvement Partnership (CSIP), October 2006), was produced, which provides practical advice for PCTs to undertake a whole-systems approach to suicide audit within a PCT locality. In addition, the guidance *Help is at Hand* (DH, September 2006) was published as a resource for people bereaved by suicide and other sudden, traumatic death.

## Delivering race equality (DRE)

3.184 *Delivering Race Equality in Mental Health Care: An Action Plan for Reform* (DH, January 2005) was published by the Department to tackle the acknowledged inequalities in service that people from some black and minority ethnic (BME) communities can experience.

3.185 There has been a lot of positive activity in the last 12 months:

- Innovative solutions have been developed by the 17 DRE-focused implementation sites, including a new web-based resource in Dorset and Somerset.
- Further community engagement projects have begun, bringing the total to around 80.
- By December 2006, about 160 community development workers were in post. Recruitment of a total of 500 by the end of 2007 is a firm target for PCTs, as stated in *The NHS in England: Operating Framework for 2007-08.*
- The 'Count Me In' census of mental health in-patients and ethnicity was repeated in 2006, helping to monitor DRE's progress.

## Strengthening the workforce

3.186 Since 1997, there have been significant increases in the numbers of consultant psychiatrists (51 per cent), mental health nurses (24 per cent), clinical psychologists (76 per cent), non-medical psychotherapists (122 per cent) and art/music/drama therapists (32 per cent) working in the NHS.

3.187 In April 2006, guidance *Recruitment and Retention of Mental Health Nurses: Good Practice Guide,* (DH, April 2006) was published to help improve the recruitment and retention of mental health nurses. Work has also been taking place around the implementation of the New Ways of Working Programme across all staff groups, and a handbook has been published for community development workers for BME communities.

## Reducing stigma and discrimination

**3.188** As part of the *From Here to Equality Strategy* (National Institute for Mental Health in England and DH, June 2004), a five-year national programme, SHiFT, has been put in place to reduce stigma and discrimination among people with mental health problems. Following the SHiFT media report, *Mind over Matter,* published in January 2005, a 'speakers bureau' was set up with 40 people with direct experience of mental health problems who have been trained and are supported to talk publicly about their experiences. The second report is planned for the summer of 2007. On 10 October 2006, SHiFT also launched Action on Stigma, to help employers improve the way they deal with mental health issues. An action plan will be published in the summer of 2007

**3.189** SHiFT supported the Samaritans' initiative in November 2006 to send DVDs to every secondary school in England, aimed at increasing mental health awareness and reducing stigma and discrimination.

## Tackling social exclusion

**3.190** The National Social Inclusion Programme (NSIP), part of CSIP, coordinates the delivery of the Social Exclusion Unit's (SEU's) report, *Mental Health and Social Exclusion.* NSIP published its second *Annual Report* in December 2006, which details the ongoing progress and successes of the programme. So far, over 90 per cent of the SEU report action points have been completed or are under way.

**3.191** Three key guidance documents were published in 2006:

- *Vocational Services for People with Severe Mental Health Problems: Commissioning Guidance* (DH, February 2006), which provides a framework to commission evidence-based vocational services and the tools to monitor the effectiveness of such services;
- *From Segregation to Inclusion: Commissioning guidance on day services for people with mental health problems* (DH, February 2006), which is designed to assist commissioners in refocusing day services into community resources that promote social inclusion; and
- *Direct Payments for People with Mental Health Problems: A Guide to Action.* (DH, February 2006).

**3.192** The programme has also worked to support the development of a new policy on inclusion and mental health, having direct input into *Reaching Out: An Action Plan on Social Exclusion* (Cabinet Office, September 2006). The action plan requires NSIP to lead the establishment of employment action teams in each region across England.

## Providing choice and improving mental health and well-being

**3.193** The Department is committed to giving people with mental health problems choice and a more personalised service, including making more information available about mental health and illness to help people manage their own care. *Choosing Health: Supporting the Physical Needs of People with Severe Mental Illness* (DH, August 2006) was published to support PCTs in planning for services that will deliver improved physical health and well-being for people living with severe mental illness.

**3.194** In November 2006, CSIP published the positive practice guidance, *Our Choices in Mental Health,* built on the summary of key findings from the NSF for Mental Health autumn assessment 2005 choice themed review. This guidance provides a framework for service commissioners and providers to improve choices for people who use mental health services.

### Improving access to services for common mental health problems

3.195 *Our Choices in Mental Health* highlighted that people who use mental health services consistently identify better access to a choice of 'talking therapies' as a key way to improve the way services are provided. Through pilot studies in Newham and Doncaster, the Department is gathering robust evidence for the further development of psychological services. This includes testing and evaluating the best ways of commissioning talking therapy services to improve the health and well-being of the whole community. Some service models will also integrate clinical services with employment advisers in order to support people to remain in or return to work.

3.196 The demonstration sites will complete their work by March 2008, but interim results are showing positive gains in health and well-being in many people referred to the service.

### Reforming mental health legislation

3.197 The Department is continuing work to reform mental health legislation and, on 16 November 2006, it introduced the *Mental Health Bill*. The purpose of the Bill is to help ensure that people with serious mental disorders can be required, where necessary, to receive the treatment they need to protect them and the public from harm, to bring mental health legislation into line with modern service provision and to strengthen patient safeguards and tackle human rights incompatibilities.

### The future direction of mental health services

3.198 Significant gains in mainstreaming and modernising services for people with severe mental health problems have been made, resulting in better access to care and better treatment. Building on this work, the priority for the Government now is to meet the mental health needs of the community as a whole.

3.199 The Department wants to see service users provided with more information, giving them more control over their care and their choice of treatment. The Department also intends to:

- create a tariff or equivalent effective payment system for mental health services;
- provide stronger primary care commissioning across a broad range of mental health services to take greater account of physical health care needs; and
- provide better integration of health and social care services around the needs of individuals with mental health problems, by means of moving to better community-based services.

## Children

3.200 All children should have the best start in life, to have the opportunity to live as healthy and active a life as possible. The Department's role is to drive policy to improve health and well-being outcomes and to reduce inequalities for children, for families and in maternity services.

3.201 Many improvements in health and social care will benefit all age groups. The Department and the NHS are also doing much specifically for children and young people. The approach and intention were set out in the *National Service Framework for Children, Young People and Maternity Services* (DH, September 2004). Delivering the ten-year plan requires health services to work in partnership with education and social care services, because as they grow up children draw on a range of public services. Integrated services are not only more effective and convenient for families, but they also offer a better chance of ensuring that those who need support or are at risk do not fall through the cracks between different agencies.

3.202 The cross-government agenda Every Child Matters has five outcomes for every child, stating that they should be able to:

- be healthy;

- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic well-being.

### Recent achievements and planned activity

**3.203** International evidence demonstrates that intensive health-led, structured home-visiting programmes radically improve outcomes for both mother and child, particularly in the most at-risk families. In the recent Social Exclusion Action Plan, the Department of Health and the Department for Education and Skills (DfES) agreed to establish ten health-led parenting support demonstration projects to test these approaches, which they launched on 8 February 2007. The sites will work through Sure Start Children's Centres. The Department of Health continues to work with DfES on maximising the potential of Sure Start Children's Centres to offer integrated 'one-stop shop' early years services in an accessible way. As at January 2007, there were 1,049 Sure Start Children's Centres. The Government is on target to establish 3,500 – one in every community – by 2010.

**3.204** The NSF makes clear that PCTs, NHS trusts and local authorities should make specific arrangements to enable a smooth transition for young people to comprehensive and integrated adult services. Following the publication of *Transition: Getting it Right for Young People* (DH, March 2006), the Department is supporting, through CSIP, the development of a network of 'transition champions' across the country – experienced health professionals who are keen to support others in improving their services for young people.

**3.205** An extensive programme of work is under way to safeguard children. This includes funding CSIP to develop a range of support for designated and named health professionals, including the pilot of a leadership development programme, a website and discussion database where practice can be shared, regional networks and two national conferences.

**3.206** In August 2006, £12 million of capital monies were distributed to SHAs to support work to safeguard children which is carried out by PCTs, NHS foundation trusts and NHS trusts.

**3.207** *Bearing Good Witness: Proposals for Reforming the Delivery of Medical Expert Evidence in Family Law Cases – A Report by the Chief Medical Officer* was published in October 2006 for consultation. It aims to identify the main problems with the current system (and makes 16 proposals to resolve them) and to secure a sustainable supply of competent, quality-assured medical expert witnesses for care and supervision cases in the future. An analysis of the outcomes will help shape the future direction of the medical expert witness service, which is expected to introduce and develop expert witness teams from within the NHS.

**3.208** £27 million is being invested over three years in children's hospices and hospice-at-home services, starting in 2006. The Department has also set up an independent review of services for children and young people who have life-limiting conditions and require palliative care. The review team has been asked to focus in particular on equity of access to services and their long-term sustainability. They will report their findings and recommendations to ministers soon.

**3.209** The Department completed the first ever mapping of child health services, which allows PCTs to compare the range of child health services being commissioned across the country and to focus improvements. The results of this year's mapping exercise will be available in April (at www.childhealthmapping.org.uk), with a full atlas being published in the autumn. This year the Department is also piloting an extension of the mapping to cover children's services more broadly.

3.210 Four teenage health demonstration sites in Bolton, Hackney, Northumberland and Portsmouth were launched in August 2006. They will explore and evaluate how services can become better equipped and coordinated to meet the health needs of young people aged 11 to 19.

3.211 The Early Years LifeCheck will help parents (and carers) to identify the support they need to ensure that their child achieves the best health outcomes possible. The tool is currently under development and will be tested in four of the spearhead PCT areas. The Teenage LifeCheck is a quick quiz-style online questionnaire for young people aged between 11 and 14 but primarily 12- to 13-year-olds, and is designed to empower young people to take greater control of and responsibility for their health and well-being. The tool went live in early February 2007 and will be tested for six months in the four teenage health demonstration sites.

3.212 We are on track to achieve the *Choosing Health: Making Healthy Choices Easier* (DH, November 2004) commitment to have all schools gaining or working towards Healthy Schools status by 2009. Over 80 per cent of schools are already participating in the programme, and we expect 55 per cent of all schools to meet the new, more rigorous criteria for Healthy Schools status by December 2007.

## Child and adolescent mental health services (CAMHS)

3.213 The Department has an operating standard to:

> Improve the life outcomes of ... children with mental health problems, by ensuring that all patients who need them have access to ... a comprehensive CAMHS.

3.214 SHAs were told in March 2005 that they would be assessed on their achievement of the PSA target by an approach that tracked the existence of care pathways for three key aspects of CAMHS, namely:

- 24/7 emergency assessment;
- CAMHS for those with learning disabilities; and
- CAMHS for 16- and 17-year-olds.

3.215 Significant progress has been made over the last year. **Figure 3.10** shows the percentage availability of these elements of service, as reported by PCTs at the end of 2005 and 2006. It is expected that 100 per cent coverage will be achieved by the end of March 2007, although this cannot be confirmed until findings are published at the end of May 2007.

### Figure 3.10: CAMHS availability

| Element of service | 2005 | % 2006 |
|---|---|---|
| 24/7 emergency assessment | 82.5 | 96.7 |
| CAMHS for those with learning disabilities | 50.5 | 87.5 |
| CAMHS for 16- and 17-year-olds | 74.3 | 90.8 |

3.216 Progress towards the PSA target over a longer timeframe is set out in **Figure 3.11**.

3.217 In November 2006, the Department and DfES published a report on the implementation of Standard 9 of the NSF for Children, Young People and Maternity Services. This looked at the short- and medium-term improvements that commissioners and providers will need to make if they are to achieve the objectives for service development set out in the NSF.

3.218 In taking forward the NSF, local CAMHS commissioners and providers are starting from different baselines, with the current provision of CAMHS varying from one area to another. Their priorities for development at any one time will differ accordingly. In all cases however, implementing such an ambitious programme of service improvement will require a sustained and concerted effort by commissioners and providers of CAMHS. The report sets out a number of recommendations and models of good practice

which help to illustrate the extent of the progress that CAMHS should expect to achieve by the mid-point of the NSF cycle in order to achieve the full target.

## Maternity services

3.219 In 2005, the Government underlined the importance of providing high-quality, safe and accessible maternity care through its manifesto commitment, which stated that: 'By 2009, all women will have choice in where and how they have their baby and what pain relief to use. We want every woman to be supported by the same midwife throughout her pregnancy. Support will be linked closely to other services that will be provided in Children's Centres.'

3.220 This reinforced the earlier messages of the 2004 published standard of the NSF. The Department further demonstrated its commitment to giving women choice in maternity services in the White Paper *Our Health, Our Care, Our Say*, and subsequently developed this commitment in *The NHS in England: Operating Framework for 2007-08.*

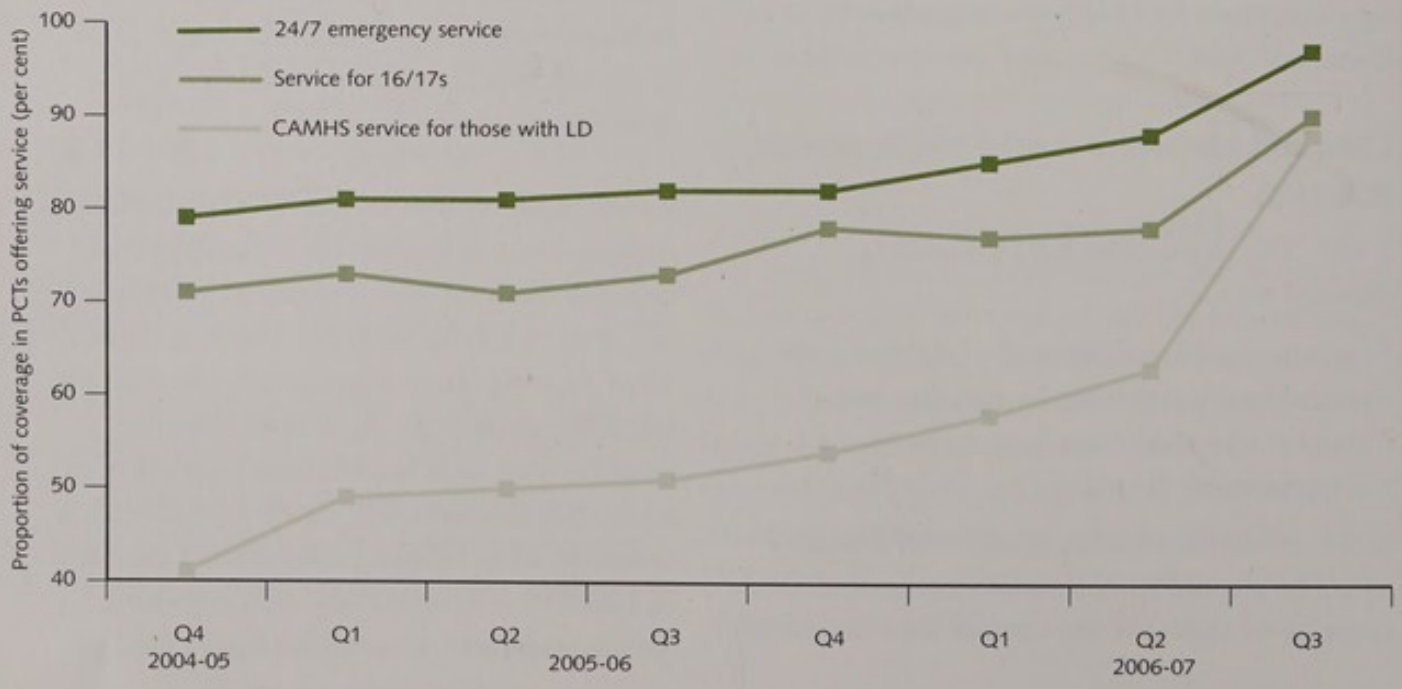
3.221 The operating framework cited maternity services as an area for preparatory work by PCTs to support the achievement of the 2009 commitments, using 2007-08 to assess current services, to identify gaps and any barriers to service development and to set out their local strategy for meeting this commitment.

### Recent achievements and planned activity

3.222 On 6 February 2007, Dr Sheila Shribman, the National Clinical Director for Children, Young People and Maternity Services, published two reports into the future of children's maternity services, *Making it Better for Mother and Baby* and *Making it Better for Children and Young People.*

3.223 The Department, in conjunction with stakeholders, has developed a maternity framework document which will set out how to deliver and achieve our commitment to giving women access, continuity of care and clinically appropriate choice in the type of maternity care they will receive. This will build on the arguments put forward in Dr Shribman's report. Central to the framework will be an articulation of the choice offer for women – for example a birth at home, a birth supported by a

Figure 3.11: CAMHS progress



midwife or a birth supported by a team of clinicians including a midwife and an obstetrician.

### Women's health

3.224 During 2006-07, the Department worked alongside the Foreign and Commonwealth Office's Forced Marriage Unit to produce guidelines for health professionals on forced marriage, due to be launched in June 2007.

3.225 The Department continues to fund, with the Home Office, a national domestic abuse coordinator, to advise ministers and take a strategic lead for domestic abuse across the NHS. We also continue to work with colleagues across government on cross-cutting programmes including the Victims of Violence and Abuse Prevention Programme and the Tackling Violent Crime Programme.

### Newborn screening

3.226 The introduction of Newborn Screening Programmes as part of the Newborn Bloodspot Programme contributes to both saving and improving the quality of lives. For example:

- Screening for sickle cell disorders, which is now offered to all newborn babies in England, is expected to prevent 15 infant deaths per year and reduce the burden of hospital visits and treatment.
- The roll-out of screening for cystic fibrosis, expected to be completed by the end of 2007, is likely to benefit an estimated 250 babies a year in England through early identification and interventions.
- Screening for medium-chain acyl-coenzyme A dehydrogenase deficiency, currently covering 60 per cent of all births, will prevent seven to eight deaths a year in children under three years old and acute serious illness will be prevented in 15 to 22 cases.
- The Newborn Hearing Screening Programme provides the opportunity for children with hearing impairments to keep pace educationally and socially with their peers if appropriate support is in place.

## The third sector and the Department of Health's relationship

3.227 The third sector (national voluntary and community organisations working in the health and social care fields) fulfils a number of roles for the Department including as service providers, advocates and partners in developing and implementing policy. Together with the NHS and social care services, the Department has a long and established history of working with the third sector for the benefit of patients, service users and carers.

3.228 The Third Sector Commissioning Task Force, launched in July 2005, has helped to address the barriers surrounding commissioning of health and social care from third sector providers. The task force's report *No Excuses. Embrace Partnership Now. Step Towards Change!* was published on 11 July 2006. The report set out what needs to happen in the context of the wider health and social care reform programmes to enable a fairer and more level playing field for third sector providers. Work to ensure that this is embedded in commissioning practice is ongoing.

3.229 The Department is reviewing how it invests in third sector organisations, with a view to turning the current arrangements for funding into a strategic portfolio of investments that will support delivery of the Department's objectives and priorities. Proposals are currently being developed, and consultations with the third sector are planned for later in 2007.

### The Section 64 (S64) general scheme of grants

3.230 This scheme helps to strengthen and further develop the partnership between the Department and third sector organisations. It is the Department's main funding stream. In 2007-08:

- 1,109 applications for grant funding were made, of which 132 (or 12 per cent) were successful;

- there will be 388 grants in total, including 132 new awards and 256 continuing grants; and
- the average new grant is £50,000 per year. For both new and continuing grants, the average is £44,000.

### The Opportunities for Volunteering Scheme (OFV)

3.231 OFV is a partnership between the Department and the voluntary and community sector. It uses the expertise of the voluntary and community sector at a local and national level to enable local people to meet need and create change within their own communities. OFV grants range from £2,000 to £40,000. They are distributed to local community organisation projects that involve volunteers in the delivery of health and social care services.

# 4 System Reforms in Health and Social Care

## Health and social care reform

**4.1** The programme of modernisation of health and social care was first set out in *The NHS Plan* (DH, July 2000). It has been further developed and updated in *The NHS Improvement Plan* (DH, June 2004); the *Choosing Health* White Paper (DH, November 2004); *Health Reform in England: Update and Next Steps* (DH, December 2005); and the *Our Health, Our Care, Our Say* White Paper (DH, January 2006).

**4.2** *Our Health, Our Care, Our Say* set a strategic vision for community health and social care services. The key principles of the White Paper are reflected in the health and social care reform programme and are being built into national policy and local service development and delivery.

**4.3** The overall goal of health and social care reform is better care, better user experience and better value for money. To deliver the White Paper's principles, our aim is to see the following:

- more choice and a stronger voice for patients and service users who will be able, in consultation with their clinicians, to choose the highest quality of care appropriate for their needs;
- services that support people to be healthy and independent and provide joined-up care that is convenient to users;
- better prevention and earlier intervention;
- practices and PCTs as commissioners, using their knowledge of local communities and extensive public and patient involvement to get the best value within available resources, working to improve the health of their population, reduce health inequalities, guarantee choice and secure the best possible services. An NHS that works in partnership with local authorities and other local services to deliver improvements and to promote equality, inclusion and respect;
- more freedom for providers to innovate and improve services in response to the needs and decisions of patients, GPs and commissioners. Further expansion of NHS foundation trusts, a continuing role for direct provision by PCTs, and more opportunities for voluntary sector, social enterprise and private sector providers where they can help deliver better services with better value for money;
- change led by clinicians and other staff, with greater freedom and support to focus on the quality of patient care, and the emergence of new roles to respond more swiftly to patient need, new treatment methods and technological change;
- effective management of the system, backed by regulation that assures national core standards and focuses intervention on the services that are most in need;
- a financial framework, including tariffs, that incentivises improvements in patient care, supports the development of care integrated around patient need (especially long-term care needs) and promotes financial responsibility and best value within allocated resources; and
- extensive, comparable information on the quality and safety of care. This will give patients and commissioners a real understanding of the choices available to them; practices the capability to track and plan care across the whole patient pathway; and providers a proper understanding of their activity and quality of care.

**4.4** Over the past year, the Department has been testing and evaluating the White Paper's principles through pilots and demonstration sites. These include individual budget pilots that test the ways in which income streams from a variety of agencies can be combined to give individuals more control over their lives, and clinically driven 'closer to home' demonstration sites examining how teams of consultants and other health professionals can safely and effectively provide a range of operations and procedures closer to where patients live.

**4.5** *Our Health, Our Care, Our Say* also made commitments to new investment in health and social care. Over the last 12 months the Department has

announced that up to £750 million is being made available over five years to develop a new generation of community hospitals and services. The first sites have been announced in Bristol, Gosport, Minehead and Sunderland. The Department has also committed £50 million to support hospices, £73 million to create a social enterprise fund and £33 million to support carers.

### Quality and health and social care reform

4.6 Quality is at the heart of the health reform agenda. The various policy instruments described elsewhere in this chapter will help to create an environment in which front-line clinical staff will be supported and enabled to improve the quality of clinical care and to develop services that are responsive to the needs of patients and care users. In particular:

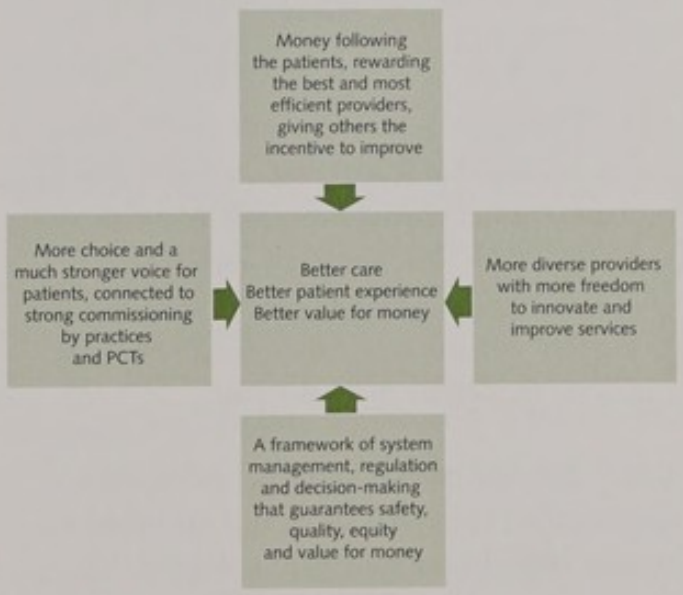
- the new arrangements for registration of healthcare providers will ensure that all providers are fit for purpose and meet national standards of quality and safety;
- commissioners will increasingly build explicit quality requirements in commissioning services, reflecting local as well as national priorities and needs;
- improved information on service quality will enable provider organisations to benchmark their performance against others' and will help patients to make informed choices on where to go for services; and
- commissioners will be accountable for the health gains they achieve for their local populations, and these will be measured using a range of metrics covering all the main aspects of prevention, public health and service delivery

4.7 The Department will be publishing a policy framework later in 2007 setting out our vision of the quality of services to which the NHS will aspire and showing how the various elements of the reform programme will help to achieve this.

## The health reform programme

4.8 The key elements of the health reform programme, and their relation to the overall goal, are set out in **Figure 4.1**. This framework provides the focus for a range of individual reforms. The overall benefits will be realised through the interactions between the reforms and the development of practical tools. This chapter sets out the achievements to date and the planned activity for each of the work streams within the overall programme.

### Figure 4.1: The organising framework for the health reforms




### Choice

4.9 Giving people more choice and control over their care and treatment is at the heart of the programme of reform. People's choices will drive improvement and innovation in healthcare provision. The Department's approach is one of extending choice progressively, ensuring that there are systems and processes in place to offer choice and that service users are empowered with the necessary information and support to exercise informed choices.

## Choice in elective care

### *Achievements*

**4.10** From May 2006, eligible patients have been able to choose not only from the four or more providers commissioned by their local PCT, but also from NHS foundation trusts across the country, provided those foundation trusts choose to include their services on the 'extended choice' menu.

**4.11** Over 2,600 services are listed on the national menu from which patients may choose. This number is continuing to increase as new NHS foundation trusts are approved and independent sector treatment centres (ISTCs) and the independent sector extended choice network (IS ECN) facilities are added to the menu.

**4.12** The results from the fourth patient choice survey, published in March 2007, indicate that 41 per cent of patients recall being offered a choice of hospital for their first outpatient appointment. This is an increase from 38 per cent in wave 3 and 35 per cent in wave 2. Headline figures for wave 5 indicate an increase to 46 per cent.

**4.13** A second edition of the groundbreaking *Choosing Your Hospital* booklet, first published in January 2006, has recently been published. It contains up-to-date information for patients and clinicians about the choices available and more information on patient experience and, for the first time, comparative data from the independent sector. A shortened version of the booklet is available in twelve different languages, large print, Braille, audio and British Sign Language. In line with the roll-out of extended choice, a booklet detailing the national menu of choices available to patients has also been published.

*Dr Devlin says, "Patients are responding very positively: there is a difference between a referral being something done to you and something in which you are actively involved. Some people are still quite surprised that they can have this choice. I always make sure I share the computer screen with patients during the consultation and talk them through the choice process."*

*Ezna says, "This was what was so nice about it – being able to see what the waiting time was. I really wanted to get it sorted out quickly so I was happy to travel 30 miles."*

### *Future Plans*

**4.14** By summer 2007, we expect there to be a choice of over 200 hospitals and treatment centres. Patients can now choose from their four local hospitals, and the Extended Choice Network of thirty-four foundation trusts and twenty-two independent sector providers.

**4.15** By 2008, patients will be able to choose from any hospital that meets NHS standards and costs.

*Ashley says, "My GP told me I would get a call to confirm an appointment and when the NHS appointments line called, the woman talked to me about the different hospitals I could choose from. That was very different to the first time round when I just got a letter saying where to go and on what day."*

### *Choose and Book*

**4.16** Choose and Book is a key enabling mechanism for choice. It is a national service that, for the first time, combines electronic booking and a choice of time, date and place for first outpatient appointments. It is bringing real improvements to patients' experience of the NHS and real benefits to clinicians and NHS services. Further details of achievements and future plans are given in chapter 8.

## Choice Beyond Elective Care

**4.17** *Health Reform in England: Update and Next Steps* included a commitment to publish a framework for choice beyond elective care. The framework will be published for consultation in spring 2007 and will include:

- the future direction for choice policy in five priority areas: cancer, maternity, mental health, end-of-life and long-term conditions;
- the possibilities for choices along the elective care pathway (e.g. diagnostics);
- options for increasing patients' choice of GP practice; and
- guidance on the information, advocacy and support measures that are needed to make choice equitable – including an overview of the Information Taskforce on Clinical Outcomes' work in developing clinical outcome measures.

### *Choice and diabetes*

**4.18** Micro and macro level commissioning is used to increase choice for people, through the 'Year of Care' project. The project will use local pilots for diabetes to test how commissioning can support choice through the development of a care-planning process that empowers people with long-term conditions to negotiate and agree what services they will access over the next year, choosing from a range of options which have been designed to meet the needs of the local population.

*With increasing public awareness, Tracey realised that she was at increased risk of type 2 diabetes and so went for a quick test at her local pharmacy. She then visited her GP who diagnosed diabetes.*

*Tracey will be offered an introductory package of care designed to keep her safe initially, and will be given advice about what first line treatments may be appropriate for her in the short term. She will also be provided with an 'information prescription' that provides her with information about her condition in a format that suits her, will be referred immediately to a local education programme where she will begin to learn the skills she needs to manage her condition, and will be given the name of a personal 'navigator' who will guide her round the system.*

*Soon after her diagnosis, Tracey will have a 'care planning' session to review her needs in a number of domains, including clinical care, health beliefs and knowledge, social and emotional issues and her already forming preferences. With the support of her GP and other professionals, she will be able to choose a package of care that suits her.*

### *Information for choice*

**4.19** People make daily choices about their health, care and services and the Department is introducing a number of new ways for people to get the right information that they need to make choices about their health and care.

**4.20** At the end of 2006, the first information prescription pilots were set up, and through 2007, twenty pilot sites will contribute to the development and evaluation of information prescriptions for people with long-term conditions. A system to accredit information producers took shape over 2006 with contracts in place to develop standards for information producers, to assess the levels of support producers will need to become accredited and further research into the market for accredited information.

4.21 In response to a recommendation in *Our Health, Our Care, Our Say*, the Department commissioned a report into the ways in which people find information about services. This will be published in 2007.

4.22 A recurring theme from consultations is the support that people often need in order to use information and ask questions in consultations with professionals. During 2006, the many questions that have been developed by professional and voluntary organisations were drawn together into a short set of generic questions that people could use in a range of consultations. These questions and tips have been tested with hard-to-reach and disadvantaged groups and are available from June 2007.

4.23 Good quality information will be essential to support patients in making informed decisions about providers and in helping to ensure that choice is equitable for all.

4.24 In January 2007, the Secretary of State announced a plan to launch a new choice website, NHS Choices in summer 2007 (see chapter 2, paragraph 2.60). It will gather together information about hospitals from various sources into one site and will contain information and links to help people decide which centre might suit them best. This is linked to the *Choosing Your Hospital* booklet (see paragraph 4.13).

4.25 The Information Taskforce on Clinical Outcomes is identifying clinical indicators that will be available for publication on the new choice website. The taskforce has discussed indicators for circulatory conditions, musculoskeletal, stroke and mental health services. Over the coming months, the taskforce will take forward a longer programme of work to deliver indicators requiring new information, including routine measures of the outcomes of treatment. Their work will include developing analytical tools to ensure that the information for patients and professionals is accessible, consistent, clear and relevant.

### Partnership for Patients

4.26 The Partnership for Patients Pilot Programme is a collaboration designed to help patients to choose and book appointments online through the libraries network. Library staff have been trained to help patients to access useful websites such as www.nhs.uk, the Healthcare Commission, and Patient Opinion

4.27 There will be a six-month pilot through thirty libraries, where patients can obtain more information to help them choose the right hospital for them and have the library staff help them to book – or in fact book their appointment for them.

### Empowering citizens: local involvement networks

4.28 We are committed to empowering citizens to give them more confidence and more opportunities to influence public services in ways that are relevant and meaningful to them, and in ways that will make a real difference to services. This is part of a wider Government commitment to community empowerment and engagement across the broad range of public services.

4.29 For health and social care, this means services that are responsive to what the people using them want and need, and that are accountable to both service users and local communities. Services that offer easily accessible support for people who need care, and that are part of the local community, not detached from it.

4.30 *A Stronger Local Voice: A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services* (DH, July 2006) set out the Government's plans to achieve these aims. As part of these plans, the Department is to:

- make provision for the abolition of the Commission for Patient and Public Involvement in Health (CPPIH) and patients' forums;
- establish Local Involvement Networks (LINks), by imposing a duty on local authorities with social

services responsibilities to make arrangements for the involvement of people in the commissioning, provision and scrutiny of health services and social services; and

- strengthen the NHS' duty to consult with patients and the public.

4.31 The legislation to establish these proposals was introduced to parliament as part of the *Local Government and Public Involvement in Health Bill* (December 2006).

## Commissioning

4.32 *Health Reform in England: Update and Next Steps* (DH, December 2005) focuses upon the development of first-rate commissioning to create an NHS where patients have more choice as well as a real voice in the design of their services.

4.33 Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean:

- the best possible health outcomes, including reduced health inequalities;
- the best possible healthcare; and
- obtained within the resources made available by the taxpayer.

4.34 Commissioners need to work with providers to secure the best health outcomes and the best services with the best value for the public's money and also to ensure that commissioning reflects people's choices. Commissioning will increasingly become the process by which the NHS is held to account.

### Achievements 2006-07

*Creating the right environment for high-quality commissioning*

4.35 *Health Reform in England: Update and Commissioning Framework* (DH, July 2006) established an over-arching national framework for commissioning, introducing powerful new levers to improve performance, quality and value for money. It sets out arrangements for:

- stronger clinical engagement through practice-based commissioning (PBC), including proposals for a governance and accountability framework for practice-based commissioning;
- stronger patient and public engagement including proposals for increasing the responsiveness and accountability to local people, e.g. through the introduction of a new PCT prospectus;
- new levers and incentives for more effective commissioning, including a series of options for how the NHS could contract for services covered by payment by results, together with plans to develop a national NHS contract for acute hospital services; and
- strengthening commissioning capacity, for instance through the range of support available for PCT commissioners and practices to access in developing their commissioning capabilities.

4.36 A second phase of the commissioning framework, the *Commissioning Framework for Health and Well-being* (DH, March 2007), was published for consultation. This is designed to enable local authority, PCT and local commissioners to work together more effectively to provide services that are tailored to the needs of individuals and local communities, and to help people maintain their health, well-being and independence wherever possible.

4.37 The framework provides an opportunity to shift the focus from only commissioning services for people who are ill to also promoting health, well-being and independence. Local authorities deal with planning, transport, housing and leisure facilities, all of which are key to building and maintaining environments conducive to healthy lives. More coherent spending across PCTs and local authorities, provides a better chance of preventing ill health and premature death and improving outcomes, and enables better targeting of resources

to help those who need the most help, to reduce health inequalities and promote equality.

4.38 The following case study illustrates the genuine difference that high quality, better integrated commissioning can make to people's lives:

*"My daughter Sunita has multiple disabilities. She's always going to need a lot of care, but we do want her to be as independent as possible. A few years ago we were struggling to get all the different things she needed – not just equipment like wheelchairs and bath hoists, but the right education, respite care that fitted in with our religious beliefs, all the things that made life easier. And Sunita ended up in hospital a lot, as we weren't very confident about looking after her when she was even a bit poorly.*

*Then we were asked if we wanted to be in charge of the money that was spent on Sunita, and be able to choose what it was spent on. Since then, we've been able to make sure that we get regular breaks, knowing that Sunita is cared for by people she really likes and who don't just look after her physically, but really understand how important religion is to us as a family. We've also been able to get a wheelchair that fits her properly, so she can get out and about a lot more. Our GP helped us find some training on how to care for Sunita when she's a bit poorly. I think he even paid for it. We know what to look for now, and feel confident about knowing when its safe to look after her at home and when the signs are bad and we need to take her to hospital. It's very reassuring."*

4.39 The commissioning framework also:

- represents the Department's formal response to the recommendations of the report of the Third Sector Commissioning Task Force (July 2006). This set out what needs to happen in the context of the wider health and social care reform programmes to enable a fairer level playing field for third sector providers; and
- reinforces the direction set in the local government White Paper *Strong and Prosperous Communities*, and consults on the new duty in the bill currently before parliament to undertake a joint strategic needs assessment.

### *Improving the commissioning of specialised services*

4.40 Sir David Carter's *Review of Commissioning Arrangements for Specialised Services* (Carter, D et al., May 2006) made 32 recommendations for improvement. This represents a blueprint for a programme of change in specialised services commissioning, designed to improve the quality and coverage of services. The key priorities from this review are set out in *Health Reform in England: Update and Commissioning Framework*, with good progress being made in 2006-07 in terms of:

- establishing the National Specialised Services Commissioning Group and National Commissioning Group with a robust, fair and transparent financial framework and governance arrangements to be operative in 2007-08;
- transferring the existing National Specialist Commissioning Advisory Group staff from the Department to new hosting arrangements in the London Strategic Health Authority, which take effect from April 2007;
- supporting the establishment of new specialised commissioning groups by developing a range of model governance documents;
- ensuring that high standards of business continuity at national and local levels have been maintained throughout the change process; and
- exploring potential improvements to the Specialised Services National Definitions Set.

### *Developing the new NHS contract*

4.41 *Health Reform in England: Update and Commissioning Framework* signalled the development of a single national contract for acute secondary care services, covered by payment by results, to apply to NHS trusts, NHS foundation trusts and independent sector providers. The aim is to ensure fairness and avoid having a confusing mixture of contract types. The NHS Contract for

Acute Hospital Services covers agreements between PCTs and providers for the delivery of acute hospital-based care. An interim version was published in December 2006 for NHS organisations to use in the 2007-08 contracting round. The 2007-08 contract will be evaluated, and a final version published in 2007 for use in 2008-09 onwards. This will be subject to consultation.

*Practice-based commissioning*

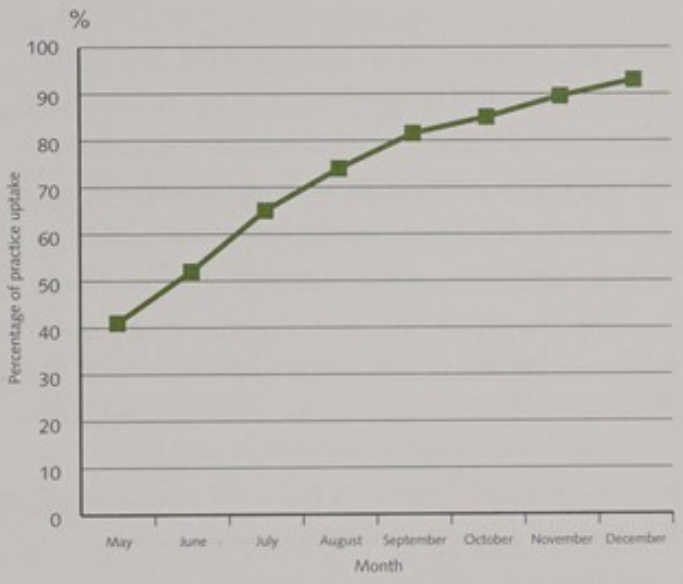
**4.42** Practice-based commissioning (PBC) places primary care professionals, including GPs, nurses and practice teams, alongside secondary care and other allied health professionals, at the heart of decision-making and commissioning health services for their local population. Under PBC, practices receive information on how their patients use health services. This information is then used to inform the redesign of services by front-line clinicians for the benefit of patients.

**4.43** Implementation of PBC in 2006 focused the creation by PCTs of an environment that would allow practices to begin commissioning. This was supported by the publication of *Practice-Based Commissioning: Practical Implementation* (DH, November 2006). This set out the next steps to further embed PBC and clarified a number of challenging issues, such as governance and accountability, and budget setting.

**4.44** PCTs were required to provide practices with indicative budgets and information, to offer an incentive for practices to become engaged, and to ensure there was a robust accountability and governance framework in place by the end of December 2006. All PCTs achieved this objective on time, but further work remains to be done to improve the quality of the support and ensure the right conditions are in place for PBC to flourish.

**4.45** Practices are entitled to a Directed Enhanced Service payment to encourage them to participate in PBC and in recognition of the clinical engagement required to produce a PBC plan, including service redesigns. **Figure 4.2** shows the percentage of practices that had taken up the incentive payment steadily increasing through 2006-07, as more practices became engaged.

**Figure 4.2: Uptake of practice incentives for England**




## Future plans

**4.46** Good progress has been made in 2006-07 towards creating the right environment for high-quality commissioning to flourish. The Department will build on this in 2007-08 by:

- consulting on the proposals within the *Commissioning Framework for Health and Well-being* (DH, March 2007). The Department is seeking views on how it can best help local commissioners work in partnership; in particular, how the proposed duty of joint strategic needs assessment and the new flexibilities for practice-based commissioning could work. A finalised version of the framework will be published in the summer of 2007;
- consulting on, refining and issuing a final version of the NHS Contract for Acute Hospital Services for use in the 2008-09 contracting round;
- developing a new contract model for out-of-hospital services; and

- continuing to support the successful implementation of PBC by developing and strengthening the budget-setting methodology used by PCTs to determine the size of individual practice-based commissioners' indicative budgets.

4.47 PBC had its foundation year in 2006. In 2007, the Department will build on this work, focusing on practical implementation of PBC in line with *Practice-Based Commissioning: Practical Implementation*. The emphasis will be on ensuring that a critical mass of clinical leaders is engaged. We will continue to work with our stakeholders, particularly the Improvement Foundation, to support clinicians, practices and PCTs.

4.48 In parallel, we are taking forward work on developing the commissioning capability of PCTs. This aims to strengthen commissioning of all patient care and follows on from the PCT Fitness for Purpose assessments. Practice-based commissioning will be at the heart of the programme.

## Payment by Results (PbR)

### Achievements 2006-07

4.49 Payment by results (PbR) is now embedded as part of the NHS landscape. Across the country, acute providers are reviewing the actual costs of their activity against PbR income, to manage in-year and to identify future improvement strategies. The scope of payment by results was extended for all NHS trusts in 2006-07 to include non-elective, accident and emergency, outpatient and emergency admissions. The tariff now covers over £22 billion worth of services.

4.50 An independent review of the tariff-setting process for 2006-07 made recommendations for improvement, which the Department accepted in full when it published an action plan in July 2006.

4.51 As part of this, the Department ran a successful road test of the 2007-08 tariff in October and November 2006, and confirmed the final tariff for 2007-08 alongside *The NHS in England: The Operating Framework for 2007-08* (DH, December 2006).

4.52 The Department is working with a range of stakeholders to develop the tariff, in particular to support White Paper recommendations to move care closer to home. The Department has published indicative tariffs for unbundling aspects of the tariff embedded in acute care, including rehabilitation and some diagnostics, to support the NHS in developing local tariffs to deliver services that meet the needs and choice of patients.

### Future plans

4.53 In the longer term, the Department is looking to continually refine the tariff and extend the scope of PbR where clinically appropriate and economically sensible. The Department has established a Clinical Advisory Panel (CAP) to strengthen the clinical underpinning of the tariff, and it continues to work with commissioners, providers, academia and other stakeholders through the Department's Expert Advisory Group (EAG).

4.54 During the year, work also continued, with the Audit Commission, to develop a Data Assurance Framework that will help improve the quality of patient-led data, which underpins the effective operation of PbR. The roll-out of the central elements of the framework, a programme of national benchmarking of activity data and targeted external audits of clinical coding, began in April 2007.

4.55 On 15 March 2007, the Department began a major consultation exercise about the future direction of PbR that will run until 22 June 2007. The *Options for the Future of Payment by Results* consultation document covers proposals to strengthen the existing building blocks of PbR policy, including classification, currency and costing, as well as ideas about how the policy can be developed and administered over the next few years. It looks at how the Department can develop the

existing process – for example by setting prices to reflect efficient service models – and also examines the issues that need to be addressed if the policy is to be extended to other areas. Extension is considered both in terms of an evolutionary process and in terms of particular issues for different types of service, such as critical care and mental health. The Department's response to the consultation will be published in due course.

## Information

### Achievements

4.56 The Department has worked jointly with NHS Connecting for Health to complete an assessment of the information needs flowing from the healthcare reform programme, so that the National Programme for IT and other components of the existing information strategy can develop in a way that is consistent with changes in the wider environment.

4.57 The Department has identified four areas for further attention:

- choice – better information to support patients to make meaningful choices;
- commissioning – better information and systems to strengthen commissioning and to enable closer integration of health and social care;
- providers – improved finance and business information systems to support fit-for-purpose providers; and
- stronger data standards and data quality.

### Future Plans

4.58 Over the coming months, the Department will work with patients and the service to elaborate what is needed, integrate these needs into current policy and agree priorities, and identify the best mix of national and local action to deliver. In particular, information will be a key theme of policy work on the future regulatory structure for health and social care, on commissioning, and on quality.

## Provider development

4.59 Reform of the provider side of the healthcare system aims to give providers more freedom to innovate and improve services in response to the needs and decisions of patients, GPs and commissioners. This involves further expansion of NHS foundation trusts, a continuing role for PCT direct provision, and more opportunities for voluntary sector, social enterprise and private sector providers whenever they can help deliver better services with better value for money.

4.60 Following the high-level review of the Department, a Directorate of Provider Development has been set up as a focused, expert resource to develop, enable and promote the new provider landscape, working in support of the NHS and social care system.

### Achievements

4.61 By the end of 2006-07 there were 62 NHS foundation trusts (NHS FTs), with independent status within the health service and greater freedoms and flexibilities than NHS trusts. NHS FTs have been very successful. There is growing consensus that foundation status and freedoms put organisations in a better position to improve services for patients, accountability to the local community and value for money for the taxpayer. For example, the Healthcare Commission's Annual Health Check for 2005-06 showed that NHS FTs outperformed non-NHS FTs on use of resources and quality of services.

4.62 The independent sector is helping to provide extra capacity and offer, patients increased choice. The Department's independent sector treatment centre (ISTC) programme is delivering a range of services for NHS patients. As of 31 December 2006 there were:

- 23 ISTCs – eight reaching full service commencement in 2006; another one provided a partial service, with full service beginning in 2007;

- six walk-in centres with a commuter focus have opened in Leeds, London, Manchester and Newcastle, and a further one is to open later in 2007;
- a mobile ophthalmology service;
- a mobile MRI scanning service; and
- a chlamydia screening service.

**4.63** Over 480,000 elective procedures, diagnostic tests and episodes of primary care have been provided to NHS patients by the independent sector through these centrally procured contracts.

**4.64** In June 2006, the Department established a Social Enterprise Unit, to stimulate and support social enterprises and their commissioners in the health and social care sector.

**4.65** In January 2007, we announced 26 social enterprise pathfinders, which will lead the way in delivering innovative services using a social enterprise business model. The learning from the pathfinders will be shared across the health and social care sector, so that others can benefit from the pathfinders' experience.

**4.66** The Department of Health, in conjunction with other major central government spending departments, was involved in developing *Partnership in Public Services: An Action Plan for Third Sector Involvement* (Cabinet Office, December 2006).

### Future plans

**4.67** The Department expects there to be 100 NHS FTs by the end of 2007, and the Government is committed to providing all NHS trusts with the opportunity to apply for foundation status at the earliest available opportunity. The decision on when to apply remains one to be taken locally.

**4.68** The Department has been working with Monitor, the independent regulator of NHS FTs, and a group of interested PCTs to explore the feasibility of NHS FT status for providers of community services. The Department is looking at how this might work in a small number of areas. Like other NHS FTs, Community NHS FTs would be publicly owned organisations that would be part of the NHS, with greater operational freedoms to respond to the needs of commissioners and patients. However, Community NHS FT status would only be one option for community provision. There is no requirement or timetable for PCTs to divest themselves of provision.

**4.69** The Department, in partnership with the local NHS, is now commissioning the second phase of ISTCs. Phase 2 of the ISTC programme comprises the two main areas of elective and diagnostic procedures. Phase 2 procurements are designed not only to increase access, capacity and plurality of provision, but also to introduce contestability into the healthcare market. A greater variety and choice within NHS services is expected to drive productivity and efficiency in the way healthcare is delivered to NHS patients by all providers. The procurement cycle for phase 2 is currently underway, and is being conducted in compliance with EU procurement law. The majority of services are expected to begin in 2007 and 2008.

**4.70** The phase 2 electives procurement is expected to deliver up to 250,000 procedures per year and create an Extended Choice Network (ECN) of independent sector providers, who will deliver up to an additional 150,000 procedures per year on an ad hoc basis. Overall, this represents an investment of approximately £3 billion over five years. The additional capacity will be provided through a variety of facilities, such as existing ISTCs, new-build specialist orthopaedic centres, refurbishments and existing NHS facilities, and will collectively contribute towards the provision of patient choice.

**4.71** The phase 2 diagnostics procurement is expected to deliver approximately 1.5 million additional diagnostic procedures per year for NHS patients, and represents an investment of over

£1 billion over five years. This additional capacity will enable the NHS to meet the Government's target that, by 2008, all NHS patients should be treated within 18 weeks of their GP referral.

4.72 Oversight of work with social enterprise, third sector and voluntary groups will be taken forward by the Third Sector and Social Enterprise Delivery Board, announced on 15 March 2007. The purpose of this group is to focus on delivering a range of demonstrable improvements to the relationships between public, social enterprise and wider third sector organisations in health and social care.

