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# Department of Health

## *Departmental Report 2009*

### The Health and Personal Social Services Programmes







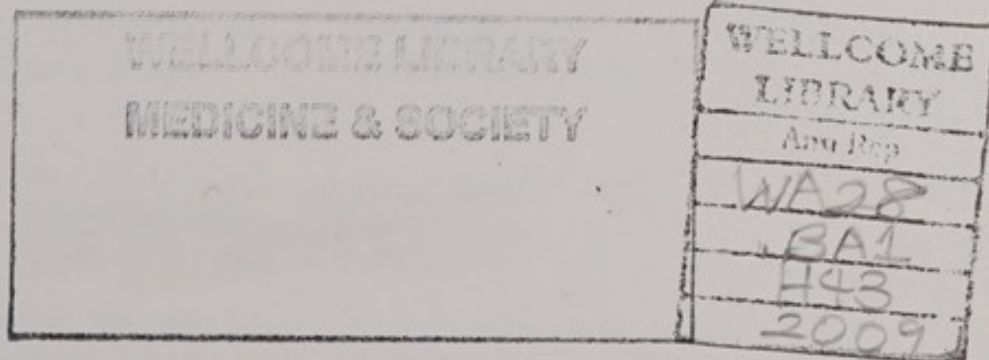
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# Departmental Report

2009

# Department of Health



## DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health  
by Command of Her Majesty  
June 2009

This is part of a series of departmental reports which, along with the Main Estimates 2009-10, the document *Public Expenditure: Statistical Analyses 2009* and the Supply Estimates 2009-10: Supplementary Budgetary Information, present the Government's outturn and planned expenditure for 2009-10 and 2010-11.

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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 2008 are available on the internet at: [www.dh.gov.uk](http://www.dh.gov.uk)

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

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## Foreword by the Secretary of State



It gives me great pleasure to present the Department's nineteenth annual report.

The year 2008-09 has been a landmark of achievement for the NHS and social care; the culmination of a journey that has benefited from sustained investment over a number of years. This investment in capacity and reform has produced a service that is truly responsive and of high quality, with patient satisfaction higher than ever before.

Everyone working in the NHS and social care should feel pride in the scale and breadth of achievements, a few of which I highlight below.

In primary care, there have been major improvements in patient access to GP services. Thanks to the hard work of GP practices and primary care trusts (PCTs), the Prime Minister's commitment in January 2008 that at least 50 per cent of GP practices in England would offer extended opening hours has been exceeded. Latest figures show that 72 per cent of GP practices are now offering this service.

From 1 April 2008, free choice was introduced in the NHS. This allows individuals to choose services from any hospital provider in England that meets NHS standards and costs, including NHS foundation trusts, NHS acute trusts and many independent sector providers. The Department of Health has rightly employed a range of media to ensure that everyone is aware of their entitlement to choice, and has information to support that choice: figures for September 2008 show that 46 per cent of patients recalled being offered a choice by their GP when they were referred to hospital.

In secondary care, the 18-week target for the maximum length of time from patient referral to treatment was met in August 2008, and sustained for each month ahead of the December deadline. This target is now embedded as a national minimum standard for all patients.

Significant progress has been made on healthcare-associated infections. Latest Health Protection Agency data show that the NHS has delivered its target to halve MRSA bloodstream infections, and *C. difficile* infections are down 33 per cent compared with 2007.

In January 2008, *Healthy Weight, Healthy Lives*, a cross-government strategy to help people maintain a healthy weight, was published. The Department has contributed to the strategy through Change4Life, a major marketing initiative launched to stakeholders in October 2008 and to the public in January 2009. This three-year programme is targeted in the first instance to help parents of younger children understand the health risks of behaviours related to poor diet and low physical activity, and make better health-related decisions. A month into the campaign, 61 per cent logo recognition had been achieved among the general public, an unprecedented level of brand awareness in government health campaigning.

September 2008 saw the launch of the new routine national HPV vaccination programme. This is a major vaccination programme which offers young people protection from cervical cancer, and signals an NHS service that prevents ill-health and prioritises keeping people well.



There have also been significant achievements in scientific developments and bioethics, including successful passage through Parliament in November 2008 of the Human Fertilisation and Embryology Act 2008, and maintaining our position at the forefront of research and development in treatments for diseases, such as Alzheimer's disease. Healthcare innovations and research are being developed more quickly in order to provide better healthcare treatments for the population.

In social care, we have engaged widely on the future shape of the care and support system, and plan to publish a Green Paper in 2009.

Of course, all these achievements cannot be sustained without a significant level of investment. I was therefore delighted to announce in December 2008 PCT revenue allocations for 2009-10 and 2010-11. The allocations represent a £164 billion investment in the NHS, £80 billion in 2009-10 and £84 billion in 2010-11. PCTs will receive an average increase in funding of 11.3 per cent over the two years, a total increase of £8.6 billion. This announcement gives the NHS planning certainty over its funding. The allocations were based on a new formula developed by the Advisory Committee on Resource Allocation which includes a separate, transparent health inequalities formula to target funds at the places with the worst health outcomes.

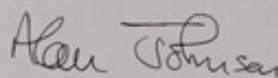
Alongside this increased investment, and in view of the current economic climate, it is right that the NHS, alongside other public services, is tasked with continuing to deliver increased efficiency in its use of resources. The NHS has a strong track record on efficiency. For example, in November 2008 significant savings were delivered through successful negotiation of a new Pharmaceutical Price Regulation Scheme. The new agreement is expected to deliver savings in the UK of around £350 million in 2009-10, and approximately £550 million a year thereafter.

In June 2008, leading surgeon and health minister Lord Darzi published *High Quality Care for All*. This reiterates that the guiding principle for staff in the NHS is to provide high-quality care, and it underpins new performance management arrangements in the NHS. These incentivise continued improvement across the three domains of quality: patient safety, effectiveness of care and patient experience.

Further, and to safeguard the NHS for future generations, an *NHS Constitution* was published in January 2009. This sets out the principles and values for the NHS in England. The Constitution sets out the rights to which patients, public and staff are entitled, and the pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe one another to ensure that the NHS operates fairly and effectively.

Thus, in this, the 90th year of the Department of Health, where a different landscape is emerging in terms of both economics and demographics, it will remain our commitment to:

- continue to deliver better health and well-being;
- continue to provide better care; and
- continue to deliver better value.



Rt Hon Alan Johnson  
Secretary of State for Health

# Ministerial Responsibilities



## **The Rt Hon Alan Johnson MP**

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### Secretary of State

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

## **Ben Bradshaw MP**

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

Responsibilities include: NHS policy and strategy; finance (including capital); system management and regulation; commissioning; NHS Choices; commercial policy; Connecting for Health (CfH); urgent, emergency and primary care; the NHS Bill; and departmental management.



## **The Rt Hon Dawn Primarolo MP**

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

Responsibilities include: public health; health protection and emergency preparedness; Food Standards Agency; health improvement national programmes; health inequalities; fertility; international and EU business; research and development; and pharmacy funding.

## **Ann Keen MP**

---

### Parliamentary Under Secretary of State for Health Services, PS(H)

Responsibilities include: healthcare quality; patient safety; workforce; National Clinical Directors and programmes; dentistry; chronic diseases and long-term conditions; children's health and maternity services; vascular screening; and the NHS Constitution.







## **Phil Hope MP**

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### **Minister of State for Care Services, MS(CS)**

Responsibilities include: social care; relationship with local government; care partnerships; mental health; prison/offender health; third sector; carers; sustainable development; end-of-life care; pharmacy policy; Social Care Advisory Board; and the Independent Sector Advisory Group.

## **Professor The Lord Darzi KBE**

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### **Parliamentary Under Secretary of State, PS(L)**

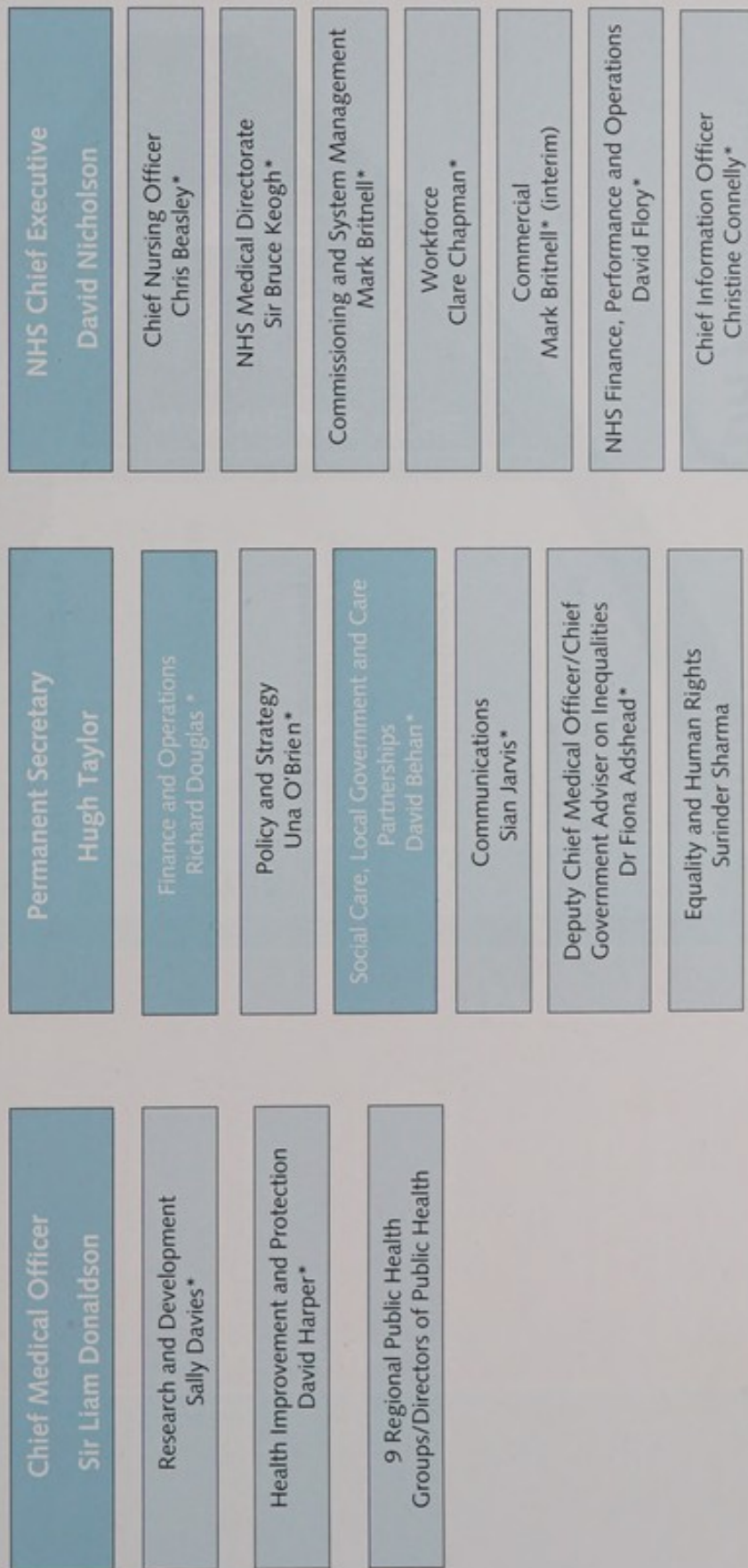
Responsibilities include: NHS Next Stage Review implementation; quality (including NHS Evidence); metrics; quality accounts; Commissioning for Quality and Innovation (CQUIN); National Quality Board; innovation (including Health Innovation and Education Clusters (HIECS)); Academic Health Science Centres (AHSCs); and innovation funds and prizes.





# Department of Health Organisation Chart

The Department of Health's structure is arranged under three permanent secretaries



Darker blue boxes show Departmental Board members.

\*Directors-general

# Department of Health Purpose, Roles and Values



# I The Department of Health – Who we are, What we do, Why we are here

## Chapter 1 Introduction and Overview



# 1 Introduction and Overview

1.1 This, the Department of Health's nineteenth 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 strategic objectives and its Public Service Agreements (PSAs). The report focuses on the Department's 2008-09 business year priorities, highlighting the key achievements that have been delivered along with key supporting data and statistics.

1.3 The report also sets out the Department's plans for future years. In particular, this focuses on activities and improvements planned for 2009-10.

1.4 This report has been structured around the major work blocks of the Department for ease of reference – its corporate work, National Health Service (NHS) work, social care work and public health work – and does not necessarily reflect how the Department carries out its business or manages and delivers funding into the system.

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

## Department of Health

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

1.7 The Department is responsible for the stewardship of over £100 billion of public funds. It advises ministers on how best to use this funding in order 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.

1.8 The Department itself does not directly deliver healthcare and social care services to the public. Instead the Department works, at both a national and a regional level, with many different external partners: other government departments, the NHS, local authorities, arm's length bodies and other public and private sector organisations.

1.9 The Department works in a different way with each of these partners because of their different legal natures, their funding connection with the Department and their different relationship to the Department.

1.10 The Department will lead for the UK in international and European Union (EU) business, including the negotiation of legal agreements.

1.11 Where the Department is operating on a UK-wide basis this will be made clear in the report; otherwise the report refers to the Department's work in England.

1.12 Further detail on the Department, its structure, governance and policies can be found in section II.

## The Department's aim

1.13 The Department's overall aim is to improve the health and well-being of the people of England. Its work includes setting national standards, shaping



the direction of the NHS and social care services, and promoting healthier living.

1.14 The Department has four distinct but inter-related roles in support of this aim:

- It sets direction for the NHS, for adult social care and public health.
- It finds the best way to support and mobilise the health and social care system to deliver improvements for patients and the public.
- It leads on the integration of health and well-being into wider government policy and the integration of wider public policy into health and social care services by working with other sectors, systems and government departments.
- It supports ministers in accounting to the public and Parliament for health and social care.

### The Department's objectives

1.15 The broad span of the Department's business is captured within its three Departmental Strategic Objectives (DSOs):

- To promote better health and well-being for all – helping people to stay healthy and well, and empowering them to live independently – and tackle health inequalities.
- To ensure better care for all – providing the best possible health and social care services, offering safe and effective care, when and where people need help and empowering them in their choices.
- To ensure better value for all – delivering affordable, efficient and sustainable services contributing to the wider economy and nation.

1.16 Beneath the umbrella of these DSOs the Department has agreed with HM Treasury the specific PSA indicators – these are the Government's highest priority outcome measures – that it will deliver on up to 2010-11. The Department will lead on two of the PSAs, and provide support and input to others that are the lead responsibility of other government departments.