4.73 From April 2007, the Department will hold a fund of more than £70 million to support social enterprises over the next four years.

## System management and regulation

### Achievements

4.74 The Government is committed to merging three existing bodies – the Healthcare Commission (HC), Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission (MHAC) – to form a new health and adult social care regulator when parliamentary time allows.

4.75 The remit of the new regulator will cover the regulation of health and adult social care services; it does not include professional regulation.

4.76 *The Future Regulation of Health and Adult Social Care in England* (DH, November 2006) outlines which particular regulatory functions will need to be undertaken from 2008 onwards, and by whom. This includes the new regulator and other organisations in the wider health and adult social care systems, as well as the Department of Health, Monitor, the Audit Commission, SHAs, commissioners and providers. Common assessment and inspection approaches will assure patients that, no matter which provider they choose, the service they receive will meet national standards of safety and quality.

4.77 The document launched a period of consultation, which closed on 28 February 2007, to consider how the new regulator could best work alongside other bodies in the health and social care systems to fulfil the functions set out in the document.

### Future plans

4.78 The changes involved in the merger of the Healthcare Commission, CSCI and MHAC have been planned for some time and form a key part of the Government's health reform strategy. The new regulator will build on the excellent work to date of the existing organisations (which will remain in place during the transition period) and the regulatory framework will be flexible enough to adapt as the NHS and adult social care systems evolve over time.

4.79 The new regulator will focus on the needs and expectations of patients and service users. This will reflect the fact that high-quality, personalised services span many different organisations and types of care.

4.80 It is envisaged that the new regulator will build on the existing functions of the three regulators going into the merger. Subject to legislation, the new regulator will focus on the following areas:

- quality and safety of health and adult social care providers – it will be responsible for a revised system of registration, which will include NHS as well as independent health and adult social care providers, and will offer patients and service users assurance that services are safe and fit for purpose; it will have powers to de-register a service or whole provider for serious and/or persistent failure to meet safety or basic quality standards;
- information and performance assessment – it will be responsible for independent assessment of NHS and adult social care commissioners and providers and for publication of this comparative information for the purpose of accountability to

Parliament and the taxpayer; it will ensure that good information is available to support patient and service user choice; and

- safeguarding the rights of patients subject to the *Mental Health Act 1983* – it will continue the important role currently undertaken by the MHAC in England.

4.81 In a separate process, we will review the necessary duties and powers required by the new regulator to keep the operation of mental health legislation under review, to ensure that mental health service users are as effectively protected by the new regulator as they are now, and to emphasise the importance of equality and Human Rights in mental health care.

4.82 Legislation to formally merge the organisations will be introduced as soon as possible when parliamentary time allows. The new regulator will be created in 2008, subject to the passage of legislation through Parliament, and operations will commence in April 2009, with the existing commissions continuing to operate their statutory functions until March 2009.

4.83 The Department and the other bodies involved recognise the need for the merger to be a managed process, and the Department will continue to work with all three bodies on the detail.

## Service improvement

### 'Quality Assurance of Major Changes to Service Provision' (Carruthers Review)

4.84 In the last year, major service changes have become a matter of national, as well as local relevance. In many instances, these have been seen as a response to short-term NHS overspending. This has made it difficult for the local NHS to argue the case for changes that will actually deliver better results for patients.

4.85 In October 2006, Sir Ian Carruthers was asked to lead a short piece of work to review how the Department and the NHS might learn from best practice and consider how the Department might improve the management and delivery of major service change in the future. This review has now come to an end, and on 28 February 2007 a paper setting out the lessons learnt and recommendations was shared with SHA chief executives.

4.86 Working alongside the SHA chief executives, the review was undertaken in three distinct stages. The first phase looked at what was currently happening in each SHA and what systems and processes were in place to engage stakeholders at each stage, from developing to implementing proposals, and the processes and procedures used to run consultations locally. The second related to business case assessment, and looked at and tested the strength of trust and SHA planning, with particular attention focusing on clinical, workforce, governance and financial implications. The third looked to the future. It considered what aspects of current service development processes could be improved and how best practice might be better shared.

4.87 In summary, the main findings are:

- reasons for change should be built on a clear evidence base of clinical and patient benefits. The case for any change needs to be stronger and better articulated. Recent reports from national clinical directors make it clear that major service changes are first and foremost about saving lives;
- clinical and staff involvement in developing proposals is critical. More needs to be done to engage clinicians, staff and their representatives in the process at a local, regional and national level;
- good preparation and understanding of the process (pre-consultation, consultation and implementation) is crucial: there is a wide variation in the quality and fitness of proposals;
- strong coherence and coordination of local proposals is essential, some areas have clear strategies, while in others the approach lacks

cohesion. PCTs should be at the centre of major service change, driving changes to service provision where appropriate;

- SHAs should use the Service Improvement Readiness Framework (this is an annex to the 28 February letter entitled 'Service Improvement: Quality Assurance of Major Changes to Service Provision') to ensure that proposals for change are sufficiently robust and fit for purpose;
- SHAs have a clear 'gateway' role to quality-assure local proposals, and make sure that proposals are fit for purpose and offer world-class services, while providing value for money for the taxpayer, before they progress to consultation;
- communications need to be strengthened: consultation documents should contain specific, relevant, clear information, written in plain English, to allow local stakeholders to comment in an informed way on local proposals; and
- new leadership teams need to review inherited schemes, and assure the Department that they are fit for purpose, while ensuring that they work with local stakeholders – consulting, listening and involving them in their local NHS.

**4.88** SHAs must take the strategic lead in ensuring that the lessons learnt from this review, and the recommendations set out, make a positive difference. SHAs must maintain a secure grip on what, when and why service proposals are being discussed in their area. Their role as 'gatekeeper' is essential to ensure that PCTs make a clear, coherent and consistent case for change, based on sound clinical, patient and financial benefits, the better to meet the needs of their local communities.

## Commissioning a Patient-led NHS

**4.89** At the heart of *Commissioning a Patient-led NHS* (DH, July 2005) was a commitment to deliver stronger PCTs with a more focused role, especially in relation to commissioning better services for patients, working more closely with local government and ensuring that we get the best value for money from the system.

**4.90** In October 2005, SHAs submitted their proposals for the reconfiguration of PCTs, and then began final consultation on 14 December 2005. Consultations ended on 22 March 2006.

**4.91** Findings from the consultations were submitted to the Department in April, and were considered by an independent panel. After considering advice from the panel, ministers announced the new configuration of SHAs on 12 April and PCTs on 16 May 2006. Overall numbers of SHAs reduced from 28 to 10 (see **Figure 4.3**), and the number of PCTs from 303 to 152. New SHAs came into effect from July and PCTs from October 2006.

**4.92** The reconfigurations will save £250 million a year by reducing management costs. These savings will be reinvested in front-line services by 2008. They will also result in:

- a closer relationship between health, social care and emergency services;
- improved and better-value services for patients;
- better emergency planning, with more resources to respond to major incidents and ensure service continues as normal; and
- more money for front-line services.

**4.93** Running alongside the reconfiguration was the development of a programme designed to test organisational 'fitness for purpose'. It incorporates an assessment tool to look at financial viability, strategic planning, governance arrangement, emergency planning and external relationships. It also contains a diagnostic tool that allows PCTs to compare best-practice commissioning across all services (including those commissioned jointly with social care), identify gaps and produce a high-level development plan. The tool was rolled out across all PCTs, and was completed in 2006-07.

## Figure 4.3: Strategic health authority configurations


| | | | | | |
|---|---|---|---|---|---|
| 1 | Northumberland, Tyne and Wear | population: 1,396,374 | North East | population: | 2,545,073 |
| 2 | County Durham and Tees Valley | 1,148,699 | | | |
| 3 | Cumbria and Lancashire | 1,929,653 | North West | | 6,827,170 |
| 4 | Cheshire and Merseyside | 2,358,474 | | | |
| 5 | Greater Manchester | 2,539,043 | | | |
| 6 | North and East Yorkshire and Northern Lincolnshire | 1,652,387 | Yorkshire and The Humber | | 5,038,849 |
| 7 | West Yorkshire | 2,108,028 | | | |
| 8 | South Yorkshire | 1,278,434 | | | |
| 9 | Trent | 2,687,496 | East Midlands | | 4,279,707 |
| 10 | Leicestershire, Northamptonshire and Rutland | 1,592,211 | | | |
| 11 | Birmingham and the Black Country | 2,274,964 | West Midlands | | 5,334,006 |
| 12 | Shropshire and Staffordshire | 1,499,568 | | | |
| 13 | West Midlands South | 1,559,474 | | | |
| 14 | Norfolk, Suffolk and Cambridgeshire | 2,238,151 | East of England | | 5,491,293 |
| 15 | Essex | 1,635,605 | | | |
| 16 | Bedfordshire and Hertfordshire | 1,617,537 | | | |
| 17 | North Central London | 1,227,957 | London | | 7,428,590 |
| 18 | North East London | 1,531,427 | | | |
| 19 | North West London | 1,834,066 | | | |
| 20 | South East London | 1,514,122 | | | |
| 21 | South West London | 1,321,018 | | | |
| 22 | Surrey and Sussex | 2,577,631 | South East Coast | | 4,187,941 |
| 23 | Kent and Medway | 1,610,310 | | | |
| 24 | Thames Valley | 2,120,859 | South Central | | 3,922,301 |
| 25 | Hampshire and Isle of Wight | 1,801,442 | | | |
| 26 | Avon, Gloucestershire and Wiltshire | 2,206,246 | South West | | 5,038,200 |
| 27 | Dorset and Somerset | 1,212,892 | | | |
| 28 | South West Peninsula | 1,619,062 | | | |

Source: 2004 mid-year estimate – resident population based on the ONS National Population Census 2001

## NHS operating framework

**4.94** The purpose of *The NHS in England: The Operating Framework for 2007-08* (DH, December 2006) is to set out the parameters within which local organisations will work in 2007-08.

**4.95** It explains why there is a need for change in 2007-08, and a further decisive shift towards building a self-improving system driven by local priorities. Specifically, it clarifies:

- the health and service priorities for the year ahead;
- the next steps in reforms and why these are important; and
- the financial objectives.

**4.96** PCTs need to work with local authorities to improve health and well-being, reduce inequalities and achieve a shift towards prevention. PCTs are expected to play their full part in the Local Area Agreement process and to agree with local authorities those aspects of local delivery plans (LDPs) that require joint work.

### Service priorities

**4.97** The NHS is an increasingly complex system dealing with a wide range of healthcare needs and services. It is the responsibility of all NHS organisations to ensure the continuous improvement of all services they are responsible for, all the time. That is why we have introduced in recent years a standards framework, which is intended to give patients and the public confidence in the fact that all aspects of healthcare are quality assured. It is also designed to encourage organisational self-improvement.

**4.98** NHS national priorities need to be seen in this context. Just because something is a priority does not mean that other things do not matter.

**4.99** PCTs and other NHS organisations are already working to three-year LDPs for the period 2005-06 to 2007-08.

**4.100** The NHS is making good progress in many of these areas. PCTs are expected to ensure that this progress is sustained and that national milestones for delivery in 2007-08 are achieved. PCTs also need to ensure that they continue to meet existing government commitments. Progress against national commitments will continue to be monitored by the Department and will form part of the Healthcare Commission's annual performance assessment.

**4.101** Four issues will require particular attention by all organisations in 2007-08 both because of the degree of challenge they pose and because of their importance to public confidence in the NHS. These are:

- achieving a maximum wait of 18 weeks from GP referral to start of treatment of patients;
- reducing rates of MRSA and other healthcare-associated infections;
- reducing health inequalities and promoting health and well-being; and
- achieving financial health.

**4.102** In addition, PCTs need to begin laying the foundations in 2007-08 for future improvements in a number of areas. The reasons for this are:

- to prepare the ground for future implementation of government commitments, including the strategy set out in *Our Health, Our Care, Our Say*;
- to address issues of public concern. These include concerns about standards and statutory obligations, identified by bodies such as the Healthcare Commission. These may be specific to an organisation or apply to all organisations in a locality; and
- to reinforce the need for PCTs to own and drive continuous improvements locally in outcomes and productivity.

### Reforms

4.103 The reform tools implemented and delivered locally, are the means by which the NHS will drive up quality, improve services and outcomes for patients, and provide better value for taxpayers. Therefore, there will be no let up in the pace of implementation. The challenge now is to engage clinicians and managers locally so that they use the reform tools to ensure their communities gain the maximum benefits of investment and reform as quickly as possible. The Department is looking to the newly established PCTs, working with practice-based commissioners, to take a leadership role in this respect.

### Finance

4.104 2006-07 will see the NHS return to net financial balance, recovering at a national level the overspend from 2005-06. For 2007-08, we need to build on this foundation to create a sustainable financial position for the future. This requires:

- delivery of a net surplus across the NHS of at least £250 million, as organisations generate surpluses to recover historic overspending;
- a significant reduction in the value of gross deficits; and
- all but a small handful of organisations operating in recurrent balance throughout the year.

4.105 Achieving these goals will leave the NHS well placed to continue delivering service improvement into the next allocation period, as levels of growth inevitably become steadier.

4.106 Delivery of these goals will be supported by:

- changes in the financial regime that continue the process of improving the transparency of performance and providing better alignment of incentives;
- an increased focus on the delivery of efficiency improvements; and
- early notification of financial planning assumptions.

## Implementation and impact of reform

4.107 The health reforms are the means to drive up quality and improve care and health outcomes for patients and the public. But reform is not something the Department can, or should, do to the NHS. Rather, local NHS organisations will put the components of reform in place and use them together to transform whole care systems.

### Achievements and future plans

4.108 In 2006-07, the Department supported local NHS leadership as they put in place the building blocks of reform. In 2007-08, it will work closely with the NHS, with both clinicians and managers, to help them further embed the reforms and derive maximum benefit from them for their patients and the public.

4.109 Getting the health reforms fully in place is a necessary first step towards a self-improving system, with patient care at its core. In 2006-07, the Department, with the SHAs, developed a reform deployment report to track how the reforms were being implemented. The monthly report provides SHAs with intelligence on the current state of reform deployment on their patch and how they compare with the national picture. It gives detailed information across key areas of the reform programme, including choice, practice-based commissioning, foundation trust status and PCT capability. The report supports discussion between the Department and SHAs on challenges to, and best practice on, implementing the reforms. In 2007-08, the report will be enlarged and cover more of the reforms, including the deployment of information systems and the shift of care from secondary to community care.

4.110 Last year, the Department supported the setting up of 'Health Reform Demonstration Systems' – an SHA-led initiative. These local health systems will use the health reforms to deliver improved outcomes and transform whole care

systems. They are large, complex and multi-organisational systems and will be at the forefront of learning about how reform can be used to improve outcomes. In 2007-08 and beyond, the systems will accelerate and improve the quality of reform implementation. The Department will be able to refine policy in light of the challenges the systems encounter.

**4.111** As the individual building blocks of health reform are implemented at the local level, and as they are used together to create a self-improving system, the Department will track their impact. This will enable the Department to understand challenges on the ground, as well as what is working well. In 2006-07, the Department began work on a framework to capture the effects of health reform across five important areas – affordability, efficiency, quality and safety, patient experience, and health equality. In 2007-08, the Department will build on this work and monitor the impact of health reforms in local health economies, as well as nationally.

**4.112** In 2006-07, to further understand the effects of the reforms, the Department worked closely with the Prime Minister's Delivery Unit (PMDU) on its biannual reports on the implementation and impact of reform. In 2007-08, the Department will again work with PMDU to understand the challenges to improved healthcare and patient outcomes.

**4.113** In 2007-08, the Department will establish a new independent research programme to evaluate the impact of health reform as it is implemented. The evaluation will enable policy-makers, both current and future, to learn what has worked well, and what has not – and to apply those lessons, in keeping with its commitment to evidence-based policy. The programme will complement and build on existing evaluation, filling the gaps through in-depth studies of individual reform mechanisms and whole-system examinations of the combined effect. There will be a strong focus on feeding early results into policy development, to allow reform policy to evolve in the light of feedback from implementation.

# 5 Improving Social Care Services

## Introduction

5.1 The McKinsey high-level review, undertaken in December 2005, made recommendations to strengthen the position of social care within the Department by the creation of a new director general post, supported by a social care directorate with four main functions:

- to provide clear national leadership for social care across central and local government, ensuring:
  - a coherent, integrated approach to the current and future role of social care in improving well-being and social inclusion;
  - a robust framework for delivery and development in social care; and
  - effective partnership working with other government departments and all key stakeholders in the wider public, voluntary and private sectors;
- to deliver the commitments on reform and improvements in social care and related health outcomes in the recent White Paper *Our Health, Our Care, Our Say* (DH, January 2006);
- to lead further policy development on adult social care in the Department, and to secure resources for adult social care provision and provide assurance at national level for the delivery of improvements in efficiency and effectiveness; and
- to oversee and take responsibility for building capacity and capability within the Department on social care, including:
  - the input of relevant expertise within policy delivery teams across the Department, including its regional presence; and
  - the development of a stronger evidence base on the current and future needs of service users and on developments in the commissioning and provision of services at local level.

5.2 A work stream to develop plans and identify resources for the new directorate was set up in January 2006 and continued through the first part of 2006-07, led by the national director. Following the appointment of the director general at the end of August, a project plan was developed to set up the directorate, which was functional from 1 January 2007 and fully operational on 1 April 2007.

5.3 The financial resources for social care are included in the overall tables for the Department rather than shown separately for 2006-07, since the directorate was not formally in place for most of the year. Further information on Personal Social Services (PSS) finance can be found in chapter 9.

## Strategy

5.4 The Government's vision for social care is set out in the White Paper *Our Health, Our Care, Our Say*. The overarching themes emphasise:

- improved prevention and early intervention;
- more choice and a stronger voice for people using services;
- improved access to services;
- tackling inequalities across health and social care; and
- support for people with long-term needs.

5.5 This vision links to other significant strategic documents which have been published by central government over the last few years, and particularly within the last 18 months, to develop a coherent picture of the way in which people's lives are supported to enable them to remain independent and to achieve their potential. These include:

- *Every Child Matters* (2003);
- *Supporting People* (ODPM, November 2005);
- *Life Chances for Disabled People* (PMSU, January 2006);
- *Opportunity Age* (DWP, March 2005); and,
- *Strong and Prosperous Communities* (DCLG, October 2006).

5.6 Social care works in partnership with health and other local authority services. Services are commissioned by local authorities for a large range

of private and voluntary organisations. Councils determine individuals' eligibility for services and eligibility for public funding. Social care services are means tested. Many people who use social care make a financial contribution to all or some of their care, with local authorities contributing the balance.

5.7 A vision for the directorate was developed and consulted upon at the end of 2006. In summary, the vision is that:

- people of all ages receive health and social care support that promotes their independence, inclusion, health and well-being;
- people have the opportunity to exercise choice and control, developing their own solutions and support to shape their lives and the services they require; and
- services are of high quality and ensure personal safety.

## Prevention and early intervention

### Partnerships for Older People Projects (POPP)

5.8 There is a growing evidence base in the care of older people that a more proactive approach to identifying and responding to needs as they emerge, and targeting people with low-level needs today, could prevent them from becoming part of the group of people with the 'greatest needs' in the future. Targeted interventions at the right time can prevent or delay the need for higher intensity or institutionalised health and social care. For example, the Department knows that too many older people are admitted to hospital, often as an emergency, when that could be avoided if the right community services were in place.

5.9 The 2004 Spending Review provided ring-fenced funding of £60 million (£20 million in 2006-07 and £40 million in 2007-08) for councils with social services responsibilities (CSSRs) to establish locally innovative pilot projects in partnership with PCTs and the voluntary, community and independent sectors. The key aim of the pilots is to deliver large-scale system reform across health and care services to deliver improved outcomes for older people through meaningful engagement with older people. The funding is being made available by the Department under the Partnerships for Older People Projects (POPP), which was launched in March 2005.

5.10 In the longer term, POPP pilots are expected to make a significant contribution to the existing evidence base on the effectiveness of prevention as highlighted in the health and social care White Paper *Our Health, Our Care, Our Say.*

### Aims and objectives of the POPP pilots

5.11 The POPP sites are aimed at enabling older people to have greater personal control over their health and well-being, to be empowered to manage their changing needs and to remain independent wherever possible. The pilots are focused on demonstrating improvements in the following three key areas, which support delivery of the two key PSA targets on long-term conditions and supporting vulnerable older people:

- providing more low-level care and support in the community to improve the health, well-being and independence of older people, and to obviate or delay the need for higher-intensity and more costly care;
- reducing avoidable emergency admissions and bed days for older people; and,
- supporting more older people to live at home or in supported housing such as sheltered or Extra Care Housing, rather than in long-term residential care.

5.12 Through the pilots, the POPP Programme is demonstrating and evaluating innovative models of service delivery, financial and partnership mechanisms, that are designed to create a sustainable shift in resources and culture away from the focus on intensive and institutionalised care and towards earlier and better targeted interventions for older people.

## Progress to date

5.13 The POPP Programme is awarding funding of up to two years to 29 partnerships across the country during 2006 to 2008, with a view to demonstrating a range of models and identifying approaches that are potentially replicable across England in different health and social care communities.

5.14 The pilots are being launched in two phases. The first phase (19 pilot sites) was launched in May 2006 and was awarded a share of £41 million. The second phase (10 pilots) was announced on 7 December 2006 and is being awarded a share of £18.5 million. The second phase pilots will become operational by 1 May 2007.

5.15 All pilots are receiving implementation support through the Care Services Improvement Partnership (CSIP) and are subject to robust evaluation at local and national level. Collectively, the pilots will demonstrate 'what works, for whom, where and in what circumstances'.

5.16 The pilots are delivering a diverse range of interventions and service delivery models, including:

- improving access to low-level care services for older people, such as help with daily living skills like shopping, gardening and housing repairs, but also improving access to specialist services for older people with chronic or complex conditions, such as dementia, long-term conditions, etc.
- proactive case-finding to identify older people most at risk of hospitalisation and of losing their independence;
- integrated needs assessment and case management work to prevent avoidable hospital admissions and, in the case of unavoidable hospital admissions, to better support older people following discharge through improved rehabilitation services;
- use of technology, such as telecare, to support older people to live safely and securely at home;
- establishing new joint health and social care teams to better integrate care pathways for older people with long-term conditions, such as stroke, diabetes, chronic obstructive pulmonary disease (COPD), etc.
- health promotion initiatives, whereby older people are trained as health trainers and support their peers in healthy living;
- providing new services to promote social inclusion for older people and increased participation in local communities – facilitated by improved access to universal services such as leisure, transport, education and employment opportunities;
- changing organisational culture through training and recruiting of older people as community leaders or networkers to organise and deliver new services;
- the complete redesign of older people's mental health services in specific pilots; and
- greater support for carers to improve their health and well-being.

## Evaluation and dissemination

5.17 The Department is funding a two-and-a-half year national evaluation of the POPP Programme. The national evaluation, which began in April 2006, is being led by the University of Hertfordshire, in partnership with the London School of Economics; the University of College London; the University of Keele; and, John Moores University. The evaluation will deliver its first progress report in June 2007 and a final report in October 2008.

5.18 The Department, through CSIP, is extracting and disseminating early lessons learnt at national level from the POPP Programme and related government initiatives, with the aim of supporting local partners in shifting the pattern of services towards cost-effective prevention. This is being done through regional events and the development of web-based resources.

### The Preventative Technology Grant

5.19 The Preventative Technology Grant (PTG) was made available to enable councils to support people to remain in their own homes. The purpose of the grant is to initiate a change in the way that services are designed and delivered, to prevent a loss of independence and maintain the well-being of people in their own homes.

5.20 The grant totals £80 million over two years (£30 million in 2006-07 and £50 million in 2007-08) and can be used for purchasing equipment and services, as well as undertaking service redesign and building the local infrastructure needed to support telecare. Telecare includes basic community alarm equipment, such as pendants and pull cords, as well as more complex devices, such as activity monitors and remote physiological monitoring of, for example, blood pressure.

5.21 To support the use of the PTG, the NHS Purchasing and Supply Agency (PASA) launched a national procurement framework for telecare in June 2006. By providing a national contract, this framework enables councils and their partners to greatly reduce the time and money spent on procuring telecare equipment and services.

5.22 The Department has issued guidance – *Building Telecare in England* (DH, July 2005) – alongside a wide range of implementation support guidance developed by CSIP.

5.23 Effective use of this grant will help local authorities and their partners achieve key PSA targets around supporting people with long-term conditions and improving the patient and user experience, in particular supporting older people to live at home. For more information on the PSA targets mentioned, refer to Annex B of this report.

5.24 CSIP assessment of councils' progress shows that eight are progressing very well and are considering mainstreaming beyond March 2008, when the grant finishes; many others are showing considerable promise and innovation, and some local authorities are starting to tackle telehealth. Some 89 councils are actively taking telecare plans forward.

### Extra Care Housing

5.25 Between 2004 and 2008, the Department has made £147 million available to local authorities to develop new Extra Care Housing with their housing partners. As part of this, £40 million will be made available to 14 schemes during 2007-08, to provide over 900 new Extra Care Housing units. To date, the Department has funded the development of over 3,600 Extra Care Housing units.

5.26 The Department's Extra Care Housing fund is in addition to the Housing Corporation's funding for Extra Care Housing, which provided £229 million for the same period. In total, the Government has made £376 million available for the development of new Extra Care Housing.

## Individualisation

### Direct Payments Uptake Project

5.27 The White Paper *Our Health, Our Care, Our Say*, identified direct payments as one of the main ways to foster independence and enable people to take control of their lives.

5.28 Access to direct payments should be available to all people eligible to receive them. Therefore, the Direct Payments Uptake Project has been developed to support local councils and their partners in working together to improve access to, and uptake of, direct payments. The project will offer the following support and resources:

- *Increasing the Uptake of Direct Payments: A Self Assessment and Action Planning Guide for Local Councils with Social Services Responsibilities and their Partners* (DH, December 2006). The guide draws on extensive research into the barriers to take-up. It will enable authorities to look at their

direct payment arrangements, test the barriers to take-up in their local areas and identify existing good practice. It details the key activities that support effective implementation of direct payments and provides local councils with the means to make an assessment of their services and the framework to develop a local action plan;

- regional events to introduce and promote the use of the guide locally, and the sharing of solutions, information and support between local councils;
- development of a web-based solutions document for use nationally. This will enable all councils to benefit from their collective experience, and draw on those solutions that best suit their local circumstances;
- joint work with the Commission for Social Care Inspection (CSCI) to look at the best way to measure outcomes for people with direct payments; and
- additionally, the Department will widen the scope of direct payments to enable people who cannot consent to having a direct payment to have one if this is in their best interests. Extending the scope of direct payments requires changes to primary legislation, and such changes will be made as soon as parliamentary time allows.

## Individual budgets

5.29 The idea behind the individual budget concept is to enable people who need social care and associated services, such as Access to Work, to design that support, and to give them the power to decide the nature of the services they need. The concept builds on the successful features of direct payments and on other initiatives to develop self-directed care, most notably the In Control Project, which was jointly developed by Mencap and the Valuing People Support Team. The concept involves major changes in the way in which community care is currently provided, and poses challenges for those commissioning and providing social care services. It also involves working with other agencies to streamline assessment and reporting systems and allow for a bundling together of disparate income streams to meet common and agreed outcomes for the individual.

5.30 The key features of individual budgets are:

- there is an up-front transparent allocation of resources, giving individuals a clear cash or notional sum for them to use towards their care or a support package;
- the assessment process is streamlined across agencies, meaning people spend less time giving information;
- a variety of different streams of support or funding, from more than one agency, are brought together;
- individuals are given the freedom to use the budget in a way that best suits their own particular requirements; and
- individuals can have support from a broker or advocate, family or friends, as they wish.

5.31 The Department of Health, Department for Communities and Local Government and the Department for Work and Pensions have worked together to develop a starting model for individual budgets. There is a wide range of income streams that could potentially be included in an individual budget, but the local authorities taking part in the pilot projects include at least social care and one or more of the following:

- council-provided social care services;
- Independent Living Funds;
- Supporting People;
- Access to Work;
- Disabled Facilities Grant; and
- Integrated Community Equipment Services.

5.32 The following 13 local authorities are piloting individual budgets: Barking and Dagenham, Barnsley, Bath and North East Somerset, Coventry, Essex, Gateshead, Kensington

and Chelsea, Leicester, Lincolnshire, Manchester, Norfolk, Oldham and West Sussex.

5.33 Individual budgets are currently limited to adults, and cover people with learning disabilities, physical disabilities, older people and those with mental health issues. The Department for Education and Skills is exploring the potential to extend pilots to include children at some future stage.

5.34 The principal aim of the pilot process is to gather evidence to enable decisions to be made about how individual budgets should be rolled out more widely.

5.35 In order to ensure that the pilots fully test the evidence, evaluation has been built into the process from the outset. Three research teams have been engaged for the evaluation: the Social Policy Research Unit at York; the Personal Social Services Research Unit at Kent, London School of Economics and Manchester; and the Social Care Workforce Research Unit at King's College London. The evaluation is fully randomised. Half the sample will consist of people who have been assigned an individual budget, while the other half will be made up of people receiving traditional council services. That way, the outcomes for both groups can be adequately compared.

### Stakeholder engagement

5.36 It is also vital that all interested parties are given the opportunity to contribute to the development of the model for individual budgets. As the pilots progress the emerging findings and their implications are being discussed with a wide range of stakeholders, both of users and providers. There is also a reference group made up of a wide range of stakeholders and chaired by Niall Dickson of the King's Fund.

### Progress to date

5.37 Pilot sites are being supported by an implementation team within CSIP. This team has provided one-to-one support for each authority, has hosted a series of national and regionally based workshops on different topics, and provided guidance and knowledge sharing by means of a dedicated website. All the pilot sites have set up their local systems and transparent resource allocation systems. They have begun to deliver individual budgets to individuals as part of their quotas for the evaluation with support planning processes in place.

### Self-assessment pilots

5.38 The Department is providing £850,000 for a 12-month project – from October 2006 to September 2007 – that is looking at different models of self-assessment, supported assessment and direct access to services. This involves 11 local authority-led pilots working closely with PCTs, the voluntary sector and other partners to explore the scope for streamlining and improving access to a range of services, including the provision of equipment and aids, telecare packages, minor and major housing adaptations, home care, information and advice, and support for carers.

5.39 The 11 pilot sites are: Birmingham City Council, Bristol City Council, Derby City Council, East Riding of Yorkshire Council, Kingston upon Hull City Council, London Borough of Barnet, London Borough of Croydon, London Borough of Hammersmith and Fulham, Nottinghamshire County Council, Royal Borough of Kingston upon Thames and St Helens Metropolitan Borough Council.

5.40 The pilot projects will be independently evaluated to provide information on the effectiveness of self-assessment and supported assessment in identifying needs, and on the quality of outcomes for different groups of services users, such as younger and older adults with physical and sensory impairments, people with learning disabilities, adult carers and people from minority ethnic communities. We expect around 4,000 service users and carers to be able to self-assess their needs for services through this project. A smaller number of

service users will also be able to self-review their existing care arrangements and to request changes to take account of altered circumstances.

5.41 Further information is available at www.socialcare.csip.org.uk

## Dignity in Care Campaign

5.42 November 2006 saw the launch of the Dignity in Care Campaign. The campaign, led by the Department and supported by a wide range of key stakeholders, aims to create a national debate about dignity and send a strong signal to care services about the importance of dignity in the care of older people.

5.43 The campaign followed a series of ministerial listening events that were held to hear from staff, people who use services and their carers about their experiences of care services. Over 700 people took part in either the listening events or the subsequent online survey.

5.44 As part of the campaign, the Department issued the Dignity Challenge, which sets out the national expectations of services which respect dignity. High-quality care services that respect people's dignity should:

- have a zero tolerance of all forms of abuse;
- support people with the same respect individuals would want for themselves or a member of their family;
- treat each person as an individual by offering a personalised service;
- enable people to maintain the maximum possible level of independence, choice and control;
- listen to and support people to express their needs and wants;
- respect people's right to privacy;
- ensure people feel able to complain without fear of retribution;
- engage with family members and carers as care partners;
- assist people to maintain confidence and a positive self-esteem; and
- act to alleviate people's loneliness and isolation.

5.45 It also invited local staff and the public to join a network of Dignity Champions, who will form an army of local volunteers willing to take action locally to improve the way older people experience care services.

5.46 A number of national policy programmes underpin the campaign. These include improving the patient environment, strengthening adult protection arrangements and inspection and regulation regimes, as well as measures to ensure the care workforce is registered and better trained to deliver dignity in care. This includes £128 million of capital money being committed to improving the environment for older people in hospices and care homes.

## Carers

5.47 On 21 February 2007, the Minister for Care Services, Ivan Lewis, formally launched details of the Government's New Deal for Carers. The minister announced a multi-million pound package of support for carers through a range of measures designed to recognise the essential work that carers carry out across the country. These include:

- a strategy review;
- telephone help and an advice line;
- an expert carers programme; and
- emergency respite care;

### Strategy review

5.48 This wide-ranging review of the 1999 National Carers Strategy will involve all government departments that impact directly on the lives of carers. Group members will include a senior group of officials from across Whitehall, as well as the

chief executives of the three main carer organisations. Ways to consult more widely are now being considered.

### Telephone help and advice line

5.49 The 1999 strategy emphasised the importance of good information for carers. The proposal is to develop a helpline, which anyone can dial from anywhere in England, that will provide comprehensive information for carers.

5.50 The Department is currently working up a specification in collaboration with carer organisations, and plans to let a contract later this year. The Department is making up to £3 million a year available to support this service.

### Expert Carers Programme

5.51 The Department is making up to £5 million per annum available to fund the programme. This will provide training specifically designed for carers, to help them develop the skills that they need to provide safe and effective care and give them the knowledge and the expertise that they will need to manage their own particular caring situations.

5.52 The programme will include training on carers' rights, stress management, services for carers, information for carers, communication skills and advocacy, as well as providing skills that will enable them to care safely and effectively, such as moving and handling, first aid, and medication.

### Emergency respite care

5.53 Finally, the Department undertook to ensure that short-term, home-based respite support is established in each council to cover crisis or emergency situations.

5.54 The Department is working with stakeholders to identify the key principles that should apply to the provision of such emergency respite care. The Department plans to issue guidance to local authorities in the summer of 2007. The Department is making £25 million available to support implementation of the guidance from October 2007.

## Continuing care

5.55 The consultation on the *National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care* ran from 19 June 2006 to 22 September 2006. The Department is now considering the responses it received to the consultation.

5.56 The consultation is a direct response to the inconsistency and confusion about eligibility for continuing care across England that led to the need for a retrospective review. The new framework will promote fair and consistent access to NHS funding across England, irrespective of location, diagnosis or personal circumstances. However, the national framework does not change the underlying legal responsibilities of the NHS and local authorities.

## Life chances of disabled people

5.57 The Government is committed to delivering the Prime Minister's Strategy Unit report on *Improving the Life Chances of Disabled People*, published in January 2005. It falls to the Department of Health to deliver many of the report's recommendations. The Social Care Directorate is working with the Office of Disability Issues (ODI) to drive forward an active programme of work to deliver greater choice and control for disabled people, and in particular is closely involved in the ODI's current Independent Living review.

5.58 The top priority is for the Department to deliver the recommendation, that by 2010, each locality (defined as that area covered by a council with social services responsibilities) should have a user-led organisation modelled on existing Centres for Independent Living, and for the Department to have also instigated a range of work in partnership with disabled people, their families and their organisations to map the current position, identify

barriers to delivery and develop proposals to deliver this objective.

## Activity and performance

### PSA target for older people

5.59 PSA SR 2004, target 8 is aimed at increasing the proportion of older people who require intensive care support to be enabled to receive such care at home, rather than in residential settings.

### Target

5.60 The SR 2004 settlement set a target of increasing the number of older people supported intensively to live at home to 34 per cent of the total being supported by social services at home and in residential care by March 2008.

### Current performance

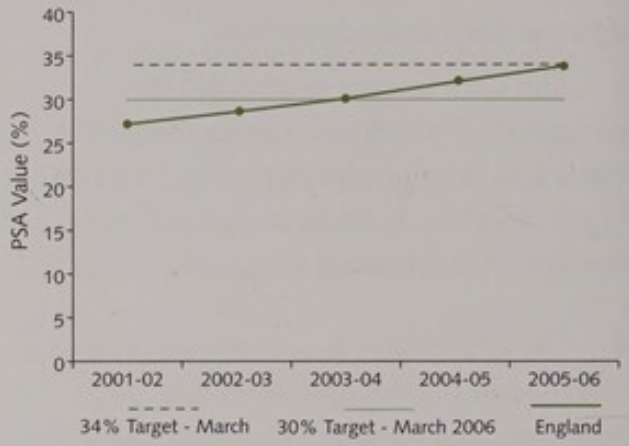
5.61 The latest available data on this PSA is on the position at the end of 2005-06. Key points from this analysis are set out in **Figure 5.1** and **Figure 5.2**.

**Figure 5.1: PSA value 2001-02 to 2005-06 for each council type**

| | 2001-02 | 2002-03[1] | 2003-04[1] | 2004-05[1] | 2005-06[1] | Numbers Change since last year |
|---|---|---|---|---|---|---|
| ENGLAND | 27.2 | 28.6 | 30.1 | 32.0 | 33.8 | 1.8 |
| Unitary Authorities | 22.9 | 24.1 | 24.9 | 27.7 | 30.0 | 2.3 |
| Shire Counties | 24.0 | 25.3 | 27.7 | 29.9 | 32.0 | 2.1 |
| Metropolitan Districts | 28.8 | 30.6 | 31.9 | 33.3 | 34.2 | 0.9 |
| Outer London | 36.7 | 38.2 | 39.4 | 41.3 | 42.6 | 1.3 |
| Inner London | 44.3 | 44.9 | 44.6 | 44.7 | 47.2 | 2.5 |

*Footnotes:*
*(1) PSA figures have been adjusted for people formerly in receipt of preserved rights.*

**Figure 5.2: Change in national PSA value 2001-02 to 2005-06 shown against targets of 30% by March 2006 and 34% by March 2008**




### Performance headlines

5.62 The national PSA value on intensive care has continued to rise, increasing to 33.8 per cent in 2005-06. This has risen from 33.0 per cent in 2004-05 and from 22.8 per cent in 1998-99.

5.63 The continuous rise in the PSA value is due, in part, to the increasing number of households receiving intensive home care. In September 2005, 98,200 households received an intensive home care service, a rise of 6 per cent over the same period in 2004.

5.64 Some 72 per cent (108 out of 150) of the councils with social services responsibilities (CSSRs) have achieved the target of 30 per cent for March 2006.

### Increasing non-intensive services

5.65 From 2005-06, a new additional part of the PSA demands that the Department secures 1 per cent annual increases in the proportion of older people receiving support to live at home.

5.66 Provisional data published in November 2006 shows that nationally there was an increase of 0.9 per cent between 2004-05 and 2005-06. Although this nearly meets the national target, it hides a wide variation in performance across individual councils – 57 councils (out of 150)

reported a drop in performance compared to 2004-05.

### National minimum standards

5.67 The Commission for Social Care Inspection's *State of Social Care in England 2005-06* report showed that the number of services meeting the national standards has increased for the fourth successive year. This is clear evidence that the new regulatory arrangements and the standards introduced in 2002 are helping to drive up the quality of care. In particular, the Department is pleased to see the large increase since 2003 in the number of top performers – that is, providers meeting more than 90 per cent of the standards.

5.68 As was promised when they were introduced, the standards and the associated legislative framework for adult social care are currently being reviewed. The focus of the review is on ensuring a targeted and proportionate system of regulation, with a focus on dignity, quality and the best possible outcomes for people who use social care services. The Department plans to consult on revised standards and changes to the associated regulatory framework for adult social care as soon as possible in 2007.

5.69 The Government has announced its proposals to merge CSCI with the Healthcare Commission and the Mental Health Act Commission, subject to legislation. The intention is that the new organisation, which will regulate health and social care services, will be created in 2008 and be fully operational in 2009.

## Adult social care resources and spending

5.70 As it is a local authority function, it is for local authorities to decide what resources to allocate and control spending for the most part.

5.71 Given the pressures it has been important for local authorities to maximise their efficiency savings and performance, against the Gershon targets of 2.5 per cent efficiency gains per year (with at least half being cashable). These are on course to be achieved.

5.72 The Social Care Directorate is expected to cost £6.8 million in 2007-08. Local spending comes from a combination of council tax, central government funding and specific grants. The first two cannot be specifically linked to social care spending, as they are raised and provided at the total authority level. Specific grants for social care were £1.6 billion in 2006-07, representing 11 per cent of total social care spend (at 2005-06 levels).

5.73 The Government has provided significant investment in local services, including the area of social care, since it took office. The Department is working with local government to identify future pressures on local authorities, and ways in which these can be mitigated, as part of the Comprehensive Spending Review 2007.

# 6 Research and Development

## Introduction

6.1 The Government's health research strategy *Best Research for Best Health: A New National Health Research Strategy* aims to create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research, focused on the needs of patients and the public.

6.2 *Best Research for Best Health* (Department of Health, January 2006) was developed to:

- support the Government's ambitions to improve the nation's health and increase the nation's wealth, as set out in the ten-year *Science and Innovation Investment Framework 2004 to 2014* (Her Majesty's Treasury, July 2004);
- place people at the centre of a research system that focuses on quality, transparency and value for money;
- respond to changes in society and the environment; and
- respond to the challenges in the current system for applied health research.

6.3 The Department's strategic goal is to establish the NHS as an internationally recognised centre of research excellence; attract, develop and retain the best research professionals to conduct people-based research; commission research focused on improving health and care; strengthen and streamline systems for research management and governance; and act as sound custodians of public money for public good.

6.4 The National Institute for Health Research (NIHR), established as a virtual organisation in April 2006, provides a key mechanism through which the Department will deliver the new R&D strategy set out in *Best Research for Best Health* and ensure coherence for publicly funded health research.

6.5 Over the last year, £659 million of NHS R&D funding has been allocated through a range of funding streams outlined in **Figure 6.1** and detailed below.

### Figure 6.1: NHS Research & Development funding, 2006-07

| Area | £ million Amount |
|---|---|
| Research programmes | 70 |
| NIHR systems | 7 |
| Faculty trainees | 17 |
| Infrastructure initiation | 58 |
| Transition funding to NHS trusts | 507 |
| **Total** | 659 |

## *Best Research for Best Health* – implementation process

6.6 Underpinning the goals of *Best Research for Best Health* is a range of related objectives that the NIHR is delivering. Eighteen implementation plans, covering each component of the strategy, have been developed, including milestones and timetables. The plans are delivered by programme management and are updated regularly (see www.nihr.ac.uk).

6.7 The funding systems underpinning *Best Research for Best Health* are based on the principles of transparency, fairness and contestability. A phased implementation of the new funding schemes started in April 2006. The process will take three years. All previous recipients of NHS R&D support funding receive transitional R&D funding at reducing levels over the next three years (£507 million in 2006-07) to enable the NHS to plan for the effect of transition. At the same time, the Department is allocating a progressively increasing amount of NHS research funding through the new schemes for agreed purposes.

## *Best Research for Best Health* – implementation progress report

### Health research programmes

6.8 In addition to strengthening existing research programmes to ensure that research vital to health

and social care is commissioned, new NHS funding schemes are being introduced to make government funding more responsive and innovative. The budget for NIHR research programmes in 2006-07 was £70 million.

6.9 A Central Commissioning Facility (CCF) was set up in 2006 to manage and administer a number of the NIHR programmes, following a formal tendering process.

6.10 New programmes launched this year include:

- NIHR Programme Grants for Applied Research: these are substantial and prestigious awards for high-priority NHS research, with grants awarded competitively for a three to five-year period. A total of 29 programme grant awards are being made following the first competition;
- NIHR Research for Patient Benefit Project Grant Programme: a national response-mode programme for high-quality, investigator-led research projects that address issues of importance to the NHS. The first competition has resulted in 26 awards across England; and
- NIHR Invention for Innovation: brings together the work of several smaller programmes (New and Emerging Applications of Technology (NEAT) and the Health Technology Devices (HTD) Programme) with a new investment stream known as the Challenge Fund for Innovation. The programme will help accelerate the take-up and use of proven new treatments and devices by the NHS, including the Department's contribution to the piloting of Healthcare Technology Cooperatives, as announced in *Better Health Through Partnership: A Programme for Action* (Healthcare Industries Task Force, November 2004).

6.11 The NIHR Health Technology Assessment (HTA) Programme is expanding. It continues to commission primary research, including public health research on disease prevention, and to assess the effectiveness of new technologies through Technology Assessment Reviews to support NICE. HTA works with the health research networks of the NIHR to identify and fund clinical trials of importance and relevance to each topic-specific network's topic area. A new response-mode clinical trials programme has started up, and it is planned that this will grow to £20 million per year. Funding has already been agreed for nine new clinical trials.

*The NIHR HTA programme has provided NICE with 107 Technology Assessment Reports (TARs), helping to inform Appraisal Committee decisions on guidance to the NHS from 1999 to 2007. The HTA programme and NICE work together both to increase uptake of NICE research recommendations and the number of high-quality research recommendations coming to the programme. One example is the evaluation of the long-term effects of photodynamic therapy for macular degeneration. All of these reports have been published in the Health Technology Assessment monograph series.*

6.12 The NIHR Service Delivery and Organisation (SDO) Programme works to improve health outcomes for people by commissioning research and producing research evidence that improves practice in relation to the organisation and delivery of health care, and by building capacity to carry out research amongst those who manage, organise and deliver services and improve their understanding of research literature and how to use research.

6.13 Additional funding has led to the development of new programmes of work in priority areas such as public health.

*One example of the impact of the NIHR SDO programme is a piece of research commissioned to gather evidence on how best to make care networks effective by drawing on lessons from both the public and private sectors. The research outputs provided an overview about how different types of network should be structured and a handy 'ten key lessons' guide to network management. It is now a key resource handbook for practising NHS managers to guide them in developing and coordinating clinical networks.*

## Systems

6.14 Progress continues to be made with research governance in order to support a vibrant and efficient research environment that commands public confidence and protects research participants. The budget for 2006-07 was £7 million. Activity included:

- piloting of an advice service for researchers began in 2006 and will be rolled out in 2007 across the NIHR Comprehensive Research Network. The service will link front-line advisers in the NIHR with national regulatory experts and other resources;
- work is underway to streamline the research ethics system, including the agreement of a procedure for NHS organisations to undertake site-specific assessment for ethical review; and
- research passports, based on a prototype used in Manchester, were piloted and evaluated in 2006, and guidance from the Department will be issued during 2007.

6.15 The NIHR website (www.nihr.ac.uk) was launched in April 2006, to facilitate communication and progress tracking by stakeholders. An NIHR portal is under development and will be launched during 2007. Work is also underway to develop a national R&D information management system and to define data standards and processes for research within the NIHR.

## Faculty

6.16 A key initiative of *Best Research for Best Health* is to build an NIHR Faculty to deliver the research needs of the NHS and the wider public. The faculty will help attract, develop and retain the best research professionals to conduct and support people-based research. An NIHR Faculty Implementation Group helped to develop the remit and plans for the faculty to ensure its successful establishment and operation, for starting in April 2007. The first cohort of NIHR senior investigators will be identified during 2007.

6.17 In the last year, the Department has budgeted £17 million for the faculty. This has been allocated to funding 134 clinical academic training posts and 31 personal research training awards.

## Health research infrastructure

6.18 We are expanding and building a world-class NHS research infrastructure, focused on delivering benefits to patients and the public in order to achieve our aim of being a leading country for public-funded research and for conducting research in partnership with other research funders, including industry. The budget to initiate this work in 2006-07 was £58 million.

6.19 Much progress has been made with the NIHR Clinical Research Network. The six topic-specific research networks (cancer, mental health, stroke, diabetes, medicines for children, dementias and neurodegenerative disorders) and a Primary Care Research Network are all operational and supporting randomised controlled clinical trials and other well-designed studies conducted by both public and private-sector funders. The NIHR Comprehensive Research Network across England is in the process of being set up and will be fully in place by April 2007. The NIHR Comprehensive Research Network will work together with the other research networks to support clinical research in the NHS into all diseases and areas of clinical need.

*Establishing networks to provide a focus for research into specific topic areas started with the National Cancer Research Network (NCRN), which was established in 2001. It had a target to double the number of new adult cancer patients entering clinical trials within three years. The NCRN achieved this target after only two years. In 2005-06, 14 percent of cancer patients in England entered NCRN clinical trials. This is the highest national per capita rate of cancer trial participation in the world. The success of the NCRN was the inspiration for the NIHR Clinical Research Network, which is currently being established.*

6.20 Eleven new NIHR Biomedical Research Centres of excellence across England have been given the task of driving the development, testing and uptake of new and better ways to prevent, diagnose and treat ill health. These centres – in London, Oxford, Cambridge, Liverpool and Newcastle – within England's leading NHS – university partnerships, will focus on 'translational research', to take advances in basic medical research out of the laboratory and into the patient. They are among the most outstanding centres of medical research in the world. They will share over £450 million over the next five years to undertake research on major killers, such as cancer and heart disease, as well as on other crucial areas, such as asthma, HIV, mental illness, blindness, and the particular health needs of children and older people.