1.17 A report on progress against each of the Department's DSOs and main PSAs can be found in **Annex C**.

### The Department's 2008-09 priorities

1.18 Taking into account the overall framework set by the DSOs and PSA indicators, the Departmental Board set out the following issues as the key business priorities for 2008-09:

- delivering our Department of State functions;
- preparing for an influenza pandemic;
- developing a strategy for the reform of social care;
- enabling local transformation of the NHS;
- reducing health inequalities;
- reducing the burden of lifestyle diseases;
- facilitating delivery of improved value for money;
- supporting cross-government work; and
- delivering high-quality and cost-effective support services.

### National Health Service

1.19 As stated, the Department is responsible for the provision of health services through the NHS. These services are delivered locally by 1.3 million staff in more than 300 organisations and through approximately 5,200 GP practice premises, as well as other primary care services. These services are in contact every day with over 1.5 million patients and their families.

1.20 Further information on the NHS's finance, performance and services can be found in section III of this report.

### Social care

1.21 The Department also sets the strategic framework for adult social care. It gives advice and guidance to local authorities, who are responsible for managing 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 25,000 social care providers, of which the great majority are small, independent sector organisations.

1.22 The social care system receives funding from two central routes – the local government revenue grant allocated by the Department for Communities and Local Government, and funding provided directly by the Department of Health.

1.23 Further information on the Department's social care, local government and care partnership work can be found in section IV of this report.

## Public health

1.24 The Department of Health is the lead department across government for the improvement and protection of the public's health, and the reduction of health inequalities.

1.25 It runs health protection programmes covering such matters as immunisation or infectious disease surveillance, and health improvement programmes such as tobacco reduction. These are the most direct elements of public health for the Department and are delivered through key partners such as the NHS, local authorities and the Health Protection Agency. However, on a broader level, the Department will work alongside other government departments and offices and also with local government in order to deliver these aims; due to the significant impact of issues such as education, employment, economic well-being, transport, environmental health and housing on people's health.

1.26 Further information on the Department's national and regional public health work is covered in section V of this report, which also refers to the crucial role played by the regional tier.



## II Managing the Department, Developing and Improving Policy, Strategy and Analysis and Supporting Ministers

- Chapter 2 Department of Health Operations
- Chapter 3 Policy and Strategy
- Chapter 4 Communications
- Chapter 5 Department of Health Finance

## 2 Department of Health Operations

### Role

To provide high-quality organisational support, infrastructures and corporate enablers that allow the Department and its ministers to conduct business efficiently and effectively.

#### Key achievements in 2008-09 included:

- Achieved faster response times to parliamentary questions.
- Introduced HR strategies covering staff health and well-being and equality and human rights.
- Published the Department's Sustainable Development Strategy.
- Delivered a fully integrated business management system.
- Established a new governance system for Departmental PSAs and DSOs.

### Summary

2.1 In this chapter you will find information on:

- human resources and people capability;
- corporate operations;
- information and communication technology (ICT); and
- Department of State functions.

### Introduction

2.2 The Finance and Operations Directorate underpins delivery of the Department's business. The strategic finance functions of securing resources from HM Treasury, allocating resources to the NHS central budgets and reporting outturn expenditure are summarised in chapter 5. This chapter focuses on the other functions of the Directorate – the wide range of corporate services, systems and centrally managed functions that enable people across the Department to carry out their work.

2.3 Like other areas of the public sector, the Department's business requirements continue to change, and corporate services need to respond positively to this. The Directorate is therefore responsible for assessing the corporate needs of the Department and its staff, and reshaping its services

to ensure that staff have the best support available – not only in terms of IT tools and equipment, but also in terms of training and development, and underpinning human resource policies.

### Human resources and people capability

2.4 The Directorate supports the Department's staff in their overall aim to improve the health and well-being of the people of England. Promoting capability, engendering corporate leadership, recruiting staff, and ensuring the equality, health and well-being of staff are a key part of the business of the Directorate.

### Capability Review and the Departmental Development Plan

2.5 The Cabinet Office published its *Capability Review* report on the Department of Health in June 2007. In response, the Department published its *Departmental Development Plan* in September 2007. The plan set out the actions needed to address the areas for improvement highlighted by the Capability Review.

2.6 The Development Plan seeks to build capability and capacity across the Department, and



to ensure that proper processes and systems are in place to support staff and deliver key health and social care priorities. Its aim is to enable the Department to become a better place to work, better to do business with and more able to deliver high-quality services, with value for money.

**2.7** The Development Plan constituted a two-year programme of work, setting out five areas for action:

- establishing a vision and clear strategic direction for the health and care system;
- agreeing the Department's role, values and business plan;
- taking a new approach to leadership;
- supporting staff to succeed; and
- improving the Department's organisation and business processes.

**2.8** A Cabinet Office stocktake at 6 months (December 2007) and 12 months (July 2008) after the Capability Review acknowledged the good progress that the Department was making. At these interim stages, it was understandable that the Department had further to go in addressing the challenges in some of the areas for action.

**2.9** The Department has sustained the improvements in its capability and performance that were acknowledged in the 12-month stocktake. An internal assessment at the 18-month stage showed continued progress and the growing impact that its development work was having, in particular continued improvement in how staff felt about the Department and the way it treats them. The picture of development looks good, and further work is being taken forward in order to put the Department in the best possible position for the Capability Re-review in June 2009.

**2.10** The development journey will not end there, however, as the Department aspires to become a continuously improving organisation. It will be linking a number of initiatives on organisational

development, adaptive change and business efficiencies in order to help shape a successor to the Development Plan in the second half of 2009, setting out its development agenda for the next two to three years.

### Corporate leadership

**2.11** During the year, corporate leadership in the Department was strengthened further through the clarification of the role of the Departmental Board, including its role in the scrutiny and challenge of corporate decisions as well as direction-setting. The work of the Department's three non-executive directors has increased in scope and scale, both in serving as members of boards and committees, and in work with directors-general and their teams outside formal meetings.

**2.12** With a view to improving the coherence of the Department's systems of governance, steps were also taken to improve communication between the boards and committees. The Corporate Management Board, the Performance Committee and the Audit Committee now submit regular updates to the Departmental Board. Communication of the outcomes of board and committee meetings to staff also improved, with the inclusion of information in monthly updates to staff, and the publication of summary records of meetings on the Department's intranet. These are also available to the public on the Department's website.

**2.13** The Departmental Board continued to be the apex of the Department's governance system, supported by:

- the NHS Management Board, bringing together the NHS Chief Executive, his senior leadership team in the Department, and all strategic health authority (SHA) chief executives, in order to give system leadership to the NHS, ensure effective two-way communication, manage NHS performance and shape policy and strategy for the NHS;



- the Corporate Management Board (CMB), bringing together all the Department's directors general, focusing on the corporate leadership of the Department itself;
- the Audit Committee, comprised entirely of non-executive members, advising the accounting officers and the Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subsidiary bodies; and four sub-committees:
  - The Performance Committee, which monitors the delivery of the Department's PSAs and DSOs, its contribution to cross-government PSAs, its delivery of financial targets, and progress on other key programmes and projects;
  - The Corporate Management and Improvement Committee (a sub-committee of CMB, to which it reports) responsible for ensuring that, operationally, the Department is managed in a consistent, efficient and effective manner, focusing on capability, planning, performance and risk management, corporate policy-making, internal communication, environmental, reputational and social issues;
  - The Committee of the Regions, which holds the Department's regional presence to account for the delivery of the Department's PSAs through local government; oversees business processes between the Department's central and the regional teams; oversees the Department's policy and operational contribution to the performance framework for local authorities and their partners; holds the Department's Place Forum to account, which helps to ensure delivery of national policy and support of local priorities; works with CMB on the prioritisation of resources to deliver the Department's regional business; and agrees a 'regional statement' about shared regional health and social care priorities with the regional directors of public health; and
  - The Policy Committee, which advises CMB on the relative priority of policies and their fit

with Departmental strategy, and promotes good policy governance through the development and articulation of standards – in particular on an evidence-based approach to the development of policy.

2.14 The Senior Civil Servants' (SCS) Forum, consisting of all SCS-level staff in the Department, met four times in 2008. The meetings are an opportunity for the Permanent Secretary, the NHS Chief Executive and the Chief Medical Officer to set direction, and for SCS members to develop the Department's thinking on high-priority corporate issues. They also promote networking and the sharing of knowledge among the SCS.

### SCS salaries

2.15 Details of SCS salaries are given in **figure B.1** in annex B. To align with the definition of salary used in the Department's resource accounts, this table now reflects salaries that include gross salary; performance pay or bonuses; overtime; reserved rights to London Weighting or London allowances; recruitment and retention allowances; private office allowances; and any other allowance to the extent that it is subject to UK taxation. In previous Departmental reports, this table reflected gross salary and allowances only.

### Recruitment

2.16 Approximately two-thirds of staff in the core Department are based in London and around one-third in Leeds. Well over half of all staff in the Department and its agencies are women, with around one-fifth coming from black and minority ethnic (BME) groups. The Department already exceeds the cross-Civil Service targets for gender, ethnicity and disability representation in its workforce. Therefore, the Department has agreed more stretching targets for its SCS representation with the Cabinet Office as part of its diversity plan. In the Department and agencies' SCS-level staff, 39.9 per cent are women against a target of 43 per cent; 9.1 per cent are BME against a target of 10



per cent; and 4.5 per cent are people with disabilities against a target of 6 per cent.

2.17 Vacancies within the Department have continued to be filled internally in the first instance. The Department successfully launched its Professional Skills for Government promotion gateway in September 2008, which succeeded in raising the standard for recruitment in the Department. Where vacancies cannot be filled, posts have then been advertised under fair and open competition across government and then by exception, externally.

2.18 All external recruitment to the Department is conducted in accordance with the Civil Service Commissioners' Recruitment Code, which requires appointment to be on merit, on the basis of fair and open competition. Further information about the work of the Civil Service Commissioners can be found at: [www.civilservicecommissioners.org](http://www.civilservicecommissioners.org). The aim at all times has been to ensure that the most suitable candidate is appointed on merit to each post. The Department's human resources division have continued to work within the internal recruitment policy and code in promoting good practice and compliance. During 2009, the Department will introduce further improvements to its recruitment and selection processes, including external recruitment.

2.19 The number of appointments through external competitions is shown in **figure B.2** in annex B broken down by gender, ethnicity and disability. Exceptions permitted under the code were exercised on the following number of occasions:

- 11 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;
- 54 secondments;
- 18 extensions of secondments; and
- 4 reappointments of former civil servants.

## Health and well-being

2.20 The Department is committed to promoting staff well-being, dignity and respect within the workplace and to fulfilling its responsibility for the health and welfare at work of all employees, underpinned by its duty of care. The Department continues to strive to be an exemplar employer. It established a Health and Well-being Board in summer 2008 and published its employee health and well-being policy in December 2008. The policy followed discussions with the Department's unions, staff representative groups, feedback from staff and other key players and a successful equality impact assessment. The Department is committed to the provision and embedding of a range of employee health and well-being policies and initiatives that provide specific support, guidance and awareness for everyone within its workforce.

2.21 In addition to its annual and quarterly staff surveys, the Department administered a specific health and well-being survey in February 2008. This covered lifestyle, job perceptions, attitudes towards the Department, health, bullying and harassment. The results were disseminated to all directors general and, together with the results of the other staff surveys, is being used to identify initiatives that will improve staff health and well-being.

## Equality

2.22 The Department's draft Single Equality Scheme was assessed by the Equality and Human Rights Commission in 2008. The scheme for 2009 to 2012 will be published in 2009. This is underpinned by a Departmental Diversity Strategy which was described by the Cabinet Office Diversity Delivery Board as "one of the strongest in government". The strategy, scheme and supporting plans were developed through discussions with the Departmental Trade Union Side, staff representative groups, and feedback from staff and other interested groups.



## Administrative costs and staffing

2.23 Departmental spending within the administration budgets principally comprises:

- civil service employee costs, including pay, superannuation, employers' national insurance, training, travel and subsistence; and
- other non-staff costs, eg accommodation, IT, etc. associated with the civil service workforce.

2.24 In line with other government departments, following the 2007 Comprehensive Spending Review (CSR) the planned expenditure continues to reduce over the three-year period, 2008-09 to 2010-11, at a rate of 5 per cent per annum in terms of real costs. This is similar to the CSR settlements for other government departments. The figures are reflected at **figure B.3** in annex B (core table 5) which gives detailed information on Departmental administration costs. Information on staffing levels is provided in **figure B.4** in annex B (core table 6).

## Expenditure on professional services

2.25 Expenditure by the Department and its executive agencies on professional services was around £271 million in 2008-09. This figure includes expenditure on consultancy, temporary agency staff, and interim personnel. See **figure B.5**, annex B.

## Corporate operations

2.26 The Finance and Operations Directorate is not only responsible for supporting the Department and its associated bodies in achieving its objectives, but also ensures that staff have access to the relevant professional corporate services and comply with the Department's corporate policies and procedures. In addition, the Directorate works on ensuring that the Department is working towards the Sustainable Operations on the Government Estate (SOGE) targets, published in 2006.

2.27 This section also sets out the how the Directorate manages executive agencies, non-

departmental public bodies and special health authorities as well as covering the Department's health and safety policy and accommodation strategy.

## Governance

### The Departmental risk register

2.28 Risk management remains at the heart of the governance arrangements for the Department. It is underpinned by a risk policy endorsed by the Departmental Board, together with guidance on risk management.

2.29 During 2008-09, the Department continued to maintain a high-level risk register, which is reviewed quarterly by the Audit Committee and the Departmental Board. A Risk Forum, comprising directors from across the Department, also meets quarterly in order to review the register, advise the Board on emerging and new risks, and consider how to promote further the embedding of good practice in risk management across the Department.

2.30 Each risk on the high-level risk register has a Senior Responsible Owner at director general level. The Departmental Board, the NHS Management Board, the Corporate Management Board, and sub-committees of these boards take responsibility for ensuring that mitigation strategies and actions are in place for all risks, and that these are followed through.

2.31 The risks on the register are regularly updated through the Department's central programme and project management arrangements, and by the governance team through its work with directorates. These mechanisms, together with the Department's forward business planning exercises, enable emerging and new risks to be identified and kept under review.

2.32 The Department's Audit Committee reviews the Department's risk management arrangements as a key element of its overview of assurance in the organisation. It reviews the high-level risk register at



each of its quarterly meetings, prior to the quarterly consideration of risk by the Departmental Board.

2.33 The number of risks on the register varied during the year as new risks were added and others removed, for example where mitigation strategies had reduced the rating of a particular risk so that it no longer required consideration by the Board. Key areas of the Department's work, in relation to which there were risks on the register during 2008-09, included:

- improving and protecting the health of the nation, including the work on contingency plans for a possible influenza pandemic and taking actions to continue to address healthcare-associated infection and reducing health inequalities;
- improving the capacity, capability and efficiency of the health and social care system, including work with the pharmaceutical industry to secure good value, branded drugs for the NHS and implementation of the NHS Next Stage Review;
- ensuring that system reform, service modernisation, IT investment (including information security) and new staff contracts deliver improved quality and value for money; and
- strengthening the Department's capacity to function as an effective Department of State, ensuring that it continues to deliver on the commitments made in response to the Capability Review and compliance with the Government's equality legislation in all aspects.