*An example of leading research from one of these centres came from a team in Oxford. They demonstrated the high early risk of major stroke after transient ischaemic attack (BMJ 2004; 328: 326-328) and developed and validated simple risk scores to identify the relatively few individuals who are at very high early risk of major stroke (Lancet 2005; 366: 29-36). This work has changed clinical guidelines and allowed emergency assessment, investigation and treatment to be focused cost-effectively. Use of simple risk scores is included in the latest US guidelines on diagnosis and initial treatment of ischaemic stroke.*

6.21 In addition, two NIHR research centres have been created for NHS patient safety and service quality. They are tasked with driving forward improvements in quality and effectiveness of care, particularly in the domain of safety of NHS services.

6.22 The NIHR supports clinical research facilities for experimental medicine in two main ways:

- a joint initiative, with the Wellcome Trust, Wolfson Foundation, British Heart Foundation, Cancer Research UK and Medical Research Council (MRC), to develop and strengthen the research and NHS infrastructure that underpins experimental medicine. Following a competitive process, new funding has been awarded to develop and strengthen clinical research facilities in nine centres in England. The NIHR plans to contribute £5 million each year to support additional NHS infrastructure associated with the increased research activity funded through this initiative, and will also contribute towards the costs of developing the experimental medicine facilities. This builds on the current joint investment by the Wellcome Trust and Department of Health in the millennium clinical research facilities in England; and
- a joint initiative with Cancer Research UK, under the umbrella of the National Cancer Research Institute (NCRI), to develop and expand a network of Experimental Cancer Medicine Centres. The support covers infrastructure costs for the early testing of novel cancer treatments or interventions in humans. Thirteen centres in England have now been assigned Experimental Cancer Medicine Centre status. A further two centres in England have been designated Experimental Cancer Medicine Centres in Development. The NIHR plans to contribute £3 million each year to support the NHS costs for this initiative.

6.23 Through the establishment of a dedicated funding stream to support the NHS costs of imaging platforms to support health research in NHS providers, 26 trusts were awarded contracts at £14 million over two years. Diagnostic imaging was identified as the most critical area in scoping work conducted by the Academy of Medical Sciences and our survey of NHS providers.

6.24 The NIHR School for Primary Care Research, under the direction of Professor Martin Roland in Manchester, is now in operation, with an annual budget of £3 million. This is the first research school to be established within the

National Institute for Health Research and builds on our existing successful investment in this field.

### Working with stakeholders

6.25 The NIHR Advisory Board was established in 2006 and meets regularly. The board comprises representatives from a wide range of stakeholder groups: research funders, charities, industry and other government departments.

6.26 The UK Clinical Research Organisation was established in 2004. It works through partnership to re-engineer the environment in which clinical research is conducted in the UK and is chaired by the Department. This is a key forum for partnership working particularly with industry and other funders

6.27 In establishing the National Institute for Health Research, the Department set out its commitment to engage patients and members of the public. The Department is working to ensure that patients and the public are involved in all stages of research, from identifying research topics, through setting research priorities, to involvement in conducting research. This will build on our present practices:

- within the NIHR Clinical Research Network, a Patient and Public Involvement Working Group has been set up to allow sharing of best practice in support of effective involvement across a wide range of activities, both locally and at a national level; and
- People in Research, a web-based resource that has been developed by the UK Clinical Research Collaboration (UKCRC), the NIHR INVOLVE Programme and others, aims to help members of the public make contact with organisations that want to actively involve people in clinical research.

6.28 A revised model Clinical Trials Agreement was launched in partnership with the NHS, the Association of the British Pharmaceutical Industry (ABPI) and the Bio Industry Association (BIA) so that approved industry-sponsored contract clinical trials in NHS patients can start as soon as possible.

6.29 The UKCRC Industry Road Map Group, chaired by the Department, brings representatives of pharma, devices and biotech companies together with the NIHR Clinical Research Network to develop processes to facilitate contract and collaborative research.

6.30 Department of Health R&D is represented on the Ministerial Industry Strategy Group, the Healthcare Industries Task Force Strategic Implementation Group and is co-chair of the PICTF Clinical Research Working Group.

6.31 The UKCRC R&D Advisory Group to NHS Connecting for Health, co-sponsored by the Department, is working to inform the new national NHS IT system, so that it is developed to support, strictly within the bounds of patient confidentiality, clinical trials and observational research for the benefit of patients. A series of pilot simulations for four research scenarios to inform the work has now reported to the UKCRC.

### Policy Research Programme

6.32 The Policy Research Programme (PRP), with an annual budget of around £30 million, continues to provide the evidence base for health and social care policy development. It commissions a broad range of health and social care research and evaluation to meet the needs identified by the Department and its ministers in the course of policy development and implementation. Examples of work funded by this programme include:

- a reviews facility at the Evidence for Policy and Practice Information (EPPI) Centre that provides a valuable resource for evidence-based health promotion and public health (see www.eppi.ioe.ac.uk);
- *Public Health Evidence: Tackling Health Inequalities* (Killoran, A, Swann, C, Kelly, MP (eds) 2006, Oxford University Press) is based in part on

research commissioned by the PRP and edited by analysts at NICE; and

- evaluation of the Expert Patient Programme before it was rolled out nationally.

## Review of UK health research funding

6.33 The Chancellor of the Exchequer announced a single, ring-fenced budget for health research in the 2006 Budget, bringing together NIHR with MRC funds. He appointed Sir David Cooksey to lead a review to build agreement on the best institutional arrangements for this budget to be administered. The Chancellor, on behalf of the Government, accepted the recommendations of David Cooksey and published his review in December 2006.

6.34 The review supports the NIHR, as key to the delivery of *Best Research for Best Health*. The Department's Research and Development Directorate will continue to set the strategic direction for the NIHR under the umbrella of the new Office for Strategic Coordination of Health Research (OSCHR), which will act as a central coordinating body for health research.

6.35 An interim OSCHR Oversight Group and interim office have been established in advance of the full OSCHR Board, in order to ensure that OSCHR can move forward quickly with its remit.

# 7 Workforce

## Introduction

7.1 The Department has played a central role in securing the right number of appropriately trained and motivated staff to deliver high-quality care for patients and users. The last five years has seen significant investment to expand the workforce and embed considerable contractual changes. The objective now is to follow through the gains of recent years and facilitate the transition to new models of health and social care delivery. This will entail refining the workforce implications of health reform and equipping the service to make the necessary changes. Greater workforce integration between the NHS, independent healthcare sector and social care will form a key theme over the remainder of the decade.

7.2 The immediate challenge for the Department is to strengthen leadership capability and support the NHS to harness the benefits from pay modernisation and more productive ways of working. The Department will continue to work closely with employers, trade unions, the education sector and patient and user groups, so that future workforce strategies are built on engagement and shared purpose.

## Meeting NHS workforce needs

7.3 The NHS has seen unprecedented levels of investment and a period of expansion in the workforce in the last ten years. With a total workforce of over 1.3 million, this represents an increase of 28 per cent since 1997. There are now around 400,000 qualified nurses (including practice nurses) and over 120,000 doctors working in the NHS.

7.4 Increased capacity, combined with improved retention, has also led to a reduction in vacancy levels, a key indicator of staff shortages. For example, the level of three-month vacancies (i.e. vacancies that have lasted three months or more) has fallen steadily, with vacancies for qualified nurses (including midwives) down from 3.4 per cent in March 2001 to 0.9 per cent in March 2006. The overall improvement in staffing levels has helped reduce waiting times, improve access to services and ensure the continued provision of high-quality treatment and care.

7.5 We are now moving away from year-on-year rapid growth in the NHS workforce to more of a steady state, where there is a closer match between demand and supply. The position from 2007 will be one of self-sufficiency, with the NHS developing its own workforce and placing less reliance on international recruitment. However, the NHS is also undergoing a period of reform, so that it becomes more patient-centred and more productive. These factors mean that workforce demand is changing.

7.6 The need to bring NHS finances back into balance and the implementation of *Commissioning a Patient-led NHS* (DH, July 2005) mean that some NHS organisations are seeking to re-balance their workforce. In many ways, the NHS has been a victim of its own success where *The NHS Plan* (DH, July 2000) targets for workforce expansion were met and, in some cases exceeded. Unfortunately, there has been a small number of compulsory redundancies, but the numbers should be put into perspective. As at the end of December 2006, there was a total of 1,446 compulsory redundancies as a result of changes in NHS trusts, primary care trusts (PCTs) and stategic health authorities (SHAs). The majority of the compulsory redundancies were non-clinical posts (around 80 per cent) and the total is less than 0.1 per cent of the total NHS workforce. Moreover, objective NHS performance data on A&E, cancer, waiting times, MRSA, access to primary care services, confirms that services are still being maintained and improved, even while trusts take action to restructure their workforces.

7.7 Although the historical workforce increases of the last ten years are unlikely to be sustained from 2007 onwards, it is clear that the NHS will continue to need new staff to replace those who

etire or take career breaks. Therefore, we need to maintain a long-term perspective on demand and supply. The NHS is a very large employer and will continue to offer many opportunities. There can be no guarantee of a job for life (in this respect healthcare is no different from any other sector), but we do believe the NHS should do what it can to maximise the opportunities for displaced and newly qualified staff, in order to ensure the self-sufficiency of the workforce. The independent healthcare sector and social care will also need new recruits. It is therefore important that newly qualified professionals are increasingly trained for, and prepared to seek employment in, a more pluralistic health and social care sector.

## The changing environment

7.8 The White Paper *Our Health, Our Care, Our Say* (DH, January 2006) points the way to more patient care being delivered in a primary and community care setting, and for this to happen there will need to be a corresponding shift in the workforce from the acute (hospital) sector. This brings with it challenges and opportunities for the workforce, with the need to consider innovative approaches to care. This may be through focusing more on prevention or changing the way staff work with the people they care for, so that it is more of a partnership.

7.9 *Health Reform in England: Update and Commissioning Framework* (DH, July 2006) described the way forward for provider reform to support delivery of the White Paper. Key features are:

- more freedom for providers to innovate and improve services in response to patient need;
- further expansion of NHS foundation trusts (NHS FTs);
- a continuing role for PCT direct provision with appropriate governance arrangements;
- exploring new models, such as community foundation trusts; and
- increased plurality of provision by the commercial, voluntary and social enterprise sectors in all sectors of healthcare.

7.10 Some NHS staff are working in independent sector treatment centres (ISTCs), although the total number to date remains small. In 2006, the Department reviewed the additionality arrangements that applied to the first wave of ISTCs for elective services. For the phase 2 ISTCs (elective and diagnostic services), NHS employees who are not in shortage professions may apply to work in an ISTC without undergoing a waiting period. In addition, all professions may apply to work in phase 2 ISTCs during their non-contracted hours. More generally, the Department is exploring what other approaches may be necessary to support and prepare the workforce to work in a more pluralistic provider environment.

7.11 Work supporting the Department's key priorities of an 18-week wait, long-term conditions, public health and urgent care is focusing on removing obstacles and promoting a more flexible workforce. New types of workers, such as Emergency Care Practitioners and Community Matrons, are becoming more common. A renewed focus on the needs of patients is seeing services delivered in the community rather than secondary care, and more account being taken of people's needs, knowledge and abilities when care plans are developed.

## Improving productivity

7.12 Productive time is about maximising the time spent by clinical, managerial and administrative staff on activities aimed at improving services for patients: that is, working smarter, not harder. As a result of joint working with the NHS Institute for Innovation and Improvement, Integrated Service Improvement Programme (ISIP) and others, the Department are on course to meet the Gershon efficiency target of £2.7 billion by March 2008. The approach taken is to encourage service planning which integrates workforce, process and technological changes, as this will maximise the

benefits of the change. For further information on efficiency, please see chapter 9.

7.13 The Productive Time Programme has developed a range of products and tools to enable front-line services to improve – for the benefit of staff, the organisation and patients. For example, within the Delivering Quality and Value series, the Department has published:

- *Focus on Benchmarking* (DH, September 2006), which highlights existing good practice, tools, techniques and data for benchmarking, alongside the Better Care Better Value Indicators;
- *Focus on HR* (DH, April 2006) which shows how the HR function can contribute to financial efficiency; and,
- *Consultant Clinical Activity* (DH, June 2006) to enable clinicians and managers to assess the activity rates of consultants across a range of specialties.

7.14 In the coming year the Department will be building on the Productive Time Programme to support the NHS in achieving workforce productivity gains. As a first step, we have included four workforce metrics within the Better Care Better Value Indicators developed jointly with the NHS Institute for Innovation and Improvement.

7.15 The workforce metrics are: FCEs per consultant, staff turnover, sickness absence, and agency costs. Through innovative skill-mix changes and the responsible use of temporary staffing, good practice shows that programmes such as the use of bank staff and annualised hours can help trusts manage better their use of agency and temporary staff. As a result, employers are able to offer flexible working patterns to all staff (and can cover absences more effectively), which further increases productivity gains.

7.16 There is also evidence of improvements in productivity being driven by service reform. The Scarborough Local Health Community Project is a good example of providing integrated patient services across primary care and hospital settings. New ways of working will enable more patients to be treated closer to home and support the patients who need to be admitted to hospital. The project will be completed by summer 2007 and will also help doctors in training to work a maximum 48-hour week.

7.17 European Working Time Directive projects are improving patient safety, and supporting clinical training and service productivity. For example, implementation of Hospital @ Night multi-disciplinary teams has reduced patient mortality at South Devon Health Care and the Homerton Hospital NHS Trust, and cut length of stay at Guy's and St Thomas'. The Hospital @ Night is delivering safer care and safer training.

7.18 A substantial programme of pilots and initiatives is continuing to support sustainable improvements in patient care and a 48-hour working week for doctors in training from August 2009. James Cook University Hospital uses the iBleep rapid-response system to contact clinical teams across the hospital at night. iBleep collects activity data recorded by staff as part of service delivery. It records the number of calls, but also the nature of the calls and the time taken to complete them. This means that the skill mix of staff required in the hospital and on call can be redefined, and tasks may be identified while currently performed by doctors, could be handled by non-medical personnel. The system is being made available across the NHS.

## Modernising education and training

7.19 Education and training programmes that reflect patient need must underpin modernisation and reform in the NHS. New ways of working, new treatments and procedures, and the shift of more services into the community to reflect patient choice require a health workforce that has the right skills for new healthcare environments. The Department

has therefore embarked on major reform programmes aimed at producing health professionals who can respond to changing needs.

7.20 Following the successful launch of foundation programmes in 2005, the Modernising Medical Careers (MMC) initiative concentrated in 2006 on identifying the right number of posts for specialty and general practice training, securing agreement from SHAs for their funding and the design and launch of a new online recruiting process. Whilst there has been widespread support for the principles of MMC, there have been difficulties with the recruitment and selection process for 2007. Interest in the new training programmes was high and resulted in a large number of applications from doctors currently in training, from those in non-training posts in the NHS and from outside the NHS. Shortcomings in the recruitment and selection process were acknowledged and resulted in the establishment of a review of the process for 2007. There will also be a broader review of MMC to ensure lessons are learned for the future. However, solutions have been proposed for the 2007 recruitment round and postgraduate deans are working closely with employers to ensure that the impact on services is kept to a minimum.

7.21 The launch of specialty and GP training in August will see the culmination of five years' work on modernising medical careers. The initiative is designed to provide better-managed training for doctors, who will train in seamless programmes, to standards set by new curricula approved by the Postgraduate Medical Education and Training Board. The curricula, supported by better assessment processes, will be competence-based and will reflect the best in modern care.

7.22 The Department is also engaged in parallel work to modernise nursing careers. The Secretary of State launched *Modernising Nursing Careers: Setting the Direction* (DH, September 2006), which outlined a strategy for nursing and nursing careers in the future. It commits the Department to a series of actions that will create a more flexible and competent workforce; forge new career pathways for nursing; prepare nurses to lead in a changed system; and update the image of nursing. Health departments are implementing the strategy across the UK, in partnership with the main stakeholders. The Department is currently leading a series of consultation events with service leads and front-line staff in all sectors to gain consensus on the way forward for health visiting, community nursing, nurse education and career paths in advanced and specialist practice.

7.23 A further work programme that is modernising allied health profession (AHP) careers is developing a competence-based career framework for AHPs and related support staff. The framework is underpinned by learning design principles developed by the Sector Skills Council and Skills for Health, which were set up to ensure that the development of new awards, qualifications and other ways of recognising achievement are undertaken in a way that builds cohesion within the health sector.

7.24 Continuing the modernising careers theme, modernising scientific careers (MSC), led by the Chief Scientific Officer, is currently being developed. This is planned as a collaborative programme with the other UK health departments and will build upon the Department's *Healthcare Science Career Framework* (DH, November 2005), the UK, wide healthcare science National Occupational Standards and the Skills for Health, Healthcare Science Programme commissioned by the Department. There are four aims to the project:

- developing a competent and flexible scientific workforce;
- updating career pathways and choices, including academic careers;
- preparing scientists to lead in a changed NHS; and

- modernising the image of healthcare science and scientists.

7.25 This will provide a fundamental shift in the future education and training of healthcare scientists that will help secure, plan and develop the future workforce. At the same time, it will introduce flexibility to both practitioners and future employers across HCS disciplines and scientific diagnostic services, that can respond to the needs of local health systems and to the provision of scientific services closer to patients.

### Financial support for healthcare students

7.26 At any one time, there are some 80,000 healthcare students training for professional status, and to support this the Department invests around £430 million a year in the NHS bursary scheme. It is important that the student support system is fair and non-discriminatory, and reflects the diverse nature of the health workforce. In 2006, therefore, we undertook a review with key stakeholders that included:

- formalisation of maternity arrangements, which allow for students to continue to receive NHS bursary payments while on maternity leave;
- action to counter potential age discrimination, resulting in an increase of £244 in the basic allowance for all new students and the introduction of a new Parent Learner Allowance for new students from 1 September 2007; and
- equalisation of the treatment for rent and mortgage payments when assessing dependants' and childcare allowances in the bursary calculation.

7.27 Work to review the NHS bursary scheme further will continue with stakeholders throughout 2007.

7.28 The system for distributing grants and bursaries also underwent major change in 2006. The Student Grants Unit (SGU) had been subject to severe criticism in the previous few years, and the Department accepted that it was underperforming in the service it provided to applicants. Major changes resulted, and the 2006 application round proceeded successfully, with the SGU meeting all of its targets. The SGU was part of the NHS Pensions Agency, and both organisations have now been transferred to the NHS Business Services Authority (BSA).

## Modernising the regulation of healthcare workers

7.29 While the public and patients rightly hold the substantial majority of health professionals in high esteem, the need for reform to sustain confidence in regulation of healthcare professionals has been underlined by the findings of a number of high-profile inquiries into doctors who have harmed their patients, most notably the Shipman, Kerr/Haslam, Ayling and Neale inquiries. The Department published a review of non-medical healthcare professional regulation and a report on the reform of medical regulation by the Chief Medical Officer, *Good Doctors, Safer Patients* (DH, July 2006). Following the publication of these reports, the Department held a public consultation from 14 July 2006 until 10 November 2006, which generated more than 2,000 responses.

7.30 Building on the responses to the consultation, the Department published the White Paper *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century* (DH, February 2007), which sets out how the Department will reform and modernise the system of professional regulation. The White Paper signals a move towards a more robust regulatory system that earns and sustains the confidence of patients, the public, healthcare professionals and employers. Some of the key changes include:

- measures to make regulators more independent, such as the appointment of council members, professional members no longer forming a majority on these councils, and an independent adjudicator for doctors;

- measures to ensure healthcare professionals are objectively revalidated throughout their career and remain up to date with clinical best practice;
- the creation of General Medical Council (GMC) affiliates to help deal with more cases concerning doctors at a local level and to ensure independent oversight of aspects of revalidation;
- changing the standard of proof used in fitness to practice cases from the criminal standard to the civil standard; and
- moving towards a more rehabilitative approach to regulation, with the development of a comprehensive strategy for prevention, treatment and rehabilitation services for all health professionals.

## Pay and pensions modernisation in the NHS

7.31 During 2006-07, the Department, working with NHS Employers, made further progress on modernising NHS pay systems. With almost all staff assimilated onto the Agenda for Change pay system by the start of the year, development for the majority of staff moved on to the introduction of the knowledge and skills framework, which links pay progression to the development of applied knowledge and skills.

7.32 During 2006, a new pay framework was also introduced for the most senior NHS managers at board level in SHAs, special health authorities (SpHAs), PCTs and ambulance trusts, which ensures greater consistency and a stronger link between pay and performance, and progress was made in negotiations on new pay arrangements for Staff and Associate Specialist Doctors.

7.33 Early indications are that the pay reforms are achieving some of the intended benefits. Recruitment and retention has improved, with vacancies in most disciplines at a historically low level, which has helped reduce waiting times for patients. Control of pay inflation has improved, with settlements and unplanned pay drift both reduced. Evidence is, however, not yet available on whether the intended productivity gains have been achieved. A review of the reforms is planned for 2007-08, including an assessment of how far they have achieved their intended aims, and the lessons to be learnt from them.

### Pension reform

7.34 During 2006-07, major progress was made in partnership with the NHS trade unions on the most significant reform of NHS pension arrangements since 1948. Under proposals published in July 2006, staff joining the NHS from December 2007 will have a modern, final salary pension scheme based on accrual of 1/60th of pensionable pay each year, with new flexibilities around retirement at a normal pension age of 65. Existing staff will have the opportunity to move to the new scheme if they wish, but if they do not do so they will retain their existing normal pension age of 60 and forgo many of the flexibilities available under the new scheme.

7.35 In both schemes, a new and more equitable system of tiered staff contributions will be introduced, with the highest-paid paying more. To meet the initial cost of the new scheme, staff will pay on average an additional 0.6 per cent. To protect the taxpayer from the risks associated with the retention of final salary, contributions made by NHS employing organisations are to be capped at 14.2 per cent immediately, and at 14.0 per cent from 2016.

7.36 From April 2006, the business of the NHS Pensions Agency was transferred to the Pensions Division of the new BSA. During the year, major BSA/Pension Division priorities have included system modernisation in preparation for the launch of the new NHS Pensions Scheme, and improving processes for the assessment and award of NHS bursaries within target timescales. They have also carried out a review of the operation of the NHS

Injury Benefits Scheme to ensure that benefits are being paid correctly.

## Primary medical care contractors

7.37 Primary care is the right place to target more investment, as every pound spent here saves the NHS money that might otherwise have been spent on drugs and hospital treatment for that patient further down the line. That is why unprecedented levels of resources have been made available for GP services, rising from £5.1 billion in 2002-03 to £7.7 billion in 2006-07. This funding is a measure of the Government's commitment to improved care.

7.38 Through the new general medical services (nGMS) contract, we have seen how effective payment incentives can be not only in delivering improvements in the range and quality of services, but also in securing increases in the GP workforce.

7.39 For example, last year, in the Quality and Outcomes Framework (QOF), the average points achieved by practices for each of the former 303 PCTs ranged from 86.6 per cent of points available to 99.7 per cent of points available. Nearly 90 per cent of the 8,406 practices that took part in 2005-06 (covering 99.6 per cent of registered patients in England) scored over 90 per cent of points available. This means that practices are delivering far more preventive work such as the monitoring and reduction of blood pressure in hypertensive patients.

7.40 Negotiated enhanced services are ensuring NHS patients are now experiencing shorter waits to see a family doctor. Almost all patients (88 per cent) are now seen within 48 hours, compared to around 50 per cent in 1997. As a consequence, some £51 million was paid to GMS and Personal Medical Services (PMS) practices as a reward for delivering 48-hour access to a GP or healthcare professional.

7.41 The success of the GMS contract can be seen in the rise in GP numbers, which have shown consistent growth: for example, between 1997 and 2005, the number of GPs increased by 4,500 (over 17 per cent).

7.42 Significant improvements agreed to the contract for 2006-07 by NHS Employers and the British Medical Association will ensure better value for money services from these arrangements. Just some of the improvements made are: no uplift for inflation, a more challenging QOF, more income tied to directly reported patient experience (e.g. the GP Patient Survey) and a recognition that the contracts, like the rest of the NHS, have to demonstrate ongoing improvements in efficiency and value for money. The Department have also directed PCTs to review their local primary medical care contracts to secure equivalent improvements.

7.43 Importantly these changes take effect at a time when there has been much interest in the reported increases in GP pay. The public, both as patients and as taxpayers, has reasonably sought reassurance that the increases in investment made in GP services will deliver genuine service improvements, as well as increased rewards for providers. Following recommendations by the Doctors and Dentists Review Body in March 2007, no further increase in GP pay is to be made through contractual arrangements in 2007-08.

## Improving workforce systems

7.44 The Department is looking at ways to improve HR efficiency, to release maximum resources for front-line patient care through shared HR services.

### Maximising the potential of the electronic staff record

7.45 The electronic staff record (ESR) aims to provide an integrated HR and payroll system for all 600 or so NHS organisations throughout England and Wales, replacing at least 38 HR and 29 payroll systems, and paying approximately 1.36 million employees when fully rolled out in spring 2008. ESR provides a real opportunity to transform the

way the NHS manages its workforce and deliver efficiency savings. There are now over 387 organisations and 726,075 employees live on ESR.

7.46 At the heart of ESR is the concept of a single staff record supported by a single data entry. The objectives for ESR are to deliver:

- a higher level of records standardisation across the NHS;
- minimised opportunities for inaccuracy and duplication in staffing records;
- improvements in information quality and reliability, helping tackle significant issues such as sickness absence;
- a significant reduction in administrative overheads;
- support for emerging regulation and registration; and
- a platform for efficient and effective competency-based career development across the NHS via ESR's online talent-management components.

## Social care workforce

7.47 There are around 1 million people working in social care in England. Of these, 13 per cent work in services for children and the rest in services for adults. There are around 76,000 professionally qualified social workers (with a close to half and half split between adults' and children's services), approximately 40,000 nurses, 3,000 occupational therapists and a small number of other professional groups in the workforce. Overall, it is estimated only 30 per cent of the entire social care workforce has a relevant qualification. In recent years, there have been severe problems of recruitment, retention and service quality in social care, and the vacancy rate in England is around 10 per cent, but rising to much higher levels in some areas.

### Policy context

7.48 The Department is in the process of a fundamental reform of social care services for adults. The Green Paper *Independence, Well-being and Choice* (DH, March 2005) was followed by the White Paper *Our Health, Our Care, Our Say* (DH, January 2006). With the pressures in the workforce and the envisaged reforms, ministers in the Department of Health and Department for Education and Skills (DfES) announced the Options for Excellence (O4E) Review of the social care workforce in July 2005. The remit of the review was to develop options for:

- improving the quality of social care practice;
- increasing the supply of qualified social workers and social care workers;
- reviewing the role(s) of qualified social workers and the fit between the role(s) and training and qualifications requirements; and
- developing the wider social care workforce to improve career opportunities and service standards.

7.49 The review published its final report *Building the Social Care Workforce of the Future* (DH, October 2006), producing a vision for the social care workforce through to 2020 and a strong case for further improvements and investment in the workforce. Bringing together the proposals developed through O4E and current workforce development activity, in 2007 the Department is setting up an Adults' Social Care Workforce Strategy Board, which will take forward a new strategic framework in England. The DfES Children's Workforce Strategy will be the vehicle to implement proposals as they affect social care workers in children's services. The broad areas of development in the overall new strategic framework are as follows:

- leadership and management – the National Strategy for Social Care Leadership and Management was launched by Skills for Care in 2005. Work on implementing the strategy has begun, through the Skills for Care regional networks. There are proposals set out by O4E to

maintain this momentum, including scoping work for a leadership academy;

- increasing the quantity of workers – the Department-managed National Social Care Recruitment Campaign delivered a burst of advertising in March 2007, with fresh materials and renewed support for employers in the regions. Recruitment of workers from overseas, both social workers and other social care staff, has also grown in importance, and in October 2006 the *Social Care Code of Practice for International Recruitment* (Social Care Institute for Excellence, October 2006) was launched;
- raising the quality of workers through training – 2006 saw the first main cohort of students qualify with the new social work degree, and the number of students beginning training is now around 38 per cent higher than five years ago. The new Post Qualifying Framework will be implemented from September 2007, and £1 million has been agreed as a contribution to the development costs of the new programmes. Very considerable effort is also being made across the whole service to train the workforce to national minimum standards;
- workforce reform, developing flexibility of roles and ways of working – the New Types of Worker initiative managed by Skills for Care came to the end of the first three-year phase in 2006 it pulled together the learning from 28 pilot projects and set up a learning network and website. This year, the work moved into implementation in the regions and locally, emphasising the development directions laid out in the Green Paper *Independence, Well-being and Choice*, and the White Paper *Our Health, Our Care, Our Say*;
- ensuring public safety through regulation – the Care Standards Act 2000 gave the General Social Care Council (GSCC) responsibility for maintaining a register of social care workers. Registration seeks to ensure both a high level of protection for service users and higher standards of training and professionalism in the social care workforce. The registration of social workers and social work students began in 2005, and by February 2006, 90,000 individuals were registered. We are now working with the GSCC to widen registration to other social care workers. It was announced on 15 February 2007 that the first groups to be registered, about 200,000 staff, will be those working in domiciliary care. Over the next few years, this will extend to a total of around 750,000 staff working in both residential and domiciliary care;
- good information and knowledge about the workforce – during 2006, the Social Care National Minimum Data Set was introduced. This will, for the first time, provide good-quality data about the whole workforce to support national, regional and local workforce planning and commissioning. By early 2007, some 4,000 employers had submitted a return. The Department is also taking steps to develop the research base underpinning our understanding of the social care workforce through the programmes of the Social Care Workforce Research Unit, based at King's College London, and by commissioning nine research projects into aspects of workforce development; and
- commissioning processes – to improve the integration and profile of the workforce within local commissioning, work is underway to develop National Occupational Standards for commissioners, and to strengthen their learning opportunities. Commissioners also need to take account of the workforce performance data available from the Commission for Social Care Inspection when contracting for services.

### Social care bursaries

7.50 Since 2003, a bursary has been paid to students on the social work degree, as an incentive to train. The CSCC has administered the bursary. The introduction of the bursary scheme played a large part in securing the increase in applications to social work courses. In April 2007, administration of the bursary will transfer to the BSA, where it will be run alongside the NHS bursary scheme. This will provide the opportunity for greater efficiency in the

scheme's administration, and for a more effective service for students.

### Quality in social work education

7.51 A three-year research project to evaluate the social work degree is due to report in the autumn of 2007. An interim report was provided as part of the Options for Excellence review. Work has been commissioned to address quality in social work education in the areas of e-learning, service user and carer participation, and inter-professional education.

### Learning resource networks

7.52 Skills for Care has been funded to continue development of learning resource networks across the country. These are intended to provide the focus for work-based learning across the social care workforce, and to help employers ensure that staff are appropriately trained and qualified to provide high-quality services to the public.

# 8 National Programme for IT

## Delivering the National Programme for IT

8.1 Information at the point of need is crucial to patient safety. The purpose of the National Programme for IT is to make the right patient information available in the right place at the right time. The benefits of this can easily be imagined, for both the patient and those responsible for delivering the best possible healthcare. Through the use of new technology, information systems will give patients more choice and health professionals more efficient access to information, thereby delivering better, safer patient care. Not surprisingly, therefore, the programme is a key building block and contributor to NHS reform and transformation.

8.2 Significant progress has already been made in delivering key elements of the programme, such as Picture Archiving and Communications Systems (PACS), Choose and Book and the National Network (N3). The taxpayer has also benefited through major savings in the cost of buying these new IT systems, thanks to a rigorous procurement process. However, on a programme as ambitious and far-reaching as this, it is not surprising that challenges have arisen and will continue over the coming years. The support, enthusiasm and appetite of patients and health professionals will be essential in overcoming these challenges. Therefore a priority is to communicate more effectively the benefits of the programme to patients, health professionals and all stakeholders, and to engage more fully with them.

8.3 The National Programme for IT is being delivered by NHS Connecting for Health. Positive effects are already being seen across the NHS in England, with growing use of these new systems bringing benefit to millions of patients. By 31 March 2007:

- over 3.25 million hospital appointments had been made using the Choose and Book system, with bookings now exceeding 17,000 a day;
- almost 17.5 million prescriptions had been issued electronically, using the Electronic Prescription Service, with the number now in excess of 120,000 a day;
- over 205 million digital images had been stored on PACS;
- over 19,000 sites, including 98 per cent of all GP practices, were connected to N3; and
- on average, 1 million emails a day were being transmitted using the NHS email service, serving a registered population of nearly 243,000.

8.4 New information technology and information systems are being designed and delivered around the needs of patients and the requirements of clinicians. They are driving the shift away from systems running along institutional lines, which segment patient care. In future, and when fully deployed, patients and clinicians will benefit from integrated health and social care community systems, which will track and record a patient's care in the NHS. The National Programme for IT is a key enabler of a patient-led NHS.

### NHS Care Record Service

8.5 Fundamental to this step change in providing improved patient care is the NHS Care Record Service, which will provide a live, interactive, secure patient record service that is accessible 24 hours a day, seven days a week by health professionals, whether they work in hospital, primary care or community services. It will enable clinicians to access patients' records securely when and where needed, via a nationally maintained information repository. Work has begun on creating a Summary Care Record for all of England's 50 million plus patients. At first, the record will contain only basic information, such as allergies, prescriptions and reactions to medicines. Later, details will be added about current health problems, along with summaries of care and the professionals treating them. It will be several years before everyone has a Summary Care Record.

*"This is going to be a safer system for patients. At the moment records are kept in separate places so it is difficult for me to know what's happened to a patient elsewhere. With the new system I will be able to find out"* – **Brian Fisher, GP, Lewisham PCT**

*"If they [the hospital] had computers, you could push a few buttons and it would all come up. Instead, I keep having to tell them all over and over again"* – **John Brown, patient**

8.6 In time, the HealthSpace feature of www.nhs.uk will provide the public with a means to access their personal health information. A pilot to enable patients to view their Summary Care Record will be held in 2007, with the aim of making this facility fully available in 2008.

8.7 *The Care Record Guarantee* (NHS Connecting for Health, May 2005) sets out the rules that govern how information held in the NHS Care Records Service will be used. It was first published in May 2005 and is reviewed annually by the Care Record Development Board. The guarantee deals with when and why information is shared and how this is controlled. It clarifies people's access to their own records, the control of access by others, how access will be monitored and policed, options people will have to further limit access, access in an emergency, and what happens when someone cannot make decisions for themselves.

## Choose and Book

8.8 The Choose and Book programme supports delivery of one of the cornerstones of the Government's health policy, giving patients more choice and involvement in the decisions made about their care.

8.9 The programme provides patients with the ability to choose, with the advice of their clinician, when and where they are referred for specialist care. Over 2 million appointments were made using this system in 2006. See **Figure 8.1**.

**Figure 8.1: Choose and Book system bookings 2004 to 2007**

| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| Quarter 1 | n/a | 268 | 176,752 | 1,036,901 |
| Quarter 2 | n/a | 1,096 | 384,399 | n/a |
| Quarter 3 | 9 | 7,254 | 666,283 | n/a |
| Quarter 4 | 63 | 62,119 | 820,716 | n/a |
| **Total** | 72 | 70,737 | 2,048,150 | 1,036,901 |

*"Choose and Book will shortcircuit a lot of wasted stages in the current paper referral process and patients will have a greater degree of certainty about their outpatient visits"* – **Jon Harrison, Consultant General Surgeon, Harrogate Healthcare NHS Trust**

*"Using the Choose and Book programme it should be possible to significantly reduce the non-attendance rate at hospital clinics"* – **Dr Celia Ingham-Clark, Surgeon, Whittington Hospital, London**

8.10 By giving patients the ability to choose the time and place of their booking, it is estimated that around 650,000 missed appointments have been avoided to date. The switch to booking through the Choose and Book system has also reduced booking time from two to three weeks via paper to about forty seconds, thereby giving GPs more time to focus on patient care.

*"Before Choose and Book the trust's 'Did Not Attend' average, where patients did not show up for their appointment was about 11.2%. But with Choose and Book it then dropped to about 1.9%. So it's a huge difference for us"* – **Laura Leutfeld, Outpatient Coordinator, Doncaster & Bassetlaw Hospitals NHS Foundation Trust**

## Electronic Prescription Service

8.11 The Electronic Prescription Service will bring benefits to patients and the NHS in terms of efficiency, accuracy of dispensing and overall convenience. Over 1.3 million prescriptions are issued every working day in England, and this figure is expected to rise by about 5 per cent each year.

8.12 Almost 17.5 million prescriptions have now been issued using the Electronic Prescription Service, and around 38 per cent of all pharmacies and 30 per cent of all GP practices now have the new technology installed. This number is expected to increase during the course of 2007.
The Electronic Prescription Service will mean that patients will no longer have to visit their GP to collect repeat prescriptions, but instead can have them sent electronically to their chosen pharmacy. GPs will spend less time administering repeat prescriptions. See **Figure 8.2**.

*"It will lighten our workload immensely, lifting the administrative burden placed on GPs and clerical staff"* – **Carole Fletcher, Dr Collett & Partners Pharmacy, Grimsby**

## Picture Archiving and Communications Systems (PACS)

8.13 Approximately 77 per cent of patients in England now have access to PACS which captures, stores, distributes and displays static or moving digital images, such as electronic X-rays or scans. The technology allows more efficient diagnosis and treatment of patients. It removes the need to print on film, with all the inherent problems of managing and storing clinical material in that format. Images can now be sent and viewed across several NHS sites, which means that patient care is benefiting as clinicians and care teams can work together to view common information, irrespective of their location. See **Figure 8.3**.

*"For patients this means fewer wasted appointments or postponed operations due to lost or poor quality X-rays or scan images and shorter waiting times to receive results. Clinicians are reaping the benefits of PACS because they can now access the right image in the right place at the right time and collaborate with other consultants to get patients the best possible diagnosis..."* **Kishore Reddy, Consultant Radiologist, Medway NHS Trust**

## N3 network

8.14 Underpinning this new technology has been the installation of the N3 infrastructure network, which provides network services and broadband connectivity to meet the NHS needs now and into the future. This fundamental overhaul began in 2004 and it now links over 19,000 sites in England, enabling the reliable and secure exchange of data. It is the largest virtual private network in Europe, and, once fully completed, will become the largest in the world. N3 is changing the way the NHS works, and it is estimated that switching to N3

**Figure 8.2: Electronic Prescription Service messages**

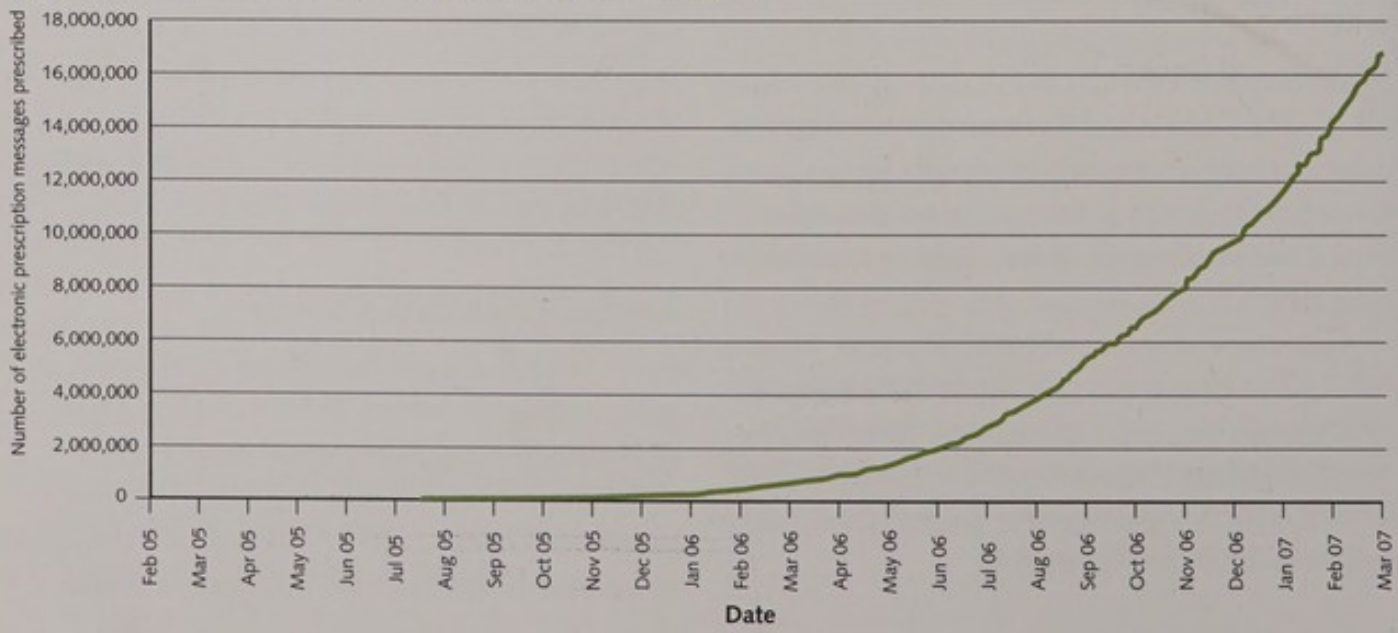
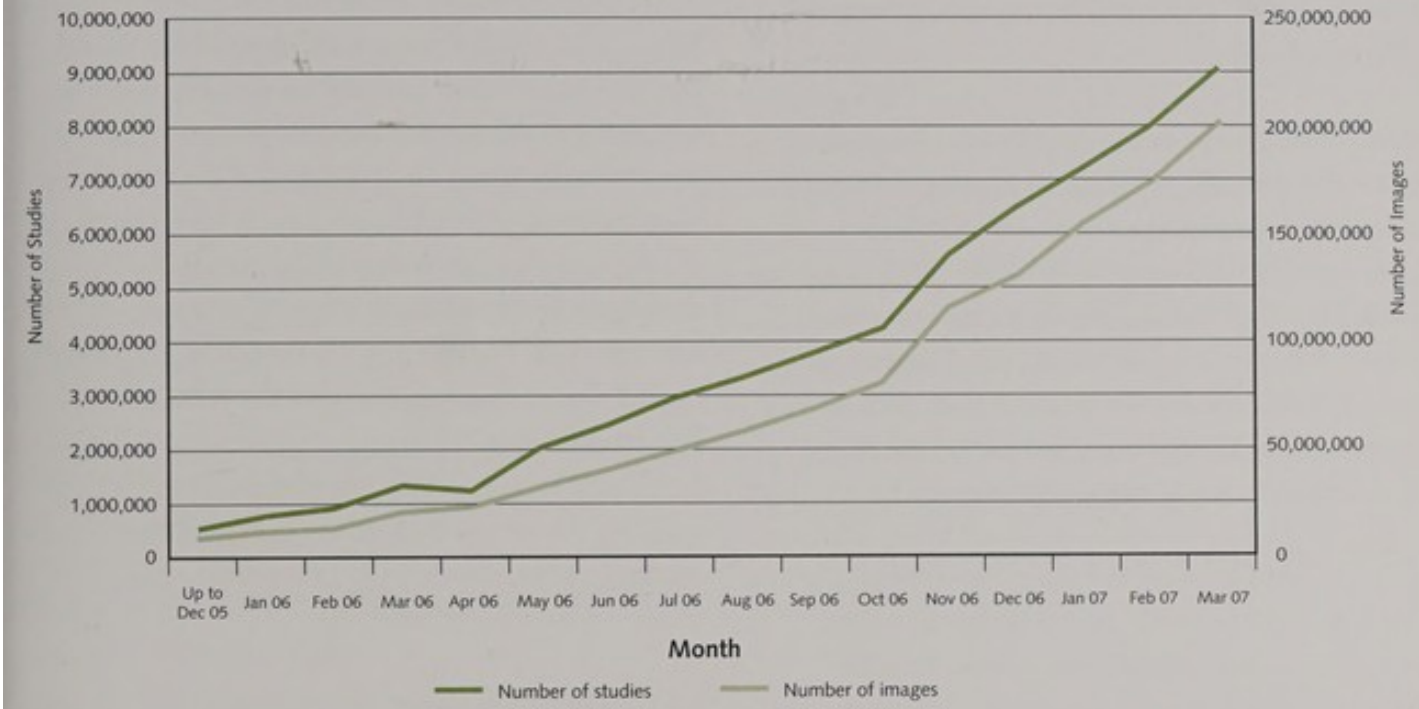


Figure 8.3: PACS images and studies stored per month




services could save the NHS £900 million over seven years, compared to previous NHSnet contracts.

## NHSmail

8.15 Integral to the new network services is NHSmail, which is a secure email and directory service for the NHS. It has been endorsed by the British Medical Association as the only email service secure enough to transfer patient information, and is now being used by an increasing number of NHS organisations. It already has 243,000 registered users, and the aim is to encourage its use across the NHS as the system of choice for all secure email and directory services. Around 1 million messages are transmitted across the NHS email system each day, one third of which contain clinical information.

*"It doesn't matter where I am, I can access NHSmail with ease and it's given me the confidence to share clinical information which I didn't have before"* – **Dr John Anderson, London**

## Other systems

8.16 Primary care practitioners are now supported by new systems that provide a range of management systems designed to deliver improved care to patients. These include the GP Payments System and the GP2GP project, which enables the transfer of a patient's electronic records when they re-register at a new GP practice, reducing the average time taken to transfer records from several weeks for paper records, to hours for electronic records. The Quality Management and Analysis System (QMAS) allows GPs to analyse the data they collect about the number of services and the quality of care they deliver, such as maternity services and chronic disease management clinics. The information provides objective evidence and feedback on the quality of care delivered to patients.

8.17 A clinical safety management system has been developed and implemented, ensuring that safety is embedded in the design, build and testing of the products NHS Connecting for Health delivers to the NHS. Drawing on an international standard for safety-critical software, each product requires a safety case, developed following structured risk assessment. This approach is designed to deliver products that are inherently safe – as safe as design and forethought will allow. Work is also taking place to introduce technology into the NHS that addresses existing patient safety problems. Projects are

underway that promote patient safety by means of correct patient identification, safer prescribing and safer handover.

8.18 NHS Connecting for Health continues to manage a portfolio of some 40 existing national IT services used across the NHS. These include National Cancer Screening Services, NHS Numbers for Babies, Ophthalmic Payments and the Blood Donor Register. New software enhancements to these systems are also being developed, such as that for bowel cancer screening, so that the NHS can continue to improve its care for patients.

8.19 The Secondary User Service supports the Government's payment by results initiative by providing timely, anonymous patient data for clinical and billing service purposes. It is a key tool for healthcare planning and comparative performance, and will help researchers undertake meaningful analysis of health trends by providing a full national database of patient activity.

## Local responsibility

8.20 For the future, responsibility for the local implementation of the National Programme for IT will rest with individual SHAs in partnership with NHS trusts. This is explained in the Department of Health document *The NHS in England: The Operating Framework for 2007-08* (DH, December 2006).

8.21 NHS Connecting for Health will support the local NHS in developing comprehensive forward-looking plans that exploit fully the opportunities afforded by the National Programme for IT. Assistance and guidance will also be provided to NHS leaders, local practitioners and both commissioning and provider organisations in how to introduce the technology safely and harness its full potential, so as to ensure that the benefits for patients, clinicians and all NHS staff are fully realised.

## International developments

8.22 The UK has been working with the World Health Organization and international partners to take forward the development of clinical terminologies based on SNOMED CT (Systemised Nomenclature of Medicines Clinical Terms) within the framework of an independent standards development organisation. The Department, through NHS Connecting for Health in England, has led the internationalisation of SNOMED CT. The availability of an agreed international standard for clinical terminologies is a vital component in ensuring the safe and effective transfer of care, especially when the delivery of care takes place across national boundaries.

8.23 The Department continues to play an active role in the development of health interoperability standards through the British Standards Institute and in collaboration with other healthcare administrations in the UK and Europe.

8.24 The UK is recognised as having one of the most advanced and ambitious eHealth implementation programmes in Europe and beyond, and it participates in a number of European forums to ensure that UK developments are in line with internationally accepted best practice, and to foster a collaborative approach to common problems.

# 9 Revenue Finance

## Overall increase in NHS funding

9.1 In 2007-08, the planned total public expenditure for the Department of Health is £104,077 million. This includes the NHS Pensions budget of £14,305 million.

9.2 **Figure A.1** (annex A, core table 1) summarises the resource plans for the Department of Health for the years 2001-02 to 2007-08. More detailed information is provided in **Figure A.2** and **Figure A.3** (annex A, core tables 2 and 3).

9.3 **Figure A.1** shows the breakdown of the Departmental Expenditure Limit (DEL) in near and non-cash in addition to the total resource.

9.4 Near cash can be defined as transactions that have an impact on cash flow in the short term, e.g. pay and pension costs, revenue expenditure on goods and services, or cash payments for the release of provisions.

9.5 Non-cash can be defined either as items that will never require a cash payment (e.g. the cost of using capital assets, depreciation, bad debts) or other items that may require cash payments but only in the longer term, e.g. provisions.

### The health and personal social services programmes

9.6 The health and adult personal social services programmes consist of spending by the Department on the following:

- NHS hospital and community health services, and discretionary family health services (HCHS or HCFHS);

  This covers hospital and community health services, prescribing costs for drugs and appliances, general medical services (GMS) (which include reimbursements of GMS GPs' practice staff, premises, out-of-hours and information management and technology expenses) and, from April 2006, general dental services. It also includes other centrally funded initiatives, services and special allocations managed centrally by the Department of Health (such as service-specific levies which fund activities in the areas of education and training and research and development); and

  HCFHS includes all GMS funding. The introduction of the new GP contract in April 2004 means that there is no longer any GMS non-discretionary funding. All GMS funding is discretionary. In order to present a consistent run of expenditure in **Figure 9.1** GMS non-discretionary expenditure has been restated as HCFHS.