## Sustainable development

### Sustainable Development Strategy

2.34 Building on work already done, the Department's Sustainable Development (SD) Strategy, *Taking the Long-term View: The Department of Health Strategy for Delivering Sustainable Development 2008 -11*, was published in October 2008. It sets out the opportunities the

Department has to promote sustainable development as:

- leader of the health and social care system, and as the government lead for public health and well-being – the Department's contribution to sustainable development as a policy-maker; and
- leading by example – the Department's contribution to SD as a government department, an employer and a sponsor of arm's length bodies.

### Sustainable Development Action Plan 2007-08

2.35 *Delivering Sustainable Development: DH Action Plan 2007-08* (SDAP), was published in October 2007 and remained active until 31 December 2008. A new 2009-11 SDAP will be published in 2009. In addition to delivering the SD strategy, the SDAP 2007-08 focused action in the four areas of people, procurement, policies and sustainable operations.

- People – the Department has established a Health and Well-being Board, launched its new mental health and volunteering policies, incorporated SD into staff induction programmes and set SD objectives for the Permanent Secretary and in the Department's board-level objectives.
- Procurement – the Department has delivered initial sustainable procurement training to all key procurers and other key staff. As part of a commitment to improve, the Department has undertaken an audit of compliance with Quick Wins standards across the Department. The new Business Management System provides us with current information, enabling identification of opportunities to improve the sustainability of contracting activities.
- Policies – the Department is aware that it must do more to make SD a concern of all policy-makers, particularly when policy is being shaped and evidence gathered. The challenge is to ensure that Departmental officials systematically consider SD issues when policy is in its early stages. During 2009, the Department plans to pilot SD within a particular policy area and raise awareness of SD more broadly.



- Sustainable operations in the Department – the Department is working towards the SOGE targets published in 2006. The Department continues to perform well in this exercise, coming in first place in 2006-07, and in fourth place in 2007-08. The Department is working closely with the Carbon Trust, and during 2009 will be embarking on a full Carbon Management Programme, covering the core Department and some of its arm's length bodies. In terms of greening the Department's IT, the managed print service was fully deployed in 2007-08 and this enabled disposal of around 1,200 less efficient devices.
- Sustainable operations and procurement in the NHS – the Department continues to work closely with the NHS SD Unit, and has established a Programme Board and an action plan to support their work to drive forward carbon reduction in the NHS. A significant output of this was the successful launch of the NHS Carbon Reduction Strategy, *Saving Carbon, Improving Health*, launched by the NHS Chief Executive on 27 January 2009. The Department supports the NHS to improve the sustainability of its procurement practice. Progress has been made by the NHS Purchasing and Supply Agency in establishing a Centre for Procurement Excellence and improving the sustainability of purchasing in accordance with the SD flexible framework for procurement.

### Health and safety policy

2.36 The Health and Safety Unit (HSU) provides advice and guidance to all the Department's employees and works with facilities management, human resources and line managers to maintain and improve health and safety in the workplace. The HSU has been involved in:

- reviewing health and safety policy to ensure compliance with current legislation and best practice;
- training staff in health and safety issues;
- health and safety inspections; and

- liaison with trades unions to discuss and recommend appropriate actions.

2.37 Accident statistics for 2008 are shown in **figure B.6** in annex B.

### Accommodation strategy

2.38 The Department continues to develop its accommodation strategy and is currently preparing an outline business case setting out the further rationalisation of its estate. The business case is due to be completed by the end of 2009.

### Lyons relocations

2.39 The Department is committed to the relocation of 1,030 posts out of London and the South East by March 2010. By December 2008, 975 relocations had been completed, 95 per cent of the March 2010 target.

2.40 During the last year, relocations have been completed by the NHS Purchasing and Supply Authority (24 posts to Chester), the General Social Care Council (GSCC) (23 posts to Rugby), the National Institute for Health and Clinical Excellence (53 posts to Manchester) and from the core Department (4 posts to Leeds and 1 post to Nelson).

2.41 Further posts will be relocated by the GSCC and the core Department. The business needs of other organisations continue to be reviewed and may lead to other confirmed moves during 2009. The Department is therefore confident that the overall Lyons target will be achieved.

### Executive agencies, non-departmental public bodies and special health authorities

2.42 At national level, but at arm's length from the Department, a network of organisations has been created in order to regulate the system, improve standards, protect public welfare and support local services (see annex D).



**2.43** These executive agencies, non-departmental public bodies and special health authorities 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 websites. Where possible and appropriate, they also hold open meetings and publish summary reports of meetings on websites, in annual reports or in press releases.

**2.44** In 2004, as part of a wider programme of change, the Department published proposals to improve efficiency and cut bureaucracy in the management of the NHS and free up more resources for the delivery of front-line services.

**2.45** Between 2003-04 and 2008-09, the ALB Change Programme has reduced the number of original ALBs from 38 to 20. Since the programme was announced, an ALB has transferred to the Department from another government department, which will take the numbers of ALBs to 21. This programme has also reduced the number of posts in the ALB sector by 25 per cent.

**2.46** As a consequence, the 2008-09 budget for the ALB sector was set with recurrent costs of over £250 million a year less when compared with their baseline costs and activity in 2003-04. A further £250 million a year will be available to the NHS from efficiency savings achieved by the NHS Purchasing and Supply Agency through better procurement.

### Public appointments

**2.47** The Department of Health is responsible for public appointments to a wide range of bodies, as detailed in **figure B.7** in annex B.

**2.48** As at 1 January 2009, the gender and ethnic balance and the proportion of non-executive members who are disabled on the boards of public

bodies for which the Department is responsible are set out in **figure B.8** in annex B.

### Establishing the Care Quality Commission

**2.49** The Health and Social Care Act 2008, which legislates for the creation of the Care Quality Commission (CQC), received Royal Assent on 21 July 2008.

**2.50** The Commission was established in shadow form on 1 October 2008 and took up its responsibilities for regulating health and adult social care from 1 April 2009. The Commission brings together the work of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. More about the CQC can be found in chapter 3.

## Information and communication technology

**2.51** This section sets out how the Directorate supports the Department in managing its business by providing effective and efficient information technology (IT) and ensuring that information is managed effectively and in line with the Government's sustainability agenda.

### IT strategy

**2.52** The Department's Information Services team continues to pursue its IT strategy as launched in 2007. In summary, the strategy addressed four themes:

- Improved business intelligence – systems, applications and technologies for collecting, providing access to and analysing information, the purpose of which is to inform decisions throughout the Department.
- Improved working environment – the working environment includes access to IT equipment and related services. The Department aims to provide fit-for-purpose technology and a first-class support service in order to maximise IT exploitation.



- Managing, retrieving and exploiting information – the Department relies on good knowledge management and easy access to all the information it needs to do its work.
- Corporate governance – Information Services has extensive governance responsibilities and the strong, formal governance structures around IT-related activities continue to steer IT investments.

2.53 Projects and initiatives started in 2008 continue to be under way to deliver the strategy, and will extend through 2009 and beyond.

### Business intelligence

2.54 The Department had multiple back-office systems and reporting channels providing inconsistent views of the same information. Trust in the quality of the 'official' data was low and the effort to reconcile data between systems was significant. Consequently, many users maintained off-system records in order to keep track of their business, which led to a reduction in the ability to control, and be compliant with, policies and procedures.

2.55 In order to provide a 'single source of truth' (factual, accurate, timely and complete data), the Department implemented the Business Management System (BMS), an integrated Oracle Enterprise resource planning solution. On 1 July 2008, BMS replaced the existing non-integrated human resource, finance and manual procurement applications. This is the first application in Europe to fully support the Official Journal of the European Union procurement processes and automated sourcing and contracts capabilities, through to invoice payments.

2.56 BMS provides the Department with an opportunity to fully understand and manage the extent of contract exposure, to leveraging Departmental buying power. BMS now provides the Department with a single, central and consistent

contracts database, which stores and manages all its contract documentation.

2.57 Implementation of daily business intelligence provides near real-time information to departmental managers and supports effective decision-making with an easy-to-use dashboard-style display of key performance indicators, updated on a daily basis. This will allow management to plan proactively for the Department's future instead of reacting to the past. In addition, the existence of a 'single source of truth' allows management to identify areas for improvement, devise corrective actions and monitor the results of implemented changes.

2.58 BMS has great scope for future development. The developments of dashboard reporting for management, and its full integration with Departmental business planning and performance management, will enable the Department to become a leading example of management best practice in government. In addition, BMS provides a foundation for establishing a shared services environment, allowing the Department to offer the solution initially to the arm's length bodies, and potentially to other government departments. This will enable other government departments and agencies to leverage this leading technology.

### Working environment

2.59 Information Services continues to take steps in improving the IT tools and services delivered to the Department. Following the Government's 'green' ICT launch, the Department has also published its 'green' ICT plans and now has plans to implement a number of initiatives to reduce the carbon footprint of its ICT over the coming years.



## Managing and retrieving information

2.60 During 2008, the Department's Knowledge and Information Management Programme has focused on:

- upgrading the intranet and other knowledge systems to improve content and support future increased functionality;
- awareness and training in the effective use of corporate systems and facilities for new and existing staff; and
- providing access to a wider evidence base by exploiting knowledge from external sources through the library and the Internet.

2.61 Over the next year, the programme will focus on document and records management with a campaign to embed good working practices and local accountability. The aim will be to improve information management behaviours in preparation for the implementation of an enterprise content management solution to replace our current document repositories. By facilitating the process of creating, modifying, storing, publishing and retrieving documents of all kinds, the new solution, and the accompanying business engagement programme, will break down silos, improve information sharing and re-use, eradicate duplication and help to streamline business processes.

## Governance

2.62 Information Services' governance bodies continue to oversee the delivery of infrastructure and IT systems projects in addition to the business as usual activities. Through its governance regimes, the Information Services Division is also driving out waste and has begun a programme of work around the responsible use of IT and IT services.

## Data handling procedures in the Department

2.63 The Information Services team has taken the lead in implementing the requirements of *Data Handling Procedures in Government: Final Report*

(Cabinet Office, 2008) within the Department, providing appropriate training and guidance to staff and ensuring that mechanisms are in place to provide assurance over the management of information assets.

2.64 The Information Services team have also supported and advised ALBs and agencies in ensuring that the Cabinet Office requirements for data handling have been met. The team has worked with the Information Governance Assurance Programme and, where appropriate, mainstreamed the Cabinet Office requirements as 'business as usual'.

## Department of State functions

2.65 The Directorate ensures that the Department operates effective Department of State functions, supporting ministers and ensuring the smooth running of Parliamentary business.

## Correspondence from the public

2.66 The Department has maintained and improved its consistently high performance in correspondence handling (refer to **figure B.9** in annex B). From 1 January 2008 to 31 December 2008, the Department received:

- 20,242 letters from MPs and Peers. Ninety-five per cent of those requiring a reply were responded to within the Department's target time of 20 days;
- 40,347 letters from members of the public. Ninety-seven per cent of those requiring a reply were responded to within 20 days;
- 29,807 e-mails from members of the public. Ninety-eight per cent of those requiring a reply were responded to within 20 days; and
- 130,000 telephone calls from members of the public. Eighty-seven per cent were answered within 30 seconds and 96 per cent within 90 seconds.

## Parliamentary questions

2.67 The Directorate is also responsible for ensuring timely responses to the 9,500 Parliamentary questions – more than any other Department – received by this Department in a typical Parliamentary session. Timeliness performance improved markedly during 2008, with more than 90 per cent of questions answered in line with internal targets in November 2008, the final month of the session. This level of performance is being sustained in the early months of the 2008-09 session.

## Freedom of Information

2.68 The Department continues to improve its performance on Freedom of Information (FOI) requests following a practice recommendation from the Information Commissioner in April 2008. The Department answered 1,349 FOI requests in 2008 and responded to 89 per cent of these within deadline. The full breakdown of Departmental performance will be available in the Ministry of Justice annual report, which will be published in summer 2009. Measures were put in place immediately to improve timeliness in handling FOI complaints, to challenge the proposed use of FOI exemptions more firmly, and to review the resources available for handling complaints. The number of outstanding internal review requests has fallen by 50 per cent, and the percentage answered within the 20 days recommended by the Information Commissioner has risen from 4 per cent (2007) to 26 per cent (2008).

## Complaints to the Parliamentary Ombudsman

2.69 The Department aims to respond to complaints within 20 working days. In addition to processing complaints received about the Department, the head of complaints will also make practice recommendations when a complaint is upheld. Details of how to make a complaint can be found on the Department's website.

2.70 For the period 1 April 2007 to 31 March 2008, the head of complaints for the Department processed 163 complaints. For the same period, the Parliamentary and Health Service Ombudsman accepted two Department referrals (refer to **figure B.10** in annex B). One of these referrals was upheld by the Parliamentary Ombudsman. Further details can be found in the *Parliamentary and Health Service Ombudsman Annual Report 2007-08* (The Stationery Office, 2008). Statistics for 1 April 2008 to 31 December 2008 are not yet available.



# 3 Policy and Strategy

## Role

To develop Departmental-wide policy and strategy, lead on health system reforms policy, and improve the Department's capability in strategy, analysis and policy.

### Key achievements in 2008-09 included:

- Launched the *NHS Constitution*.
- Established the Care Quality Commission.
- Concluded the Additional Drugs Review (the Richards Report).
- Published guidance on commissioning for quality and innovation.
- Announced the first Academic Health Science Centres (AHSCs).

## Summary

3.1 In this chapter you will find information on:

- analysis and evidence;
- strategy;
- partnerships;
- policy implementation;
- legislation;
- regulation; and
- equality and human rights.

## Introduction

3.2 The Policy and Strategy Directorate has a key role in articulating the overall strategic direction for health policy and in providing a sound evidence base to support it. The Directorate undertakes a range of work to embed the principles of health reform in Departmental policy, in both its development and implementation, as well as to promote excellent policy-making.

3.3 The Directorate comprises the central Departmental analytical and strategy functions, including horizon scanning work; the development of new policies for the NHS; and key Department of State functions, including the legislation and

design of the regulatory system for health and social care. The Directorate also acts a focal point for building policy-making capacity across the Department, including equality and human rights and stakeholder management.

## Analysis and evidence

3.4 In response to concerns highlighted in the Department's Capability Review, work is ongoing to strengthen the Department's strategic capability and capacity by improving the Department's analytical capability, in order to support the development of a more rigorous culture of evidence-based policy-making throughout the organisation. There are now programmes in place to:

- improve the commissioning of analysis by reviewing the current distribution of analytical resources, ensuring that senior analysts are more directly involved with the Policy Research Programme and establishing mechanisms for prioritising analytical work across the department;
- ensure the appropriate engagement of analysts in policy by raising awareness of the value and importance of analysis and evidence, implementing a quality assurance framework of analyses, and improving the use of impact assessments (IAs);

- establish formal external networks in order to develop and share analytical best practice on health priorities; and
- develop the capability of the Department's internal analytical resource through a dedicated programme of professional development designed to maintain a skilled and competent analytical workforce.

3.5 The Department has also bolstered its policy-making capacity by:

- launching a monthly Improving Policy Skills course covering the key aspects of the policy-making process;
- publishing *Making Sense of Health & Care*, a comprehensive guide to the content of Departmental policy, and developing an accompanying course;

- holding seven policy master classes to look at key policy challenges in detail; and
- establishing a monthly review of the quality of submissions.

## Strategy

3.6 The Department's Strategy Group is a small, flexible team of around 20 people, working collaboratively across the Department to make policy and delivery decisions more strategically resilient. Their work focuses on four key themes:

- strategic risks and opportunities for the Department;
- improving joined-up working on cross-cutting policy issues across the Department and government;
- improving the coherence in policy formulation across the Department; and

### Examples of this year's Strategy Group projects

**Making change happen:** the Strategy Group has led a project to use the 'four principles of change' across all of the Department's work, to help us continuously improve and ensure that our work has impact:

- leadership and ownership;
- co-production – or working together;
- subsidiarity – or making decisions at the right level; and
- system alignment – or joining up.

**NHS dentistry:** the Strategy Group is providing support to Professor Jimmy Steele in leading an independent review of NHS Dentistry. This was commissioned by the Secretary of State for Health following a Health Select Committee Report into Dental Services published in July 2008. The report covers people's access to NHS services, the quality of care when they get there, and reaching out to provide services for those who do not regularly see a dentist.

**NHS Constitution:** the Strategy Group led the development of the draft NHS Constitution published for consultation in June 2008. They developed the draft following extensive engagement with stakeholders, including patients, the public and staff.

**Ageing:** the Strategy Group is working jointly with the Department for Work and Pensions (DWP) and the Cabinet Office to develop a new cross-government strategy to create an age-friendly Britain. The strategy builds on *Opportunity Age: Meeting the challenges of ageing in the 21st century* (DWP, 2005) to improve services for older people, meet the needs of the ageing population and maximise the benefits for society, including individuals, business and communities. The project involves independent research and analysis as well as engagement with over 450 people across England.



## Building the Department's capabilities

**Customer insight:** this is about understanding the needs and preferences of patients and an increasingly diverse public. The Strategy Group aims to generate insight through the application of consumer research techniques in order to solve policy problems. They work with policy teams and apply these techniques in their own work.

**Horizon scanning:** the Strategy Group provides a guide to the key trends and developments likely to impact on the Department's work over the medium to long term. They work with teams in order to plan ahead to meet these challenges. They provide advice and support across the Department in 'future-proofing' policy.

The Strategy Group oversee the work of the Department's externally contracted **modelling unit**. Modelling helps to assess the impact of policy options by enabling various scenarios to be tested – for example, looking at the impact of variations in prices, workforce and activity levels, and examining the inter-relationships between different policy levers.

- building the Department's capabilities across customer insight, horizon scanning, international evidence and system modelling.

## Partnerships

### Working with external stakeholders and other government departments

3.7 In line with the Department's Development Plan, the Department is continuing to embed better stakeholder engagement practices throughout the organisation. This programme of work ranges from staff induction, training and development through to front-line engagement with stakeholders in the development and implementation of policy.

3.8 As part of a review on improving how the Department works with external partners, directors-general manage a number of key relationships on behalf of the entire Department. A wider strategy is being put in place in order to optimise senior engagement with stakeholders, adding increased value to the delivery of the Department's objectives and sharing insights to support coordination across the Department.

3.9 The Department has reviewed and strengthened the way it works with other government departments on cross-government delivery. Where it shares delivery of Public Service

Agreements (PSAs), the Department has built processes for good partnership working into the governance of these key pieces of work. The Department has also continued to build on its partnership agreements with key departments across Whitehall, including the Department for Communities and Local Government, the Ministry of Defence, the Home Office, the Ministry of Justice, and the Department for Environment, Food and Rural Affairs. These have enabled it to identify at a strategic level key policies and issues where cross-government working is essential in order to successfully deliver the Government's objectives. Good examples of success include taking forward, with the Ministry of Defence, the health commitments in the *Defence Government Command Paper* published in July 2008. Some of these commitments have already been met and significant progress has been made on others. The Department's work with the Home Office on knife crime has led to a much better understanding of how policy should be taken forward and delivered.

3.10 The Department is augmenting existing learning and development in order to give its staff the tools and techniques to improve how they work with external stakeholders. The Department will launch a 'How to' guide on stakeholder engagement and a suite of additional resources in April 2009 in order to support staff on stakeholder engagement



approaches in the development and implementation of policy.

### Working with the third sector

3.11 The third sector is vital in meeting the Government's vision for health reform, in widening choice of provision and bringing care closer to people. During 2008-09, the Department has made good progress in improving the way it works with the third sector and in enabling third sector organisations to play their full part in health and social care. The Department's third sector work is managed through a cross-cutting programme. It is underpinned by the Department's Third Sector and Social Enterprise Delivery Board, which is complemented by an external Sounding Board to ensure that the programme is positioned effectively within the wider, cross-government third sector partnership agenda.

3.12 A key element of the programme is the learning events which help facilitate, support and promote two-way learning between third sector, NHS and Department participants on relevant and timely topics. The events programme continues into 2009.

3.13 The Department has backed up its commitment to the third sector with continuing investment of funds, including the following:

- Section 64 General Scheme of Grants: awards worth a total of £17.6 million to third sector organisations were made in 2008-09: £7.1 million to fund 146 new projects and £10.5 million for the second/third year of 219 projects that started in 2006 and 2007.
- Opportunities for Volunteering Scheme: £6.7 million was made available to support local volunteering projects through this scheme. The scheme is managed on behalf of the Department by 16 national charities, including Age Concern, Mind, Mencap, Scope and RNIB.

3.14 The Department carried out a strategic review of its funding of third sector organisations. The vision for the future included:

- investment in strategic partners;
- support for innovation excellence and service development;
- promotion and support of volunteering through the development of a support strategy and the appointment of a Health and Social Care Volunteering Fund Manager; and
- contracting for expertise required at national level.

3.15 There was strong support for this vision and the principles underpinning this approach.

3.16 Full information about the consultation and copies of the documents are available at: [www.dh.gov.uk/thirdsectorfundingreview](http://www.dh.gov.uk/thirdsectorfundingreview).

3.17 The review was nominated for and won the National Compact Award for Excellence in November 2008. This award recognised the way in which the review and consultation had been delivered in partnership with the nine regional voluntary and community sector networks and a number of other third sector organisations.

### Volunteering in health and social care

3.18 In June 2008, the document *Towards a Strategy to Support Volunteering in Health and Social Care: Consultation* (DH, Third Sector Partnership Team) launched a four-month consultation with third sector, health and social care volunteer-involving organisations. It set out a proposed vision for volunteering in health and social care, as well as perceived obstacles, possible action and solutions.

3.19 Overall, the feedback was positive and supported the vision and approach. Work is now under way to develop a robust strategy on volunteering in health and social care, for publication in summer 2009.



## Strategic Partner Programme

3.20 The 2009-10 business year will see the implementation of the first phase of the Third Sector Strategic Partner Programme. All the strategic partners will work actively with their networks and memberships in order to communicate Departmental policy and direction to third sector organisations, and to build the skills and knowledge in the sector to enable them to engage in local commissioning activity.

## Policy implementation

### NHS Constitution

#### Consultation

3.21 The draft *NHS Constitution* was launched on 30 June 2008 for a period of consultation which ended on 17 October 2008. The consultation process was extensive. It was carried out primarily at a local level, with PCTs engaging many thousands of people and writing reports to their SHAs. NHS East of England, for example, engaged all 125,000 staff in the consultation, and their media campaign resulted in over a million opportunities for people to read coverage of the consultation. The Department also received over 1,000 direct responses from individuals and professional organisations.

3.22 The Constitutional Advisory Forum, made up of leading experts and stakeholders, oversaw the consultation, and presented a report of their findings to the Secretary of State for Health on 11 December 2008.

3.23 The Health Bill 2009, which was introduced in the House of Lords on 15 January, included clauses to reinforce the *NHS Constitution* and embed it in service delivery (see paragraphs 3.46–3.50 for more information on the Health Bill).

#### NHS Constitution launched

3.24 The *NHS Constitution for England* (DH, January 2009) was launched at a breakfast event at 10 Downing Street on 21 January. It was signed by the Prime Minister, the Secretary of State for

Health, the Chief Executive of the NHS and key stakeholders. It was accompanied by a number of other publications: *The Handbook to the NHS Constitution* (DH, January 2009) which acts as a user's guide; *The Statement of NHS Accountability for England* (DH, January 2009); and *The NHS Constitution: Government response to consultation* (DH, October 2008).

3.25 The Department intends to use a variety of means of communication over the coming months in order to help the NHS raise awareness and promote understanding of responsibilities among both staff and patients. The ambition is that the Constitution will form the basis of a new relationship between staff and patients at a local level – a relationship based on partnership, respect and shared commitment where everyone knows what they can expect from the NHS and what is expected from them.

3.26 The *NHS Constitution* is a 'declaratory' document; this means that the detail itself will not be put into legislation. The Health Bill 2009 proposes that all NHS organisations, primary care services, and private and third sector providers supplying NHS services in England should be legally required to have regard to the Constitution. This duty extends to the two key NHS regulators – the Care Quality Commission (CQC) and Monitor. The Health Bill also proposes a duty on the Secretary of State for Health to review and update the Constitution at least every 10 years, and the handbook at least every three years.

3.27 All the rights in the *NHS Constitution* are underpinned by existing law, except the new rights to:

- choices and information to support those choices;
- access to recommended vaccines; and
- rational decision-making on local funding.



3.28 These new rights will be created through new regulations and legal directions, and will come into force from 1 April 2009.

### Additional Drugs Review

3.29 On 17 June 2008, the Secretary of State for Health asked Professor Mike Richards, National Clinical Director for Cancer, to review policy for patients who wish to buy additional drugs privately. It was clear that there was a problem around patients with terminal illness getting access to the right drugs, and that this was causing distress to patients and their families at a very difficult time in their lives.

3.30 During the course of the Review, Professor Richards spoke to over 2,000 patients, members of the public, NHS staff, NHS managers and other stakeholders, and gathered evidence from a wide range of sources.

3.31 The outcome of this work was Professor Richards' report, *Improving Access to Medicines for NHS Patients* (DH, 2008), which was published on 4 November 2008 by the Secretary of State. In an oral statement to the House of Commons, the Secretary of State accepted all 14 of the report's recommendations, and announced a package of measures in response.

3.32 The first part of this package was a series of measures to ensure better local decision-making and greater access to drugs, free of charge, on the NHS:

- supporting the National Institute for Health and Clinical Excellence's (NICE's) proposal for greater flexibility in appraising more expensive drugs for terminally ill patients;
- working closely with the pharmaceutical industry to agree new and more flexible pricing arrangements in order to increase access to new drugs – these will include lower initial prices, with the option of higher prices if value is proven at a later date, and patient access schemes;

- improving the timeliness of the NICE appraisal process for new drugs so that they become available to patients more quickly; and
- improving the quality and consistency of local decisions by setting out core principles to guide PCTs on the funding of new drugs, where there is no NICE guidance in place.

3.33 For those few patients who may still wish to buy additional private care, the Secretary of State accepted the recommendation of Professor Richards that these patients should not have their NHS care withdrawn, as long as the private care can be delivered separately.

3.34 To ensure that the NHS is clear about how they should handle these circumstances, the Secretary of State also published on 4 November 2008 revised guidance for consultation that set out these principles. The consultation on the guidance closed on 27 January 2009, with a total of 146 responses received. The final version, *Guidance on NHS Patients Who Wish to Pay for Additional Private Care*, was published on 23 March 2009.

3.35 Patients and the public can be confident that these measures will mean greater clarity, greater fairness and, most importantly, greater access to a wider range of drugs.

### Incentives for innovation and quality

#### Academic Health Science Centres

3.36 The Government's commitment to fostering AHSCs was set out in *High Quality Care for All: NHS Next Stage Review Final Report* (DH, 2008). The rationale is to identify a small number of health and academic partners best able to realise the synergies between research, teaching and patient care. This, in turn, will better support the delivery of translational research that will benefit patients both nationally and internationally. The best and most successful AHSCs will have the concentration of expertise and excellence that enables them to compete globally with established centres such as



Harvard, John Hopkins and the Karolinska Institute.

3.37 Supported by the Department, an international panel of experts peer reviewed applications for AHSC status from a range of prestigious bodies and interviewed the shortlist. The successful candidates were announced on 10 March 2009.

### Commissioning the payment for innovation and quality

3.38 *High Quality Care for All* included a commitment to make a proportion of providers' income conditional on quality and innovation through the Commissioning for Quality and Innovation (CQUIN) payment framework. The framework is intended to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion throughout the NHS. It makes a proportion of providers' income conditional on locally agreed goals on quality covering the dimensions of safety, effectiveness, patient experience and innovation.

3.39 The Department has since published guidance on how to use the payment framework for CQUIN in 2009-10. Since the publication of the CQUIN guidance, the Department has developed pages on the NHS Institute's PCT portal ([www.institute.nhs.uk/CQUIN](http://www.institute.nhs.uk/CQUIN)) to support SHAs and PCTs in sharing their CQUIN materials.

### Personal health budgets

3.40 *High Quality Care for All* announced that the Department would build on the successes of direct payments and individual budgets in social care by launching a pilot programme to explore the potential of personal budgets in the NHS.

3.41 Personal health budgets, which would be purely voluntary, could improve both the quality of patient experience and the effectiveness of care by giving people greater choice and control over the services they receive. They could work in many

ways, including having a notional budget held by the commissioner, a budget managed on the patient's behalf by a third party, or a direct cash payment to the individual (the Department is currently seeking powers in the Health Bill to allow piloting of direct payments for healthcare).

3.42 The Department published *Personal Health Budgets: First Steps* in January 2009, to establish some key principles and to invite applications for the pilot programme. The aim is to enable PCTs and their partners to be innovative and explore the opportunities offered by personal health budgets, supported by a focused and rigorous evaluation. Around 70 applications were received covering a range of conditions and services. The programme is expected to run for three years, with the first pilots starting from summer 2009.