- NHS family health service (FHS) non-discretionary;

  This covers demand-led family health services, such as the cost of general ophthalmic services, dispensing remuneration, income from dental and prescription charges and, until 2006-07, the cost of general dental services and the associated income from dental charges

- central health and miscellaneous services (CHMS);

  Providing services which are administered centrally, for example, certain public health functions and support to the voluntary sector.

- administration of the Department of Health; and
- expenditure on personal social services by way of:
  - funding provided by the Department of Health; and
  - funding provided by the Department for Communities and Local Government.

9.7 More detail on personal social services spending can be found at the end of this chapter.

### National Health Service, England – by area of expenditure

9.8 **Figure 9.1** shows the main areas in which funds are spent for years 2003-04 to 2007-08 on a

## Figure 9.1: National Health Service, England – by area of expenditure (Stage 2 Resource Budgeting)

£ million

| | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 estimated outturn | 2007-08 plan |
|---|---|---|---|---|---|
| **Departmental programmes in Departmental Expenditure Limits National Health Service hospitals community health, family health (discretionary) and related services and NHS trusts**[1][3][2] | | | | | |
| **Revenue expenditure**[3][4][6][5] | | | | | |
| Gross | 60,303 | 65,647 | 73,420 | 79,427 | 87,963 |
| Charges and receipts | -2,146 | -2,665 | -3,127 | -3,780 | -3,918 |
| Net | 58,157 | 62,983 | 70,294 | 75,647 | 84,045 |
| **Capital expenditure** | | | | | |
| Gross | 2,854 | 2,946 | 3,062 | 4,099 | 4,468 |
| Charges and receipts | -289 | -353 | -951 | -606 | -348 |
| Net | 2,566 | 2,592 | 2,111 | 3,492 | 4,120 |
| **Total** | | | | | |
| Gross | 63,158 | 68,593 | 76,482 | 83,532 | 92,422 |
| Charges and receipts | -2,435 | -3,018 | -4,078 | -4,386 | -4,266 |
| Net | 60,723 | 65,575 | 72,405 | 79,140 | 88,166 |
| **National Health Service family health services (non-discretionary)**[2] | | | | | |
| **Revenue expenditure** | | | | | |
| Gross | 3,052 | 2,980 | 2,968 | 1,411 | 1,441 |
| Charges and receipts | -912 | -850 | -837 | -409 | -454 |
| Net | 2,141 | 2,129 | 2,131 | 1,002 | 987 |
| **Central health and miscellaneous services**[6][7] | | | | | |
| **Revenue expenditure** | | | | | |
| Gross | 1,399 | 1,465 | 1,394 | 1,653 | 1,637 |
| Charges and receipts | -115 | -124 | -142 | -175 | -143 |
| Net | 1,285 | 1,341 | 1,253 | 1,478 | 1,494 |
| **Capital expenditure** | | | | | |
| Gross | 36 | 32 | 41 | 52 | 57 |
| Charges and receipts | 0 | 0 | 0 | 0 | 0 |
| Net | 36 | 32 | 41 | 52 | 57 |
| **Total** | | | | | |
| Gross | 1,435 | 1,497 | 1,435 | 1,705 | 1,693 |
| Charges and receipts | -115 | -124 | -142 | -175 | -143 |
| Net | 1,321 | 1,373 | 1,293 | 1,530 | 1,550 |
| **Total National Health Service** | | | | | |
| **Revenue expenditure** | | | | | |
| Gross | 64,755 | 70,092 | 77,782 | 82,492 | 91,041 |
| Charges and receipts | -3,173 | -3,639 | -4,105 | -4,363 | -4,515 |
| Net | 61,582 | 66,454 | 73,677 | 78,128 | 86,525 |
| Net percentage real terms change (%) | | 5.0 | 8.8 | 3.5 | 7.8 |
| **Capital expenditure** | | | | | |
| Gross | 2,890 | 2,977 | 3,102 | 4,151 | 4,525 |
| Charges and receipts | -289 | -353 | -951 | -606 | -348 |
| Net | 2,602 | 2,624 | 2,151 | 3,544 | 4,177 |
| Net percentage real terms change (%) | | -1.8 | -19.5 | 60.8 | 14.8 |
| **Total** | | | | | |
| Gross | 67,645 | 73,070 | 80,885 | 86,642 | 95,565 |
| Charges and receipts | -3,461 | -3,992 | -5,056 | -4,970 | -4,863 |
| Net | 64,184 | 69,078 | 75,829 | 81,672 | 90,702 |
| Net percentage real terms change (%) | | 4.7 | 7.8 | 5.1 | 8.1 |
| GDP as at 21 March 2007 | 95.5 | 98.2 | 100.0 | 102.5 | 105.2 |

*Notes:*
*(1) Includes Departmental Unallocated Provision (DUP) for 2005-06 to 2007-08.*
*(2) Funding for primary dental services in 2006-07 and 2007-08 is included in the HCFHS provision. From April 2006, general dental services and personal dental services have been commissioned from funds devolved to PCTs.*
*(3) Includes (AME) funding available to NHS foundation trusts for 2003-04 and 2004-05.*
*(4) Excluding HCHS Depreciation of (£ million): 254 390 463 713 1,042*
*(5) With the introduction of PMEds allocation in 2004-05, there is no longer any GMS non-discretionary funding. All GMS funding is now discretionary. Therefore, figures for HCFHS and FHS non-discretionary for 2002-03 to 2005-06 have been restated to present a consistent run in expenditure.*
*(6) Excluding CHMS and Department administration depreciation of (£ million): 29 29 27 28 30*
*(7) 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.*
*(8) Net expenditure excludes NHS (AME).*
*(9) Figures may not sum due to rounding.*

## Figure 9.2: Comparison of net NHS expenditure for 2006-07 with that in last year's Departmental Report (Cm 6814)

| | Departmental Report 2007 Cm 7093 Figure 9.1 | Departmental Report 2006 Cm 6814 Figure 3.4 | £ million 2006-07 difference |
|---|---|---|---|
| HCFHS current | 75,653 | 76,620 | 967 |
| HCFHS capital | 3,492 | 5,180 | 1,688 |
| FHS non-discretionary | 1,002 | 1,099 | 97 |
| CHMS revenue | 1,200 | 1,180 | -19 |
| CHMS capital | 28 | 23 | -5 |
| Dept admin revenue | 279 | 261 | -18 |
| Dept admin capital | 23 | 23 | 0 |
| **NHS total**[1] | **81,678** | **84,387** | **2,708** |

*Note:*
*(1) Totals may not sum due to rounding*

Stage 2 Resource Budgeting basis. Total NHS expenditure figures are consistent with those in **Figure A.1**.

### Expenditure in 2006-07

9.9 **Figure 9.2** compares estimated outturn expenditure in 2006-07 with planned expenditure published in last year's report.

9.10 The main areas of change (£10 million or over) to the spending plans for the various parts of the programme are shown in **Figure 9.3**.

### NHS expenditure plans in 2007-08

9.11 NHS net expenditure in 2007-08 is planned to be £90.7 billion.

9.12 The largest part of NHS spending is on hospital and community health services, discretionary family health services and related services.

9.13 For 2007-08, the planned NHS net revenue expenditure is £86.5 billion and capital expenditure £4.2 billion. Of the planned revenue expenditure, PCT allocations amount to £72.3 billion with the remainder allocated to SHAs and centrally managed programmes

## Figure 9.3: Main areas of change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm 6814)

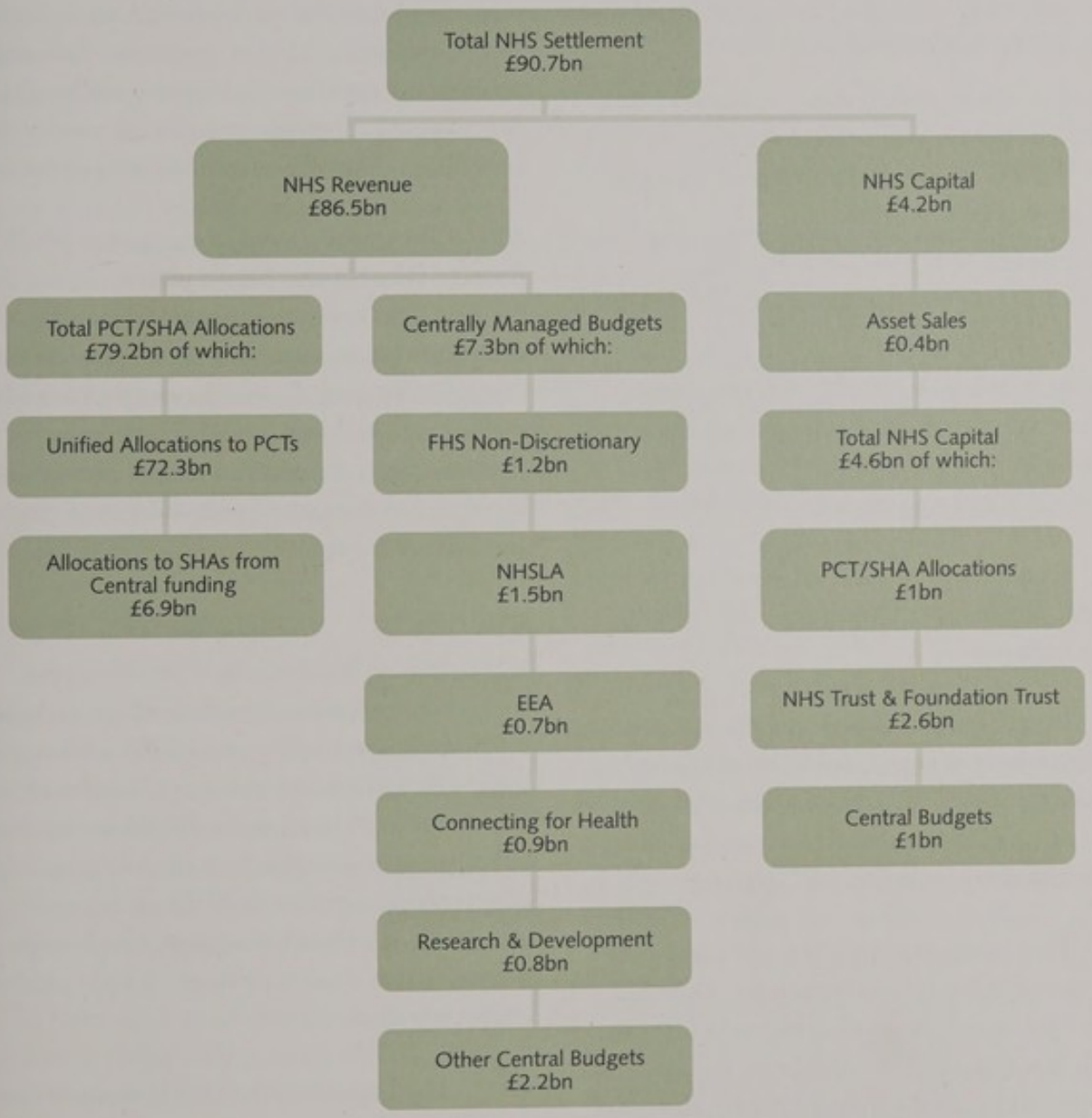
| 2006-07 | Difference[1] | | |
|---|---|---|---|
| HCFHS current | 967 | including: | 681 Forecast non-cash underspend |
| | | | 180 Forecast near cash underspend |
| | | | 220 Transfer of impairments from DEL to AME |
| | | | 50 Transfer to Personal Social Services |
| | | | 15 Transfer to Dept Admin Revenue |
| | | | 10 Transfers to Other Government Departments |
| | | | -97 Transfer from FHS non-discretionary. |
| | | | -95 Adjustment for depreciation |
| HCFHS capital | 1,688 | including: | 1,649 Forecast underspend |
| | | | 20 Transfer to Personal Social Services |
| | | | 13 Transfer to Other Government Departments |
| FHS non-discretionary | 97 | including: | 97 Transfer to HCFHS current |
| CHMS revenue | -19 | including: | 52 Forecast near cash underspend |
| | | | 6 Forcast non-cash underspend |
| | | | -49 Transfer from Personal Social Services |
| | | | -22 Transfer from Other Government Departments |
| Dept admin revenue | -18 | including: | -15 Transfer back from HCFHS current. |

*Note:*
*(1) Totals may not sum because only those changes over £10 million are included*

## NHS resources

9.14 **Figure 9.4** reflects the disposition of NHS resources in 2007-08. It shows that PCTs will control over 80 per cent of the total NHS revenue budget.

### Figure 9.4: Disposition of NHS Resources, 2007-08




*Notes:*
*(1) Figures are net of depreciation*

## NHS financial performance

### Setting the context

9.15 Returning the NHS overall to a financially sound position has been a key priority in 2006-07. At the start of the year, the Secretary of State set out three clear financial objectives:

- to deliver net financial balance across the NHS (i.e. that after the reduction in resources to cover the 2005-06 deficit, the sum of gross surpluses and gross deficits is zero);
- to see an improvement in the financial performance of all organisations which reported a deficit in 2005-06; and
- to achieve recurrent monthly run rate balance (where monthly recurrent expenditure is covered by monthly recurrent income) across as many NHS organisations as possible by 31 March 2007.

9.16 Progress against these targets is reported on a quarterly basis in the *NHS Finance Reports* laid before Parliament.

9.17 These financial objectives are to be delivered without compromising achievement of Public Service Agreement (PSA) targets. The NHS remains firmly on track to break even by the end of the year in line with these three financial targets.

9.18 This transformation in the NHS financial position should not be underestimated. There has been a huge improvement since the end of last year, perhaps best illustrated by considering the movement in the net deficit. At the end of 2004-05, this stood at £221 million, and increased to £547 million, excluding NHS foundation trusts, by the time of the 2005-06 final accounts. If this trend had continued on a straight-line basis, we might have expected a deficit of around £750 million by the end of the current year. However, the £13 million surplus reported by the NHS at the end of the third quarter of 2006-07 shows just how far the NHS as come in terms of improving its financial good health.

9.19 The Department accepts, however, that not every organisation will have regained financial balance in 2006-07. The Department continues to work closely with such organisations, acting through the strategic health authorities (SHAs) and turnaround teams as appropriate. Action plans have been agreed with SHAs to ensure that financial performance continues to improve and we recognise that some organisations may need to recover their financial position over a relatively longer timescale.

9.20 The improvement of the quality of NHS financial data has also been a priority during 2006-07. The appointment of the NHS Financial Controller has strengthened the Department's strategy to improve financial management and performance within the NHS, not least by his rigorous engagement in face-to-face performance management discussions with SHA chief executives and finance directors.

### NHS deficits

9.21 During 2006-07, the Department has engaged in a constructive debate about the causes of NHS deficits and believes that deficits have arisen for a variety of reasons and over a number of years. It is not possible to attribute deficits to any one factor taken in isolation. Independent government auditors have agreed with the Department's assessment that there is no single, simple cause of deficits, just as there is no single, simple solution for eradicating them.

9.22 The Department's Chief Economist was asked to produce a report on the causes of deficits and his findings were published on 20 February. His report entitled *Explaining NHS Deficits, 2003-04 to 2005-06* discusses a range of evidence concerning NHS deficits and explores potential explanations for the timing, geographical patterns and organisational structure of deficits.

9.23 The Department accepts that in past years a number of the accountancy rules operating in the NHS may have served to mask underlying financial

problems. The Department has increasingly tightened the NHS financial regime to prevent this and our actions will have rightly exposed the real financial position in many organisations. For example, from 2006-07 we have stopped the movement of money round the system by abolishing both brokerage and planned support. All NHS organisations now have to address underlying financial issues and take steps to ensure that they live within their means. We have also improved transparency of accounting, not least by reporting quarterly NHS financial information to Parliament.

9.24 Deficits continue to be concentrated in a minority of organisations. For example, at quarter 3 (Q3) 2006-07, 50 per cent of the gross deficit was found in just 6 per cent of organisations. By far the majority have remained in financial balance or better and are still delivering improvements to access and quality.

## Planning for 2007-08

9.25 To give the NHS greater certainty and more time to plan, the Department issued the 2007-08 *NHS Operating Framework* in December 2006, much earlier than in previous years, and published the 2007-08 tariff in October 2006, for NHS 'road testing', five full months before it was required. The Department also agreed financial plans for 2007-08 before the end of the 2006-07 financial year.

9.26 In terms of financial management, the Department is deliberately moving towards a more rules-based system which will bring some much needed rigour and transparency to the NHS. The *NHS Operating Framework* instructs the NHS to build a sustainable financial position in 2007-08, based on achieving financial balance in 2006-07. This will be especially important as we move into the new Comprehensive Spending Review and allocation period. In 2007-08, the NHS will therefore have to deliver:

- a net surplus of at least £250 million as organisations generate surpluses to recover historic overspending;
- a significant reduction in the value of gross deficits; and
- a majority of organisations operating in recurrent balance throughout the year.

## Continued improvement in 2007-08

9.27 In 2006-07, we took action to target the organisations with the most challenging underlying financial problems. In general, this involved introducing basic financial management techniques where they were absent.

9.28 In 2007-08, further improvement is needed, and this will be supported by:

- continued rapid funding growth – allocations will grow by 9.4 per cent in 2007-08;
- more effective financial planning by the Department. This includes increasing the challenge role of the Finance Directorate within the Department to ensure that unfunded cost burdens are not introduced. The Department has also given the NHS more time to plan with the early announcement of the financial planning assumptions, including the national tariff;
- continued use of strategic reserves held by SHAs although at a reduced scale compared with 2006-07. They should largely only be used to moderate the impact of resource accounting and budgeting (RAB) deductions, or to support locally agreed revenue investment linked to service change; and
- a continued focus on improving financial management where this is needed.

9.29 Through prudent management of the central NHS programme funds devolved to them in 2006-07, SHAs successfully identified savings of at least £450 million to set against the deduction made

to NHS resources at the start of the financial year in respect of prior year overspends. A combination of this reserve and an in-year surplus will completely remove the deficit carried into the 2006-07 year. The Department also expects most organisations to be in a position where they will have enough monthly income to match their monthly expenditure.

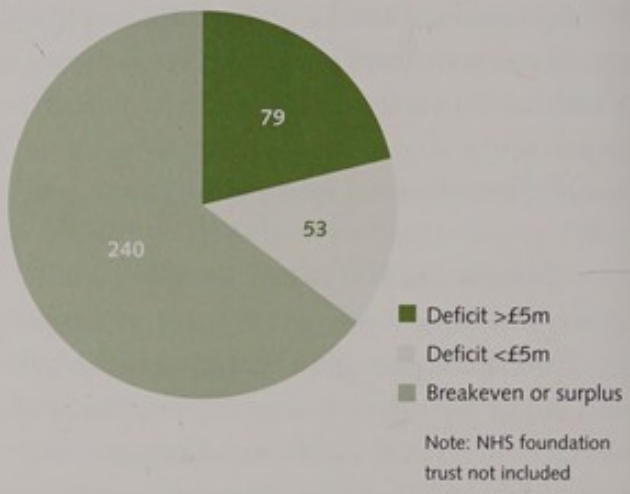
9.30 With the 9.4 per cent growth in recurrent primary care trust (PCT) allocations in 2007-08, all these factors mean that the NHS should start the 2007-08 financial year on a very sound footing and be well placed to deliver the 18-week target and local PCT priorities.

### 2006-07 NHS financial position at quarter 3 (December) (excluding NHS foundation trusts)

9.31 At the end of quarter 3 (Q3) of 2006-07:

- the NHS as a whole forecast a £13 million surplus, after applying the £450 million savings from central NHS programme funds identified by SHAs. This position compares with a £94 million deficit forecast at quarter 2 (Q2);
- the forecast gross deficit the sum of all in-year deficits before surpluses are taken into account at the end of Q3 was £1,318 million, compared with £1,179 million at Q2 and £883 million at Q1. In the 2005-06 final accounts this deficit was £1,312 million;
- 50 per cent of the gross deficit was concentrated in 6 per cent of NHS organisations;
- the majority of NHS organisations were in financial balance or better;
- 35 per cent of organisations are forecasting a deficit compared with 33 per cent at Q2, and 22 per cent at Q1. Thirty-three per cent of organisations reported a deficit in their final accounts for 2005-06;
- more organisations are reporting surpluses. At Q3, 36 per cent are forecasting a surplus compared with 28 per cent of organisations at Q2 and 18 per cent at Q1; and
- **figure 9.5** shows that at Q3 in 2006-07, around a third of organisations are forecasting a deficit and only around 20 per cent are forecasting a deficit of £5 million or more.

**Figure 9.5: 2006-07 NHS financial position, quarter 3 (December 2006)**




## NHS financial regime changes

9.32 The NHS is changing and the financial regime must change if it is to remain fit for purpose. To help inform the development of the regime we have commissioned two reviews:

- the Audit Commission published a report in July 2006 having reviewed the financial regime, with a particular emphasis on the RAB regime; and
- the Department of Health Chief Economist published a report on the causes of deficits on 20 February, *Explaining NHS Deficits, 2003-04 to 2005-06.*

9.33 Following these reports, the *NHS Operating Framework* for 2007-08 set out the continued developments to the regime. A further announcement on 28 March 2007 set out how arrangements for the application of RAB rules to NHS trusts.

### Application of resource accounting and budgeting to NHS trusts

9.34 The RAB system is a cross-government system designed to help ensure public sector organisations manage their money with an eye on

longer-term commitments and not just short-term cash flow. It has applied to the NHS since 2001-02.

9.35 Strict application of the arrangements to an NHS trust that overspends means that a trust has the overspending reduced from its income in the following year while also being required to generate a surplus in subsequent years to recover the deficit.

9.36 It has been applied in this way because it provides a strong disincentive to overspending. But the Audit Commission has called for the RAB system to be no longer applied to NHS trusts because:

- of its punitive nature – overspending in one year must be repaid in full in the following year;
- it has not been applied consistently by SHAs;
- it is not compatible with payment by results – where the annual income for providers is determined by the number of patients they treat; and
- it cannot be applied to NHS foundation trusts.

9.37 On 28 March 2007, the Department announced that NHS trusts would no longer be subject to income deductions in one year for overspending in the previous year. This does not mean we are writing off the deficits of overspending NHS trusts, which will still need to generate surpluses to meet their statutory breakeven and to repay loans. What has been eliminated is the double effect of having both an income reduction and then having to generate a surplus.

9.38 In line with these changes the Department has reversed income deductions imposed on NHS trusts in 2006-07 under the old RAB regime as a consequence of overspends in 2005-06. This totals £178 million and benefits 28 NHS trusts.

9.39 The Department has also agreed with the Audit Commission a disregard in the statutory breakeven note for any element of the cumulative deficit which has arisen solely through the application of RAB income deductions.

### Replacement of cash brokerage with loans

9.40 When an organisation is in deficit, its expenditure exceeds its income. For an organisation in deficit to pay their staff wages and other bills, they must seek additional sources of cash. For many years, cash to finance deficits has been made available to NHS trusts through an informal and opaque system of cash brokerage between NHS organisations, often funded by capital underspending.

9.41 From the final quarter of 2006-07, cash brokerage will cease and be replaced by a formal system of loans. The loans will be clearly visible in the accounts, and trusts will pay interest on the borrowing.

9.42 It should be stressed that the provision of loans is cash only, and will not disguise deficits. The increased transparency, and the requirement to pay interest, will provide a strong incentive for organisations to tackle their problems.

## Resource allocation policy

### Revenue allocations to primary care trusts for 2006-07 to 2007-08

9.43 Revenue allocations to 303 PCTs for 2006-07 and 2007-08 were announced in February 2005. The number of PCTs reduced from 303 to 152 on 1 October 2006. The information in this report and on the webpage www.dh.gov.uk/allocations is presented in terms of 303 PCTs.

9.44 **Figure 9.6** shows how 2006-07 and 2007-08 HCHS resources translate into PCT revenue allocations.

9.45 The 2006-07 and 2007-08 revenue allocations represent £135 billion investment in the NHS, just over £64 billion to PCTs in 2006-07,

## Figure 9.6: Distribution of resources for 2006 to 2008

| | 2006-07 | | 2007-08 | |
|---|---|---|---|---|
| | £m | % increase | £m | % increase |
| HCHS[1] | 74,119 | | 80,960 | |
| Capital charges and other funding adjustments | | | | |
| Total available | 75,754 | | 82,744 | |
| CFIS[2] | 11,444 | | 12,389 | |
| Total for PCT recurrent revenue allocations | 64,310 | 9.2 | 70,355 | 9.4 |

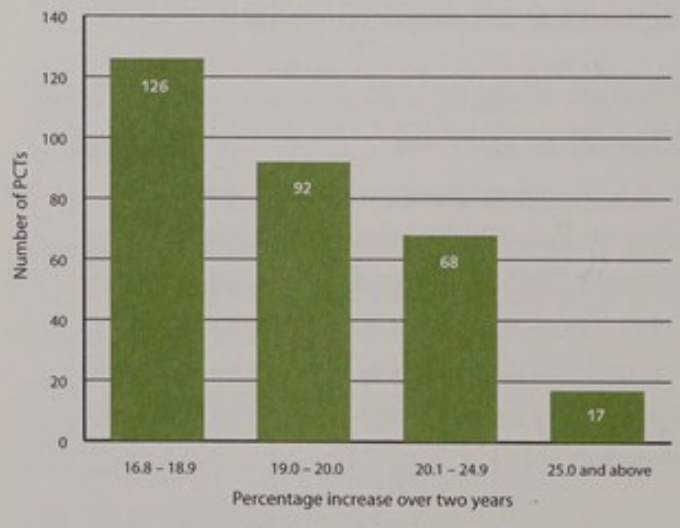
*Notes:*
*(1) Hospital and community health services*
*(2) Centrally funded initiatives and services*

and just over £70 billion in 2007-08. The average PCT growth is 9.2 per cent in 2006-07, and 9.4 per cent in 2007-08.

9.46 For 2006-07 revenue allocations, the range of PCT increases is between 16.8 per cent and 32.3 per cent over the two years, with an average of 19.5 per cent.

9.47 **Figure 9.7** shows the distribution of increases over the period 2006-07 and 2007-08 by PCT.

## Figure 9.7: Distribution of PCT allocations increases over the period 2006-07 and 2007-08




### Elements of revenue allocations

9.48 Four elements are used to set PCTs' actual allocations:

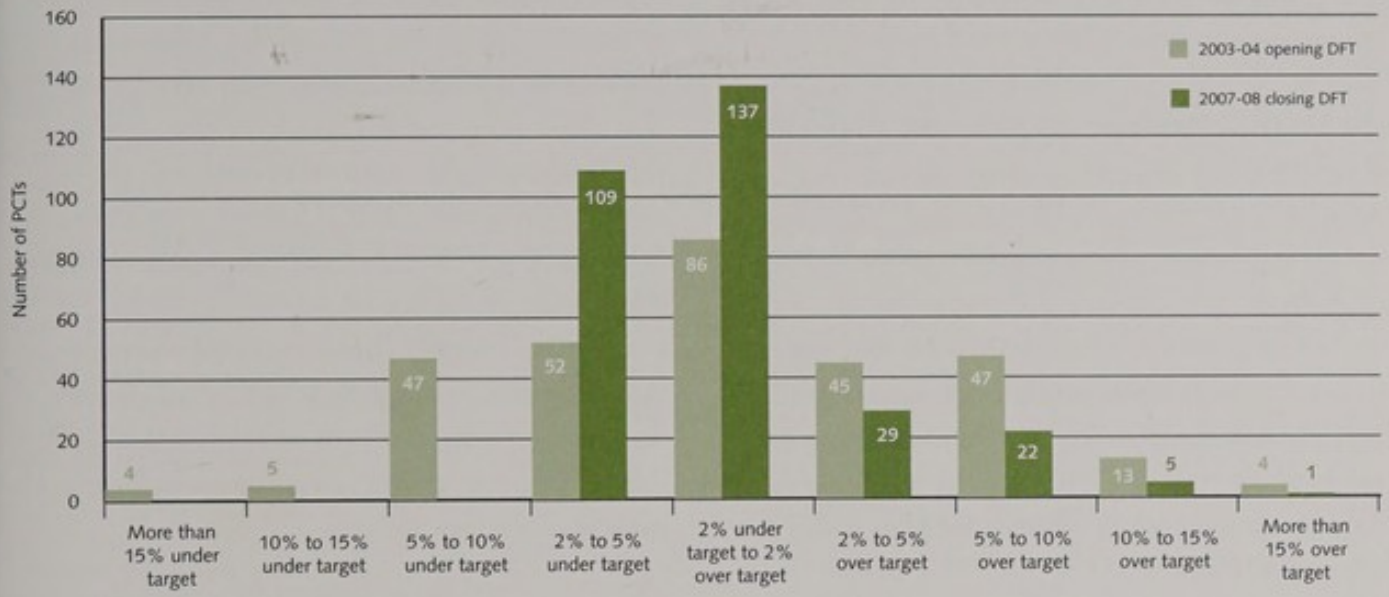
- weighted capitation targets – set according to the national weighted capitation formula which calculates PCTs' target shares of available resources based on the age distribution of the population, additional need and unavoidable geographical variations in the cost of providing services;
- recurrent baselines – represent the actual current allocation which PCTs receive. For each allocation year the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year;
- distance from target (DFT) – this is the difference between weighted capitation targets and recurrent baselines. If a weighted capitation target is greater than a recurrent baseline, a PCT is said to be under target. If a weighted capitation target is smaller than a recurrent baseline, a PCT is said to be over target; and
- pace of change policy – this determines the level of increase which all PCTs get to deliver on national and local priorities and the level of extra resources to under-target PCTs to move them closer to their weighted capitation targets. The pace of change policy is decided by Ministers for each allocations round.

### Pace of change policy

9.49 When allocations were first made to PCTs in 2003-04 (before then they had been made to health authorities), some PCTs were 22 per cent under target. By 2007-08, no PCT will be more than 3.5 per cent under target.

9.50 **Figure 9.8** shows PCTs opening 2003-04 DFTs and closing 2007-08 DFTs.

Figure 9.8: PCT opening 2003-04 and closing 2007-08 DFTs




## Changes to 2006-07 and 2007-08 revenue allocation

### Baseline changes

9.51 Comparisons should not be made between the 2006-08 revenue allocation figures and figures from previous years. This is because of changes to the funding included in PCT allocations. These are known as baseline changes.

9.52 There have been a number of significant changes to 2006-07 PCT baselines resulting from:

- devolution of funding from central budgets (including £3.8 billion for primary medical services and £584 million for NHS funded nursing care); and
- technical changes (including £1.4 billion to fund the increase in pensions indexation from 7 per cent to 14 per cent).

9.53 These changes represent a different approach to allocating resources. They do not affect affordability. They are summarised in **Figure 9.9**.

Figure 9.9: Changes to 2006-07 PCT baselines

| | £ million |
|---|---|
| 2005-06 recurrent allocation | 53,560 |
| Primary medical services allocation | 3,815 |
| NHS funded nursing care | 584 |
| Special allocations | 365 |
| Other central budgets | 81 |
| Pensions indexation | 1,367 |
| Cost of capital rebasing from 6% to 3.5% | -879 |
| **2006-07 PCT baseline** | **58,892** |

*Notes:*
*(1) Figures may not sum due to rounding.*

### Weighted capitation formula changes

9.54 Five changes were made to the formula for 2006-07 and 2007-08 allocations:

- Office for National Statistics population projections provided the population base;
- a primary medical services component replaced the GMSCL and GMSNCL components;
- the HCHS market forces factor (MFF) was reviewed to support the implementation of payment by results. The main resulting change was an increase in the number of zones in the staff MFF from 119 to 303 to match the geography of PCTs;
- the rough sleepers adjustment was dropped; and

- a growth area adjustment for PCTs in designated Department for Communities and Local Government growth areas was introduced.

### Advisory Committee on Resource Allocation

9.55 The Advisory Committee on Resource Allocation (ACRA) is an independent committee comprising NHS management, GPs and academics.

9.56 ACRA's remit is to oversee the development of the weighted-capitation formula used to inform revenue allocations to PCTs, to ensure equity in resource allocations. ACRA reports to Ministers on possible changes to the formula prior to each allocations round.

9.57 ACRA's work programme is set every year. The key strands of the current work programme are set out below:

- determining a population base for revenue allocations;
- a review of the market forces factor;
- reviewing the need element of the formula;
- further consideration of how the formula takes account of issues in rural areas; and
- helping to inform the development of a formula at practice level to aid the work on practice based commissioning.

9.58 This work will inform revenue allocations post 2007-08.

## Analysis of expenditure

### Programme budgeting

#### Background to programme budgeting

9.59 Programme budgeting is a retrospective appraisal of resource allocation, broken down into meaningful programmes, with a view to tracking future resource allocation in those same programmes.

9.60 Programme budgeting had its roots in the Rand Corporation in the USA in the 1950s. Its first major application was for the US Department of Defence in the 1960s where it was used as part of a cost accounting tool that could display, over time, the deployment of resources towards specific military objectives. Such objectives were looked at in terms of wars overseas, the support of NATO or the defence of the homeland, instead of the conventional 'inputs based' budgetary headings of tanks, missiles or diesel fuel. Allocation of new resources, or shifts between budgets, could be judged on their relative contribution to these specific objectives.

9.61 This approach can equally be applied to healthcare. Instead of seeing investment on the level of a hospital or drug budget, the focus switches to specific health objectives or medical conditions. The aim is to maximise health gain through deploying available resources to best effect. Clearly, this aim complements the commissioning role of PCTs.

#### Programme budgeting in the NHS

9.62 In 2002, the Department initiated the national Programme Budgeting Project. The aim of the project is to develop a primary source of information, which can be used by all bodies, to give a greater understanding of 'where the money is going' and 'what we are getting for the money we invest' in the NHS.

9.63 The project aims to provide an answer to these two questions by mapping all PCT (and SHA) expenditure, including that on primary care services, to programmes of care based on medical conditions. The focus on medical conditions clearly forges a closer and more obvious link between the object of expenditure and the patient care it delivers.

9.64 Analysis of expenditure in this way should help PCTs examine the health gain that can be obtained from investment, and will help inform understanding around equity and how patterns of

## Figure 9.10: Resources by programme budget categories, 2005-06

£ thousand

| Programme budget | 2005-06 Gross expenditure | 2005-06 Income | 2005-06 Net expenditure | 2004-05 Net expenditure |
|---|---|---|---|---|
| Mental Health Problems (Total) | 8,538,755 | 322,834 | 8,215,922 | 7,670,556 |
| *of which* | | | | |
| *Mental Health Sub group: Substance Abuse* | 756,974 | 28,640 | 728,334 | 611,327 |
| *Mental Health Sub group: Dementia* | 855,104 | 27,017 | 828,086 | 812,459 |
| *Mental Health Sub group: Other* | 6,926,677 | 267,176 | 6,659,501 | 6,246,770 |
| Circulation Problems (CHD) | 6,361,965 | 227,900 | 6,134,065 | 6,000,702 |
| Cancers and Tumours | 4,302,656 | 130,046 | 4,172,611 | 3,705,853 |
| Gastro Intestinal System Problems | 3,973,450 | 102,260 | 3,871,190 | 3,452,841 |
| Trauma and Injuries (includes burns) | 3,853,415 | 101,034 | 3,752,381 | 3,521,958 |
| Musculo Skeletal System Problems (excludes trauma) | 3,768,838 | 105,771 | 3,663,068 | 3,489,783 |
| Respiratory System Problems | 3,468,754 | 104,405 | 3,364,349 | 2,998,722 |
| Genito Urinary System Disorders (except infertility) | 3,507,715 | 112,215 | 3,395,500 | 3,038,728 |
| Maternity and Reproductive Health | 2,929,764 | 59,190 | 2,870,574 | 2,586,739 |
| Learning Disability Problems | 2,595,671 | 116,961 | 2,478,711 | 2,303,231 |
| Dental Problems | 2,759,703 | 343,735 | 2,415,968 | 1,979,041 |
| Neurological System Problems | 2,120,334 | 71,504 | 2,048,830 | 1,729,822 |
| Endocrine, Nutritional and Metabolic Problems (total) | 1,895,306 | 79,831 | 1,815,475 | 1,540,908 |
| *of which* | | | | |
| *Endocrine Sub-group: Diabetes* | 866,000 | 37,020 | 828,980 | 658,719 |
| *Endocrine Sub-group: Other* | 1,029,306 | 42,811 | 986,495 | 882,190 |
| Eye/Vision Problems | 1,356,043 | 27,499 | 1,328,544 | 1,286,142 |
| Skin Problems | 1,334,858 | 40,951 | 1,293,907 | 1,187,133 |
| Social Care Needs | 1,744,998 | 96,844 | 1,648,154 | 1,518,487 |
| Healthy Individuals | 1,340,573 | 53,598 | 1,286,975 | 1,113,067 |
| Infectious Diseases | 1,257,698 | 46,971 | 1,210,727 | 1,018,863 |
| Blood Disorders | 1,051,290 | 53,667 | 997,622 | 925,004 |
| Neonate Conditions | 786,390 | 36,954 | 749,436 | 772,923 |
| Poisoning | 707,623 | 15,882 | 691,742 | 590,170 |
| Hearing Problems | 321,811 | 10,432 | 311,379 | 310,341 |
| Other Areas of Spend/Conditions: | | | | |
| • General Medical Services/Personal Medical Services | 7,308,435 | 186,057 | 7,122,378 | 6,246,219 |
| • Strategic Health Authorities (inc WDCs) | 3,818,412 | 479,131 | 3,339,281 | 3,538,264 |
| • National Insurance Contribution | – | 14,255,599 | (14,255,599) | (15,133,971) |
| • Miscellaneous | 9,080,782 | 478,590 | 8,602,192 | 6,378,154 |
| **Net operating cost** | **80,185,241** | **17,659,861** | **62,525,380** | **53,777,859** |

*Source: Department of Health Resource Accounts 2005-06*
*Notes:*
*(1) The analysis contained in Schedule 5 is a calculation which uses 2005-06 activity indicative provider costs (reference costs) and prescribing information as the basis for apportioning the totality of NHS/Department spend across various programme budget categories.*
*(2) The analysis was based on a 'bottom up' approach. PCTs allocated/apportioned their spend at the local level and reported the results to the Department. Schedule 5 is an aggregate of these returns.*

expenditure map to the epidemiology of the local population.

9.65 Accordingly, the initiative will clarify the existing disposition of resources across programme areas. Equally important is the potential to accelerate modernisation. Comparative analysis, together with a process of challenge, offers the opportunity to identify best practice elsewhere for local application, in either original or modified form.

### Financial year 2005-06

9.66 2005-06 is the third year in which comparable programme budgeting data has been collected (see **Figure 9.10**). Stakeholders are therefore provided with a range of valuable comparative information, using a consistent framework, that:

- identifies where resources are currently invested, e.g. for the purpose of monitoring expenditure against national service frameworks;
- assists in evaluating the efficacy of the current pattern of resource deployment; and

## Figure 9.11: Resources by departmental aims and objectives, 2005-06

Resources by departmental aim and objective for the year ended 31 March 2006
The Department of Health's overall aim is to improve the health and well being of the people of England, through the resources available. In pursuance of this aim, the Department has the following objectives (as set as part of the 2004 Spending Review process).

| | £ million | |
|---|---|---|
| | 2005-06 | 2004-05 |
| Improve Service Standards | | |
| – Access to Services | 26,749 | 24,524 |
| – Improving the Patient/User Experience | 5,807 | 5,704 |
| Improve Health and Social Care Outcomes for Everyone | | |
| – Health of the Population | 29,111 | 26,184 |
| – Long term Conditions | 6,672 | 6,449 |
| Other | 11,847 | 8,998 |
| Total expenditure | 80,185 | 71,859 |
| Total income | (17,660) | (18,081) |
| Net operating cost | 62,525 | 53,778 |

*Source: Department of Health Resource Accounts 2005-06*

*Notes:*
*(1) The majority of income comes from National Insurance Contributions and is treated as central funding rather than allocated as a particular objective. Therefore gross operating figures have been disclosed for each objective.*
*(2) The presentation above provides high-level indicative spend against the key departmental objectives applying a method based on outturn data already collected by the NHS. Although departmental and NHS activity can contribute to both objectives at the same time, the adopted method provides a high-level and fair assessment of spend by objective. These figures should not be taken as absolute.*
*(3) Costs have been allocated to these objectives in accordance with the methodology set out in Resource Accounts accounting policies. This information is collected at a local level and subject to departmental review. The extent of judgement required in this process means that significantly different, yet still defensible, allocations of income and expenditure could have been reported.*
*(4) As the analysis by programme budgeting category provides useful information regarding NHS expenditure, it has been retained as part of the Departmental Report.*

- strengthens the process for identifying the most effective way of investing in services for the future.

9.67 It is recognised that the implementation of programme budgeting is a process that will require refinement over a long period. In particular, figures produced in the early years will be a best estimate rather than a precise measurement of expenditure.

9.68 Within this context, the Department of Health will be looking for year-on-year improvements, in both the process and outcomes of programme budgeting, as the data is increasingly being used to benchmark and plan investment decisions using marginal analysis techniques.

9.69 Programme budgeting is much more than an accountancy tool. The information produced through the implementation of programme budgeting continues to help inform and improve local commissioning decisions.

### Schedule 5

9.70 In addition to the analysis of net operating costs by programme budgeting category, Schedule 5 of the 2005-06 Resource Accounts also published details of expenditure by the departmental objectives (as set as part of the 2004 Spending Review process) of Access to Services, Improving the Patient/User Experience, Health of the Population and Long-Term Conditions. See **Figure 9.11**.

### Accounting for the additional resources

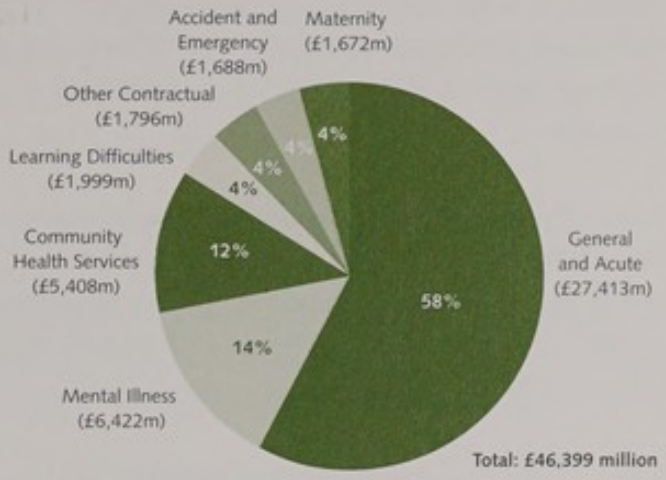
9.71 A breakdown of how the additional resources have been consumed in 2005-06 is included in **Figure 9.12**. This is calculated using gross expenditure (total revenue plus income, and excluding capital), taken from audited summarisation schedules for NHS trusts' and NHS foundation trusts' annual accounts.

## Figure 9.12: Breakdown of additional resources consumed in 2005-06

| Item of expenditure | % |
|---|---|
| Pay – directly employed staff | 36.0 |
| Pay – not directly employed | 0.4 |
| Primary care services | 8.2 |
| Capital, supplies and other services | 27.5 |
| Primary and secondary care drugs | 0.4 |
| Other | 27.6 |

*Notes:*
*(1) The pay category includes the total staff costs including 'on-costs' such as pensions and National Insurance.*
*(2) Primary care services includes expenditure on dentistry, ophthalmology and General Medical Services.*
*(3) Capital supplies and other services includes expenditure on clinical supplies and services (excluding drugs), general supplies and services, establishment and transport costs, premises and fixed plant, capital expenditure including depreciation, capital charges and the purchase of healthcare from non-NHS bodies.*
*(4) Primary and secondary care drugs category incorporates expenditure on primary and secondary care drugs.*
*(5) The 'other' category includes departmental expenditure, EEA medical costs, NHS Litigation Authority and others.*

## Figure 9.13: Hospital and community health services gross current expenditure, 2005-06




*Footnote:*
*(1) The categories and related expenditure above will not be the same as those shown in Figure 9.10 due to: the programme budgeting categories additionally include primary care expenditure for family health services; data collection sources and assumptions made for the classification of expenditure; and, differences in categorical definitions.*

## Spend by sector

### Hospital and community health services

9.72 **Figure 9.13** shows a breakdown of current gross expenditure on the hospital and community health services (HCHS) in 2005-06. The HCHS expenditure does not include spending on family health services (FHS) and primary care prescribing. It is derived from audited PCT summarised accounts on commissioning expenditure and includes the purchase of healthcare from non-NHS providers. It differs from sector information provided in previous Departmental Reports, as it excludes expenditure on HQ administration (e.g. PCT and SHA salaries, depreciation and capital charges) and other programme expenditure such as local public health campaigns and health promotions.

9.73 Additionally, the categorisation of information differs from the sector presentation, for example, expenditure on those aged 65 and over is included as part of the appropriate component whilst previously it was presented in the geriatrics sector. **Figure 9.14** provides the definitions of the different components of HCHS expenditure.

9.74 The total shown here differs from the figure shown in **Figure 9.1**, which shows expenditure in the HCFHS.

## Regional Breakdown

9.75 **Figures A.7**, **A.8** and **A.9** (see Annex A) show analyses of the Department's spending by country and region, and by function. The data presented in these tables is consistent with the country and regional analyses (CRA) published by HM Treasury in chapter 9 of *Public Expenditure Statistical Analyses (PESA) 2007.*

9.76 The analyses are set within the overall framework of total expenditure on services (TES). TES broadly represents the current and capital expenditure of the public sector, with some differences from the national accounts measure total managed expenditure. The figures show the central government and public corporation elements of TES. They include current and capital spending by the Department and its non-departmental public bodies, and public corporations' capital expenditure, but do not include capital finance to public corporations. They do not include payments to local authorities or local authorities' own expenditure. TES is a near-cash measure of public spending. Further information on TES can be found in appendix E of PESA 2007.

9.77 The data are based on a subset of spending, identifiable expenditure on services, which is capable of being analysed as being for the benefit of individual countries and regions. Expenditure that is incurred for the benefit of the UK as a whole is excluded.

9.78 Regional attribution of expenditure for the years 2001-02 to 2005-06 is based on NHS annual accounts, and for 2006-07 to 2007-08 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.

9.79 The functional analyses of spending in **Figure A.9** are based on the United Nations Classification of the Functions of Government (COFOG), the international standard. The presentations of spending by function are consistent with those used in chapter 9 of PESA 2007. These are not the same as the strategic priorities shown elsewhere in the report.

## Family health services

9.80 Family health services are services provided in the community through doctors in general practice, dentists, pharmacists and opticians, most of whom are independent contractors. Originally, terms of service were set centrally by the Department following consultation with representatives of the relevant professions. Funding for the services was demand led and not subject to in year cash limits at PCT level (although FHS expenditure had to be managed within overall NHS resources).

9.81 Recent reforms have progressively shifted the framework towards the local commissioning of services managed within discretionary budgets delegated to PCTs. By 2004-05, PCTs had taken over responsibility for all GMS services as well as the drugs bill. The GMS non-discretionary element ceased to exist as GMS funding became part of overall PCT allocations as part of the new GMS contract. As part of the Government's fundamental reform of primary dental care services, all former general dental service (GDS) and personal dental service (PDS) pilot services were integrated within permanent local commissioning arrangements managed by PCTs from 1 April 2006.

## Family health services: dental services

9.82 Between 2004-05 and 2005-06, the number of dental practices converting from the non-discretionary GDS to locally commissioned PDS pilots increased significantly. Taking into account both elements of primary dental care, the unadjusted growth in 2005-06 over 2004-05 was 13 per cent. In real terms (using the March 2007 GDP deflator), the growth in expenditure between 1995-96 and 2005-06 was 33 per cent. Expenditure in 2005-06 was enhanced by an accounting adjustment to correct the estimate of GDS creditor payments outstanding at the year-end. See **Figure 9.15**.

9.83 Further information on dental services is included in chapter 3.

### Figure 9.14: Hospital and community health services expenditure components

| Component | Definition |
|---|---|
| Learning Difficulties | Includes community learning difficulties services, single specialty hospitals and units on district general hospital (DGH) sites and community-type units. |
| Mental Illness | Includes mental illness, child and adolescent psychiatry, forensic psychiatry, psychotherapy, old age psychiatry. Includes the elderly mentally ill. Services include community mental illness services, single specialty hospitals and units on DGH sites. |
| Maternity | Includes obstetrics for patients using a hospital bed, obstetrics for ante-natal and post-natal outpatients, and general practice (maternity). Services include community maternity services. |
| General and Acute | Includes all specialty functions not identified separately in the above. Includes units for the younger physically disabled. |
| Accident and Emergency (A&E) | Includes expenditure relating to service agreements for A&E treatment services. |
| Community Health Services | Includes all community health services except community services for mental handicap, mental illness and maternity. |
| Other Contractual | Includes all other expenditure on secondary healthcare. |

## Figure 9.15: Family health services – dental services, 1995-96 to 2005-06, England

£ million

| | 1995-96 Cash | 1996-97 Cash | 1997-98 Cash | 1998-99 Cash | 1999-2000 Cash | 2000-01 Cash | 2000-01 Resource | 2001-02 Resource | 2002-03 Resource | 2003-04 Resource | 2004-05 Resource | 2005-06 Resource |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GDS[1] | 1,292 | 1,325 | 1,349 | 1,439 | 1,479 | 1,556 | 1,561 | 1,638 | 1,709 | 1,767 | 1,671 | 1,448 |
| PDS (discretionary)[2] | n/a | n/a | n/a | 4 | 12 | 21 | 21 | 36 | 41 | 48 | 280 | 757 |

*Notes:*
*(1) GDS costs are gross of patient charge income.*
*(2) Personal dental services (PDS) schemes were Primary Care Act pilots designed to test locally-managed approaches to the delivery of primary care and were mainly based on dental practices which had converted from General Dental Service (GDS) to PDS terms of service.*
*PDS expenditure figures are drawn from health authorities income and expenditure accounts, with the exception of the 2004-05 figure for gross PDS which is an estimate based on payments data obtained from Dental Practice Board.*
*PDS expenditure figures exclude any related capital investment by NHS trusts and are gross of patient charge income.*

### Family health services: general medical services

**9.84** **Figure 9.16** charts the new general medical services (nGMS) contract final spend for 2004-05, 2005-06 and inclusion of the current 2006-07 available forecast.

### Figure 9.16: Family health services – nGMS expenditure, 2004-05 to 2006-07

£ billion

| | 2004-05 | 2005-06 | 2006-07[1] |
|---|---|---|---|
| nGMS | 6.9 | 7.7 | 7.7 |

*Note:*
*(1) Forecast outturn, i.e. still subject to validation.*

**9.85** Chapter 7 provides details of the improvement of services to patients resulting from the introduction of the nGMS contract.

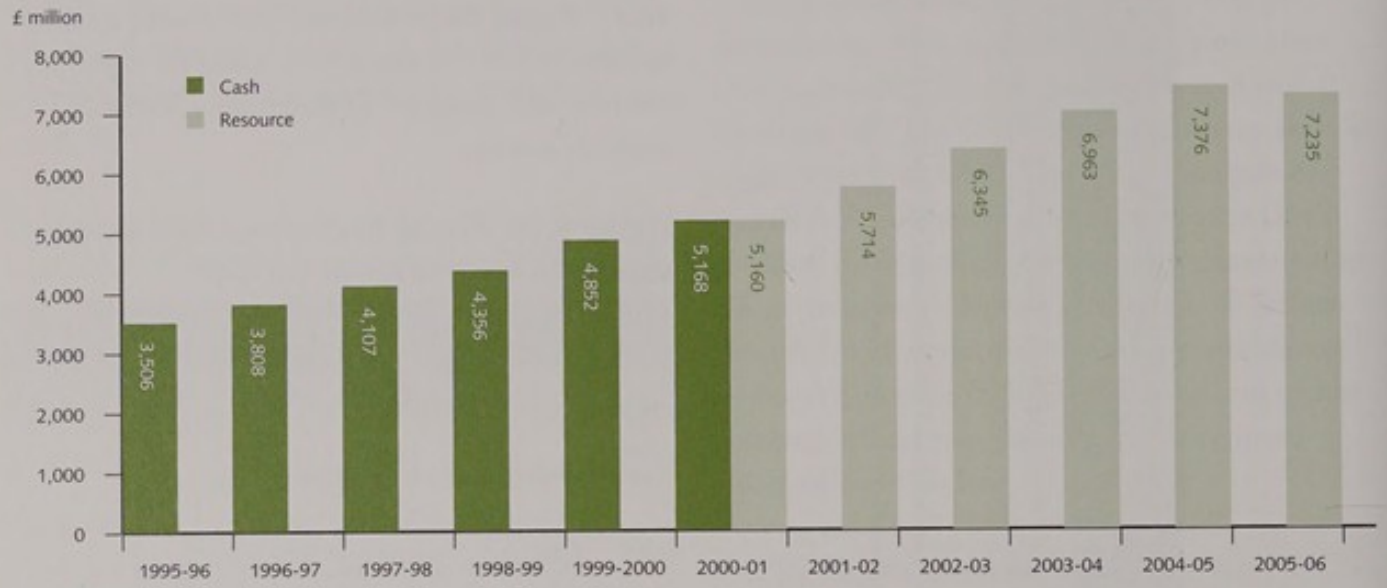
### Family health services: drugs bill

**9.86** Drugs bill gross expenditure is the amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs, medicines and certain listed appliances that have been prescribed by General Practitioners. Net drugs bill expenditure is total gross expenditure minus Pharmaceutical Price Regulation Scheme (PPRS) receipts. See **Figure 9.17** and **Figure 9.18**.

**9.87** The 2005-06 FHS drugs bill outturn for England was £7,235 million; this represents a reduction of 1.9 per cent in the FHS drugs bill over 2004-05. A combination of savings through PPRS receipts and reductions in Category 'M' generic drugs prices was effective in keeping the FHS drugs bill below that of the preceding year. See the generic medicines section below.

**9.88** In 2005-06, the number of items increased by 6 per cent over 2004-05. The major drivers of this growth were lipid regulating drugs (mainly statins), which increased by 21 per cent, antihypertensives (12 per cent), antiplatelets (11 per cent) and ulcer healing drugs (11 per cent).

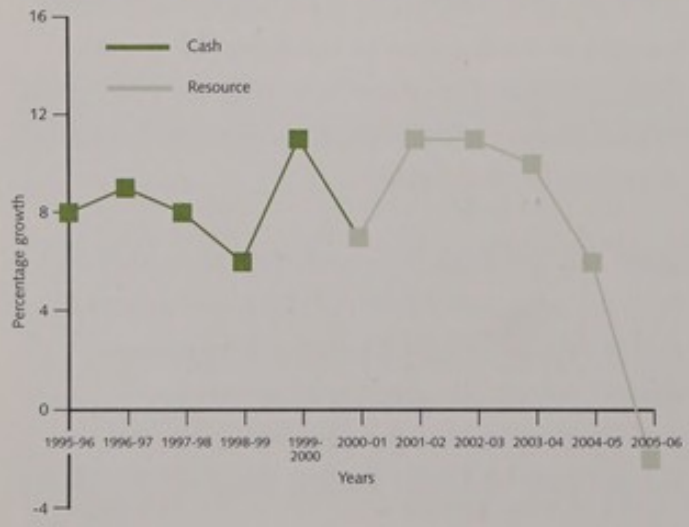
## Figure 9.17: Family health services – gross drugs bill, cash 1995-96 to 2000-01 and resource 2000-01 to 2005-06, England




*Notes:*
*(1) Drugs data source: Prescription Pricing Division of the NHS Business Services Authority, England. Figures include amounts paid to pharmacy and appliance contractors by the PPA and amounts authorised for dispensing doctors and personal administration in England, for financial years April to March.*
*The data do not cover costs for drugs prescribed in hospital but dispensed in the community or private prescriptions.*
*(2) Cash expenditure represents the amounts paid between April to March to contractors for drugs, medicines and appliances that have been prescribed by GPs and nurses and relates to February to January prescribing. Resource expenditure represents the actual cost of the prescriptions for drugs, medicines and appliances prescribed by a GP or nurse in the period April to March.*

9.89 Costs fell with large reductions in the cost in lipid regulating (-23 per cent), antihypertensives (-22 per cent) and rheumatic disease and gout (-31 per cent). For the first two groups the change was the result of DH intervention in reducing the costs of simvastatin, lisinopril and doxazosin while the fall in the last group was due to a switch away from the more expensive Cox II inhibitors following the withdrawal of rofecoxib.

## Figure 9.18: Family health services – gross drugs bill, percentage growth, cash 1995-96 to 2000-01 and resource 2000-01 to 2005-06




### Branded medicines

9.90 The 2005 PPRS, a voluntary five-year agreement negotiated with the Association of the British Pharmaceutical Industry (ABPI), replaced the 1999 PPRS from 1 January 2005. It controls the prices of branded prescription medicines supplied to the NHS by regulating the profits that companies can make on these sales.

9.91 The 2005 scheme includes a 7 per cent price reduction for branded prescription medicines, which delivered savings of £370 million in 2005 in primary care in England and it is estimated will save the NHS more than £1.8 billion over the five-year agreement.

9.92 In September 2005, the Office of Fair Trading (OFT) announced a market study of the PPRS to assess whether the scheme is the most effective means of securing value for money for the NHS, whilst offering appropriate incentives for pharmaceutical companies to invest in new medicines for the future. The OFT published its report on 20 February 2007. Its key recommendation is that the Government should reform the PPRS, replacing current profit and price

controls with a value-based approach to pricing which would ensures that the price of drugs reflects their clinical and therapeutic value to patients and the broader NHS.

9.93 The report is complex and will require careful consideration. DH and the Department of Trade and Industry (DTI) will work closely with the devolved administrations and other government departments to ensure that the government response to the OFT report takes account of all key policies, including the importance of fair prices and a fair climate for competition while recognising the importance of the pharmaceutical industry to healthcare and the development of medical advances. The Government has 120 days to respond to the report.

### Generic medicines

9.94 In April 2005, the Department introduced new long-term arrangements for the reimbursement of generic medicines. The drug tariff introduced a new category 'M' of generic medicines under Part VIII. The basic prices of category 'M' medicines reflect the average manufacturers' market prices after discount and data to amend prices in line with market changes is provided by members of two new voluntary schemes ('M' and 'W'), backed by section 33 of the *Health Act 1999*. Scheme 'M' applies to manufacturers and Scheme 'W' applies to wholesalers. With effect from 1 April 2005, category 'M' removed some £300 million from the distribution chain to be channelled back to pharmacy services as part of the new pharmacy contract arrangements.

9.95 An invoice inquiry of the medicines purchase profits available to the independent pharmacy sector revealed a medicine margin of £300 million a year over and above the baseline of £500 million medicine margin allowed for within the community pharmacy contractual framework. Accordingly category 'M' generic medicine prices were reduced by a further £150 million from 1 October 2006 to 31 March 2007, which will deliver £300 million in a full year.

### Family health services: pharmaceutical services

9.96 **Figure 9.19** shows the trend in pharmaceutical services.

9.97 Prior to 2005-06 the provision of pharmaceutical services consisted of pharmacists' remuneration and fees paid to PCTs for dispensing doctors. From 2005-06 the provision of pharmaceutical services includes an additional component paid to PCTs for practice payments, medicine use reviews (MURs) and the electronic transmission of prescriptions (ETPs). These changes are a result of the implementation of the new pharmacy contract and the resulting increase to cost which was funded by a reduction in the reimbursement prices paid to pharmacists for some medicines.

9.98 Further information on pharmaceutical services is included in chapter 3.

### Family health services: general ophthalmic services

9.99 **Figure 9.20** shows the expenditure on general ophthalmic services (GOS).

9.100 The (unadjusted) growth in 2005-06 over 2004-05 was 5.6 per cent. In real terms (using the March 2007 deflator) the growth in GOS between 1995-96 and 2005-06 was 24.9 per cent, incorporating the impact of the move from 1 April 1999 to extend the eligibility criteria for NHS sight tests to include all patients aged 60 and over.

9.101 Further information on general ophthalmic services is included in chapter 3.

### Centrally Managed NHS Programme

9.102 The budgets in the Centrally Managed NHS Programme fund additional NHS-related expenditure. In previous Departmental Reports, the programme was described as the Centrally Funded Initiatives, Services and Special Allocations (CFISSA) programme. The presentation has been changed to provide a more accurate reflection of how funds are applied between the NHS and the Department.

## Figure 9.19: Family health services – pharmaceutical services (cash and resource), 1995-96 to 2005-06, England

| | 1995-96 Cash | 1996-97 Cash | 1997-98 Cash | 1998-99 Cash | 1999-2000 Cash | 2000-01 Cash | 2000-01 Resource | 2001-02 Resource | 2002-03 Resource | 2003-04 Resource | 2004-05 Resource | 2005-06 Resource |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dispensing Costs | 706 | 746 | 768 | 781 | 808 | 856 | 857 | 879 | 919 | 959 | 965 | 1,162 |

*Notes*
*(1) The figure for 2005-06 pharmaceutical services is not comparable with that for 2004-05, as it includes payments from PCTs under the new pharmacy contract, paid for by reductions in medicine reimbursement prices. A figure for 2005-06 approximately comparable with 2004-05 would be £948 million.*

## Figure 9.20: Family health services – general ophthalmic services (cash and resource), 1995-96 to 2005-06, England

| | 1995-96 Cash | 1996-97 Cash | 1997-98 Cash | 1998-99 Cash | 1999-2000 Cash | 2000-01 Cash | 2000-01 Resource | 2001-02 Resource | 2002-03 Resource | 2003-04 Resource | 2004-05 Resource | 2005-06 Resource |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GOS | 223 | 237 | 241 | 240 | 281 | 292 | 290 | 302 | 304 | 322 | 340 | 359 |

9.103 **Figure 9.21** provides details of the programme's current budget levels for 2006-07 and 2007-08.

9.104 This programme funds additional allocations to the NHS via the NHS Bundle and other specific allocations. Other funding is for NHS-related expenditure directly incurred by the Department within the NHS (for activity such as research and development), or with the independent sector on behalf of the NHS, such as the Connecting for Health project. The programme also funds special health authority allocations.

## Figure 9.21: Centrally managed NHS budgets 2006-07 to 2007-08

| Budgets | £ million 2006-07 | 2007-08 | Notes |
|---|---|---|---|
| NHS Bundle | 5,459.643 | 6,945.780 | Includes a number of budgets previously distributed on an individual basis by DH but now allocated to SHAs including Multi Professional Education and Training Levy, Student Bursaries, Quality and Outcomes Payments to GP Practices, Prison Healthcare, National Specialist Commissioning Advisory Group, Ambulance Radio Contract, NHS Bank Revenue Support and NHS Direct |
| Arm's Length Bodies (including NHS Litigation Authority, NHS Business Services Authority, Healthcare Commission) | 1,166.396 | 1,207.494 | |
| Connecting for Health (NHS IT Programme) | 694.745 | 917.806 | Change due to reprofile of planned activity and expenditure |
| Research and Development | 659.423 | 742.836 | Funding in line with HM Treasury agreement |
| Substance Misuse Pooled Treatment budget | 349.996 | 388.000 | |
| Immunisation Programme | 204.363 | 205.400 | |
| Other allocations | 2,458.790 | 1,450.535 | Reduction as budgets moved to NHS Bundle for 2007-08 |
| Total | 10,993.357 | 11,857.851 | |

## Central health and miscellaneous services (CHMS)

9.105 The CHMS revenue budget programme includes:

- the Welfare Food Scheme;
- EEA medical costs for treatment given to United Kingdom nationals by other member states;
- funding for medical, scientific and technical services, including the National Biological Standards Board, and the Health Protection Agency; and
- grants to voluntary organisations, mainly at a national level, across the spectrum of health and social services activity.

9.106 **Figure 9.22** provides details of the CHMS programme 2006-07 and 2007-08 budget levels.

## Figure 9.22: Central health and miscellaneous services budgets 2006-07 to 2007-08

| Budgets | £ million 2006-07 | 2007-08 | Notes |
|---|---|---|---|
| European Economic Area medical costs | 650.278 | 673.292 | |
| Arm's Length Bodies (including National Biological Standards Board, Health Protection Agency, Commission for Social Care Inspection) | 299.372 | 315.003 | |
| Welfare Foods | 116.524 | 114.500 | |
| Other | 379.309 | 464.442 | Includes Tobacco Control, National School Fruit and Communications budgets, as well as grants to voluntary bodies |
| Total | 1,445.483 | 1,567.237 | |

## NHS efficiency

### Gershon efficiency programme

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

- annual efficiency gains of £6.5 billion by March 2008, at least half of which should be cashable;
- a reduction in whole time equivalent civil servants of 720 by March 2008; and
- the relocation of 1,110 whole time equivalent posts out of London and the South East by March 2010. This target has since been reduced to 1,030, to reflect the transfer of responsibility for the Mental Health Tribunal, a planned relocation, to the Department for Constitutional Affairs (DCA). The respective target for DCA has been increased to compensate.

### Efficiency gains

#### Programme structure

9.108 The programme comprises five main work streams on which progress is reported:

- productive time: modernising the provision of front-line services to be more efficient and also improving the quality of patient treatment and service, by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce;
- procurement: making better use of NHS buying power at a national level to get better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies and other consumables and pharmaceuticals;
- corporate services: ensuring NHS organisations can share and rationalise back office services, such as finance, information and communication technology (ICT) and human resources;
- social care: improving commissioning of social care and other cash releasing and non-cash releasing gains from the design of social care processes by local authorities; and
- policy funding and regulation: reducing operating costs of the Department, arm's length bodies, SHAs and PCTs through reducing processes and functions and restructuring, merging or abolishing existing organisations.

#### Measurement Processes

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

9.110 Details of agreed measurement processes are provided in an efficiency technical note (ETN) available on the Department's website www.dh.gov.uk. The health efficiency programme continues to evolve to underpin gains up to and beyond 2008. The ETN will continue to be updated to include further approved measures as required.

9.111 Efficiency gains reported under Gershon provide a specific perspective on NHS efficiency. Calculating gains by aggregating specific individual projects is not able to take account of wider changes in input costs or activity output across the NHS. The limited number of outcome measures used are unable to capture all locally realised cost improvements and efficiency gains. The dynamic and complex nature of the NHS with continuous changes to the levels and nature of demand for services makes it difficult to derive robust stand-alone efficiency measures for some projects or outcomes. These constraints were recognised explicitly for health in the latest National Audit Office report – *The Efficiency Programme: A Second Review of Progress.*

9.112 In March 2006, the OGC introduced a classification process for reporting of Gershon efficiency gains. This requires us to break down our total reported gains on two sets of criteria – status of the gains and robustness of the measurement and assurance process. The status of reported gains may be classified as preliminary, interim or final, dependent on whether source data or service quality assurance may be subject to change. The robustness (assurance) of reported gains may be classified as full, substantial or partial, dependent on the reliability of source data and the degree of audit or external assurance. A full explanation of these classifications is provided in the ETN.

## Reported gains to date

9.113 **Figure 9.23** shows the gains that have been recorded for 2004-05, 2005-06 and up to quarter 3, 2006-07. We have continued strong progress across all of the main work streams in the last year and remain on track to meet the target of £6,474 million by March 2008. £2,657 million (59.7 per cent) of the total reported gains are cashable.

9.114 **Figure 9.24** shows the breakdown of latest gains using the OGC classification process for status and robustness. We expect most preliminary data to be finalised within the next two quarters.

### Figure 9.23: Reported gains to date and forecast outturn

£ million

| Work stream | 2004-05 | 2005-06 | 2006-07 Quarter 3 | Cashable gains [5] |
|---|---|---|---|---|
| Productive time[1] [2] | 508 | 963 | 1,592 | 112 |
| Procurement | 333 | 1,319 | 2,194 | 2,024 |
| Corporate services | 14 | 38 | 48 | 16 |
| Social care | 0 | 179 | 390 | 280 |
| Policy funding and regulation[3] | 13 | 77 | 225 | 225 |
| **Total**[4] | **868** | **2,576** | **4,449** | **2,657** |

*Note:*
*(1) The previously reported 2004-05 gain for productive time was reduced from £671 million to £508 million following a correction to one of the component calculations and a more accurate apportionment of gains between March 2004 and June 2005.*
*(2) Productive time gains may be further adjusted following resolution of two outstanding areas of measurement difficulty relating to length of stay baseline and adjustment for patient episode case mix. The potential adjustment, dependent on agreed solutions, ranges from a reduction of £225 million to an increase of £150 million on current reported figures.*
*(3) £30 million of savings attributable to the core Department change programme were achieved in 2003-04. An early baseline was agreed with the OGC and HM Treasury as the programme, which had commenced in 2003, delivered a key Gershon recommendation on reducing central bureaucracy, and was used to calculate the contribution to target and to report actual gains.*
*(4) Savings from reduced central budgets will not be included due to difficulties in imputing efficiency gains to an acceptable level of robustness.*
*(5) The calculation of cashable gains does not include the value of productive time service redesign changes. These improvements reduce the cost of patient episodes which each organisation may choose to make cashable (by eliminating the spare capacity) or may use the released capacity for additional activity or services. The split of cashable and non-cashable gains for social care is advised by local authorities in the Annual Efficiency Statements.*

### Figure 9.24: Classification of reported efficiency gains

£ million

| Status of gains | Preliminary[1] | Interim[2] | Final | Total |
|---|---|---|---|---|
| | 460 | 313 | 3,676 | 4,449 |
| **Data assurance** | **Partial**[3] | **Substantial** | **Full** | **Total** |
| | 316 | 1,578 | 2,555 | 4,449 |

*Notes:*
*(1) Preliminary gains include £151 million relating to projects where the measurement process has only recently been established and is awaiting formal approval from the OGC. The difference (£225 million) between the current reported gain and the lowest scenario potential outcome of outstanding measurement issues for hospital length of stay is also reported as preliminary.*
*(2) Calculated gains that are awaiting formal approval of measurement process have been classified as partial assurance but should improve to substantial or full when this has been completed.*
*(3) For projects where we are still finalising balancing quality measures or are still awaiting data on agreed quality measures, their gains to date totalling £226 million have been classified as interim.*

### Assurance of service quality

9.115 In reporting efficiency gains, we are required to demonstrate that these have not been achieved at the expense of reductions in service quality. We have agreed balancing quality measures appropriate to individual work streams and projects. Details are provided in the ETN. In summary the main measures for each work stream are:

- procurement: no specific extra measures as quality is assured by adherence to contractual product specifications;
- productive time: patient satisfaction, hospital readmissions, mortality rates, waiting times, PSA targets, Healthcare Commission quality assessments;
- social care: measures specific to each efficiency project determined by local authorities;
- policy funding and regulation: PSA targets, DH response times, comparison of old and new arm's length body services to be developed; and
- corporate services: adherence to service level agreements (SLAs), some further measures under development.

9.116 The assurance measures in place are all showing maintained and, in most cases, improved service quality, with the exception of hospital readmissions. Readmissions as a percentage of total admissions have been rising since 2002 (prior to the start of the efficiency programme). This is most likely a logical consequence of reducing admissions of less seriously ill patients who are now treated in other settings. Further analysis of this area is in process.

## Progress highlights

### Productive time

- the average length of stay has continued to fall as a result of service redesign and more effective management of patient treatment pathways. The reduced average cost of hospital stays has improved efficiency by at least £300 million per year since the start of the productive time programme;
- there has been a reduction of over 2 million emergency bed days per year since March 2004 and this trend should increase as the strategies for treatment of long-term conditions and *Our Health, Our Care, Our Say* (keeping patients out of hospital) is fully embedded;
- over 900 Emergency Care Practitioners (ECPs) have now been employed by ambulance trusts. ECPs treat emergency patients in situ, reducing the number of A&E admissions and saving over £20 million per year in A&E costs following their introduction in 2004;
- over 7 million patient appointments in GP surgeries were administered by Nurse Practitioners in the last year, freeing GPs to spend more time with patients suffering more urgent and complex illnesses;
- improving medical techniques, technology and associated process redesign means that an increasing number of treatments are being done as day cases. Over 71 per cent of all planned procedures are now done this way, reducing treatment costs by over £40 million in the last year and enabling more patients to go home earlier;
- NHS organisations are now provided with quarterly performance information on key measures of service efficiency – the Better Care, Better Value indicators. These enable them to benchmark performance against similar providers and identify potential opportunities for improvement. The metrics are supplemented by productivity guidance setting out the best practices associated with high efficiency performance; and
- NHS organisations are using techniques such as Lean to identify and realise significant cost savings and improved patient service. Savings and improvements are being achieved in many elements of service delivery and support processes and not all are captured by national performance indicators used to calculate Gershon efficiency savings.

## Procurement

- in addition to the price reductions for branded (PPRS) and generic drugs effective in 2004 and 2005, renewal of the generic drugs (category M) contract for 2006-07 resulted in a further £300 million annual reduction;
- the second wave of national contracts for NHS supplies and services became operational in July, increasing annualised savings to £200 million;
- the agreement to outsource NHS Logistics to DHL was concluded and the contract became operational on 1 October 2006. DHL have assumed responsibility for procuring a number of product categories that should result in further savings of at least £100 million per year by the end of 2008; and
- three regional procurement hubs aligned to new SHAs are realising annualised savings of £60 million. Business cases and plans are being developed for six further hubs to be operational in 2007.

## Corporate services

- the Shared Services Joint Venture, established in April 2005 between the Department and Xansa, has over 100 NHS organisations contracted for finance and accounting services. A successful feasibility study on shared service options for HR will be followed by a regional trial in 2007. An increase in the work that Xansa can transfer from their Wakefield base to India will further increase savings that will be redistributed to participating NHS organisations. The venture remains at the forefront of public sector shared service strategies and is regularly showcased to other Government departments.

## Policy funding & regulation

- the Commissioning a Patient-led NHS programme for restructuring and reducing the number of SHAs and PCTs resulted in a fully new structure operational from October 2006. New SHA and PCT operating budgets commit to operating cost reductions of at least £250 million per year; and, following the reduction in the number of arm's length bodies to 26 in March 2006, overall operating costs have reduced by a further £115 million for the current year. The programme remains on track to deliver annual savings of £250 million from March 2008. Chapter 4 provides further information on this.

## Social care

- the 2005-06 Annual Efficiency Statements from local authorities confirmed annual efficiencies increasing to £306 million. Mid-year updates from councils confirm the expectation of a further £200 million of efficiency gains in 2006-07;
- the Care Services Efficiency Delivery (CSED) programme has established a highly effective partnership with local authorities, supporting the rollout of six major efficiency initiatives that should contribute over £250 million of new annual efficiency savings by March 2008; and
- the major initiatives comprise:
  - redesign of the referral, assessment and care management process for care service users;
  - adoption of automated electronic systems for monitoring visits and time spent by homecare workers resulting in a number of efficiency and service improvement opportunities;
  - developing solutions to better forecast demand for services and resulting capacity planning enabling more efficient use of resources;
  - targeting direct support interventions of service users to maximise their long-term independence and reduce whole life cost of care;
  - developing tools and solutions to embed value for money principles into buying and commissioning processes for social care; and
  - review of community equipment and wheelchair services providing an improved model of service delivery.

### Expected progress in 2007-08

9.117 The Department expects to achieve the remaining £2 billion of annual efficiency gains to meet our 2008 target. Achievement will be underpinned by key deliverables in each work stream.

### Productive time

- continued process improvement by local organisations underpinned by the Better Care, Better Value indicators, resulting in particular in further reductions in length of stay and emergency bed days; and
- local improvement plans continuing to focus on efficiency opportunities across all areas of service provision supported by improvement methodologies such as Lean.

### Procurement

- exploiting the improved buying opportunities through the DHL contract;
- increased local uptake of national contracts supported by benchmarking information; and
- completion of the rollout of regional procurement hubs.

### Corporate services

- continued sign-up of NHS organisations to the Shared Services Joint Venture, expansion and completion of the regional trial on HR services.

### Policy funding and regulation

- further reduction in arm's length bodies operating budgets reflecting efficiency gains realised by remaining arm's length bodies; and
- full realisation of operating cost savings by SHAs and PCTs.

### Social care

- continuing to promote and support the six major efficiency initiatives.

### Reduced Civil Service headcount

9.118 The Department committed to a gross reduction of 1,400 full time equivalent civil servant posts in the core departments through its change programme launched in early 2003. Of these approximately half (680) were expected to be transfers to other NHS bodies and the remainder (720) were net reductions as defined in the Gershon target.

9.119 Although the initiation of this programme pre-dated the formal baseline for the Gershon programme, its objectives aligned wholly to Gershon's recommendations on reducing central regulatory and administrative functions. A 2003 baseline was agreed and the 720 net target was agreed on this basis.

9.120 The substantive programme of workforce reduction took place during 2003-04. By March 2004, the reduction had reached 709. Since 2004, the delivered reduction has fluctuated within a narrow range. At December 2006, the reduction is 650, seventy short of the agreed target.

9.121 The Department has just completed a detailed business planning process, matching resources to its reduced operating budget for 2007-08. A voluntary exit scheme (VES), to be completed by June 2007, will reduce headcount by around seventy in line with the lower operating requirements.

### Lyons relocations

9.122 The Department is committed to the relocation of 1,030 posts out of London and the South East by March 2010.

9.123 By December 2006, 594 relocations had been completed. During the last year relocations have been completed by the Health and Social Care Information Centre (76 posts to Leeds), the NHS Institute (128 posts to Warwick), the National Institute for Health and Clinical Excellence (20

posts to Manchester) and NHS Professionals (27 posts to Wakefield).

9.124 Relocation processes are pending for the General Social Care Council and a further tranche of staff for the Information Centre. These will all be complete by September 2007.

9.125 The Department has agreed and communicated an accommodation strategy that will result in further relocation of posts to Leeds and the reduction from four to two central London offices. Further relocations will result from the planned merger of the Healthcare Commission and the Commission for Social Care Inspection. A number of other potential relocations within other NHS organisations will be confirmed during 2007 so that the overall Lyons target can be achieved by 2010.

## NHS productivity

9.126 To measure progress against the 2002 Spending Review value for money PSA target, the Department developed an interim cost efficiency measure. The measure is calculated by comparing increases in NHS expenditure adjusted for both input cost inflation and increases in expenditure on improving the quality of NHS services, with increases in NHS outputs as calculated by the NHS output index. This latter index is derived using data published in the *National Schedule of Reference Costs* using over 1,900 activity categories. In 2005-06, we estimated that value for money through cost efficiency increased by around 1.2 per cent. The cost efficiency measure was always regarded as an interim measure to be used whilst further development work was undertaken.

## NHS management costs

9.127 The cost of managers in the NHS, as a percentage of overall spend, continues to fall.

9.128 Currently, the figure for management costs is under 4 per cent of the total NHS expenditure, whereas it was 5 per cent in 1997-98. See **Figure 9.25**.

9.129 In addition, NHS organisations are currently working towards producing a recurrent saving of £250 million in the costs of administration and management across the NHS, to be reinvested in services in 2008-09.

9.130 As at 31 December 2006, 79 per cent of compulsory redundancies in the NHS were in non-clinical grades which includes managers and administrative staff.

### Figure 9.25: NHS Management Costs, 1996-97 to 2005-06

| Year | Total (S)HA, PCT and NHS trust management costs (£ thousands) | NHS total expenditure (£ million) | % management costs of NHS budget |
|---|---|---|---|
| 1996-97 | 1,675,800 | 32,997 | 5.10% |
| 1997-98 | 1,727,556 | 34,664 | 5.00% |
| 1998-99 | 1,703,364 | 36,608 | 4.70% |
| 1999-2000 | 1,783,212 | 40,201 | 4.40% |
| 2000-01 | 1,867,239 | 43,932 | 4.30% |
| 2001-02 | 1,992,453 | 49,021 | 4.10% |
| 2002-03 | 2,131,891 | 54,052 | 3.90% |
| 2003-04 | 2,387,709 | 63,001 | 3.80% |
| 2004-05 | 2,576,984 | 69,706 | 3.70% |
| 2005-06 | 2,724,336 | 76,339 | 3.60% |

*Notes:*
*(1) NHS trusts 1996-97 to 2005-06.*
*(2) Health authorities for 1996-1997 to 2001-02.*
*(3) Strategic health authorities 2002-03 to 2005-06.*
*(4) Primary care trusts 2000-01 to 2005-06.*
*(5) Figures exclude NHS foundation trusts from 2004-05.*

## Personal Social Services

9.131 As part of the 2004 Spending Review, the Chancellor confirmed the central government provision for adult Personal Social Services (PSS) to be funded by both the Department of Health and the Department for Communities and Local Government during the period 2005-06 to 2007-08. These plans mean an average growth in resources for PSS of 2.7 per cent in real terms over the three years. These new spending plans are set out in **Figure 9.26**.

### Figure 9.26: Funding announced for PSS by the Chancellor in the 2004 Spending Review

£ billion

| | 2004-05 plan | 2005-06 plan | 2006-07 plan | 2007-08 plan |
|---|---|---|---|---|
| Total expenditure | 10.7 | 11.5 | 12.0 | 12.5 |
| % real terms increase | | 5.6 | 1.2 | 1.4 |

### Total Personal Social Services expenditure

9.132 The Department of Health provides a significant proportion of the financial resources needed to deliver the social care commitments of local authorities in England. **Figure 9.27** shows the latest available local authority current and capital expenditure on social care services. Between 1995-96 and 2005-06, the net current expenditure has increased by 76 per cent.

### Personal Social Services revenue provision

9.133 As part of the first multi-year Local Government Finance Settlement 2006 to 2008, the Department has allocated the following resources to local authorities:

- for 2006-07, £1.59 billion for adults' social services and the child and adolescent mental health services element of children's services; and
- for 2007-08, £1.62 billion for adults' social services and the child and adolescent mental health services element of children's services.

9.134 This move to a multi-year settlement is intended to encourage both certainty of funding and opportunities for improved budget planning within councils with social care responsibilities. From 2008-09, full three-year settlements will be allocated in line with each spending review cycle, aligning social care allocations with the pattern of funding already in place for the NHS.

### Figure 9.27: Expenditure by local authorities on personal social services

£ million

| | 1995-96 outturn | 1996-97 outturn | 1997-98 outturn | 1998-99 outturn | 1999-2000 outturn | 2000-01 outturn | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Current expenditure | | | | | | | | | | | |
| gross[1] | 8,390 | 9,260 | 9,980 | 10,850 | 12,050 | 12,850 | 13,600 | 15,200 | 16,840 | 18,220 | 19,320 |
| charges[1] | 1,080 | 1,320 | 1,530 | 1,790 | 2,000 | 2,150 | 2,230 | 2,310 | 2,080 | 2,000 | 2,070 |
| net | | | | | | | | | | | |
| cash | 7,310 | 7,940 | 8,450 | 9,060 | 10,050 | 10,700 | 11,370 | 12,890 | 14,760 | 16,220 | 17,250 |
| real terms[2] | 9,390 | 9,870 | 10,210 | 10,660 | 11,600 | 12,170 | 12,640 | 13,900 | 15,460 | 16,530 | 17,250 |
| Capital expenditure[1] | | | | | | | | | | | |
| gross | 200 | 180 | 150 | 140 | 134 | 156 | 158 | 199 | 260 | 285 | 387 |
| income | 40 | 44 | 43 | 53 | 51 | 63 | 70 | 75 | 74 | 75 | 84 |
| net | 160 | 136 | 107 | 87 | 83 | 93 | 88 | 124 | 186 | 210 | 303 |
| Total local authority expenditure | | | | | | | | | | | |
| gross | 8,590 | 9,440 | 10,130 | 10,990 | 12,184 | 13,006 | 13,758 | 15,399 | 17,100 | 18,505 | 19,707 |
| charges/income | 1,120 | 1,364 | 1,573 | 1,843 | 2,051 | 2,213 | 2,300 | 2,385 | 2,154 | 2,075 | 2,154 |
| net | 7,470 | 8,076 | 8,557 | 9,147 | 10,133 | 10,793 | 11,458 | 13,014 | 14,946 | 16,430 | 17,553 |

*Source: PSS EX1, RO and RA local authorities' Returns*

*Notes:*
*(1) Gross current expenditure, income from charges and capital figures are not available for 2006-07.*
*(2) At 2005-06 prices using the GDP deflator.*

## Figure 9.28: Personal Social Services provision for adults, 2005-06 to 2007-08

| | 2005-06 | 2006-07 | £ million 2007-08 |
|---|---|---|---|
| **Specific revenue grants:** | | | |
| Preserved Rights | 348.230 | 297.565 | 275.248 |
| Residential Allowance | 214.455 | | |
| Access and Systems Capacity[1] | 642.000 | 546.000 | 546.000 |
| Delayed Discharges | 100.000 | 100.000 | 100.000 |
| Carers | 185.000 | 185.000 | 185.000 |
| Mental Health | 132.950 | 132.900 | 132.900 |
| AIDS Support | 16.500 | 16.500 | 16.500 |
| National Training Strategy | 94.859 | 107.859 | 107.859 |
| Human Resources Development Strategy | 62.750 | 49.750 | 49.750 |
| Child and Adolescent Mental Health Services | 90.539 | 90.539 | 90.539 |
| CSCI Reimbursement[2] | 0.750 | 0.750 | 0.750 |
| Individual Budget Pilots | | 6.000 | 6.000 |
| Partnerships for Older People Projects (POPP) | | 20.000 | 40.000 |
| Preventative Technology | | 30.000 | 50.000 |
| Mental Capacity Act and Independent Mental Capacity Advocate Service | | 6.485 | 14.625 |
| *DH funded. Allocated by other government departments*[3] | 8.500 | 7.500 | 7.500 |
| **Total revenue grants** | **1,896.533** | **1,596.848** | **1,622.671** |
| **Capital resources** | | | |
| Single Capital Pot SCE(R) | | | |
| Ringfenced SCE(R) for mental health | | | |
| AIDS/HIV | 3.100 | 3.100 | 3.100 |
| Improving Information Management Grant | 25.000 | 25.000 | 25.000 |
| Extra Care Housing Grant | | 20.000 | 40.000 |
| **Total capital resources** | **28.100** | **48.100** | **68.100** |
| **Total PSS provision**[4] | **1,924.633** | **1,644.948** | **1,690.771** |

*Notes:*
*(1) The 2005-06 Access and Systems Capacity funding included an additional £100 million agreed by the Government. This non-recurrent addition was not made in 2006-07 or 2007-08.*
*(2) This is the reimbursement of the top-slice agreed to fund the CSCI review panel stage. It will be issued as one specific grant in 2006-07 and 2007-08, whereas it was issued as two separate grants in 2005-06.*
*(3) Funding allocated by other government departments includes:*
*– CAMHS £3 million transfer to the Department for Education and Skills for each of the years 2005-06, 2006-07 and 2007-08.*
*– Young People's Substance Misuse £4.5 million transfer to Home Office recurring in 2005-06, 2006-07 and 2007-08.*
*(4) FSS has now been removed from PSS allocations. For comparative purposes the 2005-06 FSS has been removed from the table.*

9.135 **Figure 9.28** sets out revenue and capital resources to be made available for adults' social services in 2006-07 and 2007-08, with funding levels for 2005-06 included for comparative purposes. Adults' PSS specific grant funding has decreased by just over £300 million between 2005-06 and 2006-07. There are two principal reasons for this:

- unlike in 2005-06, an additional £100 million transfer is not to be made from the NHS to the Access and Systems Capacity grant (in either of the next two years); and
- the Residential Allowance grant funding has been completely rolled into general grant through the relative needs formula, in line with government policy to minimise the separate grant streams.

9.136 Adult social services are funded by the general grant, distributed by the Department for Communities and Local Government (DCLG) by each council's ability to raise revenue through council tax and by specific grant allocation from central government departments. From 2006-07, a new method of allocating 'Formula' grant was used. This new allocation model, developed by DCLG contains four funding blocks:

- the central allocation;
- relative needs amounts;
- relative resource element; and
- floor damping blocks.

9.137 To avoid any potentially misleading inference that formula amounts could approximate to required expenditure at local authority level, the former Formula Spending Share has been replaced

by relative needs formulae (RNF) for each service block (e.g. older people, younger adults, children). Each local authority now receives a proportionate share of the overall control total for a service block, where that share is expressed as a proportion and not in monetary terms.

9.138 The new needs-based RNF allocation formulae for adults' social care incorporate the latest available 2001 census data, and have been developed following a rigorous process of academic research. These formulae will better reflect actual need for services, and therefore allocate resources, more accurately and equitably. DH also recognised that the new model has produced significant step-changes in allocations for some councils, and has therefore applied appropriate floor damping mechanisms to help local authorities manage any redistributive effect.

### Personal Social Services Capital resources

9.139 In each of 2006-07 and 2007-08, the Department will make available a total of £27.7 million for the adults' PSS single capital pot element of supported capital expenditure (revenue) (SCE(R)) and £22.6 million for mental health. SCE(R) supports the cost of a certain level of capital borrowing. These borrowing costs comprise interest on outstanding debt and repayment of debt. Total capital distribution in this category is allocated using the Department's own distribution formula.

9.140 A further £25 million will be issued as a specific capital grant as part of the Improving Information Management Programme in 2006-07 and 2007-08. £60 million will be distributed to councils over the two-year period in the form of Extra Care Housing capital grant. This will be split in the proportion of £20 million in 2006-07 and £40 million in 2007-08. In addition, a total of £6.2 million capital grant is made available in respect of AIDS/HIV services over the period 2006 to 2008.

9.141 Local authorities can continue to use revenue and receipts from the sale of capital assets to fund their capital programmes, including Personal Social Services.

### How the resources are used

9.142 The Department's social care allocations support services for three main client groups:

- children and adolescents, insofar as they are supported by the Child and Adolescent Mental Health Services (CAMHS) grant and elements of the Carers grant, National Training Strategy grant, Human Resources Development Strategy grant and the Improving Information Management grant;
- younger adults aged 18 to 64, requiring services ranging from specialist services for those with physical and learning difficulties, mental health problems, and issues relating to drugs or HIV and AIDS; and
- older people aged 65 and above, requiring principally specialised residential and intensive home care services.

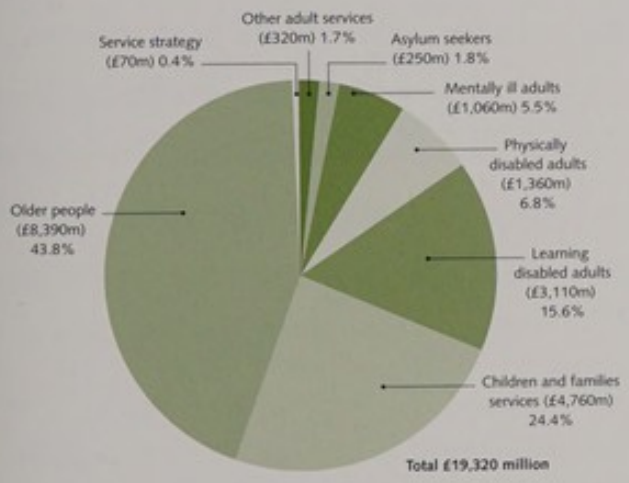
9.143 Funding provided by the Department for adults' social care has a direct impact upon PSA targets set for the Spending Review 2004 period. By offering improved care in community settings for people with long-term conditions, and providing improved services, quality of life and independence for vulnerable older people, individual PSS grant funding specifically supports PSA targets 4 and 8. Further PSS initiatives can be linked to PSA targets 3, 6 and 7.

9.144 The Department is responsible for establishing overall policy in respect of social care, leaving councils with a significant degree of flexibility in delivering their adults' social care commitments according to local priorities and the needs of the community they represent. The figures provided show the actual expenditure by local authorities on Personal Social Services in 2005-06.

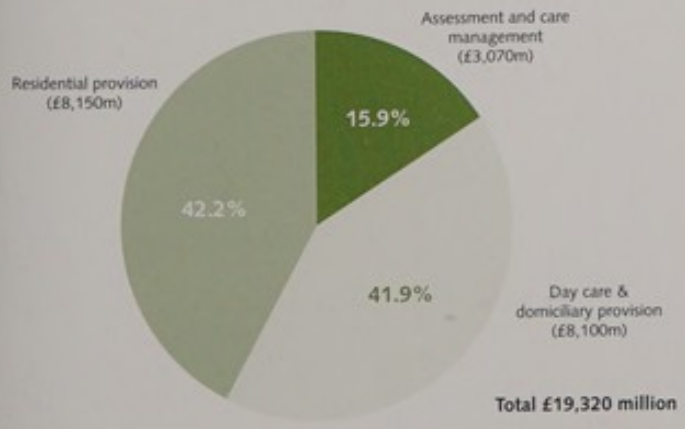
**Figure 9.29** shows gross expenditure by client group in 2005-06. **Figure 9.30** displays the breakdown by type of provision.

9.145 In 2005-06, gross expenditure in England on Personal Social Services was £19.3 billion. The largest items of expenditure were for residential care (42 per cent) and day and domiciliary care (42 per cent). Within spending on residential care, most was spent on residential and nursing home care provided by the independent sector.

## Figure 9.29: Local authority Personal Social Services gross expenditure by client group, 2005-06




## Figure 9.30: Local authority Personal Social Services gross expenditure by type of service, 2005-06



# 10 Capital Finance

## Characteristics of capital investment

**10.1** In contrast to revenue expenditure, which is expenditure on goods and services to be consumed in the current financial year, capital investment is expenditure now (typically on buildings and large pieces of equipment) which will continue to provide benefits into a number of future financial years. To count as NHS capital expenditure, the expenditure must generally be on assets that individually cost £5,000 or more and that are recorded on the balance sheet as fixed assets.

## Available capital resources

**10.2** In this, the third year covered by the 2004 Spending Review (SR 2004), the public capital resources available to the NHS will total almost £4.2 billion, compared to an estimated outturn spend of just under £3.6 billion in 2006-07. This would amount to an increase of £600 million (around 17 per cent), giving the health service further scope to improve the quality of the assets with which services are delivered. In 2007-08, as in previous years, there will be further investment through the private finance initiative (PFI) and through NHS LIFT, the public private partnership (PPP) vehicle for transforming primary care premises. Some capital assets will also result from the independent sector treatment centres programme.

**10.3** The capital resources available to health are set out in **Figure 10.1**. NHS capital DEL for 2007-08 has been updated to reflect the most recent forecasts of spending, excluding exceptional items. NHS spending plans are unaffected. The remainder of this chapter explains how NHS systems reforms will impact on the management of capital investment and how public capital resources will be distributed to the NHS. It also outlines the priorities for capital investment during 2007-08 and progress with the PPP arrangements for delivering improved NHS facilities.

**Figure 10.1: NHS capital spending, 2005–06 to 2007–08 (resources)**

| | 2005-06 outturn | 2006-07 estimated outturn | £ million 2007-08 plan |
|---|---|---|---|
| Government spending | 2,443 | 3,554 | 4,177 |
| *Percentage real terms growth*[1] | - | *41.2* | *14.7* |
| Receipts from land sales | 951 | 606 | 348 |
| *Percentage real terms growth*[1] | - | *-38.0* | *-44.1* |
| PFI investment | 1,160 | 1,094 | 1,318 |
| *Percentage real terms growth*[1] | - | *-8.2* | *17.3* |
| Total | 4,554 | 5,244 | 5,843 |

*Note:*
*(1) Real terms growth calculated using GDP deflators of 2.38%/2.46%/2.66%.*

## NHS structural reforms and capital funding system reforms

**10.4** During 2006-07, there were significant changes to the configurations and functions of SHAs and PCTs. Reconfiguration on this scale is not expected during 2007-08. Reforms will however continue, with the transition of further NHS trusts to NHS foundation trust (NHS FT) status, and this change is being supported by reforms to the methodology for allocating capital to NHS trusts. Further information on this is included below.

**10.5** NHS FTs are free to reinvest all cash generated from their operations, rather than relying on operational and strategic capital allocations for the maintenance and replacement of their assets, and they may borrow under prudential borrowing arrangements (explained below) to fund further capital investment. At the time of writing, there are 62 NHS FTs, with further applications under consideration by the Department and Monitor, the independent regulator of NHS FTs.

**10.6** Until last year, a significant proportion of the capital resources available to the NHS were allocated on a formulaic basis to NHS trusts and PCTs, as operational capital (based on depreciation and thus the current asset-bases), and to SHAs, as strategic capital (based on weighted capitation), or from central programme capital budgets, targeted at particular investment objectives.

10.7 A potential drawback with continuing with this system of allocations is that it may not be sufficiently responsive to patient choice:

- capital may be allocated to organisations that under patient choice attract less activity and thus less revenue income with which to service the capital charges resulting from their investment; and,
- organisations that attract additional activity and revenue income may not readily have access to the capital resources necessary to upgrade and expand facilities.

10.8 A further consideration is that NHS trusts may develop investment plans under the current capital allocations system that may not be allowable within the prudential borrowing limits (PBLs) that they would have as NHS FTs, thereby creating an obstacle to their transition to foundation status.

10.9 For these reasons, NHS trusts will, from the beginning of 2007-08, access capital under similar arrangements to those applying to NHS FTs. These prudential borrowing based capital financing arrangements are explained in the paragraphs immediately below. Because foundation trust status is not an issue for PCTs, they will continue to receive capital resources through the allocations system during 2007-08, though changes are not ruled out for subsequent years.

## The introduction of prudential borrowing arrangements

10.10 Since the first NHS FTs were established in 2004, it had been intended that they would not be dependent on capital allocations. In addition to being free to reinvest all cash generated through their operations (i.e. cash generated through depreciation, asset-sales and operating surpluses), they may borrow to invest further under prudential borrowing arrangements. Under these arrangements, they may draw loans if their projections of future cash-flows show that they would be able to afford the resultant payments of interest and principal.

10.11 Each NHS FT has a PBL that determines the maximum amount of debt that it may take on. PBLs are set according to a *Prudential Borrowing Code* (Monitor, March 2005) and is available on the website of Monitor at www.monitor-nhsft.gov.uk.

10.12 Loans differ from the public dividend capital (PDC) that is currently issued to cover most additional investment in that they are repayable according to a pre-agreed repayment schedule and attract interest at a fixed rate on the balance that at any time is outstanding. There will however, be a transitional period during which allocations of public dividend capital will still be available.

10.13 NHS FTs are authorised to borrow from commercial banks and also from the Department. The Department has established a loan facility to make long-term loans available to them and several have been agreed to date.

10.14 From 2007-08, borrowing arrangements will increasingly govern access to capital funding for NHS trusts. Guidance on these for NHS trusts was issued to SHAs in December 2006.