### European Commission draft directive and current EU regulations on cross-border healthcare

3.43 On 2 July 2008, the European Commission published a draft directive clarifying and codifying the rules on cross-border healthcare. The directive is intended to cover a narrow field relating to a patient's right to receive treatment in another EU country, and to be reimbursed in their own healthcare system under certain circumstances. This has potentially profound consequences for the NHS and contains complex provisions.

3.44 The Department believes that a directive in this area could codify case law, which would provide clarity to patients and member states. As a result of careful background work by the UK and other member states, the draft directive contains various helpful principles. It is now under discussion in European institutions, and a final directive is not expected until late 2009 at the very earliest.

3.45 The Department is the lead negotiator for the UK (consulting colleagues from the devolved administrations). To help inform the UK's negotiating position, the Department held a public



consultation on the issues in late 2008. The Department will continue to push for the best outcome for UK patients and the NHS in negotiations on the draft directive.

3.46 There are also long-standing EU regulations covering how British citizens who work, visit or retire to other European Economic Area member states access healthcare. The Department has a large central budget in support of these costs. This directive will not affect these rules.

## Legislation

### Health Bill 2009

3.47 The Health Bill 2009 was introduced into Parliament on 15 January 2009. It proposes measures to improve the quality of NHS care and the performance of NHS services, to improve public health, and two miscellaneous matters.

3.48 In particular, the Bill enables the implementation of a number of measures arising from *High Quality Care for All*, the final report of Lord Darzi's NHS Next Stage Review.

#### What the Health Bill will do

3.49 The Bill establishes a legal duty to have regard to the *NHS Constitution*, enables the piloting of direct payments for healthcare, creates new 'quality accounts' that will help improve the quality of health services, and introduces innovation prizes to further encourage the enterprise and innovation culture within the NHS. These measures arise from the comprehensive Next Stage Review of the NHS and follow an extensive public and stakeholder consultation process.

3.50 In addition, the Bill will introduce powers to suspend chairs and non-executive directors of SHAs and other health bodies, establish a regime for unsustainable NHS providers, strengthen tobacco control, and reform pharmacy services. These policies were the subject of full public consultations throughout 2008. In particular, the *Consultation on*

*the Future of Tobacco Control* (DH, May 2008) received a vast number of responses, nearly 100,000.

3.51 The Bill also contains two miscellaneous measures. The first is to extend the remit of the Local Government Ombudsman to enable him to consider complaints from people who arrange their own adult social care. The second is to enable Her Majesty's Revenue and Customs to continue to assist in statistical enquiries carried out by or on behalf of the Department relating to the earnings and expenses of GPs and dentists, by providing relevant data in a summarised and anonymised form.

## Regulation

### Better regulation

3.52 The Department is committed to ensuring delivery of its priorities through better regulation.

#### Better regulation culture governance

3.53 The better regulation agenda is supported by a Departmental Board-level Better Regulation Champion and a better regulation network of officials throughout the Department and key arm's length bodies. Delivery of the agenda is overseen by the Department's Policy Committee, a committee of the Departmental Board, and supported by the Better Regulation and Simplification Branch. Supporting action includes:

- a rolling programme of targeted training for business units on IAs, administrative burdens, data burdens, consultations and the Simplification Plan; and
- a Departmental External Gateway and Financial Challenge panel for public sector policy proposals.

### Simplification Plan and Administrative Burdens Measurement Exercise

3.54 The Department (like other government departments) participated in the Administrative Burdens Measurement Exercise in 2005-06. The administrative cost of compliance for the private



sector with the Department's 90 regulations in force in May 2005 was £1.2 billion. The Department has agreed to aim for a net reduction of 25 per cent (ie £300 million) by March 2010.

3.55 The Department published its third annual *Simplification Plan* in December 2008, which details progress towards the 25 per cent burden reduction target and how the Department proposes to deliver its key priorities, through better regulation, to 2010. The programme covers work to address regulatory burdens on NHS and social care front-line services and the Department's business and third sector partners while continuing to safeguard public health, ensure medicines are safe and effective, and that those providing care services continue to ensure protection for the vulnerable and elderly.

3.56 The plan builds on the tradition of reducing bureaucracy in the private and public sector and the *2008 Simplification Plan* included the following key initiatives:

#### Private sector

- Better Regulation of Medicines Initiative (BROMI) Variations Regulations – saving £12 million.
- BROMI self-certification labelling – saving an estimated £900,000.
- Medicines and Healthcare products Regulatory Agency (MHRA) removal of fee category – saving the industry £2.5 million.
- Electronic prescription system – reduce annual administrative burdens by £37.9 million, best case scenario and once the system is fully bedded.

#### Public sector

- The Department continues to make positive progress in delivering *Cutting Bureaucracy for our Public Services* (the Stationery Office, 2007), a better regulation strategy for the public sector across government.
- The autumn *Pre-Budget Report 2007* (HM Treasury, October 2007) introduced a target to

reduce the data burden on the front line by 30 per cent by 2010. The Department is working with key stakeholders, including the Information Centre for Health and Social Care, in order to achieve this. To date the Department has made a 10 per cent reduction in health data collections and a 29 per cent reduction in social care data collections.

- Increased importance has been placed on the work of the Provider Advisory Group for regulators in healthcare. This group represents the wide range of healthcare providers, and they have been instrumental in advising on the impact of existing and proposed regulatory frameworks. During the last year, they have brought focus and pace to work on reducing duplication and bureaucratic burdens, through identifying and removing key irritants.

#### Better regulation Europe

3.57 The European Council agreed to set a target to reduce administrative burdens derived from EU legislation by 25 per cent by 2012. An EU-wide burdens measurement exercise has taken place and the European Commission is taking fast-track action, to reduce burdens in priority areas, which include pharmaceutical and clinical trials. BROMI has been adopted by the EU, streamlining processes without changing the regulations. MHRA are taking the lead on a number of key EU initiatives:

- BROMI principles adopted for EU burdens reduction on medicines regulation;
- simplification of medicines variation regulations; and
- developing common standards for the electronic transfer of data between EU members.

3.58 These initiatives have the potential for significant UK and EU burdens reduction.

#### Impact assessments

3.59 Forty-five IAs were published on the Department's website in 2008-09; in addition,



12 full final IAs, accompanying regulations, were placed in the libraries of both the Houses of Parliament. The Department's compliance with the IA process was 100 per cent during this period. No legislation introduced by this Department included a sunset clause (which allows a law to be removed automatically after a fixed period unless action is taken to keep it in place).

3.60 Regulatory measures stemming from the EU and supported with an IA included:

- The Medical Devices (Amendment) Regulations 2008; and
- The Medicines for Human Use (Clinical Trials) Regulations 2004.

### Legislation

3.61 Two Department of the Health Bills (the Health and Social Care Bill and the Human Fertilisation and Embryology Bill) received Royal Assent during 2008-09.

3.62 The Department made 115 Statutory Instruments (including Orders that are not laid before Parliament) during the period April 2008 to March 2009.

### Post-implementation reviews

3.63 During 2008-09, the Department and its agencies began a number of reviews including:

- The Medicines (Advisory Bodies) (No. 2) Regulation 2005; and
- The Medicines (Traditional Herbal Medicinal Products for Human Use) Regulations 2005.

### Taking a more risk-based approach enforcing regulation – the Care Quality Commission

3.64 The CQC was established in October 2008. On 1 April 2009, it took over as the regulator for health and adult social care. The new Commission brings together roles previously carried out by three bodies – the Commission for Social Care Inspection, the Healthcare Commission and the

Mental Health Act Commission. This is in line with the Department's Arm's Length Bodies Review and the *Hampton Review's* recommendation for fewer, sector-based regulators.

3.65 The new regulator will carry out its functions in accordance with the Government's five principles of better regulation, ie activities should be proportionate, targeted, accountable, consistent and transparent.

3.66 Under duties set out in the Health and Social Care Act 2008, the CQC is required to operate with regard to the broader principles of better regulation in order to:

- ensure its actions are proportionate to risk;
- reflect best practice among other regulators and inspectorates;
- co-operate with particular bodies;
- engage with service users and carers;
- appoint an advisory committee;
- consult on and publish details about when and how it will carry out inspections; and
- carry out its functions effectively, efficiently and economically.

3.67 The new regulator will also have a number of powers designed to ensure that, working in collaboration with other sector gatekeepers, the burden on the front line, that is created by other bodies operating in the health and adult social care sector is minimised.

3.68 The Secretary of State announced the appointment of Baroness Young as shadow chair of the CQC on 15 April 2008. Cynthia Bower was subsequently appointed shadow chief executive. Five of the six commissioners have been appointed, and key director-level appointments have been made.

### Sponsorship of the Commission

3.69 The Department of Health has sought to build a trusting relationship with the new CQC,



where it encourages and promotes its independence within a framework where everyone's roles are clear. An interim framework document has been agreed to govern the relationship between the Department and the CQC.

### Public consultations

3.70 During the last 12 months, the Department has continued to ensure high levels of compliance of its public consultations with the Government's Code of Practice on Consultation. Of the 48 public consultation exercises undertaken, 39 (81 per cent) were compliant with all the criteria. Of the nine consultations that did not meet all the criteria, all were either technical consultations with an extremely limited audience, or consultations with a short timeframe that were part of a policy development process involving a significant proportion of other stakeholder engagement activities.

3.71 The Department played an active role in the development of the Government's new Code of Practice, supporting the work led by the Better Regulation Executive. This was launched in November 2008, and during 2009 the Department will be launching a toolkit for policy leads to ensure consistent best practice in consultation activities. During 2009, the Department is also working with all of our arm's length bodies to ensure that the Code, its associated guidance and the Departmental toolkit are available and implemented in their consultation activities. The Department will be listing all the arm's length bodies that have applied the Code to their activities and it is anticipated that their compliance will be similarly reported.

3.72 Embedding the role of Departmental Consultation Co-ordinator within the Better Regulation team has enabled a focus on the openness and transparency of Departmental policy development. During the year, of the 48 public consultation exercises undertaken, all have either had a summary of consultation responses already published, or are in the process of doing so.

3.73 The Department has continued to promote active engagement in consultation, being inclusive and adopting innovative methods to help deliver high-quality policy development and service redesign. The Department's public-facing consultation work has built on a range of different approaches to stakeholder engagement reflecting the varying size and scale of our consultation exercises. This has included qualitative interviews and discussion groups, quantitative surveys and a variety of online responses and discussion forums. There has also been an increase in more deliberative forms of engagement, participation and co-production.

### The new regulatory framework for health and adult social care

Healthcare-associated infections and arrangements for 2009-10

3.74 From April 2009, changes have been introduced to the arrangements for regulation in relation to healthcare-associated infections. NHS bodies are required to register with the CQC and to provide assurance that they are protecting people from healthcare-associated infections. The CQC will have a wider range of enforcement powers than the Healthcare Commission. Plans to carry forward the existing Health Act 2006 *Code of Practice for the Prevention and Control of Healthcare Associated Infections* into this new environment were consulted on during summer 2008. The Government's response to this consultation was published, and all relevant regulations laid on 12 January 2009. These regulations were debated in both Houses of Parliament and came into force on 1 April 2009.

Registration of health and adult social care providers

3.75 The consultation on the framework for the registration of health and adult social care providers for 2010-11 onwards closed on 17 June 2008. It attracted 230 responses from a wide range of organisations and individuals, with strong support for the main high-level questions and the extension of the registration system to primary care providers.



There were also proposals to bring additional areas not covered in the consultation into registration. In response to comments received, the Department has developed a more rigorous evidence base and methodology for assessing risk, which is informing decisions on the scope of registration. Respondents also submitted a range of constructive suggestions for improving the detail of what should be in the requirements.

3.76 On 30 March 2009, the Department published a response to this consultation and launched a consultation on the secondary legislation. The document does the following:

- responds to the previous consultation on scope, registered managers, registration requirements and primary care;
- launches the next consultation on the draft regulations, which will set scope and the registration requirements into secondary legislation;
- sets out and consults on the policy related to the other regulations required to support the registration framework; and
- enables the CQC to progress with developing its systems.

3.77 It also communicates the Department's overall policy on the registration framework for health and adult social care and set outs how it fits within the overall regulatory framework and the quality framework in *High Quality Care for All*.

## Equality and human rights

3.78 The Department continued to promote equality and human rights as central to health and social care delivering good-quality services to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. This is a core principle of the *NHS Constitution* and is an integral part of the work of the Department.

## Reporting on equality and human rights

3.79 The Department's draft Single Equality Scheme set out how it will progress action on discrimination across the six equality strands. Representing all equality strands, the Scheme is scheduled for publication in 2009. The Scheme reflects new arrangements for supporting the production of equality impact assessments (EqIA).

3.80 On 1 December 2008, the first *Secretary of State: Report on Disability Equality: Health and Care Services* was published. The report sets out progress since the introduction of the Disability Equality Duty and identifies a range of actions for capitalising on that progress, highlighting policies from across the Department and those made jointly with other stakeholders that support equality of opportunity for disabled people.

3.81 During 2008, SHA chief executives reported on their plans for improving disability equality locally. The results will help shape the 2009-10 disability equality programme.

## Governance of equality and human rights

3.82 A high-level Equality and Human Rights Assurance Group (EHRAG) was established early in 2009. A sub-group of the Departmental Board, it provides clear leadership and challenge across the equality and human rights agenda. The Equality Monitoring Group has continued during the year, providing leadership on the collection and use of equality data across the NHS and social care. Over the next year, the group will link more closely to the work of EHRAG.

3.83 An independent review of how equality stakeholders engage with the Department commenced during the year, with findings due to be reported during 2009-10. The review will consider arrangements currently in place including those through the Gender, Age Discrimination, Human Rights in Health and Social Care and Lesbian, Gay, Bisexual and Transgender Advisory Groups, as well as more ad hoc stakeholder arrangements.



## Equality Bill

3.84 The Department has worked closely with the Government Equalities Office on the matters covered by the Equality Bill, and on the proposed EU directive banning discrimination in services on grounds of disability, race, religion or belief, gender or sexual orientation. In addition, a specific work programme to tackle unjustifiable age discrimination in health and social care has been established.

## Supporting equality and human rights

3.85 The Department continues to provide guidance and support through publications and activity-based programmes. Publications this year have focused on the equality strands within the Equality Bill not previously covered by legislation; these included practical guides for the NHS on religion or belief, sexual orientation and transgender issues.

3.86 Phase 2 of the Human Rights in Healthcare project ended in October 2008 with the delivery of the second edition of *Human Rights in Healthcare: A framework for local action* (DH, 2008). There is continuing support to other NHS-based equality programmes including Pacesetters, Race for Health and Single Equality Scheme learning sites. A total of 75 trusts participate in the three programmes and their progress is reported through a monthly e-bulletin.

3.87 Specific equality programmes, such as Valuing People Now (learning disability) and Delivering Race Equality (in mental health care), are reported in chapter 13 of this report.