## Capital investment plans

10.15 The following paragraphs provide some explanation of the planned use of resources in 2007-08, and what individual budgets are intended to deliver.

### Investments Contracted For By the Department and its agencies

10.16 Where it is commercially and operationally appropriate to do so, the Department will sign contracts for the provision of services that may include the provision of fixed assets. In these circumstances, the expenditure is counted as expenditure by the Department, even where the main beneficiaries of the services are NHS trusts and PCTs.

10.17 In the last few years, the most significant example of this has been NHS Connecting for Health's, the National Programme for IT (see chapter 8) that will transform information provision in the NHS. Further information on this programme, including the key deliverables, its benefits to patients and clinicians and its important role in achieving several PSA targets, can be found in chapter 8. In summary, the national programme will deliver:

- electronic appointment booking;
- an NHS National Care Record Service; and,
- an electronic prescribing service, and an underpinning IT infrastructure with sufficient capacity to support the critical national applications and local systems.

10.18 We are also investing in a range of other bodies that provide services to the NHS, including bodies such as the Healthcare Commission that provide regulatory services and bodies such as the NHS Blood and Transplant that provide essential input for NHS services. This includes some capital funding for initiatives to improve the efficiency of capital procurement and for implementing an Electronic Staff Record IT system and a range of smaller initiatives.

### Main Capital Allocations to SHAs and PCTs

10.19 One of the highest investment priorities is to ensure that local NHS organisations are able to implement the capital investments that they consider necessary to maintain the facilities in which local health services are provided and the further small and medium sized investments, which they consider necessary to improve the quality of local services and access to them. As in previous years, PCTs will receive allocations of operational capital directly from the Department for this purpose, and also strategic capital via their SHAs.

10.20 Operational capital is allocated unconditionally to PCTs and is predominantly spent on maintaining buildings and replacing equipment. The £168 million allocated so far, for spend in 2007-08 is around 29 percent higher than the PCTs' share of operational capital in 2006-07.

10.21 £155 million is to be allocated as strategic capital. Strategic capital is typically used by SHAs to fund larger investments that are prioritised within the health communities for which they are responsible. During 2007-08, trusts will access capital under different arrangements, so the £155 million is only for investment in developments put forward by PCTs.

10.22 Until 2006-07, SHAs received strategic capital for investments at both NHS trusts and PCTs, without any stipulation as to how much they should spend in each sector. As a consequence, there is no comparable figure with which to compare the £155 million in 2007-08.

10.23 The operational and strategic capital allocations were announced on 6 February 2007, along with allocations from a £60 million programme capital budget for improving dental premises.

### Programme Budgets for Allocation to the PCT Sector

10.24 The Department's capital investment plans are, at least in part, based on the need to achieve key Spending Review commitments, including in particular the 18-week maximum waiting time for treatment, and other service targets such as those contained in national service frameworks.

10.25 In deciding how the programme capital should be managed, the Department has considered carefully whether it is essential to manage the funding centrally, for example where the distribution of need varies from region to region, or whether the funding is best managed locally because investment needs are best understood at that level. Where the funding is best managed locally, it is included in the 'main capital allocations' described above.

10.26 The following explains some of the key investment programmes.

### Community hospitals – £150 million

10.27 The largest programme budget is the £750 million that was announced to facilitate the development of community hospitals and services in accordance with the objectives set out in the policy document *Our Health, Our Care, Our Community: Investing in the Future of Community Hospitals and Services* (DH, July 2006). Four schemes have so far been approved, and over twenty further schemes are under consideration.

10.28 The first four schemes to be approved are:

- Washington Primary Care Centre in Sunderland – a new £9 million health centre conveniently located in a shopping centre. Opening in 2008, the centre will provide a walk-in urgent care and illness unit, diagnostic and treatment services, kidney dialysis and substance misuse service;
- Gosport War Memorial Hospital, Hampshire – a £6 million refurbishment of the existing community hospital. The investment will deliver six additional consulting suites, an endoscopy clinic, additional diagnostic imaging facilities, and 10 rehabilitation beds;
- Yate Health and Children's Integrated Services Centre, Bristol – a new £9 million health centre (£5 million provided by the Department) offering outpatient and diagnostic services, an urgent care service, 10 GPs and community audiology, midwifery, baby clinics; and,
- Minehead Community Hospital – a major £24.5 million redevelopment of the outdated community hospital into a modern health, leisure and educational park called 'New Horizons'. The 20-bed hospital will include a new diagnostic centre and day theatre, as well as new dental facilities and urgent care unit.

### Dental Premises Capital Modernisation Funding – £60 million

10.29 This budget is the second instalment of a £100 million capital fund that was announced last year to finance infrastructure improvements for NHS primary dental services during 2006-07 and 2007-08. This funding is intended to support dentists in modernising premises and equipment, and to allow PCTs to give greater financial support to help dentists establish new practices or expand existing surgeries.

### Substance Misuse Capital – £48 million

10.30 Capital funding has been made available to fund the capital costs of increasing the number of in-patient places for drug treatment and drug rehabilitation. In-patient and residential facilities are under-provided for within drug treatment pathways and unlike other types of drug treatment have not grown in recent years. A shortage of these facilities reduces patient choice and the proportion of patients who become drug-free.

### Capital Resources Set Aside For the Trust Sector

10.31 Although the prudential borrowing arrangements explained above will increasingly govern the access to capital funding of NHS Foundation Trusts and NHS Trusts, their capital investment is charged to the Department's capital resource total so funds must be set aside to cover this. The budget is based on central modelling of the trust sector's ability to afford the revenue capital charges that result from investment.

10.32 Trusts will spend this cash on their own investment priorities, including the capital maintenance of their buildings and the replacement of major pieces of clinical equipment. This freedom replaces the operational capital that NHS trusts received up to 2006-07.

### Capital resources set aside for the trust sector

10.34 Programme Capital for the Trust Sector

10.33 The new prudential borrowing arrangements should ensure that where a trust requires capital investment, and can afford to service the repayments and interest, the capital funding will be available. As a consequence, most of the programme capital for 2007-08 is to complete programmes that were announced in earlier financial years. Examples of the initiatives that are to be met from this funding include the following.

### Coronary Heart Disease

10.34 A significant amount of the 2007-08 programme capital is to be put towards completing the modernisation and expansion programme for cardiac services that includes nineteen cardiac centres, which will expand cardiac services with around twenty-seven additional cardiac theatres, critical care capacity, diagnostic services, outpatient facilities and 620 extra beds. To date, twelve schemes have been completed and a further four are expected to be completed in 2007-08.

10.35 This investment has already helped to reduce waiting times for heart surgery patients in the areas served by the units receiving funding. Capital investment is also being targeted at expanding diagnostic angiography to reduce waiting times for tests and in-patient admissions and catheter laboratories to support increased access to angioplasty.

### Mental Health

10.36 There is a central capital fund in 2007-08 for investment in mental health facilities. In addition to funding improvements to in-patient psychiatric wards and intensive care environments and increasing the provision of 'dedicated places of safety' for psychiatric assessment, as required by section 136 of the *Mental Health Act 1983*, there will be continued investment in developing facilities for people with dangerous severe personality disorder (DSPD) and high secure facilities. There will also be investment in facilities to permit the transfer of some patients into more appropriate care settings and to develop specialist facilities for particular client groups, including medium secure facilities for deaf people and dedicated units for women.

### Energy Efficiency

10.37 In January 2006, the Department announced that a £100 million capital fund would be available to finance improvements in energy efficiency at NHS facilities and, in particular, for schemes that will contribute towards achievement of the carbon reduction target currently applying to the NHS. The NHS has been tasked with reducing the level of primary energy consumption by 15 percent or 0.15 MtC (million tonnes carbon) from March 2000 levels by March 2010. £60 million has been set aside in 2007-08's capital budget for this purpose.

## Restrictions on capital to revenue transfers

10.38 In 2007-08, the Department has no flexibility to vire capital funds to revenue. There is however flexibility to facilitate capital grants to the private sector and public corporations within capital budgets. These are accounted for as revenue expenditure in the Department's resource accounts, but are classified as capital investment in the national accounts and budgets. The funding must however be used to invest in buildings and equipment assets and cannot be diverted to other uses, such as financing deficits.

## Delivery of public capital funded buildings and works – NHS ProCure21

10.39 ProCure21 (P21) was launched in April 2000 as the NHS' response to *Rethinking Construction* (Department for Trade and Industry, July 1998) and HM Treasury's *Achieving Excellence* (HMT, March 1999) It provides a standardised approach to the procurement of public capital funded healthcare facilities in the NHS, based upon

long-term relationships with pre-selected supply chains.

10.40 A competitive Official Journal of the European Union (OJEU) tendering process took place to select principal supply chain partners (PSCPs) for a national framework. NHS trusts can select a partner from this framework without the need to go through an additional OJEU process.

10.41 The P21 Programme was rolled-out nationally in September 2003. To date, over 140 projects with a total value of £590 million have been completed, with many others registered with the programme and under development. Examples of completed Procure 21 schemes include the following:

- The Royal Liverpool and Broadgreen University Hospital NHS Trust – Cardiothoracic Centre Treatment Centre – £72 million;
- Newham University Hospitals NHS Trust Diagnostic and Treatment Centre – £15 million;
- Southampton University Hospitals NHS Trust – Oncology Unit Phase 2 – £7 million; and,
- North Tyneside and Northumberland Mental Health Trust – Bamburgh Mental Health Clinic – £16 million.

10.42 Indications so far are that P21 has reduced the pre-construction period by at least six months. P21 should not only save time. The long-term partnerships being developed between the NHS and the PSCPs will allow them to gain a better understanding of the NHS' requirements and, as a consequence, better support the NHS in planning the development of facilities in the future. The intention is that NHS facilities are completed on time, within budget and are well designed to provide first class facilities for NHS patients.

10.43 The ProCure21 Programme is delivering the first four facilities to be developed through the Community Hospitals Initiative.

## Public private partnerships and innovative investments

10.44 The NHS is continuing its major programme of investment through the use of public private partnerships:

- the private finance initiative (PFI), which continues to deliver most of the major hospital building schemes; and,
- NHS Local Improvement Finance Trust (LIFT), an investment vehicle for modernising primary care premises.

10.45 Recent progress of these initiatives and their plans for 2007-08 are outlined below.

## PFI and the 100 Hospital Schemes Target

10.46 During 2006, thirteen PFI schemes with a combined capital value of £1.2 billion became operational and a further six schemes reached financial close and commenced building. This means that in total, 84 hospital schemes (63 of which are PFI) are now operational and a further 25 are under construction, of which 24 will be operational by 2010. This means that The NHS Plan (DH, July 2000) target of ensuring that over 100 hospital schemes are delivered by the end of 2010 is certain to be met.

10.47 The new schemes under construction continue to vary widely in terms of size, purpose and location. Examples include:

- the largest hospital build scheme in the history of the NHS, which will see a new £1 billion redevelopment of the Barts & the London NHS Trust. This will include a new acute teaching hospital at the Royal London Hospital and the redevelopment of St Bartholomew's Hospital (Barts) as a Cancer and Cardiac Centre of Excellence;
- a new £67 million Cancer Centre by Hull & East Yorkshire Hospitals, which will provide treatment

and palliative care for patients with cancer and blood disorders; and,

- a new community hospital at Brentwood that is being built for South West Essex Teaching PCT costing £30 million.

10.48 In *The NHS in England: The Operating Framework for 2006-07* (DH, January 2006), the Government reaffirmed its commitment to the hospital building programme and confirmed that PFI would continue to be the delivery vehicle for the majority of major capital developments in acute services.

10.49 In doing so a reappraisal process was set up, led by the Department, to ensure that NHS trusts taking forward major PFI scheme properly take into account the current reforms to the NHS like choice, payment by results and moving services out of hospital into primary care and community settings. Investment planning plays a key part in modernising services, as opposed to simply replacing obsolete buildings, so these trusts have to re-assess fundamentally their service configuration and patient pathways and demonstrate that their projects are affordable and meet both current and future patient needs in this new environment

10.50 A first wave of six schemes were reappraised at Tameside, Salford, Walsall, Leicester, North Staffordshire and South Devon NHS Trusts and decisions announced in August 2006. All the schemes were allowed to proceed to the next stage of the approvals process and work towards signing contracts, subject to some reductions in their capital values and revenue costs. In addition, major PFI schemes at three other trusts – Barts and the London, St Helen's and Knowsley and the University Hospital Birmingham Foundation Trust, which were very close to signing contracts when the reappraisal was announced, had their key assumptions tested under the review criteria and were also approved to proceed subject to some capital and revenue cost reductions. All three successfully signed contracts and are now under construction.

10.51 Seven schemes at North Bristol & South Gloucestershire PCT, Mid Yorkshire, Tees, Esk & Wear Valleys, Maidstone & Tunbridge Wells, Peterborough & Stamford, North Middlesex and Mid Essex Trusts were reappraised in a second wave announced in February 2007. Again, all were approved to proceed to the next stage of their approvals process subject to some reductions in their value.

10.52 For the balance of 2007 the reappraisal exercise will turn its attention to the major PFI schemes that have yet to engage with the market.

## NHS LIFT

10.53 The NHS Local Improvement Finance Trust (NHS LIFT) continues to contribute to the redevelopment of the primary care infrastructure.

10.54 Rather than simply replacing outdated facilities, we are encouraging the NHS to build premises offering many services traditionally only found in hospitals. Many NHS LIFT projects involve the local authority, and many of the facilities provided are joint health and social care centres.

10.55 As well as new GP surgeries, there are now 'super surgeries' in many areas across the country, where NHS patients can get minor surgery for hernia repairs, sports injuries and even vasectomies. In addition, X-rays, medical tests, speech and language therapy, chiropody, physiotherapy, dentistry, and pharmacies are available in some of the new centres.

10.56 LIFT is also one way of taking forward community hospitals under the community hospitals and services programme.

10.57 Forty-two LIFT schemes have been set up. Seven more are in procurement. To date, over 100 primary care premises are open to patients with over

fifty more expected to open in 2007. NHS LIFT has now attracted over £1 billion of private capital investment and this level of investment will continue to grow in 2007-08 and beyond. This programme is supported by £210 million of public capital.

10.58 Examples of the new premises being built under NHS LIFT include:

- the £31 million St Peter's Centre in Burnley, which provides a joint health and leisure facility, including a swimming pool;
- Colchester Primary Care Centre, which has a renal dialysis centre, serving patients who would formerly have had to travel to London, Ipswich or Cambridge for treatment;
- Birmingham Road Health Centre in Sandwell provides nurse-led clinics for diabetes and leg ulcers; and,
- the new Heart of Hounslow Centre for Health has an innovative design whereby brilliantly coloured glass in the central atrium fills the space with light and colour, around which a wide range of services are provided.

10.59 The centres are more convenient for patients, particularly older patients and those with long-term conditions, as they offer care closer to home. In addition, these modern, spacious and hygienic buildings help improve the morale of staff and help to attract more GPs into inner-city areas.

10.60 During 2006, the Department bought out the Partnerships UK (PUK) stake in Partnerships for Health (PFH) thereby acquiring sole ownership of the LIFT investment vehicle.

## Asset disposal

10.61 The Department is continuing with the programme of disposal of surplus property in the ownership of the Secretary of State for Health. In doing so, the Department will continue to work closely with English Partnerships, both in respect of the portfolio of nearly 100 surplus sites transferred to them as part of a ground breaking agreement with the then ODPM in April 2005 (referred to in last year's Departmental Report), and also in respect of other surplus sites that would assist the Government's sustainable communities programme.

10.62 Income from central disposals has made a valuable contribution to the Department's capital funding in recent years. Income of around £100 million was received from land sales in 2006-07 including 'overage' payments from sales completed in earlier years.

## Investment in Personal Social Services

10.63 In social care, new investment has been primarily through revenue funding, which allows local authorities to commission, develop or purchase services, to launch joint funded partnerships and to develop innovation in social care. These goals may also be pursued through the use of the private finance initiative, for which PFI Credits are available to local authorities to help meet the capital cost of such developments.

10.64 For 2007-08, there have been further increases in the capital funding available to deliver personal social services comparable to those for the NHS. Not included in the above capital disposition is £121 million (£20 million more than in 2006-07), earmarked to support investment in personal social services, as well as £115 million of PFI Credits to support the development, via the private finance initiative, of typically larger social care investments. The £115 million PFI Credits allocation is net of £20 million of PFI Credits that were transferred to DfES in both 2006-07 and 2007-08 following the move of children's social services to that department.

10.65 Asset-based services can also be supported via the mechanisms set out in the 1999 *Health Act Partnership Arrangements*, which enable:

- pooled funds;
- lead commissioning;
- integrated provision; and,
- money transfer powers.

10.66 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.

# 11 Managing the Department of Health and Developing Policy

## Introduction

11.1 As described in chapter 1, the overall aim of the Department is to improve the health and well-being of the people of England. It has three distinct but interrelated roles:

- it is the major Department of State for a broad and complex range of governmental activity;
- it is the effective national headquarters of the NHS; and
- it is responsible for setting policy on public health, social care and a swathe of related topics from genetics to international work.

11.2 Furthermore, the Department supports the Secretary of State with delivery of her three main priorities for 2006-07 which are to:

- achieve financial balance by March 2007 for the NHS and the Department;
- support the NHS and social care to improve their services; and
- embed reform so people can start to see the benefits of it.

## Managing the Department of Health

11.3 Following a review of the challenges facing the next stages of reform of the health and care system initiated by the Secretary of State and the then joint NHS Chief Executive and DH Permanent Secretary, a number of changes were announced in early 2006 to the Department's structure and associated arrangements. During the first half of 2006, the Department took action to implement the conclusions of this high-level review of its top structure and capability. This included:

- development of the new Policy and Strategy Directorate;
- action to strengthen the challenge role of finance, including appointments to new posts of group and business finance controllers in support of the Director General, Finance and Investment;
- creation of new Directorates for Commissioning and for Provider Development;
- appointment of a Director General for Social Care, to lead a new directorate;
- expanded membership for the Departmental Management Board (DMB), and development of a new structure of board committees, to strengthen corporate governance; and
- new and stronger corporate support arrangements for the Department, based on a business partnering model.

11.4 Sir Nigel Crisp, joint NHS Chief Executive and DH Permanent Secretary, decided to retire in March 2006. Following this, Sir Ian Carruthers was appointed as acting NHS Chief Executive and Hugh Taylor as acting DH Permanent Secretary. It was subsequently decided to split the role permanently. The transitional arrangements continued through 2006, with David Nicholson taking up post as NHS Chief Executive in September 2006 and Hugh Taylor appointed as DH Permanent Secretary in December 2006.

11.5 The Permanent Secretary is responsible for the overall management of the Department's business while the NHS Chief Executive is responsible for the management of the health service. The Chief Medical Officer is the UK Government's principal medical adviser and is the professional head of all medical staff in England.

11.6 In addition, since July 2006, the Department has been structured around 18 directors-general who each head up a directorate and report directly to either the Permanent Secretary, the Chief Executive of the NHS, or the Chief Medical Officer as illustrated in the departmental structure diagram at the front of this publication.

11.7 The DMB is now supported by six committees:

- NHS Management Board;

- Policy Committee;
- Corporate Management Board;
- Finance Committee;
- Audit Committee; and
- Senior Pay Committee.

11.8 This reconfigured structure will also ensure that arrangements give the right profile to the Department's work on social care and to work with local government and other partners on health and well-being.

11.9 The Department is in tranche 4 of the Cabinet Secretary's programme of departmental capability reviews. The fieldwork of the Department's review is taking place in May 2007, with a report and the Department's action plan to follow in the summer.

## Administration costs and staffing tables

11.10 The administration costs for the Department, agreed in the 2004 Spending Review, reflected the reduction in size and shape of the Department as a consequence of the departmental change programme commenced in 2003. The changes support the ongoing transformation of the whole NHS and social care system.

11.11 The transitional costs of these changes were met by bringing forward expenditure to meet the early transitional costs and reprofiling the administration spending review figures for 2004-05, 2005-06 and 2006-07. These changes are reflected at **Figure A.5** (annex A, core table 5) which gives detailed information on departmental administration costs. Information on staffing levels is provided in **Figure A.6** (annex A, core table 6).

11.12 No maladministration payments were made in 2006.

## The DH risk register

11.13 Risk management remains at the heart of the new governance arrangements for the Department. During the last year, the Department has continued to maintain a high-level risk register, which is reviewed quarterly by the DMB.

11.14 The appropriate sub-committee of the DMB, or in some cases the relevant programme board, takes responsibility for ensuring that mitigation strategies are in place for all risks, and that these are followed through. To promote personal responsibility, board members retain ownership of risks in their respective policy and service areas.

11.15 The risks on the register are regularly updated through the Department's central programme and project management arrangements. These mechanisms, together with the Department's forward business planning exercises, enable emerging and new risks to be identified. Risks are also identified by the board itself.

11.16 The Department's Audit Committee also reviews risk management arrangement processes at each of its meetings. Its deliberations and subsequent actions have also contributed to keeping the risk register up to date.

11.17 The number of risks on the risk register has varied during the year as new risks have been added and other risks removed, usually because mitigation strategies have been successful. Key areas covered by the risk register over the past year have included:

- improving the capacity, capability and efficiency of the health and social care system, including work in the Department and the NHS to restore financial balance to the NHS;
- improving and protecting the health of the nation, including the work of the Department, alongside the NHS and other government departments, to prepare contingency plans for a possible flu pandemic;

- ensuring that system reform, service modernisation, IT investment and new staff contracts deliver improved value for money and quality by, for example, working with the NHS to promote staff engagement with reforms in IT and the workforce; and
- strengthening the Department's capacity to function as an effective Department of State, including work to prepare for an external capability review in 2007, and to ensure that the Department gives sufficient priority to the promotion of race equality in all aspects of its work.

## Non-departmental public bodies (NDPBs), special health authorities (SpHAs) and executive agencies

11.18 At national level, but at 'arm's length' from the Department, a network of organisations has been created to regulate the system, improve standards, protect public welfare and support local services.

11.19 These non-departmental public bodies, special health authorities and executive agencies continue to operate under measures introduced by the Government in 1998. These policies have increased the public accountability of the Department's arm's length bodies (ALBs) and strengthened public confidence in them. They each have members' codes, published registers of members' interests and internet sites. Where possible, and appropriate, they also hold open meetings and publish summary reports of meetings on internet sites, in annual reports or in press releases.

11.20 In 2004, the Department published proposals as part of a wider programme of change to improve efficiency and cut bureaucracy in the management of the NHS and free up more resources for the delivery of front-line services.

11.21 Between 2003-04 and 2007-08, the ALB change programme is reducing the number of ALBs from 38 to 19 by the end of 2008. This programme will reduce the number of posts by 25 per cent and redistribute £500 million of recurrent spend to the front line.

11.22 As a consequence, the 2006-07 budget for the ALB sector was set with recurrent costs of over £200 million a year less than 2003-04. Further significant savings are also planned in 2007-08 leading to delivery of the £250 million reduction in ALB costs when compared with their baseline costs and activity in 2003-04.

## Public appointments

11.23 The Department is responsible for public appointments in a wide range of bodies, as detailed in **Figure 11.1**.

### Figure 11.1: Public appointments sponsored by the Department – members in post at 1 January 2007

| Type of body | Chairs | Members | Total |
|---|---|---|---|
| Strategic health authorities | 10 | 42 | 52 |
| NHS trusts | 173 | 929 | 1,102 |
| Primary care trusts | 148 | 793 | 941 |
| Special health authorities | 9 | 187 | 196 |
| Advisory non-departmental public bodies | 30 | 399 | 429 |
| Executive non-departmental public bodies | 11 | 125 | 136 |
| Other bodies | 2 | 79 | 81 |
| **Total** | **383** | **2,554** | **2,937** |

11.24 As at 1 January 2007, the gender and ethnic balance and the proportion of non-executive board members who are disabled on the boards of public bodies for which the Department is responsible are set out in **Figure 11.2**.

### Figure 11.2: Public Appointments – Progress by gender and ethnic balance at 1 January 2007

| | |
|---|---|
| Total number of appointments | 2,937 |
| % of board members (including chairs) who are women | 39.1 |
| % of board members (including chairs) from black and ethnic minorities | 10.6 |
| % of board members (including chairs) who are disabled | 4.8 |

### The Appointments Commission

11.25 The *Health Act 2006* included provision for the creation of a new organisation, the Appointments Commission. The Appointments Commission was established on 1 October 2006 as a non-departmental public body. The NHS Appointments Commission's responsibilities transferred to the new Appointments Commission and they were also given powers to provide services in relation to public appointments for other government departments.

11.26 The Appointments Commission is responsible for the recruitment, selection and appointment of all public appointments to all local NHS boards (NHS trusts, primary care trusts (PCTs) and strategic health authorities (SHAs) and to the Department's non-departmental public bodies and special health authorities.

11.27 The Commission continues to manage the comprehensive appraisal programme for all of those it appoints, ensuring that they have access to the training and support programmes they need in order to be fully effective in their roles.

11.28 There have been a number of key developments affecting the future of the Commission itself. Although the new organisation has wider functions than those of the former NHS Appointments Commission, its main focus remains the provision of support to the Department in relation to public appointments and board governance. However, other government departments are now also able to benefit from the Commission's unique expertise and value for money in public appointment, recruitment and selection.

## Recruitment

11.29 Approximately two-thirds of the 2,300 staff of the core Department are based in London and around one-third in Leeds. The Department ranks second for the highest proportion of women at Senior Civil Service (SCS) level (40.5 per cent), and is already above the 2008 cross-Civil Service target of 37 per cent. In total, over half of the Department's staff are women.

11.30 Taking SCS staff in our agencies into account, the Department also ranks third for the highest proportion of black and minority ethnic (BME) groups at SCS level (8.8 per cent). Nearly 18 per cent of all departmental staff are from BME groups.

11.31 In compliance with departmental Human Resources policy, vacancies within the Department have continued to be advertised internally in the first instance. Where appropriate and necessary, some posts have also been advertised in parallel under fair and open competition both across Government and externally.

11.32 Any external recruitment has continued to be conducted on the basis of fair and open competition in accordance with the provisions of the Civil Service Commissioners' Recruitment Code. The aim at all times has been to ensure that the best person is appointed to each post. The Department's Human Resources Directorate and network of independent assessors have continued to work within the internal recruitment policy and Code in promoting good practice and compliance.

11.33 The number of appointments in external competitions is shown in **Figure 11.3** broken down by gender. Exceptions permitted under the Code were exercised on the following number of occasions:

- seven extensions, up to a maximum of 24 months, of appointments originally made for up to 12 months. These appointments were extended to enable the completion of work that required more time than originally estimated;
- 24 secondments;
- five extensions of secondments; and
- two reappointments of former civil servants.

### Figure 11.3: Recruitment into the Department of Health in 2006

| | Total | Male | Female |
|---|---|---|---|
| **Permanent staff joining in 2006 who were still employed by the Department on 31 March 2007** | | | |
| Senior Civil Service | 15 | 11 | 4 |
| Fast Stream | 21 | 9 | 12 |
| Posts at former UG6 and below | 121 | 53 | 68 |
| **Total** | **157** | **73** | **84** |
| **Permanent staff joining in 2006 who were no longer employed by the Department on 31 March 2007** | | | |
| **Total** | **42** | **18** | **24** |
| **All permanent staff joining in 2006** | | | |
| Senior Civil Service | 17 | 12 | 5 |
| Fast Stream | 22 | 10 | 12 |
| Posts at former UG6 and below | 160 | 69 | 91 |
| **Total** | **199** | **91** | **108** |

*Source: Personnel and Related Information System (PARIS)*

## SCS salaries

11.34 Details of SCS salaries for the Department of Health are given in **Figure 11.4**.

### Figure 11.4: Salaries of SCS staff in post in the Department of Health at 1 April 2006

| Payband (per annum) | Number of staff |
|---|---|
| £55,000 – £59,999 | 11 |
| £60,000 – £64,999 | 24 |
| £65,000 – £69,999 | 34 |
| £70,000 – £74,999 | 47 |
| £75,000 – £79,999 | 30 |
| £80,000 – £84,999 | 24 |
| £85,000 – £89,999 | 19 |
| £90,000 – £94,999 | 14 |
| £95,000 – £99,999 | 12 |
| £100,000 – £104,999 | 9 |
| £105,000 – £109,999 | 8 |
| £110,000 – £114,999 | 10 |
| £115,000 – £119,999 | 5 |
| £120,000 – £124,999 | 7 |
| £125,000 – £129,999 | 6 |
| £130,000 – £134,999 | 4 |
| £135,000 – £139,999 | 4 |
| £140,000 – £144,999 | 2 |
| £145,000 – £149,999 | 2 |
| Over £150,000 | 7 |
| **Total** | **279** |

*Source: DH Payroll System*

*Notes:*
*(1) Figures include staff on secondment out of the Department and exclude staff on secondment into the Department.*
*(2) Salaries include all pay-related allowances.*

## Expenditure on professional services

11.35 Expenditure by the Department and its executive agencies on professional services was around £304 million in 2006-07. See **Figure 11.5**. Following a change in the definition used by the Office of Government Commerce (OGC) for this expenditure, this figure includes expenditure on agency staff used for staff substitution and interim management. It also includes expenditure by executive agencies and Connecting for Health. The Department has improved its data collection systems, but the data should be regarded as an approximation. Further improvements are planned to the data collection systems to make the data more accurate in the future.

11.36 The NAO reported the Department's expenditure on consultancy as £126 million in 2005-06, based on the definition then used by the OGC in 2006 and excluding Connecting for Health. The equivalent figure for 2006-07 is around £141 million.

### Figure 11.5: Expenditure on professional services 2006-07

| Organisation | £ million Spend |
|---|---|
| Department of Health consultancy expenditure | 141 |
| Department of Health expenditure on agency staff for staff substitution and interim management | 63 |
| Executive agencies and Connecting for Health | 100 |
| **Total** | **304** |

*Notes:*
*(1) Expenditure is reported against the Office of Government Commerce (OGC) definition of professional services.*
*(2) Figures are an estimate based upon limitations in the current Departmental finance systems.*

## Accommodation and information & communication technology (ICT)

### Accommodation

11.37 The Department has embarked on a new Accommodation Strategy and will continue to rationalise its estate from the existing five buildings. The project to implement the strategy commenced in 2007 and is planned to be completed by 2011.

Work to complete the refurbishment of Quarry House in Leeds is planned to be completed during 2007.

### Relocation (Lyons Review)

11.38 The Department is committed to the Lyons target relocation of 1,030 whole time equivalent posts out of London and the South East by March 2010. The Department's original target of 1,030 has been reduced by 80 posts as a consequence of the transfer of the Mental Health Review Tribunal to the Department for Constitutional Affairs. By December 2006, 594 relocations had been completed.

11.39 Further relocation processes are also under way in the General Social Care Council and the Health &and Social Care Information Centre. These will be completed during 2007, increasing the Department's total contribution to around 660. In addition, around 180 core posts are expected to relocate to Quarry House, Leeds, although the exact timing has still to be determined.

11.40 The reorganisation of the Department's Information Services Division has been completed with a new structure and working arrangements in place. This includes improved governance, a closer relationship with the business with simplified points of engagement, and a focus on customer support and service. The contract with Computer Sciences Corporation for the supply and operation of the ICT infrastructure has been reviewed and extended for a further two years. This has resulted in improved value for money and provision of services.

11.41 To support the proposed move to an Enterprise Architecture provision of IT service, Information Services is undertaking analysis of its current business priorities, IT portfolio and applications infrastructure in order to facilitate the reuse of data, logic and infrastructure, thereby reducing the support burden whilst improving service delivery opportunities.

11.42 Information Services has also rationalised its arrangements for use of external project resources by implementing a framework agreement with the Sapient Corporation for the flexible provision of resources.

### Programme Showa

11.43 The Department is making significant investment, through Programme Showa, to improve the efficiency and effectiveness of its financial, procurement and HR functions, thereby enabling more accurate, focused and relevant management reporting. Programme Showa aims to provide efficiency gains in back-office headcount and lower operating costs, as well as its associated business improvements, and includes the outsourcing of the service to NHS Shared Business Services.

## Knowledge management

11.44 The Department continues to maintain and improve its corporate knowledge base. Building on the 2005 training and engagement programme, the Department's knowledge management programme has continued with a variety of corporate and local initiatives. As a result:

- all new entrants are invited to a knowledge management induction course and training on the main corporate systems is available for both new and existing staff;
- the knowledge management team have helped several divisions establish action plans and the network of Knowledge Management Champions established last year has helped to share experience and best practice; and
- a new knowledge management strategy for 2007 onwards was launched at a recent Knowledge Management Week, which coincided with events in all departmental buildings including workshops, surgeries and advanced training on a range of topics including corporate memory, storytelling techniques, information governance and programme management.

11.45 Increasingly, staff are benefiting from the wider use of collaborative working tools for sharing information at workgroup and project level. Information Services Division is also taking forward an initiative to improve document and records management, starting with a drive to reduce email box size and improve use of our electronic record system. A review of library provision has also led to rationalisation of two service points to a single centre permanently based in Leeds.

## Performance in responding to correspondence from the public

11.46 Since the centralisation of the correspondence function in 2004, the Department has become consistently high performing in handling the significant increase in the volumes of communications it receives. In 2006, the Department handled a:

- 29 per cent increase in ministerial correspondence;
- 20 per cent increase in letters and emails from the public; and
- 47 per cent increase in telephone calls answered.

11.47 **Figure 11.6** shows the performance targets achieved for letters addressed to ministers, emails received through the website and telephone calls received in the Customer Service Call Centre since 2002.

11.48 Looking ahead to 2007, volumes of correspondence are anticipated to remain high with NHS reconfiguration, finance issues, dental access and guidelines on drugs, amongst other issues, continuing to generate both Parliamentary and public interest.

### Figure 11.6: Correspondence from the public – achievement against performance targets

Percentage

| Type of correspondence | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Private office (PO) case[1] | 29.0 | 54.0 | 80.9 | 90.1 | 88.9 |
| Treat official (TO) case[2] | 35.6 | 67.2 | 88.0 | 97.3 | 92.3 |
| Departmental email (DE)[3] | 8.0 | 87.1 | 95.4 | 96.6 | 95.8 |
| Calls[4] | n/a | n/a | 42.0 | 76.1 | 88.1 |

*Source:*
*Correspondence: 2002-03 figures based on Cabinet Office Annual report for POs and cases recorded electronically since July 2002 for TOs and DEs. From 2004 onwards, all PO, TO and DE cases from Department of Health Correspondence Database. Figures include all cases with Whitehall Standard target date and exclude cases where no reply is required. Figures do not include cases for other government departments, or agencies which are reported separately.*
*Calls: Department of Health (DH) Callscan System. Figures include all calls taken during the period. Data is not available before 2004.*
*Footnotes:*
*(1) Letters signed by ministers.*
*(2) Letters signed by officials on behalf of ministers.*
*(3) Emails received through the Department's website.*
*(4) Telephone calls received in the call centre.*

## A healthier workplace

11.49 The Department is committed to helping and encouraging staff to think about their health and well-being both inside and outside work. The schemes that the Department has on offer have their roots in the *Choosing Health* White Paper and the *Health Challenge England* paper, as well as the Department's desire for a fitter and better motivated workforce.

11.50 The 2006 Staff Survey indicated that still more needed to be done to promote employee health within the Department. In response to this feedback it has launched Health Challenge for DH, a sustained programme of health-boosting schemes, such as tackling poor diet, lack of physical exercise, stress and work-life balance.

11.51 Two employee health events were held in February 2007, which provided advice on healthy living, as well as offering staff health checks and workshops on men's health, better backs and stress. Staff were also reminded of the availability of sporting facilities and the employee assistance programme already established by the Department, as well as the variety of policies to support flexible working, including flexi-time, part-time working, special leave and career breaks.

11.52 Top management are also engaged in improving staff work-life balance, and the Senior Leadership Team have signed up to take positive steps to respect people's work-life balance by setting meetings at reasonable times and using technology to limit travel.

### Health and safety policy

11.53 The Department's Health and Safety Unit (H&SU) is part of the IS Accommodation and Building Services Branch (ABS). The Department continues to provide health and safety advice and guidance to all our employees. The Department's facilities management providers also have a key role to play in ensuring Departmental buildings are safe for employees to work in. This role is managed by ABS and the H&SU through the facilities management contract.

11.54 The Departmental health and safety policy continues to be revised in line with current regulations and good practices. As part of this the Department has completed a series of fire risk assessments to ensure that it complies with the new *Fire Reform Order.*

11.55 Training activities, including fire warden, workstation risk assessor and first aid training, have been promoted and delivered successfully over the last year. The H&SU actively participated in the successful employee health road shows, providing health and safety advice and guidance to staff, together with an in-house free eyesight testing service.

11.56 A system of regular inspection and meetings involving the trade's union side, staff representatives and the H&SU continues to operate with success in the Department's buildings.

11.57 An electronic accident reporting system has been operational since the 1 July 2006. **See Figure 11.7.**

**Figure 11.7: Department of Health accident statistics for 2006**

| | Number |
|---|---|
| Total reported accidents | 30 |
| Of which: | |
| Resulting in absence [1] | 3 |
| Total reported near misses [2] | 3 |

*Footnotes:*
*(1) Two absences were RIDDORS. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurences Regulations. Reports are sent to the Health and Safety Incident Centre.*
*(2) Near misses are any unplanned occurrence that does not lead to injury of personnel or damage to property, plant or equipment, but may have done in different circumstances*

## Sustainable policy and operations

### Sustainable development

11.58 The Department funded the Sustainable Development Commission's (SDC) *Healthy Futures* programme during 2006-07, to support and develop the NHS contribution to sustainable development and public health. Central to *Healthy Futures* is the NHS' Good Corporate Citizen self-assessment model. Developed by the SDC, this web-based interactive model enables NHS organisations to self-assess their performance, receive a score of their progress and receive advice. The model encapsulates and builds on existing work and is structured around the areas of procurement, employment and skills, community engagement and partnership working, buildings, facilities management and transport.

11.59 The Department's Estate and Facilities Division continues to provide advice and guidance to promote the sustainable development agenda across the NHS in England to ensure that environmental considerations are taken into account in the activities and services of the NHS. Work has been ongoing in this area since 2002. In 2006-07, *Transport and Car Park Management* guidance and a UK-wide joint agencies document *Safe Management of Healthcare Waste* were issued.

11.60 In accordance with the Government's commitment towards climate change, the NHS was set stretching mandatory energy and carbon

efficiency targets. This is to achieve, by March 2010, a 15 per cent energy efficiency saving and also to achieve performance indicator standards for new builds and refurbishments and for the existing estate. A mid-term analysis of progress towards the target shows that with an increasing estate and increasing service provision, the NHS might not meet this target.

11.61 The NHS Environmental Assessment Tool is being developed and reviewed with a view to producing a more demanding accreditation tool that will be available during 2008 to encourage and facilitate a more dynamic approach to sustainable construction within the healthcare sector. The NHS in England will continue to receive advice and guidance to address waste management and water management and conservation.

11.62 In 2006-07, the Sustainable Procurement Task Force's (SPTF) report and the UK Government's response and *Sustainable Procurement Action Plan* (SPAP) were published. The Department published an interim response for health and social care as part of the Government's SPAP. A full response will be published in the summer of 2007 following wider consultation. Procurement is a key feature of our *Sustainable Development (SD) Action Plan* (DH, March 2006). In relation to wider procurement in the NHS, the NHS Purchasing and Supply Agency (PASA) continues to lead through the development of training, research, best practice and guidance, and engagement with sustainable procurement initiatives at a national and regional level (see www.pasa.nhs.uk). NHS PASA and the Department continue to work closely with other government departments to identify and share best practice.

11.63 The Department's *Sustainable Development (SD) Action Plan* commits the Department to sustainable action on both operational performance, and on policy issues. The action plan was reviewed by the SDC, which assessed it to be 'gearing up', the second category from top (see www.sd-commission.gov.uk). The Department itself regularly reviews progress and delivery of the plan. A report and new action plan for 2007-08 will be published in 2007. A high-level steering group has been established, to ensure that sustainable development principles and priorities are incorporated into all departmental policy. The group will also consider whether and how to build sustainable development into future performance regimes, including consideration of the role of regulators.

### Sustainable operations

11.64 The SDC report *Sustainable Development in Government* (SDC, March 2007) presents the findings for all Government departments based on data submitted for 2005-06 (see www.sd-commission.org.uk). This placed the Department of Health in second place, after DTI. The Department has shown strong performance in maintaining low water consumption and in reducing its overall energy consumption and waste. Effort will be concentrated on areas of low performance in the future in particular in obtaining accurate travel data, and in fully implementing environmental management systems in our main buildings.

11.65 In May 2006, new government operational targets were published, requiring activity in the priority areas of climate change and energy; sustainable consumption and production; and natural resource protection. The Department is committed to achieving the targets, and is currently developing policies to ensure that it succeeds. A separate Operational Action Plan has been produced and will be incorporated into the Department's next *Sustainable Development Action Plan*

## Global and EU developments

### Health is global

11.66 Global health has risen fast up the international agenda in recent years. Emerging public health risks such as SARS, avian and pandemic flu, the economic and social burden on

developing countries of diseases such as malaria and HIV/AIDS and the increased burden to national security caused by major disasters all make the need for cooperation with our international partners to generate solutions more important now than ever before.

### UK engagement in the World Health Organization (WHO) and other global health bodies

11.67 The Department is responsible for coordinating the Government's engagement with WHO. Key UK objectives include building pandemic influenza preparedness, combating the global rise of obesity, diabetes and other non-communicable diseases, and tackling the root causes of ill health and health inequalities. Working closely with the Department for International Development, the Department seeks to influence WHO's policy and activity through contacts at all levels.

11.68 In 2006-07, the UK chaired the Standing Committee of WHO's European Regional Office and from May 2007 to 2010, the UK will become a member of the WHO Executive Board, one of its principal decision-making bodies. Preparations are ongoing for the UK's participation in the 2008 WHO European Ministerial Conference, which will discuss how to strengthen health systems to cope with challenges such as the rising burden of non-communicable diseases and an ageing population.

11.69 The Department has also been working regularly with other international organisations, such as the Council of Europe, Commonwealth Secretariat, Global Health Security Initiative and the Commonwealth Fund, to combat global health risks.

### Towards a global health strategy

11.70 The Chief Medical Officer published a report *Health is Global: Proposals for a UK Government-wide strategy* (DH, March 2007) with the aim of stimulating a wide debate about the importance of global health and what the Government's priorities should be in this area. The Department is leading the follow-up work to develop the Government's global health strategy.

11.71 In February 2007, Nigel Crisp completed, at the request of the Prime Minister, a review of how the NHS might contribute to improving health in developing countries. An Inter-Ministerial Group, chaired by health ministers, is overseeing implementation of his recommendations.

### Health in the European Union

11.72 The past year has seen some notable developments in Europe on health. Historically, work on health in the EU has focused on the public health agenda. European court judgments such as the Watts case and developments stemming from the Lisbon Agenda have prompted wider consideration of health services and the movement of patients and professionals. Meanwhile, the introduction of the European Health Insurance Card in the UK has gone from strength to strength, winning a national award for Best Government IT Project.

### Health services and the EU

11.73 The Department was active in 2006 in developing a statement of the values and principles that are common to the health systems of all of the EU member states. This was endorsed by EU health ministers in June 2006. The statement recognised areas where there are similarities between health systems and areas where there could be great benefit in exchange of best practice and information. The statement also emphasised the important differences between the organisation and delivery of health services across the EU, and the key principle that it is for each member state to make decisions about how health services are provided nationally.

11.74 This statement has helped to frame the discussion currently taking place in Europe about the need for further legal clarity on how people move around the EU in order to seek medical treatment. Following the 'Common Values and Principles' statement, the European Commission published a communication and consultation document on possible Community action in this area. The Department ran a consultation on this document in the UK, and has worked to engage a wide range of stakeholders on this issue. A follow-up to the communication is expected later in 2007.

### Patient mobility and the Watts case

11.75 The European Court of Justice delivered its judgment on the case of Mrs Yvonne Watts in May 2006. This high profile judgment confirmed that European case law on the rights of patients to seek elective treatment in another EU member state applies to tax-funded health systems such as the NHS.

11.76 The Department has been considering the implications of the judgment over the past year and guidance was issued to the NHS and the public at the end of April, and will provide clear, succinct advice on managing requests from patients for treatment in another EU member state.

### The European Health Insurance Card (EHIC)

11.77 The successful introduction of the EHIC, which allows UK residents travelling in most European countries to show that they are entitled to receive treatment that becomes necessary during their trip, was awarded the BT Government Computing Award for best 'Government to Citizen' project in April 2006.

11.78 By the end of January 2007, the EHIC project had delivered 23.5 million cards to people in the UK. The number of online applications has continued to be exceptionally high and is the most popular method of application.

## Emergency preparedness

11.79 In the field of emergency preparedness, the Department is continuing to develop and improve its capacity to contribute to both cross-Government and international work on meeting the challenges of terrorism and other major emergencies

11.80 Through its Emergency Preparedness Division, the Department provides effective leadership, guidance and direction to the NHS and other key stakeholders. This work is a part of the Department's role in cross-government and international collaboration on the response to terrorism and other emergency situations.
In particular, work continues on strengthening UK defences and building UK resilience to manage the consequences of major emergencies, particularly through issuing guidance, funding relevant training and development, and promoting and taking part in regular exercises to test plans and procedures.

11.81 In 2006, work concentrated on personal protective equipment (PPE), hot zone working, children's needs, clinical leadership and reassessing the training needs for emergency services. Guidance and leaflets were issued on the treatment and management of mass casualties, and addressing current gaps in insurance cover for NHS staff responding to acts of terrorism.

11.82 A National Capabilities Survey was also undertaken to assess cross-government, multi-agency resilience. The process of issuing improved PPE suits for use by emergency service staff was begun – this equipment enhances the NHS' ability to provide an effective onsite response to major incidents. The training of emergency responders to chemical, biological, radiation and nuclear (CBRN) incidents was funded by the Department, as was a pilot project to allow health intervention at an incident involving contamination. The Department also funded various exercises aimed at testing levels of preparedness for a major incident, such as a pandemic influenza outbreak.

11.83 Work in 2007 will focus on further developing a number of the projects begun in 2006. The roll-out of improved PPE suits for use by emergency service staff is scheduled to be completed and work is already under way on an Urban Search and Rescue (USAR) programme to train ambulance staff to treat casualties in collapsed structures and hazardous situations. Guidance on *Planning for Emergencies Involving a Significant Number of Children* is also scheduled to be published which will result in paediatric equipment and drug doses being available in sufficient quantities. The development of guidance on bomb and blast injuries and evacuation and sheltering will be undertaken. The expert Emergency Planning Clinical Advisory Group will continue to provide specialist advice to the Department on issues relating to the delivery of clinical care within the NHS' response to a major incident. The training of emergency responders to CBRN incidents will also continue to be an important focus.

## Scientific developments and bioethics

### Stem cells

11.84 Progress on the UK Stem Cell Initiative's recommendation 1 continues. The recommendation called for the establishment of a public private partnership to develop predictive toxicology tools from stem cell lines.

11.85 A consortium consisting of Government (DH, DTI, The Scottish Executive, The Medical Research Council and The Biotechnology and Biological Sciences Research Council) and industry partners is working to establish a not-for-profit company, which will be called Stem Cells for Safer Medicines (SCFSM). The company will be led by a small company board, with an independent chair, which will report to a council of founder members. The work of the company will be further supported by an Ethical Review Board and a Scientific Advisory Board. There will be a pilot phase, which is expected to be about two years, with a whole life project time of up to six years (pilot phase plus four years).

### Human fertilisation

11.86 In December 2006, the Government published proposals for revised legislation on assisted reproduction and embryo research. The document is called *Review of the Human Fertilisation and Embryology Act – Proposals for Revised Legislation (including Establishment of the Regulatory Authority for Tissue and Embryos)* and follows an extensive review of the present law, the *Human Fertilisation and Embryology Act 1990*, which began in 2004.

11.87 The document also includes further details on the proposal to create the Regulatory Authority for Tissue and Embryos (RATE), which will replace the regulatory bodies the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA).

11.88 A draft Bill containing the Government's proposals based on the results of the consultation will go through the Parliamentary scrutiny process in 2007.

11.89 Ahead of legislation and in recognition of the ALB target date of April 2008, a single chair of both organisations, Shirley Harrison, has now taken up post and work to bring the two organisations together is gathering speed. A number of project groups have been established to ensure closer and strategic working. The groups involve colleagues from the Department, HTA and HFEA and concentrate on all aspects of the day-to-day workings of both organisations. A decision on a future single location for both organisations is also nearing completion.

### Genetics

11.90 Three years on from the publication of the genetics White Paper *Our Inheritance, Our Future – Realising the Potential of Genetics in the NHS*, most of the commitments are well on track to deliver. For example, following investment to modernise and

expand laboratory capacity most genetic test results can now be turned round in less than eight weeks, delivering a significant improvement in the waiting time for these complex tests.

11.91 In line with the commitment in the White Paper we are now reviewing progress in implementing the various initiatives. There have also been further developments in genetic science, technology and healthcare that may have the potential to deliver real benefits for patients so this is the right time to take stock and assess what will be needed for the future. Reviews of specific initiatives have already confirmed the value and continuing need for the work of the National Genetics Reference Laboratories and the National Genetics Education and Development Centre and we will be renewing and extending the contracts for this work. Once the review is completed the genetics team will take the recommendations forward.