## Social exclusion

3.88 The socially excluded adults PSA is a key part of the Government's commitment to improving the life chances of vulnerable groups. The long-term costs of failing to tackle social exclusion are significant, not only for individuals themselves but also for their families, for local

communities and services, and for society as a whole. The challenge to public services is also clear: too often vulnerable individuals fall between service providers, are not given the range of support they need, or fall out of contact with services entirely.

3.89 The socially excluded adults PSA aims to ensure that excluded adults have the resources and foundations to live a more stable and successful life, by increasing the proportion of four at-risk client groups in settled accommodation and in employment, education or training. These client groups are:

- adult offenders under probation supervision;
- care leavers;
- adults with moderate to severe learning disabilities; and
- adults in contact with secondary mental health services.

3.90 In focusing on these four client groups the PSA is not intended to cover all socially excluded adults. Instead, it represents a first step in challenging systems and services to be more responsive to individuals with complex needs, with the expectation that where it is successful for these groups, there will be valuable lessons and benefits for all vulnerable individuals.

3.91 The Department has lead responsibility for the learning disability and mental health client groups. In 2008-09, the Department started to collect data for the baseline. The Department jointly owns four of the indicators for this PSA, all of which require the establishment of new data collections. The Department has also begun work on strategies to deliver the employment outcome for the learning disability and mental health client groups, both of which are due to be completed in 2009.

3.92 The key partner departments are:

- the Cabinet Office (lead department);
- the Department for Communities and Local Government (accommodation outcome); and
- the Department for Work and Pensions, the Department for Innovation, Universities and Skills, and the Department for Children, Schools and Families (employment outcome).

3.93 Cross-government working takes place at the PSA 16 Delivery Board for senior officials and the Life Chances Sub-Committee on Social Exclusion for government ministers. The Department is working closely with the regional tier in Government Offices and intends to work through deputy regional directors of social care to develop regional delivery plans. At the front line, health and social care services, as well as employment and housing agencies, are all critical to delivering improved outcomes.



# 4 Communications

## Role

To promote better health, better care and better value through first-class communications and social marketing.

### Key achievements in 2008-09 included:

Launched Change4Life.

Provided communications to support the launch of *High Quality Care for All*.

Delivered an integrated communications programme to celebrate the NHS's 60th anniversary.

Developed and implemented a new tobacco control marketing strategy.

## Summary

4.1 In this chapter you will find information on:

- background, purpose and structure;
- strategic overview for 2008-09;
- marketing campaigns and communication programmes;
- working with regions;
- financial reporting, evaluation and accountability; and
- plans for 2009-10.

## Background, purpose and structure

4.2 Both the structure and the culture of the Communications Directorate are focused on audience groups. The Directorate's objectives for each group are:

- for NHS patients and service users:
  - to increase trust and confidence in the NHS and social care services by improving and managing the reputation of these systems and the Department;
- for the public:
  - to enable people to take responsibility for their own health and the health of their children

by providing information that is relevant and motivating for them;

- to explain the Department's policies clearly and succinctly; and
- to make ministers and senior officials available and accountable to the media and the public; and
- for the Department, NHS and social care staff:
  - to help build confidence and promote cultural and behavioural change; and
  - to engage Department staff in decisions about how the Department operates.

4.3 The range of functions comprises:

- the media centre, which is responsible for providing a full media relations service to ministers, the NHS and wider Department;
- the NHS and social care marketing team, which is responsible for creating, delivering and evaluating behaviour change marketing programmes;
- the NHS communications team, which is responsible for developing and delivering the communication and engagement strategy for NHS staff and stakeholders, and for providing leadership across the NHS for communications;
- the corporate communications team, which is responsible for departmental staff communications

and engagement, electronic communications and the Department's publishing programme; and

- the strategy, planning and insight team, which is responsible for advising on communications strategy, managing departmental brands, developing and disseminating audience insight and providing a range of support services to the Directorate.

## Strategic overview for 2008-09

4.4 The Communications Directorate operates by supporting other parts of the Department to achieve their policy objectives. It has the flexibility to change the focus of its activities each year to fit with changing priorities.

4.5 In 2008-09, the Department's strategic priorities were:

- better health and well-being for all: reducing the burden of lifestyle diseases, reducing health inequalities and preparing for an influenza pandemic;
- better care for all: enhancing the local transformation of the NHS and developing a strategy for the reform of social care; and
- better value for all: developing the Department's capability, working across government, delivering its Department of State functions, delivering high-quality, cost-effective support services and facilitating the delivery of better value for money.

4.6 The Communications Directorate supports each of these objectives in different ways:

- It supports better health and well-being for all by running a series of behaviour change marketing programmes. In 2008-09, the Directorate has: delivered a range of communications activity around health-risking behaviour, including launching the Change4Life campaign to help families make better decisions about diet and activity; campaigned on major health protection issues; and worked to prepare communications

activity to reduce the impact of an influenza pandemic.

- It supports better care for all by delivering communications activity to enable the local transformation of the NHS and to build understanding of the reform of social care. In 2008-09, the Directorate: delivered a major communications programme to support the publication of *High Quality Care for All* and the NHS Constitution; worked with the NHS communications community to develop capacity and capability; developed a new brand strategy to make better use of the NHS corporate identity; and developed an insight-led strategic communications strategy to support the reform of social care.
- It supports better value for all by a series of measures to improve transparency, capability, cross-government working and support to ministers. In 2008-09, for example, the Communications Directorate provided ministers with a media function and visits programme; supported the departmental development plan with a series of internal events and products; and developed new standards for evaluating marketing campaigns.

4.7 The Directorate is staffed primarily by communications specialists, who have been recruited against a set of competences specified by the Government Communications Network, in addition to the generic skills specified by Professional Skills for Government. In January 2009 the Directorate produced a strategic framework – *Promoting Health and Care* – that sets out for an internal audience its commitments for delivering excellence in communications.

## Marketing campaigns and communication programmes

4.8 The purpose of the Department's public health social marketing activity is to support people in making better choices about those decisions that impact on their and their family's health. The



investment in advertising-led campaigning in 2008-09 was in excess of £60 million (refer to **figure F.1** in annex F). The most significant areas of investment were tobacco control and anti-obesity marketing, although the Department delivered campaigns on a broad range of other issues throughout the year.

## Tobacco control marketing

4.9 A new, three-year tobacco control marketing strategy was developed in 2007. Building on previous successful campaigns, this strategy represented a new focus for the Department: it was targeted exclusively at one segment of society (routine and manual workers) and had a greater emphasis on driving campaign response and channelling smokers who wished to give up through NHS support services. The first campaign based on the revised strategy was launched in December 2007, and drew the highest volume of response ever received by a smoking cessation campaign (over 800,000 total responses). Campaign recognition also reached an all-time high (93 per cent), with 44 per cent of smokers who had seen the campaign claiming to take some quitting-related action.

4.10 In the course of 2008-09, the Department delivered a series of campaigns designed to drive

further response; to provide better support during the quitting process; or to reinforce the motivation to give up. The campaigns have consistently delivered outstanding results, and overall response levels to date are significantly up, compared with 2007-08 activity. Between April and December 2008, marketing activity generated over 1.5 million responses, 714,000 more than the same period in 2007. The 'Wanna Be Like You' and 'Scared' campaigns targeted routine and manual worker audiences and both achieved 84 per cent prompted awareness.

## Change4Life anti-obesity marketing

4.11 In March 2008, *Healthy Weight, Healthy Lives: A cross-government strategy for England* (HM Government, 2008) to help people maintain a healthy weight, was published. This committed the Department to developing a major marketing initiative to help parents of younger children, in the first instance, to understand the health risks of behaviours related to poor diet and low physical activity, and make better health-related decisions.

4.12 Change4Life, the programme developed to deliver this strategy, was launched to stakeholders in October 2008 and to the public in January 2009. As a complex, multi-phased marketing programme,

Figure 4.1: Marketing awards, 2008-09

Issue	Awards	Category	Awarded for...	Date awarded
Tobacco control	Thinkbox TV Brilliance	June TV Brilliance: winner	'Wanna Be Like You', June 2008	July 2008
	Marketing Week: Marketing Effectiveness	Best Public Sector campaign of year: winner	'Get Unhooked', January to March 2007	November 2008
	Marketing Week: Marketing Effectiveness	Best Campaign of year: winner	'Get Unhooked', January to March 2007	November 2008
	Civil Service Awards	The Communication Award: winner	Tobacco control marketing comms strategy, 2008-10	November 2008
	Health Business Awards	NHS Publicity Campaign: winner	'Wanna Be Like You', June 2008	December 2008
Alcohol harm reduction	Health Business Awards	NHS Publicity Campaign: runner-up	'Units: they all add up'	December 2008
Frank: substance abuse advice	IAB creative showcase	December creative showcase: winner	Cocaine	December 2008
	FWA	Site of the day: winner	Cocaine	January 2009
Hepatitis C	IVCA Awards	Best documentary: gold award	Inside & Out – prison DVD	April 2008
	IVCA Awards	Best direction: bronze award	Inside & Out – prison DVD	April 2008
	IVCA Awards	Best editing: bronze award	Inside & Out – prison DVD	April 2008
	Communiqué awards	Best patient or public campaign	FaCe it campaign	July 2008
	PRCA Awards	Public sector campaign award	Hepatitis C awareness	November 2008
	New York International Film and Video Awards	Gold award	Inside & Out – prison DVD	January 2009

Source: Communications Directorate, DH.



scheduled to build over a three-year period and develop a movement to promote healthy behaviours, there are limits to the type of evaluation available at this point. However, the early indicators – concerning the level of awareness and response from launch – are positive. The website received more than 250,000 visits to the homepage in the first month; over 2 million items of collateral were requested by NHS staff; and by early February 2009, 34 major commercial partners had signed up to support the movement. After the first month, the campaign had achieved 61 per cent logo recognition among the general public, an unprecedented level of brand awareness in government health campaigning.

4.13 In addition to these programmes, in the course of 2008-09, the Department developed and delivered marketing strategies to cover a wide range of health improvement and protection issues, including: alcohol harm reduction; sexual health; drug misuse; influenza vaccinations; hepatitis care awareness; and respiratory hand hygiene campaigning.

4.14 In 2008-09, marketing activity was increasingly delivered in cooperation with or by regional teams. The tobacco control marketing strategy involved the recruitment of a specialist regional marketing agency in order to increase capacity and activity in priority regions in the first instance. The Change4life programme insight and research were shared with regional teams through a rolling roadshow from September 2008.

### NHS60 and High Quality Care for All

4.15 On 5 July 2008, the NHS celebrated the 60th anniversary of its founding. For the Communications Directorate, this provided an opportunity to: improve public confidence in the NHS; raise staff morale; deliver health and well-being messaging, particularly to children and young people; and support publication of *High Quality Care for All*, the NHS Next Stage Review final report, which was launched to coincide with the anniversary.

4.16 The strategy was to organise a small number of high-profile national events such as a National Service of Celebration at Westminster Abbey, and to encourage and support stakeholder and local NHS organisations to organise their own activities, as it was known that these would be most relevant and credible to staff and the public. The local NHS and stakeholder organisations were encouraged to support the anniversary through meetings, and a toolkit with collateral for NHS communicators was publicised via NHS Comms Link, the secure website for NHS communicators. This cooperative approach to the celebration ensured maximum impact, for relatively small investment. As a key focus of the anniversary was the provision of services to children, the Department also commissioned Michael Rosen, the Children's Laureate, to write a poem to celebrate the NHS at this time.

#### *These Are The Hands* by Michael Rosen

These are the hands  
That touch us first  
Feel your head  
Find the pulse  
And make your bed.

These are the hands  
That tap your back  
Test the skin  
Hold your arm  
Wheel the bin  
Change the bulb  
Fix the drip  
Pour the jug  
Replace your hip.

These are the hands  
That fill the bath  
Mop the floor  
Flick the switch  
Soothe the sore  
Burn the swabs  
Give us a jab  
Throw out sharps  
Design the lab.



And these are the hands  
 That stop the leaks  
 Empty the pan  
 Wipe the pipes  
 Carry the can  
 Clamp the veins  
 Make the cast  
 Log the dose  
 And touch us last.

4.17 Partly as a result of this activity, the anniversary produced over 700 items of media coverage, more than two-thirds of which were positive. Awareness of the anniversary among the public increased from 8 per cent in June 2008 to 42 per cent in July, while awareness amongst NHS staff rose from 60 per cent to 97 per cent over a similar period. This heightened awareness reinforced positive feelings towards the service.

4.18 The Communications Directorate worked with colleagues across the Department to support the launch of *High Quality Care for All: NHS Next Stage Review Final Report*, in June 2008. After publication, the Directorate worked with the project leads of all 90 commitments to ensure that communications aspects were considered, and led on the creation of an overarching narrative to explain the direction in which the NHS is moving.

### NHS Constitution

4.19 On 21 January 2009, the Prime Minister and the Secretary of State signed the NHS Constitution, the first in the history of the NHS. The Communications Directorate supported the Constitution with a communications strategy that covered both the period before the signing – including a 17-week consultation period – and the extended period afterwards, explaining the importance of the Constitution to staff and patients. The signing of the Constitution represents one milestone in a multi-phased engagement process, with the next period (to autumn 2009) dedicated to building awareness and understanding of the NHS Constitution among staff groups, who the

Department knows are, in turn, a trusted source of information for patients. At the heart of this approach is the principle of co-production, with the Communications Directorate working closely with NHS communicators and other stakeholders.

### Corporate communication

4.20 As part of the Departmental Development Plan initiative, the Directorate introduced a fully revised internal communications programme in the course of the year, including a new face-to-face briefing system, to ensure a better cascade of leadership messages to staff and a more formalised feedback loop. Another key element of this revised programme of activity was the Department's first all-staff events, held in London and Leeds and attended by over 2,000 Department staff. Some 85 per cent of attendees rated the events as 'good' or 'very good'.

4.21 The work on the Development Plan was part of a broader range of corporate communications activity delivered by the Department in 2008-09. The Communications Directorate is responsible for the departmental website, which recorded approximately 1 million visitors each month throughout this year. It also manages the Department's publications programme, providing 34 million copies of documents to NHS and public enquirers in the course of the year.

### Social care bulletin

4.22 As part of its objective to support the reform of social care, the Communications Directorate has brought up-to-date, easy-to-read explanations of the latest policy news to social care staff and stakeholders in the quarterly *Social Care Bulletin*. Over 5,000 staff now subscribe to the bulletin. The Communications Directorate also helped to launch the first ever People's Award for Dignity in Care in January 2009, as part of the wider Health and Social Care Awards. The award will help to identify best practice and encourage individuals and organisations to embed dignity as a core care principle across health and social care sectors.