11.92 The Genetics and Insurance Committee (GAIC) and the Gene Therapy Advisory Committee (GTAC) will continue with their work in 2007. The Human Genetics Committee contributed to the Government's review of the Genetics White Paper in late 2006. The committee will continue to provide advice on the social, ethical and legal implications of new developments in human genetics over the coming year.

## Modernising Government Action Plans

### Better regulation

11.93 The Department is committed to ensuring the delivery of its priorities through better regulation. This includes developing and implementing an ambitious better regulation programme, which enhances public confidence and reduces burdens on business, charitable and voluntary sectors as well as on front-line public sector staff.

### Better regulation culture governance

11.94 The better regulation agenda is supported by a departmental board-level Better Regulation Champion and a better regulation network of senior officials throughout the Department. Delivery of the agenda is overseen by the Department's Policy Committee, a committee of the DMB, and is supported by the Better Regulation and Simplication Branch in the Secretariat. Supporting action includes:

- the development of a better regulation checklist for private offices and officials;
- a programme of training events for staff involved in policy and regulatory work to familiarise them with the new regulatory impact assessment process and the Simplification Programme and Plan;
- the Departmental External Gateway and financial challenge panel for public sector policy proposals; and
- a new e-learning tool developed for better policy making which reinforces the importance of early regulatory impact assessment.

### Simplification Plan and Administrative Burdens Measurement Exercise (ABME)

11.95 The Government agreed to the recommendations of the report of the Better Regulation Task Force *Less is More* and of the *Hampton* report on inspection and regulation. Therefore, the Department (like other government departments) took part in the Administrative Burdens Measurement Exercise and published a simplification plan.

11.96 The administrative cost of compliance with the Department's 90 regulations and codes of practice in force in May 2005, affecting business, charities and voluntary organisations, was assessed as £1.2 billion. The Department has agreed to aim for a net reduction of 25 per cent (i.e. £300 million) by March 2010.

11.97 The Simplification Plan sets out how the Department proposes to deliver its key priorities through better regulation over the next four years. The programme covers work to reduce regulatory burdens on NHS and social care front-line services and our private and voluntary sector partners. This will be done whilst continuing to safeguard public health, ensuring medicines are safe and effective and those providing care services continue to ensure protection for the vulnerable and elderly.

11.98 The plan builds on the Department's tradition of reducing bureaucracy in the NHS, and activities for the NHS and social care include:

- producing a recurrent saving of £250 million in the costs of administration and management across the NHS, to be reinvested in services in 2008-09;
- rationalisation of the number of arm's length bodies by half;
- reducing the burden of data collection;
- working jointly with Cabinet Office and other government departments to develop a new comprehensive action plan for better regulation in public services;
- continued work by the Departmental External Gateway. The total of new plan requirements, targets, collections or directions stopped by the Gateway since August 2003 is now over 1,000. The Department has undertaken further pilot work to establish a baseline of data collection activity in the NHS and to measure both the source of the data requests and the burden they generate for NHS staff; and
- pilot work by the Department with front-line staff to test the effectiveness of using diary studies as a potential success measure.

11.99 The plan also sets out initial steps towards the target reduction in the administrative burden on the private sector, including:

- over £100 million estimated savings through local risk improvements and reforms in pharmaceutical regulation, including the Better Regulation of Medicines Initiative (BROMI); and
- the wider review of health and social care regulations (see chapter 4).

### Better Regulation Europe

11.100 The EU Commission adopted the *Action Programme for Reducing Administrative Burdens in the EU* in January 2007. The programme envisages measurement of the administrative costs of regulation within a selected group of policy areas, following which, at the end of 2008, a burdens reduction plan will be prepared. Legislation affecting pharmaceuticals is listed as a priority area for measurement. The Medicines and Healthcare produces Regulatory Agency (MHRA), with industry support, is working to influence negotiation of new or amending European legislation.

### Regulatory impact assessments (RIAs)

11.101 The Department published 24 RIAs on its website in 2006-07, in addition 22 full final RIAs which accompanied regulations were placed in the libraries of both the Houses of Parliament. The Department's compliance with the RIA process was 100 percent during this period. No legislation introduced by the Department included a sunset clause (sun setting allows a law to be removed automatically after a fixed period unless action is taken to keep it in place).

11.102 Regulatory measures which stem from the EU supported RIAs included the:

- introduction of picture warnings on tobacco packs;
- adaptation of medicines for paediatric use;
- proposal for a Regulation of the European Parliament and of the Council on advanced therapy medicinal products and amending Directive 2001/83/EC and Regulation (EC) No 726/2004; and

- implementation of EC reclassification of medical devices for hip, knee and shoulder joints.

### Legislation

**11.103** Five Department of Health Bills (*The NHS Redress Bill 2005, The Health Bill 2005, NHS Bill 2006, NHS (Wales) Bill 2006, and NHS (Consequential Provisions) Bill 2006*) received Royal Assent during 2006-07.

**11.104** The Department made 131 Statutory Instruments (including Orders that are not laid before Parliament) during the period April 2006 to March 2007.

### Regulatory reform orders (RROs)

**11.105** One regulatory change – the removal of the cancer cures consent regime – is being taken forward as part of an umbrella order under the *Regulatory Reform Act 2001*, addressing several local authority consent requirements and being coordinated by the Department for Communities and Local Government. The RRO is scheduled to be laid in spring 2007.

### Post implementation reviews

**11.106** During 2006-07, the Department and its agencies began a number of reviews including the following:

- statutory warnings on medicines labelling;
- *Medicines Act* legislation;
- primary medical care contracting arrangements; and
- European Commission Directive on the Reclassification of Breast Implants in the Framework of Directive 93/42/EEC on Medical Devices (Directive 2003/12/EC).

### Taking a more risk-based approach to enforcing regulation

**11.107** In 2006, and in keeping with *Hampton* principles, the Department amended existing regulations to introduce a new risk-based assessment of services by the Commission for Social Care Inspection (CSCI), enabling it to focus inspection effort where it is most needed. As a result the inspection frequency of care homes and other providers of social care services is now a minimum of once every three years allowing CSCI to inspect higher quality providers less often than those needing attention. This measure will significantly reduce the overall volume of inspection as well as the effort needed by providers to prepare for, and undergo, on-site inspections.

**11.108** The MHRA also continued to develop a more risk-based approach to regulation, which it commenced in 2005. When fully implemented, this new risk aware approach will result in significant savings for some sectors of the pharmaceutical industry, as both the frequency of inspection and the time spent on site during an inspection will reduce for low-risk companies.

**11.109** During 2006, the Department also consulted on proposals to rationalise the number of health and adult social care inspection bodies to allow for substantial reductions in the amount of inspection and associated cost and burden, and also to enable regulation and inspection activity to focus on what is relevant to the people who use these vital public services. The Department is taking forward work to merge the Healthcare Commission, CSCI and the Mental Health Act Commission in 2008, subject to primary legislation.

### Public consultations

**11.110** The Department has continued to promote active engagement in consultations, being inclusive, and adopting innovative methods, but much of the Department's public-facing work has followed on from the previous year's *Your Health, Your Care, Your Say* consultation, and there have been no further consultations of similar scope or complexity. However, some consultations have made use of electronic templates for responses and a number of consultations have made provision for direct on-line responses.

11.111 The Department undertook 37 public consultations in the year from 1 April 2006. Almost three-quarters of these met the 12-week minimum consultation period. Of the ten consultations that did not meet this requirement, seven were either technical consultations with an extremely limited audience or short consultations within a policy process which had previously included a full-length consultation.

## Equality and human rights

### Disability and gender equality scheme guides

11.112 During 2006-07, the Equality and Human Rights Group (EHRG) published two guides to help NHS organisations comply with new legislation which places a positive duty on public organisations to promote disability and gender equality and provide evidence within their scheme for how this is being met:

- *Creating a Disability Equality Scheme: A Practical Guide for the NHS*, published in October 2006, provides best practice advice on producing a disability equality scheme (DES) as required by the disability equality duty which came into effect on 4 December 2006; and
- *Creating a Gender Equality Scheme: A Practical Guide for the NHS*, published in February 2007, provides best practice advice on how NHS organisations might produce a gender equality scheme (GES) as required by the gender equality duty which came into effect in April 2007.

### Department Single Equality Scheme (DH SES)

11.113 The Department, as part of meeting its duties under the *Disability Discrimination Act 2005*, has produced a scheme which sets out how the Department will progress action on discrimination across the six equality strands, including disability. A stakeholder event, seeking to consult and involve disabled people in the production of the DH SES, was held and the subsequent agreed actions incorporated into the DH SES and action. Further consultation events will be held to obtain feedback before the final launch in June 2007.

### NHS Single Equality Scheme Learning Site Project

11.114 In order to support NHS organisations in delivering the equalities agenda and complying with current and imminent public sector duties, the EHRG is providing support and guidance for SHA Equality Leads and selected 'learning sites' (NHS organisations) across the service.

11.115 Most organisations may have developed, or are developing, their own race, disability and gender schemes. In consideration of this and in anticipation of further duties in relation to age, religion and belief and sexual orientation, the project aims to support the equalities agenda in a coherent and cross-cutting way, without diluting any of the individual equality strands, through the development of single equality schemes (SES).

11.116 The learning, development and outcomes from the learning sites are shared and disseminated throughout the NHS principally via the '10 Steps to Developing Your SES' webpage on the Department's website: www.dh.gov.uk/en/PolicyAndGuidance/Equalityandhumanrights/Browsable/DH_066006

11.117 The selected sites reflect a diverse range of NHS organisations:

- a good geographical spread mirroring the new SHA and PCT configurations and complementary to existing equalities programmes. So far the sites are drawn from London, the North and South, urban and rural locations;
- learning sites are broadly representative of the different types of NHS organisations, i.e. NHS foundation trusts, PCTs, ambulance services, and acute and mental health trusts;
- learning sites reflect a broad spectrum of progress and approaches to the SES; and

- 'buddying up' to engage a wider audience, spread the learning and increase capacity of the project.

### Department of Health and Disability Rights Commission Partnership Framework

11.118 The Department, in partnership with the Disability Rights Commission (DRC), has formed a partnership framework, within which is the commitment to conduct forums to invite stakeholders:

- to review progress and make recommendations for future priority setting;
- to spotlight national disability equality developments for health and social care and showcase examples of best practice; and
- to commence a comprehensive evaluation of the Department and DRC Partnership Framework.

### Commission for Racial Equality (CRE) Action Plan

11.119 The CRE has informed the Department that it is minded to formally investigate the Department's performance in meeting its statutory duties, particularly in conducting race equality impact assessments. In response, the Department has developed a detailed action plan addressing the CRE's concerns and is taking forward a range of measures to improve its performance on conducting and publishing race equality impact assessments. The Department is now in discussion with the CRE as to how best to take this forward.

11.120 Delivering on race equality in relation to patients, the public and staff is central to the work of the Department, NHS and social care. The Department takes its race equality responsibilities very seriously and acknowledges that there is a lot more to do including the work identified by the CRE. The robust CRE action plan will ensure that the Department embeds the race duties more firmly into policy development and programme and project management, and that equality impact assessments are routinely carried out and published, and genuinely better inform policy and legislation. The plan also sets out the actions that will be taken to ensure full compliance with the race relations employment duty.

11.121 The action plan includes:

- a review of the Department's Public Service Agreements to ensure that we are promoting race equality in their delivery;
- the establishment of an advisory panel made up of employees and external experts to strengthen current internal arrangements on equality impact assessment of emerging policies. Several departmental policy teams are currently engaged with this piece of work and the EHRG will be looking at mechanisms to embed and raise awareness of equality impact assessments across the Department;
- a review of the Department's 2005 to 2008 Race Equality Scheme Action Plan. The plan will be revised as part of the single equality scheme (final version to be published in April 2007);
- close working with other Whitehall departments to learn from their experience, with regular events to raise awareness being held; and
- working with national directors and key policy teams to ensure that they integrate equality and human rights issues into all their programmes.

### Pacesetters Programme

11.122 During 2006, the EHRG worked closely with four SHAs on the flagship Pacesetters Programme (West Midlands, East Midlands, Yorkshire and the Humber and South West). The Department is also in negotiation with a further two SHAs concerning participation in the programme during 2007.

11.123 Pacesetters is a three-year programme which aims to deliver equality and diversity improvements and innovations resulting in:

- patient and user involvement in the design and delivery of services;

- reduced health inequalities for patients and service users; and
- working environments that are fair and free of discrimination.

11.124 Within each SHA, three trusts have been identified to specifically participate in the programme. The programme was formally launched in the West Midlands on 13 November 2006. Further local launches are being planned for April and May 2007.

11.125 Each SHA and its three participating trusts will be working on a range of local and core issues. The core elements of the programme cover both workforce and patient care issues. Each participating trust will actively work on three key local issues each one with a patient user focus. The aim of the programme is to test innovative approaches that reduce health inequalities for minority groups and embed equality and diversity into all NHS activities.

11.126 In 2006-07, each of the participating SHAs was allocated £200,000 to assist them in making Pacesetter Lead appointments and to take forward work on identifying the local change ideas they wish to tackle. The long-term aim is to spread effective learning and change across the NHS.

### Engaging with faith communities

11.127 The Department is aware of the diverse health needs within communities and the key role played by faith organisations in supporting the NHS and social care organisations to improve the health and well-being of local people. The Department maintains close contact with a Multi-Faith Group as part of our commitment to a multi-faith approach to NHS chaplaincy. The Department continues to engage faith communities in public health campaigns. For example, it commissioned a *Ramadan Health and Spirituality Guide*, which was launched at Tower Hamlets PCT in September 2006. The Department also commissioned two workshops aimed at strengthening faith and minority ethnic groups' capacity to deliver health and social services (including promoting greater access to our Section 64 Scheme of Grants).

### Mosaic

11.128 The Mosaic project (details available at www.mosaic.nhs.uk) was established in partnership with South East London Strategic Health Authority in 2004 to promote race equality through and in procurement. The project focuses on three main areas:

- working with NHS organisations and staff;
- working with NHS prime or first tier suppliers and getting them to understand the legal responsibility to the *Race Relations Act* (RRA) and review their own work practices in relation to BME communities; and
- promoting the use of small and medium-sized enterprises, and BME suppliers in particular.

### Sexual Orientation and Gender Identity Advisory Group

11.129 The Department has continued to work with external stakeholders on the development and delivery of a programme of work to promote equality and eliminate discrimination for lesbian, gay, bisexual and transgender (LGBT) people in health and social care (as both service users and employees). In June 2006, the Department launched a number of resources (available at www.dh.gov.uk/EqualityAndHumanRights ) to support the strategy, including:

- *Real Stories, Real Lives: LGBT People and the NHS:* a DVD to be used as a practical tool in training staff and raising awareness;
- *Core Standards for Training on Sexual Orientation* (by Diverse Identities);
- *Monitoring of Sexual Orientation in the Health Sector* (by Stonewall);
- *Harassment and Sexual Orientation in the Health Sector* (by Stonewall); and

- *Reducing Health Inequalities for Lesbian, Gay and Bisexual People: Evidence of Healthcare Needs* (by Stonewall).

11.130 The Department was also a sponsor of the inaugural National LGBT Health Summit. The summit, held in London on 16 and 17 June 2006 with 150 delegates from across the UK, highlighted key health issues and inequalities facing LGBT communities.

### Human rights

11.131 The Department is working in partnership with the British Institute of Human Rights and several NHS organisations with the aim of bringing together existing and developing best practice into a framework that can be used by organisations across the NHS to help them in taking forward a human rights based approach in delivering services. The project is successfully working with several trusts including Southwark PCT, Heart of Birmingham Teaching PCT, Mersey Care NHS Trust, Tees, Esk and Wear Valleys NHS Trust and Surrey and Borders Partnership NHS Trust to develop a human rights framework that can help other organisations in the NHS use a human rights based approach to improve service planning and delivery.

### Race for Health

11.132 The Race for Health programme enables PCTs to make the health service in their areas significantly fairer for BME communities. The programme supports a network of 13 PCTs around the country, working in partnership with local BME communities to improve health, modernise services, increase choice and create greater diversity within the NHS workforce. Through community engagement and leadership, it aims to make significant improvements in delivering race equality in:

- the workforce, from recruitment to retention and promotion, tackling 'snow-capping';
- commissioning, including the planning, designing and buying-in of services and products; and
- service improvements, making significant progress in tackling the real inequalities in the access, experience and health outcomes experienced by BME people.

11.133 The overarching theme for Race for Health during 2006-07 was 'Commissioning, Community and Cohesion'. The Race for Health National Conference on 22 and 23 November 2006 involved working in partnership with the King's Fund on the business case for race equality and with the Institute for Community Cohesion on the challenges and rewards for the NHS in promoting community cohesion. The conference also explored why race equality is vital to healthcare commissioning and was preceded by the launch of *Towards Race Equality in Health*, the Race for Health guide to policy and good practice for commissioning services.

11.134 Race for Health has now agreed to recruit an additional set of PCTs that are being 'twinned' with the existing 13 PCTs. Members have undertaken focused work to ensure full compliance with legislative duties on equality. Member PCTs continue to host regular peer review visits to examine the wider work on race equality that has been undertaken locally to take forward the Race for Health vision of an NHS in which the health needs of BME people drive the health services that they receive.

### NHS SHA Equality Leads

11.135 The Department continues to support SHAs and their local NHS organisations in promoting the equality and human rights agenda across the NHS by bringing together SHA Equality Leads to discuss and consult on equality issues.

# A Core Data Tables

## Figure A.1: Department of Health public spending (core table 1)

£ million

| | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 estimated outturn | 2007-08 plan |
|---|---|---|---|---|---|---|---|
| **Consumption of resources** | | | | | | | |
| NHS | 51,994 | 55,405 | 61,865 | 66,873 | 74,168 | 78,869 | 87,598 |
| Personal social services | 729 | 1,590 | 1,617 | 2,110 | 2,070 | 1,830 | 1,930 |
| NHS pensions [1&2] | 3,949 | 4,569 | 6,194 | 6,396 | 9,281 | 10,267 | 14,305 |
| NHS (AME) | 45 | 57 | 60 | 30 | 74 | 135 | 150 |
| Credit guarantee finance (AME) [3] | 31 | 39 | 40 | 24 | 54 | 82 | 93 |
| **Total Department of Health resource budget** | **56,749** | **61,660** | **69,776** | **75,435** | **85,647** | **91,183** | **104,077** |
| *Of which:* | | | | | | | |
| Department of Health Departmental Expenditure Limit (DEL) | 52,723 | 56,995 | 63,480 | 68,983 | 76,238 | 80,699 | 89,529 |
| *Of which Near Cash* | 49,027 | 54,459 | 61,178 | 68,784 | 74,192 | 78,007 | 85,653 |
| *Of which Non-Cash* | 3,696 | 2,536 | 2,304 | 199 | 2,046 | 2,692 | 3,876 |
| **Capital Spending** | | | | | | | |
| NHS [4] | 1,719 | 2,073 | 2,602 | 2,624 | 2,151 | 3,544 | 4,177 |
| Personal Social Services | 93 | 72 | 84 | 83 | 92 | 122 | 143 |
| NHS (AME) | | | | 229 | 292 | | |
| Credit Guarantee Finance (AME) [3] | | | | | 357 | 96 | 52 |
| **Total Department of Health Capital Budget** | **1,812** | **2,145** | **2,686** | **2,937** | **2,893** | **3,762** | **4,372** |
| *Of which:* | | | | | | | |
| Department of Health Departmental Expenditure Limit (DEL) | 1,812 | 2,145 | 2,686 | 2,478 | 1,952 | 3,666 | 4,320 |
| **Total Public Spending in Department of Health [5]** | **58,333** | **63,470** | **72,170** | **77,941** | **88,040** | **94,194** | **107,354** |
| *Of which:* | | | | | | | |
| NHS [6&7] | 53,486 | 57,152 | 64,183 | 69,078 | 75,829 | 81,672 | 90,702 |
| Personal Social Services [8] | 822 | 1,653 | 1,693 | 2,182 | 2,153 | 1,936 | 2,061 |
| NHS Pensions | 3,949 | 4,569 | 6,194 | 6,396 | 9,281 | 10,267 | 14,305 |
| Credit Guarantee Finance (AME) [3] | | | | 24 | 411 | 178 | 145 |
| **Spending by local authorities on functions relevant to the Department** | | | | | | | |
| **Current** | **11,457** | **12,931** | **14,748** | **16,121** | **17,243** | **17,565** | |
| *Of which:* | | | | | | | |
| Funded by grants from the Department of Health | 1,133 | 1,881 | 1,816 | 2,148 | 2,141 | 1,759 | |
| **Capital** | **90** | **125** | **186** | **209** | **300** | **342** | |
| *Of which:* | | | | | | | |
| Financed by grants from the Department of Health | 50 | 72 | 132 | 140 | 122 | 234 | |

*Footnotes:*

*(1) NHS Pensions is the resource budget of the pension scheme, and it is included in core table 1 because it is part of the Department of Health resource budget. Figures from 1999-2000 have been restated to reflect the requirement specified by Financial Reporting Standard 17 – Retirement Benefits.*

*(2) Employers National Insurance Contributions increased from 7% to 14% from 1 April 2004.*

*(3) HM Treasury funding available for Private Finance Initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with Treasury.*

*(4) Includes funding available to NHS foundation trusts from 2004-05.*

*(5) Total public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £228/334/291/431/500/757/1,086 million (this excludes impairments funded in AME which is outside DEL).*

*(6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £228/325/283/419/490/741/1,073 million (this excludes impairments funded in AME which is outside DEL).*

*(7) For a more detailed breakdown of NHS expenditure in England see figure 9.1.*

*(8) PSS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £0/9/8/12/10/16/13 million.*

*(9) Figures may not sum due to rounding.*

## Figure A.2: Department of Health resource budget (core table 2)

£ million

| | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 estimated outturn | 2007-08 plan |
|---|---|---|---|---|---|---|---|
| **Consumption of resources by activity** | | | | | | | |
| **National Health Service (NHS)** | **51,994** | **55,405** | **61,866** | **66,873** | **74,168** | **78,869** | **87,598** |
| *Of which:* | | | | | | | |
| **Hospital and Community Health Services** | **49,082** | **52,448** | **58,412** | **63,373** | **70,757** | **76,360** | **85,088** |
| *of which:* | | | | | | | |
| Health authorities unified budget and central allocations and grants to local authorities | 49,082 | 52,448 | 58,412 | 63,373 | 70,757 | 76,360 | 85,088 |
| **Family Health Services** | **1,951** | **2,024** | **2,141** | **2,129** | **2,131** | **1,002** | **987** |
| *of which:* | | | | | | | |
| General dental services [1] | 1,166 | 1,221 | 1,283 | 1,246 | 1,038 | 23 | 0 |
| General ophthalmic services | 302 | 304 | 322 | 341 | 358 | 381 | 379 |
| Pharmaceutical services | 893 | 919 | 962 | 966 | 1,162 | 998 | 1,059 |
| Prescription charges income | -411 | -421 | -426 | -422 | -427 | -400 | -452 |
| **Central Health and Miscellaneous Services** | **649** | **600** | **993** | **1,062** | **979** | **1,213** | **1,242** |
| *of which:* | | | | | | | |
| Welfare Foods DEL | 101 | 102 | 138 | 119 | 104 | 116 | 115 |
| EEA Medical Costs | 207 | 251 | 390 | 429 | 517 | 596 | 635 |
| Other central health and miscellaneous services | 341 | 246 | 465 | 514 | 359 | 501 | 492 |
| **Departmental Administration Including Agencies** | **312** | **333** | **320** | **309** | **300** | **293** | **282** |
| **Personal Social Services (PSS)** | **729** | **1,590** | **1,617** | **2,110** | **2,070** | **1,830** | **1,930** |
| *of which:* | | | | | | | |
| Personal social services | 45 | 158 | 192 | 240 | 191 | 247 | 316 |
| Local authority personal social services grants | 684 | 1,432 | 1,425 | 1,871 | 1,880 | 1,583 | 1,614 |
| *of which:* | | | | | | | |
| Training Support Programme for social services staff | 47 | 58 | 57 | 55 | | | |
| Grants for adults | 274 | 863 | 937 | 1,465 | 1,459 | 1,170 | 1,173 |
| Grants for children | 95 | 194 | 60 | 65 | 91 | 91 | 91 |
| Human resources development strategy | | | 10 | 24 | 63 | 50 | 50 |
| Grants funded from the Invest to Save Fund | 1 | 2 | | | | | |
| Performance fund | | 48 | 96 | | | | |
| **NHS – Superannuations – England & Wales** | **3,949** | **4,569** | **6,194** | **6,396** | **9,281** | **10,267** | **14,305** |
| **Credit Guarantee Finance [2]** | **31** | **39** | **40** | **24** | **54** | **82** | **93** |
| **NHS (AME)** | **45** | **57** | **60** | **30** | **74** | **135** | **150** |
| **Total Department of Health Resource Budget** | **56,749** | **61,660** | **69,776** | **75,434** | **85,647** | **91,183** | **104,077** |

*Footnotes:*

*(1) General dental services (GDS) data represents the net cost, after taking account of patient charge income, for non discretionary services only. Outturn trends are affected by the progressive movement of dental practices into personal dental service pilots. From April 2006 provision for general dental services is included within the general HCFHS resources as dental care is now commissioned from funds devolved to PCTs. The GDS provision identified for 2006-07 represents the possible costs of completing payments in respect of GDS services delivered up to March 2006.*

*(2) HM Treasury funding available for Private Finance Initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with Treasury.*

*(3) Figures may not sum due to rounding.*

## Figure A.3: Department of Health capital budget (core table 3)

£ million

| | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 estimated outturn | 2007-08 plan |
|---|---|---|---|---|---|---|---|
| **National Health Service (NHS)** | **1,719** | **2,073** | **2,602** | **2,624** | **2,151** | **3,544** | **4,177** |
| *Of which:* | | | | | | | |
| **Hospital and Community Health Services** [1] | **1,693** | **2,043** | **2,566** | **2,592** | **2,111** | **3,492** | **4,120** |
| *of which:* | | | | | | | |
| Health authorities unified budget and central allocations and grants to local authorities | 1,693 | 2,043 | 2,566 | 2,592 | 2,111 | 3,492 | 4,120 |
| **Central Health and Miscellaneous Services** | **13** | **20** | **13** | **16** | **22** | **28** | **34** |
| **Departmental Administration Including Agencies** | **13** | **10** | **23** | **16** | **19** | **23** | **23** |
| **Personal Social Services (PSS)** | **93** | **72** | **84** | **83** | **92** | **122** | **143** |
| *of which:* | | | | | | | |
| Personal social services (including credit approvals) | 90 | 47 | 59 | 58 | 67 | 74 | 75 |
| Local authority personal social services grants | 3 | 25 | 25 | 25 | 25 | 48 | 68 |
| *of which:* | | | | | | | |
| Grants funded from the Invest to Save Fund | 0 | 0 | | | | | |
| Improving information management | 3 | 25 | 25 | 25 | 25 | 25 | 25 |
| **Credit Guarantee Finance (AME)** [2] | **0** | **0** | **0** | **0** | **357** | **96** | **52** |
| **NHS (AME)** | | | | **229** | **292** | | |
| **Total Department of Health Capital Budget** | **1,812** | **2,145** | **2,686** | **2,937** | **2,893** | **3,762** | **4,372** |

*Notes:*
*(1) Includes funding available to NHS foundation trusts from 2004-05.*
*(2) HM Treasury funding available for Private Finance Initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with Treasury.*
*(3) Figures may not sum due to rounding.*

## Figure A.4: Total capital employed by the Department (core table 4)

£ million

| | 1998-99 outturn | 1999-2000 outturn | 2000-01 outturn | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 projected | 2007-08 projected |
|---|---|---|---|---|---|---|---|---|---|---|
| Within the Departmental account [1] [2] | 17,896 | 15,813 | 15,146 | 12,574 | 12,290 | 11,597 | 14,333 | 14,551 | 14,942 | 15,346 |
| Investment outside accounting boundary [3] [4] [5] [6] | 15,853 | 22,529 | 23,011 | 23,250 | 24,860 | 27,468 | 32,693 | 33,608 | 34,507 | 35,441 |
| **Total Capital Employed** | **33,749** | **38,342** | **38,157** | **35,824** | **37,150** | **39,065** | **47,026** | **48,159** | **49,449** | **50,787** |

*Notes:*
*(1) This includes all entities within the DH resource accounting boundary, such as the central DH, SHAs and PCTs.*
*(2) Source: DH consolidated resource accounts.*
*(3) Figures up to 1999-2000 include the NHS Litigation Authority, which moved inside the accounting boundary in 2000-01.*
*(4) Figures up to 2001-02 include the Health Development Agency, which moved inside the accounting boundary in 2002-03.*
*(5) This includes, for example, NHS trusts and the National Blood Authority.*
*(6) In 2000-01, part of NHS supplies (the Purchasing and Supply Agency) moved inside the boundary and, from 2001-02, Rampton, Broadmoor and Ashworth Special Health Authorities moved outside the accounting boundary.*

## Figure A.5: Department of Health administration costs (core table 5)

£ million

| | 2000-01 outturn | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 plan | 2007-08 plan [1] |
|---|---|---|---|---|---|---|---|---|
| **Administration expenditure** | | | | | | | | |
| Paybill | 141 | 151 | 142 | 140 | 113 | 114 | 126 | 103 |
| Other | 122 | 135 | 162 | 155 | 165 | 148 | 120 | 126 |
| **Total administration expenditure** | **263** | **286** | **304** | **295** | **278** | **262** | **246** | **229** |
| Administration income | -4 | -8 | -8 | -13 | -10 | -16 | -6 | -4 |
| **Total administration budget** | **259** | **278** | **296** | **283** | **268** | **246** | **240** | **225** |
| **Analysis by activity:** | | | | | | | | |
| Central department | 254 | 278 | 296 | 283 | 268 | 246 | 240 | 225 |
| Youth treatment service | 5 | - | - | - | - | - | - | - |
| **Total administration budget** | **259** | **278** | **296** | **283** | **268** | **246** | **240** | **225** |

*Notes:*
*(1) The split between paybill and other is to be confirmed following the business planning round.*

## Figure A.6: Staff numbers (core table 6)

| | Financial year average | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2001-02 actual | 2002-03 actual | 2003-04 actual | 2004-05 actual | 2005-06 actual | 2006-07 plan | 2006-07 estimated outturn | 2007-08 plan[6] |
| **Department of Health** (Gross Control Area) [1] | | | | | | | | |
| Core DH (Full Time Equivalents) | 3,809 | 3,390 | 2,964 | 2,050 | 2,245 | 2,245 | 2,250 | 2,245 |
| Other | nil | nil | nil | nil | nil | nil | nil | nil |
| Designated to transfer from DH (Full Time Equivalents) | | | | 139 | 119 | 100 | 65 | nil |
| Agencies | | | | | | | | |
| NHS Pensions Agency (Full Time Equivalents) [2] | 466 | 268 | 258 | nil | nil | nil | nil | nil |
| MHRA (Full Time Equivalents) [3] | nil | nil | 747 | 781 | 819 | 877 | 830 | 889 |
| Medical Devices Agency [3] | 149 | 156 | nil | nil | nil | nil | nil | nil |
| Medicines Control Agency [3] | 574 | 519 | nil | nil | nil | nil | nil | nil |
| NHS Purchasing and Supplies Agency (Full Time Equivalents) [4] | 291 | 309 | 318 | 332 | 350 | 348 | 321 | 331 |
| NHS Estates [5] | 435 | 390 | 375 | 314 | nil | nil | nil | nil |
| **Total Department of Health** | **5,724** | **5,032** | **4,662** | **3,616** | **3,533** | **3,570** | **3,466** | **3,465** |

*Notes:*
*(1) Up to 2005-06, reporting of actuals has been as at 31 March of the year in question. For 2006-07, actual figures are an average across the financial year and are compiled on the same basis as in Departmental Resource Accounts. In particular they include, for the first time, ministers and special advisers.*
*(2) The NHS Pensions Agency became a special health authority (part of the NHS) in April 2004.*
*(3) The Medicines Control Agency (MCA) and Medical Devices Agency (MDA) merged with effect from 1 April 2003 to become the Medicines and Healthcare products Regulatory Agency (MHRA). The variance between the 2006-07 plan and estimated outturn is due to the MHRA managed policy on staff headcount numbers.*
*(4) NHS PASA has revised its 2003-04 staff number following an internal review of records. The Procurement Policy Advisory Unit (PPAU) and the Centre for Evidence Based Purchasing (CEP) joined PASA from the core Department from 2004-05 following an organisational review. The variance between the 2006-07 plan and estimated outturn is due to the outsourcing of activities and associated staffing to DHL/NHS Supply Chain during 2006.*
*(5) NHS Estates became a Trading Fund on 1 April 1999. Figures from 2003-04 include staff in Inventures. NHS Estates was abolished on 31 March 2005.*
*(6) Future planned staff numbers are subject to change.*
*(7) The Department announced a major change programme in March 2003, under which it committed itself to reducing its workforce from 3,645 full-time equivalent posts to 2,245. The reduction of 1,400 was to consist of 680 transfers to other organisations and the removal of 720 posts. This change programme predated the 2004 Spending Review, but it was agreed that the Department could adopt the change programme target reduction as its Spending Review (Gershon) target. By the end of December 2006, the Department's full-time equivalent staffing was 2,301 (excluding ministers and special advisers), representing a reduction of 1,344 from March 2003. This consisted of 694 transfers and 650 posts removed.*

## Figure A.7: Department of Health identifiable expenditure on services, by country and region (core table 7)

| | £ million | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 plan | 2007-08 plan |
| North East | 2,717.1 | 2,998.9 | 3,199.2 | 3,593.8 | 3,895.6 | 4,318.6 | 4,711.8 |
| North West | 7,022.4 | 7,913.8 | 8,771.3 | 9,561.1 | 10,299.3 | 11,301.7 | 12,200.6 |
| Yorkshire and Humberside | 4,763.8 | 5,348.5 | 5,949.4 | 6,671.8 | 7,311.3 | 7,870.5 | 8,453.8 |
| East Midlands | 3,833.9 | 3,936.3 | 4,439.3 | 4,976.7 | 5,406.9 | 6,056.1 | 6,532.6 |
| West Midlands | 5,173.4 | 5,505.3 | 6,011.3 | 6,723.9 | 7,244.0 | 8,024.6 | 8,683.5 |
| Eastern | 4,566.5 | 5,287.2 | 5,742.9 | 6,445.7 | 6,858.2 | 7,287.9 | 8,242.7 |
| London | 8,266.9 | 9,182.7 | 10,151.6 | 11,429.3 | 11,978.1 | 12,286.6 | 13,684.1 |
| South East | 7,239.8 | 7,970.8 | 8,668.0 | 9,650.2 | 10,023.4 | 11,143.5 | 12,324.9 |
| South West | 4,619.7 | 4,905.5 | 5,412.9 | 6,084.5 | 6,642.7 | 7,231.5 | 7,964.4 |
| **Total England** | **48,203.5** | **53,048.9** | **58,345.9** | **65,136.9** | **69,659.5** | **75,521.1** | **82,798.3** |
| Scotland | -0.9 | -0.2 | -16.8 | -18.3 | -22.2 | -23.8 | -26.3 |
| Wales | -8.8 | -7.1 | -148.4 | -162.3 | -196.9 | -204.0 | -224.2 |
| Northern Ireland | 1.9 | 0.6 | -1.5 | -2.0 | -2.6 | -3.1 | -3.4 |
| **Total UK identifiable expenditure** | **48,195.6** | **53,042.2** | **58,179.2** | **64,954.4** | **69,437.9** | **75,290.2** | **82,544.4** |
| Outside UK | 248.4 | 298.6 | 237.3 | 418.9 | 304.1 | 504.1 | 563.7 |
| **Total identifiable expenditure** | **48,444.0** | **53,340.8** | **58,416.5** | **65,373.3** | **69,742.0** | **75,794.3** | **83,108.1** |
| Non-identifiable expenditure | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1,153.0 | 894.0 |
| **Total expenditure on services** | **48,444.0** | **53,340.8** | **58,416.5** | **65,373.3** | **69,742.0** | **76,947.3** | **84,002.1** |

*Source: HM Treasury public expenditure database*

*Notes:*
*(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in departmental budgets. They do include pay, procurement, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.*
*(2) The figures were taken from the HM Treasury public expenditure database in December 2006 and the regional distributions were completed in January/February 2007. Therefore, the tables may not show the latest position and are not consistent with other tables in the Departmental Report.*
*(3) Regional attribution of expenditure for the years 2001-02 to 2005-06 is based on NHS annual accounts, and for 2006-07 to 2007-08 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.*

## Figure A.8: Department of Health identifiable expenditure on services, by country and region, per head (core table 8)

£ per head

| | 2001-02 outturn | 2002-03 outturn | 2003-04 outturn | 2004-05 outturn | 2005-06 outturn | 2006-07 plan | 2007-08 plan |
|---|---|---|---|---|---|---|---|
| North East | 1,069.7 | 1,181.6 | 1,259.8 | 1,412.0 | 1,522.7 | 1,691.2 | 1,842.9 |
| North West | 1,036.8 | 1,166.6 | 1,289.0 | 1,400.4 | 1,504.4 | 1,644.8 | 1,770.8 |
| Yorkshire and Humberside | 957.2 | 1,071.2 | 1,187.7 | 1,324.1 | 1,443.8 | 1,542.0 | 1,646.9 |
| East Midlands | 915.1 | 932.1 | 1,044.0 | 1,162.9 | 1,255.6 | 1,397.0 | 1,498.1 |
| West Midlands | 979.7 | 1,037.9 | 1,130.0 | 1,260.6 | 1,350.1 | 1,493.4 | 1,611.1 |
| Eastern | 845.6 | 975.1 | 1,051.2 | 1,173.8 | 1,237.6 | 1,309.0 | 1,471.5 |
| London | 1,129.0 | 1,245.7 | 1,374.1 | 1,538.6 | 1,593.3 | 1,618.5 | 1,788.1 |
| South East | 902.3 | 990.9 | 1,072.7 | 1,189.9 | 1,227.7 | 1,358.1 | 1,494.8 |
| South West | 934.5 | 987.5 | 1,082.7 | 1,207.7 | 1,310.8 | 1,414.4 | 1,547.6 |
| **Total England** | **974.8** | **1,068.5** | **1,170.3** | **1,300.3** | **1,381.3** | **1,489.2** | **1,624.3** |
| Scotland | -0.2 | 0.0 | -3.3 | -3.6 | -4.3 | -4.7 | -5.1 |
| Wales | -3.0 | -2.4 | -50.5 | -55.0 | -66.6 | -68.5 | -75.0 |
| Northern Ireland | 1.1 | 0.4 | -0.9 | -1.1 | -1.5 | -1.8 | -2.0 |
| **Total UK identifiable expenditure** | **815.3** | **894.1** | **976.9** | **1,085.6** | **1,153.3** | **1,243.8** | **1,357.2** |

*Source: HM Treasury public expenditure database*

*Notes:*
*(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in departmental budgets. They do include pay, procurement, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.*
*(2) The figures were taken from the HM Treasury public expenditure database in December 2006, and the regional distributions were completed in January/February 2007. Therefore, the tables may not show the latest position and are not consistent with other tables in the Departmental Report.*
*(3) Regional attribution of expenditure for the years 2001-02 to 2005-06 is based on NHS annual accounts, and for 2006-07 to 2007-08 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.*

## Figure A.9: Department of Health identifiable expenditure on services by function, by country and region, 2005-06 (core table 9)

£ million

| | Health: | | | Social protection: | | | |
|---|---|---|---|---|---|---|---|
| | Central and other health services | Medical services | Total health | Personal social services | Public sector occupational pensions | Total social protection | Grand total |
| North East | 41.6 | 3,977.8 | 4,019.4 | 11.7 | -135.5 | -123.8 | 3,895.6 |
| North West | 111.3 | 10,525.8 | 10,637.0 | 31.3 | -369.1 | -337.8 | 10,299.3 |
| Yorkshire and Humberside | 78.0 | 7,464.9 | 7,542.9 | 21.9 | -253.5 | -231.6 | 7,311.3 |
| East Midlands | 57.6 | 5,528.5 | 5,586.2 | 16.2 | -195.5 | -179.3 | 5,406.9 |
| West Midlands | 77.6 | 7,387.9 | 7,465.5 | 21.8 | -243.3 | -221.5 | 7,244.0 |
| Eastern | 73.0 | 7,030.7 | 7,103.7 | 20.5 | -266.1 | -245.5 | 6,858.2 |
| London | 129.0 | 12,147.5 | 12,276.5 | 36.3 | -334.6 | -298.4 | 11,978.1 |
| South East | 109.3 | 10,317.9 | 10,427.2 | 30.7 | -434.5 | -403.8 | 10,023.4 |
| South West | 70.9 | 6,858.9 | 6,929.8 | 19.9 | -307.0 | -287.1 | 6,642.7 |
| **Total England** | **748.4** | **71,239.8** | **71,988.2** | **210.4** | **-2,539.1** | **-2,328.7** | **69,659.5** |
| Scotland | 0.0 | 0.1 | 0.1 | 0.0 | -22.2 | -22.2 | -22.2 |
| Wales | 0.0 | 0.0 | 0.0 | 0.0 | -196.9 | -196.9 | -196.9 |
| Northern Ireland | 0.0 | 0.6 | 0.6 | 0.0 | -3.1 | -3.1 | -2.6 |
| **UK identifiable expenditure** | **748.4** | **71,240.4** | **71,988.8** | **210.4** | **-2,761.3** | **-2,551.0** | **69,437.9** |
| **Outside UK** | **388.3** | **0.0** | **388.3** | **0.0** | **-84.2** | **-84.2** | **304.1** |
| **Total identifiable expenditure** | **1,136.7** | **71,240.4** | **72,377.1** | **210.4** | **-2,845.5** | **-2,635.2** | **69,742.0** |
| **Not identifiable** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |
| **Total** | **1,136.7** | **71,240.4** | **72,377.1** | **210.4** | **-2,845.5** | **-2,635.2** | **69,742.0** |

*Source: HM Treasury public expenditure database*
*Note:*
*(1) The functional categories used are the standard United Nations Classifications of the Functions of Government (COFOG) categories. This is not the same as the strategic priorities used elsewhere in the report.*

# B Public Service Agreement and Operating Standards

Targets are intended to be outcome focused, delivering further improvements in key areas of public service delivery and capturing the outcomes that matter to people, and this inevitably means that measurement may be complex in some cases. The Department is committed to ensuring that the data used in monitoring and reporting on Public Service Agreements (PSAs) is robust and reliable. The data systems underpinning PSA targets are subject to validation by the National Audit Office (NAO). The Department accepts that there are some areas where data collection needs to improve, and work is under way to ensure that this happens. The Department works closely with HM Treasury, the Prime Minister's Delivery Unit (PMDU) and analytical experts to ensure improvements to data relating to all target areas.

# Departmental Public Service Agreement targets (SR 2004) analysis

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

## Objective I: Health of the population

| PSA target | Measure | Progress |
|---|---|---|
| **Target 1**<br>Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women. | **Life expectancy at birth for males and females in England.** | **Overall life expectancy – encouraging progress**<br>In the period 2003 to 2005, the period life expectancy in England at birth was as follows:<br>Male – 76.9 years<br>Female – 81.1 years<br>These have risen from a baseline of 75.0 years for males and 79.9 years for females for the period 1997 to 1999. |
| Substantially reduce mortality rates by 2010:<br>– from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole; | **Death rate from heart disease, strokes and related illnesses** among people aged under 75. | **Heart disease, strokes and related illnesses overall mortality – on course**<br>The 1995 to1997 baseline figure for overall mortality for heart disease in people aged under 75 in England was 141.0 deaths per 100,000 population. In the period 2003 to 2005 (three-year average latest available data) the rate had fallen to 90.5 deaths per 100,000 – a fall of 35.9%.<br>Three-year average rates have fallen for each period since the baseline. If the trend of the last ten years continues, the target will be met.<br>**Inequality dimension – on course**<br>Three-year average rates have fallen in the spearhead group and England as a whole for each period since the baseline. During this period, the inequality gap has reduced from a baseline absolute gap of 36.7 deaths per 100,000 population in the period 1995 to 1997 to 26.4 deaths per 100,000 population in the period 2003 to 2005. (The target for 2010 is to reduce the absolute gap to 22.0 deaths per 100,000 population or less.) The gap has, therefore, reduced by 27.9% since the baseline, compared with the required target reduction of at least 40% by 2009 to 2011. |
| – from cancer by at least 20% in people under 75 with at least a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole; | **Death rate from cancer amongst people aged under 75** | **Overall mortality – on course**<br>The 1995 to 1997 basline figure for overall mortality for cancer in people aged under 75 in England was 141.2 deaths per 100,000 population. In the period 2003 to 2005 (three-year average, latest available data) the rate had fallen to 119.0 deaths per 100,000 – a fall of 15.7%.<br>Three-year average rates have fallen for each period since the baseline. If the trend of the last ten years were to continue the target would be met.<br>**Inequality dimension – met early**<br>Three-year average rates have fallen in the spearhead group and England as a whole for each period since the baseline. Following a small increase in the inequality gap in the first monitoring period, the gap has reduced from a baseline absolute gap of 20.7 deaths per 100,000 population between 1995 and 1997 to 18.1 deaths per 100,000 population between 2003 and 2005. (The target for 2010 is to reduce the absolute gap to 19.5 deaths per 100,000 population or less).<br>The gap has therefore reduced by 12.7% since the baseline, compared to the required target reduction of at least 6% by |

| PSA target | Measure | Progress |
|---|---|---|
| – from suicide and injury of undetermined intent by at least 20%. | **Death rate from intentional self-harm and injury of undetermined intent** among people of all ages.<br>Baseline is average of 1995, 1996 and 1997.<br>(All using ONS mortality statistics age-standardised to allow for changes in the age structure of the population.) | **Suicide and injury of undetermined intent – encouraging progress**<br>The three-year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen and, in the period 2003 and 2005, was 7.4% below the baseline. Although progress is towards the target, the rate of decline has slowed in recent years and, if the current trend continues, the 2009 to 2011 target will not be met. |
| **Target 2**<br>Reduce health inequalities by 10% by 2010, as measured by infant mortality and life expectancy at birth. | **Mortality in infancy by social class:** the gap in infant mortality between 'routine and manual' groups and the population as a whole.<br>Baseline is average of 1997, 1998 and 1999. | **Infant mortality – challenging target**<br>Data for the period 2003 to 2005 (three-year average) shows a slight narrowing in the gap between the 'routine and manual' groups and the population as a whole, compared with last year. However, over the period since the target baseline, the gap has widened, and the infant mortality rate among the 'routine and manual' group is now 18% higher than in the total population. This compares with 13% higher in the baseline period of 1997 to 1999, although there have been year-on-year fluctuations in intervening years. |
| | **Life expectancy by local authority:** the gap between the fifth of areas with the 'worst health and deprivation indicators' (the Spearhead group) and the population as a whole.<br>Baseline is average of 1995, 1996 and 1997. | **Life expectancy at birth – challenging target**<br>Data for the period 2003 to 2005 (three-year average – latest available data) indicates that since the target baseline (1995 to 1997), the relative gap in life expectancy between England and the Spearhead group has increased for both males and females, with a larger increase for females. For males, the relative gap has increased by 2%, for females by 8%.<br>Although the new data for 2003 to 2005 indicates a widening in the relative gap between England and the Spearhead group since the target baseline, the gap shows little change over 2002 to 2004 figures, with a very small widening for men and no further widening for women.<br>The data for 2003 to 2005 shows that three-fifths of Spearhead areas are on track to narrow the gap between their life expectancy and that of England by 10% by 2010 compared with the baseline for either males or females or both: 24% are on track for males only, with a further 24% on track for females and 11% on track for both. |
| **Target 3**<br>Tackle the underlying determinants of health and health inequalities by:<br>– reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among 'routine and manual' groups to 26% or less; | **Smoking:** reduction in numbers of adult and 'routine and manual' groups of smokers.<br>Prevalence from General Household Survey. | **Adult smoking rates – on course**<br>The percentage of adults smoking has fallen by three percentage points since 2001. While 27% of the whole population smoked in 2001, this figure had fallen to 24% in 2005.<br>**Reduction in prevalence among 'routine and manual' groups – encouraging progress**<br>The 'routine and manual' figures were 33% in 2001 and 31% in 2005. |
| – halting the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole (joint target with the Department for Education and Skills (DfES) and the Department of Culture, Media and Sport); | **Obesity:** Prevalence of obesity as defined by national Body Mass Index percentile classification for children aged between two and ten years (inclusive) measured through the Health Survey for England (HSE).<br>Halting the increase would mean no statistically significant change in prevalence between the two three-year periods, 2005 to 2007 and 2008 to 2010. | **Obesity – early stages**<br>Progress against the target will be measured through the HSE of obesity prevalence in children aged between two and ten.<br>Annual performance measured by comparing HSE figures for aggregate three-year periods, i.e. 2002 to 2004 against 2003 to 2005, against 2004 to 2006, and so on, until 2008 to 2010. Three-year aggregates are used to account for the limited sample size.<br>The prevalence of obesity in 2- to 10-year-old English children for the three-year period 2002 to 2004 was 14.9%. The equivalent figure for 2003 to 2005 was 14.9%; this was 15.8% of boys and 14.0% of girls. |

| PSA target | Measure | Progress |
|---|---|---|
| – reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health (joint target with the DfES). | **Teenage Conceptions:** The under-18 conception rate is the number of conceptions to under-18-year-olds per thousand females aged between 15 and 17. Baseline year is 1998. ONS conception statistics. | **Teenage conceptions – encouraging progress**<br>The under-18 conception target is now a shared PSA target between the Department of Health and DfES in light of the move of the Teenage Pregnancy Unit to DfES in June 2003.<br>Teenage pregnancy rates are falling. Between the 1998 baseline year and 2004 (the latest year for which data is available) the under-18 conception rate has fallen by 11.8% and the under-16 rate has fallen by 14.8%. Both rates are now at their lowest level for 20 years, but we need to accelerate progress to achieve our target to halve the conception rate by 2010. |

## Objective II: Long-term conditions

| PSA target | Measure | Progress |
|---|---|---|
| **Target 4**<br>To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions. | **Reduction in number of emergency bed days** as measured through hospital episode statistics | **Reduction in number of emergency bed days – met early**<br>Between 2003-04 and 2005-06, the number of emergency bed days decreased by 5.4%, from 32,457,517 to 30,699,595. |

## Objective III: Access to services

| PSA target | Measure | Progress |
|---|---|---|
| **Target 5**<br>To ensure that, by 2008, no one waits more than 18 weeks from GP referral to hospital treatment. | **18 weeks** will be measured in two ways:<br>a. waiting times for individual stages of treatment; and<br>b. waiting times for referral to treatment.<br>To ensure delivery, plans will be monitored and performance managed against trajectories for both. | **18 weeks – on course**<br>Until now, the NHS has only measured stages of a patient's overall waiting time from referral to the start of treatment. Developmental work with a set of pioneer sites has delivered systems for measuring referral to treatment (RTT) that can be adopted locally.<br>The NHS completed an RTT baseline exercise in October 2006 that estimated the overall position on RTT times and highlighted key challenges to delivering the 18-week pathway. It will inform forward planning to deliver 18 weeks. About 35% of patients admitted for in-patient or day-case treatment completed their pathways within 18 weeks. Between 70% and 80% of patients who were not admitted for treatment completed their pathways within 18 weeks.<br>Mandatory routine reporting of RTT times commenced in January 2007 for admitted patients. From April 2007, submission of RTT data will be mandatory for all patients, including those who are treated without being admitted.<br>The Department is currently assessing data quality and intends to commence routine publication of RTT figures once it is assured that the data is of sufficient quality.<br>Local delivery plans are being refreshed to ensure that the NHS has robust plans and monitoring arrangements in place to deliver 18 weeks. |

| PSA target | Measure | Progress |
|---|---|---|
| **Target 6**<br>Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year on year the proportion of users successfully sustaining or completing treatment programmes. | **Annual returns from the National Drug Treatment Monitoring Service (NDTMS)**, which provides details on the number of drug misusers entering in, successfully completing and sustaining treatment. | **Participation in drug treatment – met early**<br>The results from the NDTMS reveal that 181,390 people received specialist, structured drug treatment in England during 2005-06, an increase of 13% on 2004-05 (160,453) and 113% on the 1998-99 baseline of 85,000.<br>**Effectiveness of drug treatment – on course**<br>In addition, in 2005-06, 78% of those in drug treatment either successfully completed their programme or were retained in treatment for at least 12 weeks (measure of effectiveness). This is an increase from 75% in 2004-05 and means the Department remains on track to meet the target to increase year on year the proportion of drug users in treatment who either are being retained or successfully complete their treatment programmes. |

## Objective IV: Patient and user experience

| PSA target | Measure | Progress |
|---|---|---|
| **Target 7**<br>Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider. | **The national survey programme** (under the administration of the Healthcare Commission) will gather feedback from patients on different aspects of their experience of care in NHS trusts. | **Improving the patient experience – on course**<br>Since the first survey was conducted in 2001-02, over 1.2 million patients have taken part in 16 surveys across seven different NHS settings.<br>PSA scores are an average score out of 100 – calculated by aggregating scores from five domains of patient experience:<br>– improving access and waiting;<br>– building closer relationships;<br>– better information, more choice;<br>– safe, high-quality, coordinated care; and<br>– clean, friendly, comfortable place to be.<br>To date, figures for three of the five settings covered by the PSA suggest small improvements. These improvements have been recorded in:<br>– the adult in-patient survey (75.7 in 2003-04 to 76.2 in 2005-06);<br>– the primary care survey (76.9 in 2003-04 to 77.0 in 2005-06; 2005-06 results are obtained from a national survey conducted by the Department, and are marginally lower than the 77.4 recorded in the Healthcare Commission PCT survey administered in 2004-05); and<br>– the community mental health services survey (74.2 in 2003-04 to 74.7 in 2004-05; results for 2005-06 cannot be compared due to changes in question wording).<br>There has been a small decline in the outpatient survey (76.9 in 2002-03 to 76.7 in 2004-05).<br>Results from the emergency care survey cannot be compared due to changes in survey questions.<br>Full details of progress against the patient experience PSA target is published on the Department's website: www.dh.gov.uk/assetRoot/04/14/25/41/04142541.pdf<br>In 2005-06, two Healthcare Commission-administered surveys were conducted: an adult in-patient survey (results published in May 2006) and a community mental health services survey (published in September 2006). The results for each NHS organisation participating in these surveys – and nationally aggregated data – are available on the Healthcare Commission website at: www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys.cfm |

| PSA Target | Measure | Progress |
|---|---|---|
| | | In 2005-06, the Department also conducted a PCT survey, and results were published in January 2007. While this differs from previous PCT surveys in that it was conducted at national level only (rather than by each PCT), the same methodology and questionnaire were used; results can, therefore, be compared with previous Healthcare Commission administered surveys. Results are available on the Department's website:<br>www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/NationalSurveyOfNHSPatients/GPSurvey19992002/fs/en<br>Confirmation of the future survey programme (for 2006-07 and 2007-08 respectively) is available on the Healthcare Commission website. |
| **Target 8**<br>Improve the quality of life and independence of vulnerable older people by supporting them to live, wherever possible, in their own homes by:<br>– increasing the proportion of older people being supported to live in their own homes by 1% annually in 2007 and 2008; and | **Those being helped to live at home** are those that receive community-based services but are not in residential or nursing care. Only those that are care managed by social services, i.e. are assessed by social services and have a care plan, will be included in the target. | **Older people supported to live at home – on course**<br>The baseline year for this target is 2005-06. The first national comparison is now available and shows a national increase averaging 0.9% compared with 2004-05.<br>To recognise the crucial voluntary and community sector (VCS) contribution to non-intensive home care, a related data collection to assess the VCS contribution to this target commenced last year. The first results will be available in spring 2007. |
| – increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care. | **Those people receiving more than ten contact hours of home care and six or more visits per week** divided by the population of people supported by councils in residential care and nursing homes. | **Older people supported intensively to live at home – on course**<br>In England, the number of older people supported intensively to live at home in 2005-06 shows a strong upward trend, increasing to 33.8% of the total supported by councils in residential care and in their own homes, 0.2 percentage points below the target of 34% by March 2008.<br>The continual rise in the PSA value is due, in part, to the increasing number of households receiving intensive home care (i.e. the target has not been met simply by reducing numbers of care home residents). In September 2005, 98,200 households received an intensive home care service, a rise of 6% from the same period in 2004. |

## Departmental Public Service Agreement targets (SR 2002) analysis

Targets 2, 3, 4 and part of 7 have been adopted into the SR 2004 operating standards. Targets 5, 6, 8, 9, 10 and parts of 7 and 11 have been subsumed into SR 2004 targets. Information on the remaining targets 1, 12 and part of 11 is provided below.

### Objective I: Improve service standards

| PSA target | Measure | Progress |
|---|---|---|
| **Target 1**<br>Reduce the maximum wait for an outpatient appointment to three months and the maximum wait for in-patient treatment to six months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum in-patient and day-case waiting time to three months by 2008. | Number of patients waiting. | **Outpatient waiting times – met**<br>Number waiting more than three months (13 weeks):<br>• December 2002 – 223,575<br>• December 2003 – 121,908<br>• December 2004 – 62,752<br>• February 2005 – 56,202<br>• December 2005 – 198(1)<br>• February 2006 – 198(2)<br>• February 2007 – 119(3)<br>*(1) Of the 198, 153 were English residents waiting in Welsh hospitals*<br>*(2) Of the 198, 134 were English residents waiting in Welsh hospitals*<br>*(3) Of the 119, 98 were English residents waiting in welsh hospitals*<br>**In-patient waiting times – met**<br>Number waiting more than six months:<br>• February 2001 – 251,474<br>• February 2002 – 242,900<br>• February 2003 – 207,271<br>• February 2004 – 113,485<br>• February 2005 – 60,493<br>• February 2006 – 165(1) (2)<br>• February 2007 – 378(3)<br>*(1) Of the 165, 25 were English residents waiting in Welsh hospitals*<br>*(2) Figure revised since publication of the Departmental Report 2006*<br>*(3) Of the 378, 11 were English residents waiting in Welsh hospitals* |

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

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

### Objective III: Improve value for money

| PSA target | Measure | Progress |
|---|---|---|
| **Target 12**<br>Value for money in the NHS and personal social services will improve by at least 2% per annum, with annual improvements of 1% in both cost efficiency and service effectiveness. | **Value for money based on unit costs of procedures and services**, adjusted for quality, underlying inflation and mix of cases.<br>Service-effectiveness element of target based on quality indicators published by the Department. | **Value for money – too early to assess**<br>Using our interim value for money measure, in 2005-06 value for money through cost efficiency increased by around 1.2%. As before, we are continuing to work with the relevant experts at ONS to expand our efficiency measures so that they take account of a greater range of quality improvements that the NHS is delivering. |

## Departmental Public Service Agreement targets (SR 2000) analysis

The majority of SR 2000 targets were subsumed within the SR 2002 targets, and details were given in previous performance reports. Of those, three targets that were not carried forward, target 6 was met and final reporting has taken place, responsibility for target 7 now lies with DfES, and target 10 is reported on here.

### Objective V: Value for money

| PSA target | Measure | Progress |
|---|---|---|
| **Target 10**<br>The cost of care commissioned from trusts that perform well against indicators of fair access, quality and responsiveness, will become the benchmark for the NHS. Everyone will be expected to reach the level of the best over the next five years, with agreed milestones for 2003-04. | Reference Cost Index. | **Reference Cost Index – not met. This is final reporting for this target**<br>The NHS Trust National Reference Cost Indices for 1999-2000, 2000-01, 2001-02 and 2002-03 provide evidence of the extent to which variation in performance is reducing. The dispersion of costs between NHS trusts, as measured by the coefficient of variation of the trimmed market forces factor adjusted Reference Cost Index (RCI) for NHS trusts, has been decreasing. The coefficient of variation (defined as standard deviation divided by mean) fell from 24% in 1999-2000, to 21% in 2000-01, to 17% in 2001-02, to 15% in 2002-03, to 12% in 2003-04 and it remained at 12% in 2004-05. |

## Departmental Public Service Agreement targets (CSR 1998) analysis

Targets 1, 2, 5, 13 and 20 were subsumed into SR 2002 targets. Final reporting took place in the Autumn Performance Report 2003 and Departmental Report 2004 on the majority of the other targets; information on those that remain live, targets 3, 4 and 32, is given below.

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

| PSA Target | Measure | Progress |
|---|---|---|
| **Target 3**<br>Reduction in the death rate from accidents by at least 20% by 2010, from a baseline of 15.9 per 100,000 population for the three years 1995 to 1997. | Death rate from accidents. | **Death rate from accidents – slippage**<br>Data for 2003 to 2005 (three-year average – latest available data) shows a rate of 16.0 deaths per 100,000 population – a rise of 1.5% from the baseline (1995 to 1997). |
| **Target 4**<br>Reduction in the rate of hospital admission for serious accidental injury by at least 10% by 2010, from a baseline estimate of 315.9 admissions per 100,000 population for the financial year 1995-96. | **Rate of hospital admission for serious accidental** injury requiring a hospital stay of four or more days. | **Rate of hospital admissions for serious accidental injury – slippage**<br>Data treated as singular. Single year data for financial year 2004-05 show a rate of 332.4 admissions per 100,000 population – an increase of 5.2% from the baseline estimate (1995-96). |

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

| PSA target | Measure | Progress |
|---|---|---|
| **Target 32**<br>As part of the new Framework for Managing Human Resources in the NHS, targets for managing sickness absence were set consistent with the Cabinet Office recommendations of a reduction of 20% by April 2000. Performance improvement on targets will also be set for NHS trusts on managing violence to staff in the NHS, aimed at reducing the levels of absence due to sickness or injury caused by violence. | **Measurement of the time staff are absent from work** as a proportion of staff time available. | **Sickness absence – some progress made. This is final reporting for this target**<br>The Department of Health NHS sickness absence survey 2005 found that the sickness absence rate, defined as the amount of time lost through absences as a percentage of staff time available, was 4.5%, down from 4.6% in 2004.<br>**Managing violence – some progress made. This is final reporting for this target**<br>Targets were set for managing violence:<br>– To reduce the number of incidences by 20% by the end of 2001-02; and,<br>– To reduce the number of incidences by 30% by the end of 2003-04.<br>A total of 58,695 physical assaults occurred during 2005-06 on NHS staff working in all healthcare sectors. This represents a 1,690 or 2.8% reduction in physical assaults compared with the previous total in 2004-05 of 60,385. This includes a 7% increase in confidence of staff reporting incidents of physical assault.<br>In November 2003, the NHS Security Management Service, introduced a comprehensive framework of measures to tackle violence against NHS staff.<br>In 2004-05, it is estimated that 85,000 front-line NHS staff received conflict-resolution training on how to identify and de-escalate potentially violent situations from occurring in the first place, and in 2005-06, this figure rose to over 250,000.<br>The number of criminal sanctions taken against those that had physically assaulted NHS staff rose by 12% – from 759 in 2004-05 to 850 in 2005-06. (a rise of over 1,500% from 2003-04).<br>Broken down into sectors over the same period, this represents 11,100 assaults in the acute sector, 5,145 in PCTs, 1,104 in ambulance trusts and 41,345 in the mental health and learning disability environments.<br>The Healthcare Commission's staff survey in 2005 saw a 3% reduction in NHS staff saying that they had experienced violence and abuse over the figure for 2004. |

# Departmental operating standards

| Standard | Measure | Progress |
|---|---|---|
| **Standard 1**<br>Reduce to four hours the maximum wait in accident and emergency (A&E) from arrival to admission, transfer or discharge.<br>Note: Following discussions with clinicians' representatives, a 2% tolerance was introduced for the minority of patients that clinically require more than four hours in A&E. This meant that providers were performance managed to ensure that 98% of patients were seen, diagnosed and treated within four hours of their arrival at A&E. | **Total time patients spend in A&E** from arrival to admission, transfer or discharge. This includes major A&E departments, walk-in centres and minor injury units. | **A&E total time – met (for 2005-06 as a whole) and sustained**<br>Between October and December 2006, 98.2% of attenders at all types of A&E department, in England were admitted, transferred or discharged within four hours of arrival.<br>This continues the excellent performance level achieved for 2005-06 as a whole, where 98.2% of patients were seen, diagnosed and treated within four hours of their arrival at A&E, as well as the first two quarters of 2006-07 when performance was above the 98% operational standard. |

| Standard | Measure | Progress |
|---|---|---|
| **Standard 2**<br>Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours. | PCT performance is measured through the monthly **Primary Care Access Survey (PCAS)**, one of the LDPRs. Monitoring the national access target, we are now developing indicators based on:<br>– results of the new GP Patient Survey; and<br>– PCAS – as revised. | **Primary care access – met**<br>Since December 2004, PCTs have reported through PCAS each month that 99+% of patients could be offered an appointment within two working days to see a GP.<br>Patient surveys typically show success levels of between 80% and 90% (88% in the recent Picker survey, published in January 2007).<br>The Department has made changes to PCAS to strengthen it. We intend to continue this process and will be encouraging PCTs to make use of the information from the new GP Patient Survey.<br>Since July 2006, PCTs have been asked to survey each practice on a random day within a three-week envelope, rather than all practices on the same pre-notified day. PCTs are also asking for the third, as well as the first, available GP appointment – to get a better idea of the depth of access.<br>PCTs reported in the September 2006 PCAS that:<br>– 99.6% (based on first available appointment) or 97.6% (based on third available appointment) of patients could be offered a GP appointment within two working days; and<br>– 99.7% of patients could be offered a primary care professional appointment within one working day.<br>The third available appointment results also show greater variation at PCT level than those for the first available appointment – which is more consistent with what patients report. The intention is now to use third available appointment as the sole survey measure – shifting fully to third available appointment in 2007-08. We will also consider whether PCAS should in future be run quarterly, rather than monthly. |
| **Standard 3**<br>Ensure that every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. | **DH monthly central data collection** measures percentage of patients given the opportunity to choose most convenient date from a range of dates. | **Booking – met**<br>Number of day cases booked over the past year:<br>• January 2004 – 84.6%<br>• January 2005 – 98.2%<br>• January 2006 – 99.6%<br>• January 2007 – 99.7%<br>The number of in-patient's appointments booked (day cases & ordinary admissions) over the past year:<br>• January 2004 – 75.1%<br>• January 2005 – 94.1%<br>• January 2006 – 99.5%<br>• January 2007 – 99.7%<br>Outpatient booking over the past year:<br>• January 2004 – 52.7%<br>• January 2005 – 82.5%<br>• January 2006 – 98.8%<br>• January 2007 – 98.7%<br>**Electronic booking**<br>The Choose and Book system was launched in summer 2004, and enables patients to book initial hospital appointments at a time and place of their choice while in the GP surgery, or later either on the internet or on the telephone through the Choose and Book appointments line. Choose and Book will continue to be rolled out through 2006 and 2007.<br>**Choice**<br>To monitor implementation of choice at referral, the Department is carrying out surveys to measure whether patients recall being offered choice when their GP refers them to hospital. These are carried out every two months. 2006 figures indicate that around 41% of patients who are eligible recall being offered choice. Future results are expected to show that the percentage of patients who recalled being offered choice will increase, as the process becomes more embedded. |

| Standard | Measure | Progress |
|---|---|---|
| **Standard 4**<br>Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis services and child and adolescent mental health services (CAMHS). | **Annual mapping of CAMHS to monitor success.** | **Access to CAMHS – on course**<br>Progress towards this target is being measured by the percentage of PCTs which have care pathways to three essential elements of comprehensive CAMHS. The position as at December 2006 is set out below:<br>– 24/7 emergency assessment: 96.7%;<br>– CAMHS for children and young people with a learning disability: 87.5%;<br>– CAMHS for 16- and 17-year-olds: 90.8%. |
| | For **crisis services** there are two main forms of measurement:<br>a. number of patients who are subject to at least one consultant episode (acute home-based) per annum is measured; and<br>b. number of crisis resolution teams established. | **Access to crisis services**<br>The key enabler for improving access to crisis services is the implementation of sufficient numbers of crisis resolution teams and their achieving the full caseload.<br>Number of crisis resolution teams in place:<br>• September 2002 – 62<br>• March 2003 – 102<br>• September 2003 – 137<br>• March 2004 – 179<br>• September 2004 – 212<br>• March 2005 – 343<br>• January 2006 – 343<br>Number of people receiving crisis resolution services:<br>• 2002-03 (Q4) – 28,500<br>• 2003-04 (Q4) – 45,800<br>• 2004-05 (Q4) – 68,800<br>• 2005-06 (Q4) – 83,800(1)<br>*(1) In Q3 2005-06, the guidance was revised. Q4 data shows the number of home treatment episodes. Figures are not comparable to previous years.* |

# C Executive agencies of the Department of Health and other bodies

## Medicines and Healthcare products Regulatory Agency (MHRA)

The Medicines and Healthcare products Regulatory Agency (MHRA) helps safeguard public health through the regulation of medicines and medical devices. It does this by ensuring that they meet the standards of safety, quality, performance and effectiveness and are used safely.

Its main sources of funding are from fees from the pharmaceutical industry for the licensing of medicines and funding from the Department of Health for the regulation of medical devices.

The main tasks carried out by the MHRA are to assess medicines before they can be used in the UK and to ensure compliance with statutory requirements for the manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices. The agency also operates systems for recording, monitoring and investigating adverse reports and incidents, and taking enforcement action to safeguard public health. The agency provides advice and support to the Department of Health ministers on policy issues and represents the UK in European and other international areas concerning the regulation of medicines and medical devices.

The MHRA has also recently taken on the authorising and inspecting of blood establishments, monitoring compliance of hospital blood banks and the assessment of serious adverse events and reactions associated with blood and blood components (haemovigilance).

For further information visit the website at: www.mhra.gov.uk

## NHS Purchasing and Supply Agency (NHS PASA)

The NHS Purchasing and Supply Agency (NHS PASA) was established in April 2000. NHS PASA works to ensure that the NHS in England makes the most effective use of its resources by getting the best possible value for money when purchasing goods and services. Its prime target is to release money that could be better spent on patient care by achieving purchasing savings and improving supply performance across the NHS.

Currently, the organisational structure for NHS PASA is under review. Details will be made available on their website as decisions are made: www.pasa.nhs.uk

For further information about NHS PASA telephone 0118 980 8841, or email pasa@pasa.nhs.uk.

## Other bodies (including executive non-departmental public bodies and special health authorities)

### Executive non-departmental public bodies

Appointments Commission (AC)
www.appointments.org.uk

Commission for Patient and Public Involvement in Health (CPPIH)
www.cppih.org

Commission for Social Care Inspection (CSCI)
www.csci.org.uk

Council for Healthcare Regulatory Excellence (CHRE)
www.chre.org.uk

General Social Care Council (GSCC)
www.gscc.org.uk

Healthcare Commission (HC)
www.healthcarecommission.org.uk

Health Protection Agency (HPA)
www.hpa.org.uk

Human Fertilisation and Embryology Authority (HFEA)
www.hfea.gov.uk

Human Tissue Authority (HTA)
www.hta.gov.uk

Independent Regulator of NHS Foundation Trusts (MONITOR)
www.monitor-nhsft.gov.uk

National Institute for Biological Standards and Control (NIBSC)
www.nibsc.ac.uk

Postgraduate Medical Education and Training Board (PMETB)
www.pmetb.org.uk

### Special health authorities

Information Centre for Health and Social Care (HSCIC)
www.ic.nhs.uk

Mental Health Act Commission (MHAC)
www.mhac.org.uk

National Institute for Health and Clinical Excellence (NICE)
www.nice.org.uk

National Patient Safety Agency (NPSA)
www.npsa.nhs.uk

National Treatment Agency for Substance Misuse (NTA)
www.nta-nhs.org.uk

NHS Blood and Transplant (NHS BT)
www.nhsbt.nhs.uk

NHS Business Services Authority (NHS BSA)
www.nhsbsa.nhs.uk

NHS Direct (NHS D)
www.nhsdirect.nhs.uk

NHS Institute for Innovation and Improvement (NHSi)
www.institute.nhs.uk

NHS Litigation Authority (NHS LA)
www.nhsla.com

NHS Professionals (NHS P)
www.nhsprofessionals.nhs.uk

### Other NHS bodies

Plasma Resources UK Limited

For further information contact Richard Lawes (richard.lawes@dh.gsi.gov.uk)

### Tribunal non-departmental bodies

Care Standards Tribunal
www.carestandardstribunal.gov.uk

Pharmaceutical Price Control Tribunal

For further information contact Mat Otton-Goulder, Medicines Pricing and Supply, Skipton House, 80 London Road, London SE1 6LH.

For a full listing of public bodies that exist to support the Department's business, please go to www.appointments.org.uk. This information will be available from the summer of 2007.

# D Public Accounts Committee: reports published in 2006

Six Public Accounts Committee (PAC) reports were published in the calendar year of 2006. For each report a Treasury Minute has been produced (a Treasury Minute is the Government's considered response to a PAC report).

The list of PAC reports, with date of publication, is as follows:

1. *Tackling Cancer: Improving the Patient Journey* – **12 January 2006**
2. *The NHS Cancer Plan* – **26 January 2006**
3. *The Refinancing of the Norfolk and Norwich PFI Hospital* – **3 May 2006**
4. *NHS Local Improvement Finance Trusts* – **4 July 2006**
5. *A Safer Place for Patients: Learning to Improve Patient Safety* – **6 July 2006**
6. *Reducing Brain Damage: Faster Access to Better Stroke Care* – **11 July 2006**

## Tackling Cancer: Improving the Patient Journey

The Committee concluded that cancer patients are being cared for better than they were five years ago but noted that the system sometimes lets patients down in their last days. It made a number of recommendations including: promoting access to national and local dedicated self-help networks for cancer sufferers; measuring progress towards implementing NICE guidance on supportive and palliative care for adults with cancer; and improving quality and choice of end of life care.

Action taken on PAC conclusions and recommendations includes:

- a commitment in the 2006 White Paper *Our Health, Our Care, Our Say* to introduce information prescriptions: pilots are being rolled out, including four sites focused on cancer, and will run until the end of 2007;
- the launch of a website by the Cancer Services Collaborative to support cancer networks in improving patient information delivery: www.cancerimprovement.nhs.uk/View.aspx?page=/cross_tumour/patient_carer.html; and
- developing an End of Life Care Strategy for adults. Specific areas that will be considered as part of the strategy include the care pathway for someone approaching the end of life, the services required to meet their needs and the quality of this care along with issues such as care homes, stronger commissioning and workforce.

## The NHS Cancer Plan

The Committee concluded that there had been significant progress in improving cancer services with more money reaching the front line, although it noted that a full national programme to educate people to the signs of cancer was still awaited. Recommendations to the Department included providing information to the public about signs and symptoms of cancer, publishing progress against key

cancer outcomes annually and updating the 2000 Cancer Plan to cover the period to 2010.

Action taken on PAC conclusions and recommendations includes:

- the preparation of a report summarising the outcome of the national programme of cancer peer review to assess the quality of services provided by cancer networks. This is expected to be available in the spring; and
- the announcement of a Cancer Reform Strategy to build on the progress of the NHS Cancer Plan by spreading best practice and recommending what more needs to be done by cancer networks and the NHS to improve clinical outcomes, drive up quality and increase value for money. Specific areas that will be considered as part of the strategy include:
  - provider development and service models
  - commissioning and levers for change
  - value for money – costs and benefits
  - clinical outcomes
  - awareness of cancer symptoms and early detection
  - patient experience.

## The Refinancing of the Norfolk and Norwich PFI Hospital

The Committee concluded that the public sector did not fare as well as the private sector consortium (Octagon), as the Trust only secured 29 per cent of the £116 million refinancing gain and could have to pay up to £257 million more if it needs to end the contract early. The Trust had also taken a step in the dark in agreeing to extend the minimum period of the PFI contract to 2037 as it was impossible to predict so far in advance the nature and extent of the services that might be needed. It recommended that staff involved in such deals should be fully trained to understand the complex refinancing issues and experienced advisers should be appointed to help in robust negotiations.

Action taken on PAC conclusions and recommendations includes:

- at the time of this refinancing the Trust used the Treasury's voluntary code (*Refinancing of Early PFI Transactions – Code of Conduct*) which set the 70:30 share of refinancing gains in favour of the private sector. All PFI contracts are now required to include provisions to share refinancing gains on a 50:50 basis in accordance with the 2004 Office of Government Commerce guidance;
- all trusts must consider the value for money case for extending a contract. By extending the contract, the Trust was getting the use of a first-class, state-of-the-art hospital for another five years at a fixed cost in real terms. All PFI schemes must incorporate flexibility and adaptability in their design and variations can be made to the contract, as has already happened at the Trust; and
- all staff managing PFI projects must understand the issues arising from a refinancing and they should appoint experienced advisers to assist them in negotiating refinancing. The staff and advisers need to apply the terms of extant guidance such as the Treasury *Code of Conduct* and the *Application Note – Value for Money in Refinancing*, and consult with the Partnerships UK Refinancing Taskforce where necessary as part of the process of approving refinancing.

## NHS Local Improvement Finance Trusts (NHS LIFT)

The NHS LIFT initiative is a £1 billion programme of public and private investment in the provision of new primary care services. The Committee was undecided as to whether this represented value for money or not. The Committee recommended that the Department and Partnerships for Health speed up their development of a mechanism for evaluating LIFT; that LIFT projects prepared by primary care trusts (PCTs) must clearly compare the cost of LIFT with that of other procurement routes; that Strategic Partnering Boards (SPBs), in consultation with LIFTCo, should set cost reduction targets for new

projects in the light of experience in the local LIFT area and that these should be reviewed annually, once buildings are operational.

Action taken on PAC conclusions and recommendations includes:

- the Valuation Office Agency has been commissioned to take forward work for the Department and Partnerships for Health to collate and analyse cost data from all existing LIFT schemes, including data on lease, construction, funding, maintenance and lifecycle costs. This data will then be used to develop benchmarks for the various costs of a LIFT scheme, against which future LIFT schemes can be measured. PCTs using LIFT to develop schemes will be able to compare clearly the cost of LIFT with that of other procurement routes. The Department will ensure that the mechanism and methodologies underlying this benchmarking work are published; and
- the work the Department is commissioning on the benchmarking of costs will provide SPBs with up-to-date information on what may, and may not, be considered an acceptable cost. While SPBs cannot ensure that costs are reduced across the board, the Department will expect them to identify areas where cost reductions can be achieved and to secure cost reductions in those areas. Where cost reductions are not possible, the Department will expect SPBs to identify the likely increase in costs, if any, and to identify ways of minimising that increase.

## A Safer Place for Patients: Learning to Improve Patient Safety

The Committee concluded that there is a failure to secure accurate information on serious incidents and deaths and, as a result, a failure to learn from previous experiences. The National Patient Safety Agency (NPSA) was set up precisely to put a national reporting and learning system in place but the system was late and led to serious delay in the development and sharing of effective solutions. The Committee recommended the NPSA should compare its own data with the incident report data collected by the National Audit Office; trusts should evaluate their own levels of under-reporting and target specific training and feedback at those groups less likely to report; trusts should assess their safety culture using one of the established tools and implement action plans to address the issues identified; and all trusts should, as a matter of course, inform patients and their carers if they have been involved in an incident even if they suffered no harm.

Action taken on PAC conclusions and recommendations includes:

- the National Reporting and Learning System (NRLS) will be redesigned to ensure that sources of risk and harm to patients are identified and information on near misses is gathered. The NPSA will be expected to focus its effort on the processes for reporting, collecting and analysing patient safety data to inform rapid patient safety learning, priority setting and coordinated activity across the NHS;
- new Patient Safety Action Teams (PSATs) will be established. One of their new roles will be to support quicker identification of serious adverse events or potential problems that could lead to death or serious injury for future patients. Experts within PSATs will also be expected to provide support in data analysis of patient safety incidents and solution development; and
- the establishment of a national patient safety campaign will seek to encourage and support front-line clinicians and managers to deliver safer healthcare. There will be also be a review of current initiatives to involve patients and carers in patient safety and a national patient safety network will be established.

## Reducing Brain Damage: Faster Access to Better Stroke Care

The Committee concluded that the cost of stroke, in both economic and human terms, could be reduced by reorganising services and using existing capacity more wisely to prevent more strokes from occurring, to provide more rapid and responsive acute stroke treatment, and to coordinate post-acute support and rehabilitation services more effectively. It recommended that performance should be benchmarked to raise the profile of stroke with commissioners and clinicians; that all suspected stroke patients should be scanned within 24 hours of arrival at an acute hospital; that all stroke patients should be admitted to a specialist stroke unit as soon as possible following diagnosis; and that services and information should be improved for stroke patients and carers in the community.

Action taken on PAC conclusions and recommendations includes:

- the Department is working with a wide range of stakeholders to develop a national stroke strategy that will cover prevention of strokes, fast and effective acute treatment and high quality rehabilitation and support;
- the Department has developed toolkits for commissioners and providers to benchmark themselves against other services. These also demonstrate the benefits of increasing access to stroke units, improving access to emergency scans and clot-busting treatments, providing intensive rehabilitation through Early Supported Discharge teams, and providing rapid access to 'one-stop' clinics for transient ischaemic attacks (minor strokes); and
- the Department has published a stroke commissioning guide to help commissioners assess local need, review how well services are meeting the need currently and identify where to invest in the future to deliver high quality stroke services.

# E Spending on publicity and advertising and income from sponsorship 2006–07

## Sponsorship guidelines

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.

### Figure E.1: Departmental spending on publicity and advertising and sponsorship, 2006–07

| | £ million |
|---|---|
| Campaigns run by the Department | Amount |
| Tobacco control | 20.6 |
| Sexual health | 5.4 |
| Drugs prevention (DH's contribution to joint campaign with Home Office and Department for Education and Skills) | 3.1 |
| Alcohol (DH's contribution to joint campaign with Home Office) | 1.4 |
| Hepatitis C | 1.5 |
| Flu immunisation | 1.5 |
| Social work/care | 3.5 |
| Tobacco legislation | 3.2 |
| Keep warm, keep well | 0.5 |
| **Total** | 40.7 |

## Figure E.2: Sponsorship received by the Department from other organisations, 2006-07

| Sponsor/Partner | Amount received £ | Support received |
|---|---|---|
| Durex | 218,000 | 312,000 condoms for sampling as part of sexual health campaign |
| Trojan | 105,000 | 150,000 condoms for sampling as part of sexual health campaign |
| Radio 1 | 1,153,744 | On-air promotion of sexual health campaign, including postage of 50,000 condoms |
| MTV | 50,350 | TV promotion of sexual health campaign |
| Club 18–30 | 6,500 | Media space in brochures as part of sexual health campaign |
| Escapades | 180,000 | Media and freesite poster space as part of sexual health campaign |
| 2wentys | 183,000 | Media and freesite poster space as part of sexual health campaign |
| D2 (retailer) | 80,000 | Print and distribution of materials as part of sexual health campaign |
| Co-op Pharmacies | 100,000 | Print and distribution of materials as part of sexual health campaign |
| Lloyds Pharamacy | 5,000 | Print of in-store materials as part of sexual health campaign |
| Pasante | 35,000 | Condoms for sampling as part of sexual health campaign |
| Luminar Leisure | 50,000 | Media space and online promotion as part of sexual health campaign |
| National Union of Students (NUS) | 35,000 | Media space for posters as part of sexual health campaign |
| Pfizer | 45,000 | Sponsorship of eyecare conference run jointly by Department of Health and Royal National Institute of the Blind |
| Colgate | 20,000 | Funding for oral health conferences |
| Habbo Hotel website | 36,980 | Online advice forum and promotion for FRANK drugs campaign and donation of 60,000 5p credits as prizes. |
| BT | 322,000 | Media value of large variety of free advertising for FRANK drugs campaign in 1,300 BT internet kiosk. |
| Club 18–30 | 96,900 | In-resort distribution of FRANK collateral, reps' talks, website, newsletter, competition to promote drugs advice and information |
| Addictive Interactive | 14,200 | Promotion of FRANK campaign messages and viral on 21 clubbing/music sites, plus an e-flyer |
| Clubs for Young People | 6,250 | Promotion of FRANK online game via e-newsletter, e-zine and website editorial |
| Freeloader | 7,080 | Two weeks' free exposure on site's homepage and two months' additional promotion of FRANK messages online |
| Dubit | 5,700 | Promotion of FRANK viral game on website and within e-newsletter |
| Ministry of Sound | 11,400 | Ran competition on website and promoted FRANK messages and viral online and via e-newsletter |
| SwapitShop | 47,200 | Ran variety of FRANK promotional activity online and via e-newsletter |
| JJB Fitness Clubs | 60,000 | Tobacco cessation messaging in all lockers at fitness clubs |
| Loot | 50,000 | Tobacco cessation advertising placement |
| Alliance | 90,000 | Print and exposure within stores for tobacco cessation marketing materials |
| Greene King | 80,000 | Poster campaign, payslip messaging and leaflet distribution for tobacco cessation campaign |
| Football clubs - Middlesbrough, Reading, West Ham, Arsenal, Manchester City | 7,000 | Media space around stadiums for tobacco cessation campaign |

## Figure E.3: Sponsorship paid by DH to other organisations, 2006-07

| Recipient | Amount sponsored £ | Support donated |
|---|---|---|
| Social Enterprise Coalition | 35,250 | Sponsorship of National Social Enterprise Conference |
| Child Accident Prevention Trust | 25,000 | Sponsorship of Child Safety Week |
| Fresh 40 independent chart show | 280,555 | Sponsorship of Fresh 40 independent radio chart show, as part of FRANK drugs prevention campaign. Media value of FRANK messaging generated independently audited at £566,667. |

# F List of Figures

# G Glossary

### A&E

Accident and emergency services.

### 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 are 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.

### Acute services

Medical and surgical interventions provided in hospitals.

### Alternative Provider of Medical Services (APMS)

Under new general medical services (nGMS) contract arrangements, this is one type of contract primary care trusts can have with primary care providers. This contract is particularly designed to bring in new types of provision such as social enterprise and the voluntary sector.

### 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 the DEL and categorised separately as Annually Managed Expenditure (AME).

### Arm's length bodies (ALBs)

These are stand-alone national organisations sponsored by the Department undertaking national functions. There are three main types of ALB:

- executive agencies;
- executive non-departmental public bodies; and
- special health authorities.

### Atkinson Review

Review of the measurement of government output and productivity.

### 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, primary care trusts 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 primary care trusts. 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.

### Corporate Governance

System by which organisations are directed and controlled.

### Cost of capital

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

### Credit approvals

Central government permission for individual local authorities to borrow or raise other forms of credit for capital purposes.

### Departmental Expenditure Limit (DEL)

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

### Depreciation

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

### Distance from target

The difference between a primary care trust's allocation and its target fair share of resources informed by the weighted capitation formula.

### Drugs bill

Drugs bill gross expenditure is the cash amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs, medicines and certain listed appliances which have been prescribed by NHS practitioners. Net drugs bill expenditure is less Pharmaceutical Price Regulation Scheme (PPRS) receipts. Funding is subject to local resource limits and forms part of primary care trusts' discretionary allocations.

### Estimated outturn

The expected level of spending or income for a budget, which will be recorded in the Department's accounts.

### Estimates

See Supply Estimate.

### 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.

### General dental services (GDS)

The GDS offers patients personal dental care via general dental practitioners (GDPs), who mainly work as independent contractors from High Street and local surgeries. Although the GDS was formerly managed as a national, non-discretionary service, since April 2006 general dental services have been locally commissioned from funds devolved to primary care trusts. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

### General medical services (GMS)

These are services covered by contract arrangements agreed at national level by GPs to provide one-to-one medical services, for example: giving appropriate health promotion advice, offering consultations and physical examinations, offering appropriate examinations and immunisations.

The introduction of the new General Medical Services (nGMS) contract represents a fundamental change in the way in which practices are incentivised to deliver patient care. Whilst it retains the independent contractor status for GPs, it moves away from remunerating individual doctors to a practice-based contract funded within primary care trusts' discretionary allocations.

The new contract provides a range of new mechanisms allowing practices greater flexibility in determining the range of services they wish to provide, including rewards for delivering clinical and organisational quality, modernisation of GP infrastructure including premises and IT, and unprecedented levels of investment through the Gross Investment Guarantee. All these mechanisms are designed to deliver a wider range of quality services for patients and to empower patients to make best use of primary care services.

See also Alternative Provider of Medical Services (APMS) and Personal medical services (PMS).

### General ophthalmic services (GOS)

The GOS offers priority groups of patients free NHS sight tests or vouchers to help with the purchase of glasses. NHS sight tests are mainly available to children, people aged 60 or over, adults on low income, or people suffering from or predisposed to eye disease. NHS optical vouchers are mainly available for children, adults on low incomes, and those who need certain complex lenses. Services are provided by optometrists and ophthalmic medical practitioners who work as independent contractors from high street opticians. Although the GOS is administered by primary care

trusts (PCTs) as part of the family health services, optical contractors are engaged under a uniform national contract. Funding is provided from the national demand-led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's discretionary allocation.

### Gershon Review

Efficiency review of Whitehall departments looking at common core functions.

### Green Paper

Consultation document issued by a government department

### 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.

### 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.

### Healthcare Resource Groups

Grouping of similar clinical procedures that require approximately similar levels of resource input.

### Health Improvement Programmes

An action programme to improve health and health care locally and led by the primary care trust. It will involve NHS trusts and other primary care professionals, working in partnership with the local authority and engaging other local interests.

### Hospital and community health services (HCHS)

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by primary care trusts and provided by NHS trusts. HCHS provision is discretionary and also includes funding for those elements of family health services 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.

### Independent sector treatment centre

The independent sector treatment centre programme provides the NHS with extra capacity quickly, and utilises the talents of some of the world's leading independent healthcare companies to deliver high quality care for NHS patients.

### In-patient

A person admitted on to a hospital ward for treatment.

### Near cash

Transactions that have an impact on cash flow in the short term, e.g. pay and pension costs, revenue expenditure on goods and services, or cash payments for the release of provisions.

### NHS foundation trusts

NHS foundation trusts (NHSFTs) are independent Public Benefit Corporations authorised to provide goods and services for the purposes of the health service in England. NHSFTs are free-standing, not-for-profit healthcare organisations. They remain firmly part of the NHS and are subject to NHS standards, performance ratings and systems of inspection. However, NHSFTs are controlled and run locally, not nationally.

The Secretary of State for Health does not have the power to direct NHSFTs. NHSFTs are governed by a Board of Governors comprising people elected

from and by members of the public, patients and staff. Local stakeholders such as primary care trusts (PCTs) are also represented on the Board of Governors. Monitor (the statutory name of which is the Independent Regulator of NHS Foundation Trusts) authorises NHS trusts as NHSFTs and ensures they abide by their terms of authorisation ('licence' to operate) and the legislation. Accountability for NHSFTs is to local people, commissioning PCTs, Monitor and Parliament, rather than to central government.

### NHS LIFT

NHS LIFT stands for NHS Local Improvement Finance Trust. A local LIFT will build and refurbish primary care premises which it will own. It will rent accommodation to GPs on a lease basis (as well as other parties such as chemists, opticians, dentists etc).

### 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 primary care trusts 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.

### National Service Framework

National Service Frameworks (NSFs) are long-term strategies for improving specific areas of care. They set measurable goals within set timeframes. Each NSF is developed with the assistance of external stakeholders in groups which usually contain health professionals, service users and carers, health service managers, partner agencies and other advocates, adopting an inclusive process to engage the full range of views.

### Non-cash

Items that will either never require a cash payment (e.g. the cost of using capital assets, depreciation, bad debts) or other items classified as non-cash which may require cash payments but in the longer term (e.g. provisions).

### Non-discretionary

Expenditure that is not subject to a cash limit, mainly 'demand-led' family health services, including the cost of general dental and ophthalmic services, dispensing remuneration and income from dental and prescription charges.

### Operational capital

Operational capital is used to maintain NHS organisations' capital stock to a minimum standard, as well as for minor developments and equipment replacement.

It was referred to historically as 'block capital' and between 2003-04 and 2006-07 was allocated directly to NHS trusts and primary care trusts (PCTs). From 2007-08, NHS trusts will no longer receive operational capital allocations and will operate under a new borrowing regime similar to foundation trusts. PCTs will continue to receive operational capital.

The allocation uses a formula that is depreciation based and takes into account the levels of building and equipment stock.

### Outpatient

A person treated in a hospital but not admitted on to a ward.

### Outturn

The actual year end position in cash terms.

### Payment by Results (PbR)

A financial framework in which providers are paid according to the level of activity undertaken. Payment is based upon a national tariff system.

### Performance indicator

A benchmark measure against which an individual organisation is compared.

### Personal dental services (PDS)

PDS schemes initially started as pilots offering 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. From April 2006, the former PDS pilots assumed permanent status within the new framework of primary dental care services locally commissioned by primary care trusts. PDS agreements may also be used for the commissioning of specialist dental care services within the community. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

### Personal medical services (PMS)

A PMS contract is agreed locally between the commissioner and the provider. This means that primary care service provision is responsive to the local needs of the population. As a result PMS has been successful in reaching deprived and underdoctored areas. Many PMS pilots focus on the care of vulnerable groups including the homeless, ethnic minorities, and mentally ill patients. Funding for PMS contracts is within primary care trusts' discretionary allocations.

### Personal Social Services (PSS)

These are personal care services for vulnerable people, including those with special needs because of old age or physical disability, and children in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and social workers who provide help and support for a wide range of people.

### Pharmaceutical services (PhS)

Pharmaceutical services cover the supply of drugs, medicines and appliances prescribed by NHS practitioners. Gross PhS expenditure includes total drugs bill costs (see Drugs bill) and dispensing costs. Dispensing costs are the remuneration paid to contractors for dispensing prescriptions written by NHS practitioners. This includes payments to pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items. Net PhS expenditure is the gross expenditure less associated income from prescription charges.

Funding for the total drugs bill is subject to local resource limits and forms part of PCTs' hospital and community health services discretionary allocations. However, funding for dispensing costs is provided from the national demand-led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's discretionary allocation.

### Primary care

This covers family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

### Primary care trust (PCT)

Primary care trusts are responsible for identifying from within their available resources the healthcare needs of their relevant population, and for securing through their contracts with providers a package of hospital and community health services to reflect those needs. PCTs have a responsibility to ensure satisfactory collaboration and joint planning with local authorities and other agencies. The number of PCTs reduced from 303 to 152 on 1 October 2006.

### Primary care trust medical services (PCTMS)

Under new general medical services (nGMS) contract arrangements, this is primary care trust (PCT) provided medical services and is a form of primary medical services provision where a PCT employs the GPs, nurses and others in the primary health team. It is used for providing care where it has not proved possible to attract GPs to open practices.

### Private finance initiative (PFI)

This is 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 and 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.

### Public Accounts Committee

This is parliamentary select committee. Its main role is the examination of the reports produced by the Comptroller and Auditor General on his value for money studies of the economy, efficiency and effectiveness with which government departments and other bodies have used their resources to further their objectives.

### Public Service Agreements

These are output targets agreed with HM Treasury detailing the exact outcomes departments will deliver with the money provided.

### Real terms

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

### Reference costs

This is a schedule of costs of healthcare resource groups that allows direct comparison of the relative costs of different providers.

### Regulatory impact assessment

A regulatory impact assessment (RIA) is a short, structured document which is published with regulatory proposals and new legislation. It briefly describes the issue which has given rise to a need for regulation and compares various possible options for dealing with that issue.

### Request for resources (RfR)

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 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 for 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 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

Revenue is expenditure other than capital, for example, staff salaries and drug budgets. Also known as current expenditure.

### Secondary care

This is care provided in hospitals.

### Social services

These are local authority departments that provide direct services in the community to clients.

### Special health authority (SpHA)

SpHAs 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 the Secretary of State. They originate under Section 11 of the NHS Act 1977, which gives the Secretary of State the power to establish a special body for the purpose of performing certain specified functions on his behalf.

### Specific grants

These are grants (usually for current expenditure) allocated by central government to local authorities for expenditure on specified services, reflecting ministerial priorities.

### Spending Review

This is the practice of reviewing and setting departmental expenditure plans, normally conducted every two years.

### Strategic capital

Strategic capital is allocated to support larger capital projects that primary care trusts (PCTs) cannot afford to fund from operational capital.

It was formerly known as 'discretionary capital' and is allocated directly to strategic health authorities, whose responsibility is to distribute it to PCTs according to local priorities.

The formula is capitation based and, in the main, follows the revenue resource allocation formula.

### Strategic health authority (SHA)

Ten new strategic health authorities, covering the whole of England, were established in July 2006. Their boundaries are aligned with the boundaries of one or more local authorities and broadly reflect clinical networks. As the headquarters of the local NHS, they are the main link between the Department of Health and the NHS and are responsible for ensuring that all NHS organisations work together to deliver the NHS Plan for modernised patient-centred services. Their main functions include creating a strategic framework for the delivery of the NHS Plan locally; drawing together local delivery plans, and performance management, of local NHS bodies; and building capacity and supporting performance improvement.

### Supply Estimate

The term is loosely used for the Main Estimates, a request by the Department of Health to Parliament for funds required in the coming financial year. There are also Supplementary Estimates. Supply Estimates are subdivided into groups (Classes) which contain provision (usually by a single department) covering services of a broadly similar nature. A subdivision 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 – 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 and 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, commissioners received separate revenue funding streams for hospital and community health services, discretionary funding for GP practice staff, premises and computers, and family health services prescribing. The White Paper *The new NHS: Modern, Dependable* proposed unifying these funding streams. Since April 1999, commissioners have received a single unified allocation.

### Voluntary and community sector (VCS)

This comprises independent organisations that provide services directly to the community and specific client groups.

### Vote

See Supply Estimate.

### Walk-in centre

NHS walk-in centres offer the public quick access to advice and treatment for minor ailments and injuries. No appointment is necessary.

### Weighted Capitation Formula

This is a formula that uses primary care trust (PCT) populations which are then weighted for the cost of care by age group, for relative need over and above that accounted for by age and for unavoidable geographical variations in the cost of providing services (the market forces factor). It determines PCTs' target share of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare need.

### White Paper

This is a statement of policy document issued by a government department.

Printed in the UK for The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID5574798 05/07

Printed on Paper containing 75% fibre content minimum.

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

**Online**
www.tsoshop.co.uk

**Mail, Telephone, Fax & E-mail**
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ISBN 978-0-10-170932-3

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