## Media centre

4.23 The Department's media centre is a 24-hours-a-day, seven-days-a-week operation, which supports ministers in communicating the detail of often complex health policy to the media, and provides the media with a point of contact for their range of queries. In the course of 2008-09, the media centre issued approximately 440 press releases, and dealt with an average of 10,000 media enquiries each month. It dealt with stories including the creation of new GP health centres and extended opening hours, progress on the 18-week target, the Human Fertilisation and Embryology Act 2008, tackling healthcare-associated infections, mental health, social care and the publication of *High Quality Care for All*. The media centre also generated coverage for public health advice around smoking, alcohol, cancer and stroke.

## Working with regions

4.24 The Department provides professional leadership across the NHS for communications; and an objective of the Communications Directorate is the development of capability and capacity of NHS communicators. The Communications Directorate manages a range of communication channels to help engage NHS staff and stakeholders' understanding of, and engagement in, their roles. In 2008-09, it produced 155 bulletins, tailored to different staff groups including nurses, GPs, chief executives and allied health professionals. In addition, the NHS Comms Link site for NHS communicators was redeveloped and relaunched to provide easier access to a range of information and tools and better networking opportunities. The service has more than 4,000 registered users, and recorded on average 6,646 visits each month throughout 2008-09.

4.25 The Communicate 08 conference on 5-6 November brought together 300 NHS communicators to share knowledge and best practice from a series of expert contributors and one another. Cooperation between the Department and the NHS on communications issues will be further

enhanced by the proposed development of NHS Online which was scoped in the course of 2008-09, and is due to be piloted in 2009-10. The media centre liaised regularly with regional press teams, providing advice and support.

## Financial reporting, evaluation and accountability

4.26 Departmental communication programmes report regularly to ministers and Parliament, both on investment and outcomes from their activity. Total promotional spend for 2008-09, as well as sponsorship paid and received, is listed in **figure F.2** and **F.3** in annex F.

4.27 The Communications Directorate invests in a variety of research to inform communications planning and evaluate the impact of its activity. In 2008-09, the total invested in communications-specific research was more than £3.3 million. The communications research programme includes tracking the attitudes towards the NHS of the public every four months and of staff every six months, as well as a range of projects targeted at specific audiences, including users of social care services. Reports are published regularly on the Departmental website as part of the Freedom of Information publications scheme. In addition, the Directorate provided extensive evidence to the House of Lords Select Committee on Communications, for their report on the implementation of the Phillis Review recommendations (*1st Report of Session 2008-09: Government Communications*, The Stationery Office, January 2009).



4.28 According to the most recent public research available at the time of publication (**figure 4.2**), public satisfaction in the running of the NHS was 73 per cent. This is the highest figure since the tracking survey began in 2000.

4.29 Ensuring value and return on investment is a high priority for the Communications Directorate. In 2008-09, it completed a review of best practice evaluation of marketing activity, which both set clear standards on evaluation and created a set of tools to help campaign teams achieve these. The Department's marketing evaluation principles anchor marketing activity in behaviour change theory, and reinforce the need to work with regional colleagues to pilot activity before rolling it out nationally.

## Plans for 2009-10

4.30 In 2009-10, the Communications Directorate will continue to support ministers in developing public understanding of government health policy, especially around challenging issues

such as maternity services, dentistry and health inequalities.

4.31 The Directorate will continue to lead behaviour-change social marketing programmes, including the second phase of Change4Life, as it moves beyond its families core target audience. The Directorate will support the Department in delivering *High Quality Care for All*, and communicating to patients, NHS staff and the public the improvements that have been made since publication of the review last summer.

4.32 The Communications Directorate will lead on further developing capacity and capability across the NHS communications community. This will include delivering the 'what good looks like' project to set clear standards and expectations for all NHS communication – both at an organisational and an individual level. It will also deliver the NHS Online service. Delivering robust strategic communications activity across the NHS will help to achieve key policy agendas, such as world class commissioning, which include a requirement to demonstrate communications competency at organisational level.

Figure 4.2: Overall, how satisfied or dissatisfied are you with the running of the NHS nowadays?



Source: Ipsos MORI/DH Public Perceptions of the NHS Tracker, December 2008.

4.33 The Communications Directorate will continue to be involved in finding new ways to present the NHS – both services and advice – in a clear, coherent and easily accessible way for patients and the broader public. Projects such as the development of an overarching digital strategy for the Department, NHS and social care information and the review of the uses made of the NHS brand will provide ministers and NHS leaders with specialist advice and recommendations.



# 5 Department of Health Finance

## Role

To acquire, allocate and account for the financial resources required to deliver objectives across the Department and the NHS.

### Key achievements in 2008-09 included:

- Revenue allocations to primary care trusts for 2009-10 and 2010-11.
- Made ready to implement the International Financial Reporting Standards (IFRSs) in 2009-10.
- Made progress toward 'faster closure' of the Departmental resource account.

## Summary

5.1 In this chapter you will find information on:

- revenue allocations to primary care trusts for 2009-10 and 2010-11;
- International Financial Reporting Standards;
- faster closure of the annual accounts;
- 2007 Comprehensive Spending Review (CSR) settlement; and
- value for money.

## Introduction

5.2 This chapter is structured in three sections. The first section discusses achievements in finance in 2008-09. The second section looks at the resources available to the Department following the CSR settlement for the years 2008-09, 2009-10 and 2010-11, and how these funds flow through the NHS and the wider Department. It links to detailed tables in annex A. The final section discusses value for money.

## Revenue allocations to PCTs for 2009-10 and 2010-11

5.3 Revenue allocations to PCTs for 2009-10 and 2010-11 were announced in December 2008 on the basis of a new funding formula developed by the Advisory Committee on Resource Allocation

(ACRA). The allocations represent £164 billion investment in the NHS, £80 billion in 2009-10 and £84 billion in 2010-11. PCTs will receive an average increase in funding of 11.3 per cent over the two years, a total increase of £8.6 billion. Further information about these and earlier allocations can be found at: [www.dh.gov.uk/allocations](http://www.dh.gov.uk/allocations).

5.4 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 PCT populations adjusted for:
  - their age distribution;
  - additional need over and above that relating to age; and
  - unavoidable geographical variations in the cost of providing services (the market forces factor).
- Recurrent baselines – representing the actual current allocation that PCTs receive. For each allocation year, the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year.
- Distances from targets – the differences 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.

- Pace of change policy – determining the level of increase that all PCTs receive to deliver on national and local priorities, and the level of extra resources focused on under-target PCTs to move them closer to their weighted capitation targets. PCTs do not receive their target allocation immediately but are moved to it over a number of years in order to minimise financial instability in the NHS, and in recognition of the fact that there are unavoidable cost pressures that all PCTs will need to meet. The pace of change policy is decided by ministers for each round of allocations.

## International Financial Reporting Standards

5.5 As part of the government-wide initiative, the Department implemented IFRSs on 1 April 2009. This will bring benefits in consistency and international comparability of financial reports.

5.6 The Department continues to make good progress and a significant amount of work has already been performed to prepare for the transition, including the establishment of a project group and work streams to look at individual areas.

5.7 In achieving this progress, the Department has worked very closely in partnership with the National Audit Office, the Audit Commission and Monitor (the Independent Regulator of NHS Foundation Trusts). IFRS will result in changes in accounting for, and disclosure of, many of the transactions entered into by the Department, the NHS and arm's length bodies (ALBs).

5.8 As part of the groundwork for these changes, a restatement of the opening balance sheet (as at 1 April 2008) has been undertaken by the core Department, the NHS and each ALB. In addition, the Department has worked with HM Treasury to provide them with data at key trigger points over the past year, and this has included extensive

analysis for the financial instrument accounting standards.

## Faster closure of the annual accounts

5.9 It has been a key objective for 2008-09 that the Department will lay an unqualified resource account before Parliament prior to the 2009 summer recess. Largely because of the complexity of the Department's relationship with the NHS, and the fact that currently it has to consolidate over 200 separate accounts, the Department is the last government department to achieve faster close of the resource account. The anticipated July delivery date represents a whole three-month improvement on the 2007-08 laying date of 9 October. Successful delivery of this objective has depended on detailed project planning both within the Department, and by key partners in the NHS and ALBs. All key partners have formed separate implementation groups to drive progress within their own area of influence, not least by identifying local faster close champions to change attitudes and culture, by providing necessary training, by the sharing of best practice and by critically assessing organisational readiness for the change. Lasting success also depends on a general recognition that accounting should be a whole year, and not just a year-end, process.

5.10 Governance for the faster close project has been provided by a high-level steering group with a direct link to the Department's Audit Committee. In achieving this good progress, the Department and its partners have collaborated closely with colleagues from the National Audit Office and the Audit Commission. Achieving pre-recess close of the accounts in 2008-09 is by no means the end of the story. Faster close must now become part of mainstream Departmental business, achieved (and improved on) in each and every year through a process of continuous business and system improvement. As part of this improvement process, in 2009-10 the Department intends to work with IT partners in order to implement a commercial



consolidation package to drive further improvements. This will put it in a strong position to meet the challenges posed by HM Treasury's desire to align accounting, budget and estimates processes to an ever more challenging timetable.

## 2007 Comprehensive Spending Review settlement

5.11 In the *Pre-Budget Report 2007* (HM Treasury, October 2007), the Chancellor announced the 2007 Comprehensive Spending Review (CSR 2007) settlement for the Department covering the financial years 2008-09, 2009-10, and 2010-11 (Refer to **figure A.1** in annex A).

5.12 As is usual, the opening position for these years has changed slightly via the quarterly estimates process, to reflect minor changes in the disposition of funding between the NHS and Personal Social Services (PSS), technical accounting changes, and transfers of function and funding between the Department and other government departments.

5.13 However, the *Pre-Budget Report 2008* (HM Treasury, November 2008) announced changes that have a material impact on the Department's funding in these years.

5.14 A £5 billion increase in the Government's value for money target was announced for 2010-11. The Departmental contribution to this new target was announced in Budget 2009 at £2.3 billion. This is reflected in an equivalent reduction in the Department's revenue Departmental Expenditure Limit (DEL) in 2010-11 (refer to paragraph 5.53 for further details).

5.15 Although the impact of the value for money efficiency savings have seen the overall departmental revenue DEL reduce, this has not impacted on PCT allocations which have been announced at 5.5 per cent growth in 2009-10 and 2010-11. This will contribute to the fiscal stimulus, ensuring that money flows to the front line and through local economies at the time when it is most needed.

5.16 Some £100 million of planned capital expenditure in 2010-11 was transferred into 2009-10 as part of the fiscal stimulus package, and Department Unallocated Provision capital funding in 2010-11 of £1.285 billion was withdrawn.

5.17 The £100 million expenditure brought forward is to fund the upgrade of GP premises to a teaching standard and targeting funding on those areas that have historically had a lower provision of doctors.

5.18 The scale of the capital expenditure programme has been unaffected by these changes.

5.19 The track of changes to NHS funding are given in **figure A.2** in annex A, and of current funding in **figure A.3** in annex A.

### Disposition of Department resources

5.20 Figures **A.4**, **A.5** and **A.7** in annex A give a high-level breakdown of historic and planned disposition of NHS resources from 2003-04 up to 2010-11. The specification of these tables is mandated by HM Treasury and categories of expenditure are as recorded on their database.

### Overall funding

5.21 Planned NHS net expenditure in 2009-10 is £102.7 billion. NHS net public spending is based on the total of the revenue budget plus the capital budget, less depreciation.

5.22 Planned PSS expenditure net of depreciation in 2009-10 is £1.7 billion.

5.23 In addition to DEL funding **figure A.4** includes funding from outside DEL, for example:

- NHS pensions; and
- funding given to the NHS by HM Treasury from their annually managed expenditure.

5.24 Revenue expenditure is further split into technical HM Treasury accounting currencies of near cash and non-cash.

5.25 Near cash can be defined as transactions that have an impact on cash flow in the short term, eg pay and pensions costs, revenue expenditure on goods and services, or cash payments for the release of provisions.

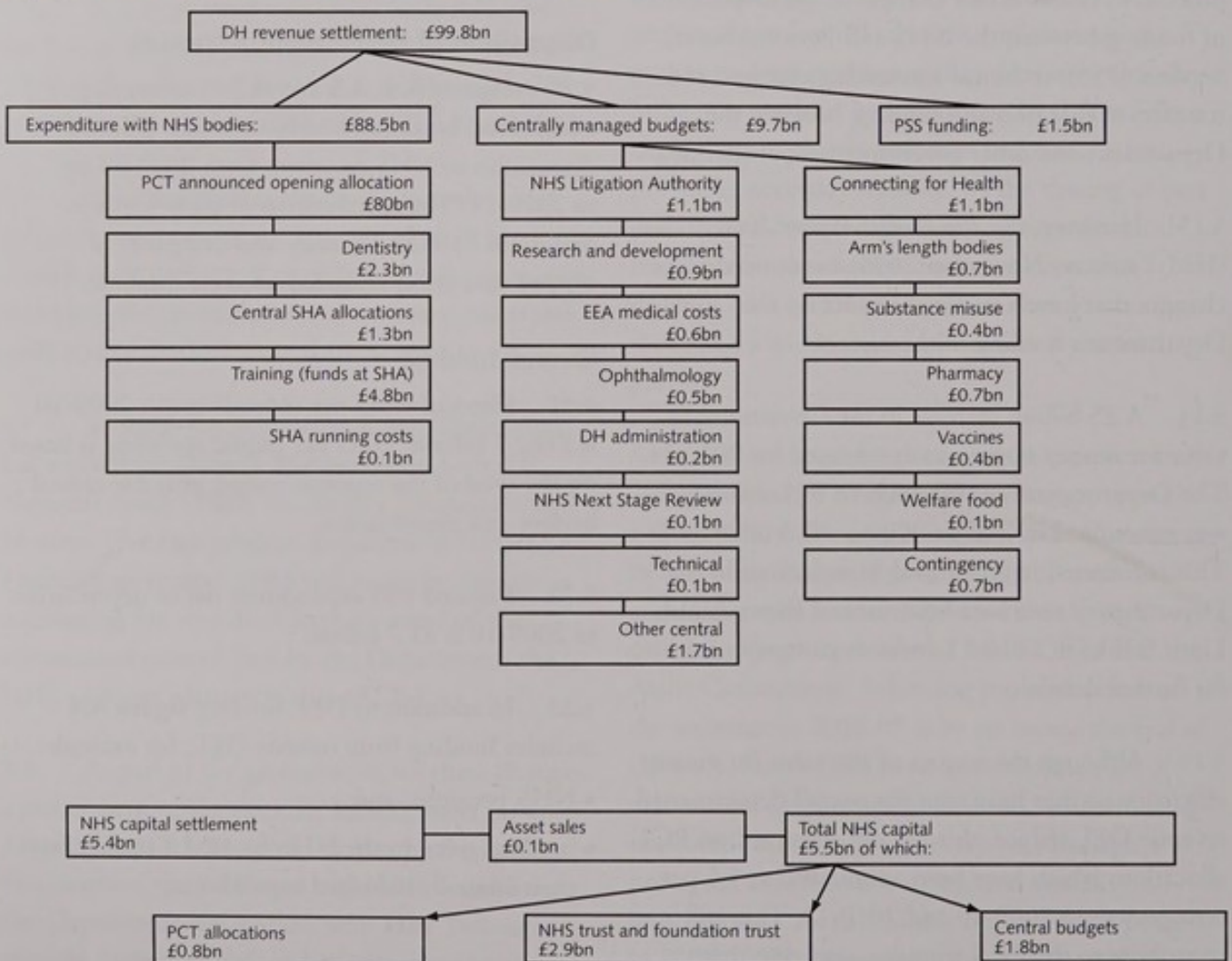
5.26 Non-cash can be defined as items that will never require a cash payment (eg the cost of using capital assets – depreciation, bad debts) or other items that may require cash payments but only in the longer term, eg provisions.

### Revenue funding

5.27 **Figure A.5** gives a high-level disposition of revenue expenditure. It illustrates that under HM Treasury's categorisation of expenditure, the bulk of funding, particularly in recent years, lies in NHS hospital and community health services and discretionary health services (HCFHS). This area covers:

- hospital and community health services;
- prescribing costs for drugs and general appliances;
- central and strategic health authority managed budgets that are spent in the NHS, eg training, research and development; and
- general medical services, and since 2006, general dentistry services.

Figure 5.1: Disposition of Department of Health resources in 2009-10



Notes:  
(1) Amounts may not sum exactly due to rounding.



5.28 An alternative presentation of HCFHS expenditure using published accounts is shown in **figure A.6** in annex A.

5.29 The tables highlight that a significant and increasing proportion of Departmental resources flow directly to PCTs and SHAs.

### Department of Health plans

5.30 **Figure 5.1** shows the disposition of Departmental resources for 2009-10.

### Financial performance

5.31 The Department's key financial functions are configured to support the coordination of the spending review for the NHS and social care and the in-year reporting and performance management of financial resources. The Finance and Operations Directorate is responsible for articulating the financial requirements of the NHS and social care and accounting for the way in which financial resources are allocated and then used.

5.32 In light of this, two measures of financial performance are included in annex A:

- planned performance against outturn on overall Department of Health expenditure (**figure A.8** and **figure A.9**); and
- distance from target PCT allocations (**figure A.10**).

5.33 Managerial performance of the NHS and PSS, for example the position on surpluses and deficits and the performance of local organisations, is discussed in chapter 6 (NHS finance, performance and operations) and Social care, local government and care partnerships, who facilitate delivery through in year performance management.

### Distance from target

5.34 Whenever the resource allocation formula, or the data it uses, is updated, PCTs' distance from target allocations will change and some will move from over to under target or vice versa. The

Department is committed to moving all PCTs towards their target allocations as quickly as possible, but this must be balanced by the need to ensure that all PCTs are appropriately supported with stable funding that both supports existing commitments and allows long-term planning, as well as recognising the unavoidable cost pressures that all PCTs face. Therefore, the Department has ensured that no PCT will receive less than 5.2 per cent growth in 2009-10 and 5.1 per cent in 2010-11.

5.35 The most under-target PCTs will benefit from the highest increases in funding. At the start of 2009-10, the most under-target PCT will be 10.6 per cent below target. Over the next two years, that PCT's allocation will grow by more than 17 per cent and it will end 2010-11 only 6.2 per cent below target. This is a significant achievement by historical standards; for instance, at the start of 2003-04, some PCTs were 22 per cent below target and in 2005-06 some were 16 per cent below.

### Advisory Committee on Resource Allocation

5.36 ACRA is an independent committee comprising NHS managers, GPs and academics.

5.37 ACRA's role is to oversee the development of the weighted capitation formula used to inform revenue allocations to PCTs, to ensure equal opportunity of access to healthcare for people at equal risk, and to contribute to the reduction in avoidable health inequalities. ACRA reports to ministers on possible changes to the formula before each round of allocations.

5.38 Prior to the 2009-10 and 2010-11 PCT allocations, ACRA carried out a comprehensive review of the main elements of the formula, including:

- the need element of the formula;
- the market forces factor; and
- the population base for revenue allocations.



5.39 The review resulted in a new funding formula which builds and improves on the previous formula by introducing:

- a separate, transparent health inequalities formula which targets funds at the places with the worst health outcomes;
- a new needs formula which enables need according to age and other factors to be assessed together for the first time; and
- a new market forces factor, which reduces unrealistic variations between PCTs and between secondary care providers.

5.40 Further details of ACRA's review and the recommendations made to ministers can be found on the Department's website at: [www.dh.gov.uk/allocations](http://www.dh.gov.uk/allocations). The final research reports supporting ACRA's review have been published and are also available on the above website.

5.41 ACRA will continue to oversee the development of the formula to inform revenue allocations for 2011-12 onwards.

## Financial analysis

### HM Treasury analyses

5.42 Found in Annex A, these cover:

- total capital employed by the Department (**figure A.11**);
- analyses by country and region (**figure A.12**) (core table 7);
- analyses by country and region per head (**figure A.13**) (core table 8); and
- analyses by country and region by function (**figure A.14**) (core table 9).

5.43 The data presented in figures A.12 to A.14 is consistent with the country and regional analyses published in chapter 9 of *Public Expenditure Statistical Analyses (PESA) 2009*.

5.44 The analyses are set within the framework of total expenditure on services (TES). TES broadly represents the current and capital expenditure in the public sector, with some differences from the national accounts measure of 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. Nor do they include payments to local authorities of 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 2009*.

5.45 The data is 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.

5.46 Regional attribution of expenditure for the years 2003-04 to 2007-08 is based on NHS annual accounts, and for 2008-09 to 2010-11 on allocations to the NHS. Central expenditure is attributed pro rata to NHS expenditure for all years.

5.47 The functional analyses of spending in figure A.14 are based on the United Nations Classification of the Functions of Government, the international standard. The presentations of spending by function are consistent with those used in chapter 9 of *PESA 2009*. These are not the same as the strategic priorities shown elsewhere in this report.

### PCT and SHA expenditure analysis

5.48 These form the major component of HCFHS funding:

- PCT expenditure (**figure A.15**); and
- SHA expenditure (**figure A.16**).



## Time series on particular expenditures

5.49 These cover:

- GP contract (**figure A.17**);
- general ophthalmic services (**figure A.18**);
- primary dental services (**figure A.19**);
- pharmaceutical services and the Community Pharmacy Contractual Framework (**figure A.20**);
- drugs – primary care (**figure A.21**) and secondary care (**figure A.22**);
- purchase of healthcare from non-NHS bodies (**figure A.23**); and
- expenditure by local authorities on PSS (figures A.24, A.25 and A.26).

## Value for money

### Background

5.50 Improving value for money (VfM) is a key priority for the Department, and providing better value for all is one of the Department's three Departmental Strategic Objectives (DSOs). Building on the Department's significant VfM improvements recorded in recent years as part of the Gershon Efficiency Programme, the Department has put in place ambitious targets to further improve VfM over the next three years and to explore potential for making further step changes in VfM in the longer term.

5.51 In late 2008, the Department published details of savings achieved under the four years of the Gershon Programme (2004 to 2008). This showed that annual savings of almost £7.9 billion were achieved by March 2008, significantly exceeding the target of £6.47 billion. Further details and a breakdown of these savings can be found in the Department's *Autumn Performance Report 2008* (DH, December 2008).

### Comprehensive Spending Review

5.52 The additional investment in the NHS announced in the CSR 2007 settlement was accompanied by a requirement for the Department

to secure NHS VfM savings of £8.2 billion by 2010-11 when compared with a baseline of 2007-08. This is in line with requirements for all government departments. HM Treasury guidance requires that all these savings are sustained over time, net of costs and cash-releasing.

5.53 Clearly, it is important that the Department and the NHS, alongside all the public services, play their part in helping the economy through the downturn. As outlined above, the 2009 Budget statement announced that additional savings of £5 billion across public services, including £2.3 billion from the Department, will be delivered in 2010-11.

5.54 The revised target builds on the success of the Department's Gershon Programme by going further and faster. The Department's approach to delivering the original target was described in *Value for Money Delivery Agreement 2008-2011* (DH, December 2007) and its approach to delivering the additional £2.3 billion of savings in 2010-11 was included in the Government's *2009 Value for money update* (HM Government, April 2009).

5.55 The NHS's strong track record in delivering VfM savings, its strong financial foundations and the sustained investment it has received in recent years mean that it is in a strong position to meet this additional challenge. Prudent financial planning means that allocations made to PCTs, announced in December 2008, are unaffected by the Budget announcement. These provide funding growth of 5.5 per cent in both 2009-10 and 2010-11.

5.56 *The NHS – England: The Operating Framework for 2009-10* (DH, December 2008) made clear the need for the NHS to use this growth in resources to prepare for slower growth in the years ahead. To support the NHS in doing so, the Department announced in March 2009 that a new NHS Productivity and Efficiency Unit would be established, headed by Margaret Edwards and hosted in NHS London. This unit will play a vital



role in helping the NHS to identify and disseminate innovative new ways of improving VfM and productivity.

### Approach to achieving VfM

5.57 The Department's approach to securing VfM improvements in the NHS reflects the movement away from centrally determined targets towards more devolved priority setting and delivery. Nevertheless, the Department has several key roles to play in ensuring that the Government's national VfM target is met.

5.58 Firstly, the Department sets the overall level of VfM savings required from the NHS, which is fully incorporated in setting tariff prices – the prices at which hospitals are paid for providing NHS services. The Department has announced that, in line with the revised VfM target, the efficiency requirement used when setting tariff prices will rise from 3 per cent in 2009-10 to 3.5 per cent in 2010-11.

5.59 Local NHS organisations are responsible for identifying and delivering local actions in order to deliver the VfM improvements that ensure they can live within this tariff income.

5.60 Secondly, the Department is responsible for key central actions that will contribute towards local delivery of VfM improvements. For example:

- the Department has negotiated a new Pharmaceutical Price Regulation Scheme (PPRS), announced in November 2008, that will deliver significant reductions in the prices of branded prescription drugs over the coming years; and
- harnessing the purchasing power of the NHS by negotiating national framework contracts for purchasing a wide range of goods and services and promoting other means of collaborative procurement. The Department launched a new Commercial Operating Model in May 2009, which will contribute to further NHS use of, and benefit from, collaborative purchasing arrangements.

5.61 Thirdly, the Department has identified a number of key opportunities for VfM savings that will offer potential for most or all local NHS organisations to benefit. These were described in detail in our *Value for Money Delivery Agreement 2008–2011*. The Government's *2009 Value for money update*, provides an update on how the Department intends to deliver its revised target, including drawing on the work of the Public Value Programme and the Operational Efficiency Programme.

5.62 Local NHS organisations will be responsible for detailed implementation of these, based on analysis of their local performance and conditions, together with other actions that are specific to their local circumstances.

5.63 To support local adoption and delivery of key common opportunities, the Department has worked with the NHS Institute for Innovation and Improvement to develop a range of Better Care Better Value indicators, which allow NHS organisations to benchmark their current performance against other organisations and to estimate the potential for local savings.

5.64 In addition, wherever possible the Department has developed, national key performance indicators (KPIs) in order to track progress against key components of VfM savings. These indicators are not targets, at either a national or a local level, but are used in combination to track overall national progress towards our VfM target and to provide assurance that savings are being made. Further detail on these KPIs was included in the *Value for Money Delivery Agreement 2008–2011*.

5.65 The devolved approach that the Government has taken towards the NHS means that it is not feasible to capture all VfM savings in these national indicators. Therefore, while these indicators will be used to track and assure overall progress nationally, they will not necessarily capture all VfM savings delivered locally. Therefore, the Department



recognises that nationally measured VfM savings are likely to understate total savings delivered in the NHS.

### Governance and assurance arrangements

5.66 The Department's Performance Committee oversees progress against, and delivery of, the overall VfM target, alongside oversight of progress against Public Service Agreements (PSAs), DSOs and financial performance.

5.67 In addition to the oversight and challenge provided by the Performance Committee, the Department has also commissioned Internal Audit to undertake a review of the governance, reporting and measurement processes associated with the Department's VfM programme.

5.68 Further, the National Audit Office will provide independent scrutiny of government departments' reported VfM savings through the CSR 2007 period and are currently developing their approach to doing so. Finally, annual reporting of progress in the Department's Autumn Performance Reports and future Departmental Reports will allow public scrutiny.

### Progress

5.69 Delivery of the Department's VfM programme for the CSR 2007 period (April 2008 to March 2011) is at an early stage. Given time lags in the collection and collation of data, there are currently only limited data available with which to measure progress towards the Department's VfM target. On the basis of currently available provisional in-year data, savings of over £1,000 million were made in 2008-09. These are detailed below, along with a report on progress so far in the three major VfM delivery programmes:

- pharmaceuticals;
- procurement; and
- patient pathways.

### Pharmaceuticals

5.70 The Government announced in November 2008 that final agreement had been reached with industry for a new PPRS. This will be effective from 2009 for a minimum of five years and includes a 3.9 per cent reduction in the prices of branded pharmaceuticals from February 2009, with a further price cut of 1.9 per cent from January 2010. This new agreement is expected to deliver VfM savings in the UK of around £350 million in 2009-10 and approximately £550 million a year thereafter. This builds on savings of £1.8 billion achieved under the five years of the previous PPRS agreement. Savings from the new PPRS do not begin to accrue until 2009 so are not included in the provisional savings for 2009-10.

5.71 Significant savings were also achieved under the Gershon Programme by reducing the prices of generic drugs through the terms of the community pharmacy contract. The Department will continue to monitor pharmacy margins and make further price reductions if, and when, they are warranted under the terms of the contract. The UK has among the highest rates of generic medicine use amongst comparator countries. Continued performance management to encourage generic use instead of more expensive brands saved around £30 million in 2008-09.

### Procurement

5.72 Building on significant achievements under the Gershon Programme, savings of over £480 million have been delivered in the first nine months of 2008-09 through national framework contracts and regional collaborative procurement hubs, which have both secured continued improvements in the prices paid by the NHS for goods and services.

### Patient pathways

5.73 Savings in the first nine months of 2008-09 of £500 million have been made by reducing average lengths of hospital stay and by reducing growth in accident and emergency attendances.



## Gershon over-delivery

5.74 The original spending review (SR) 2004 target of £6,470 million was significantly exceeded by March 2008. A significant proportion of this over-delivery has been achieved in projects and initiatives for which further gains had been forecast as part of CSR 2007 efficiency (VfM) savings plans. This is particularly the case in productive time (service improvement), procurement and pharmaceuticals. Early delivery of these gains clearly reduces the scope to deliver during CSR 2007.

5.75 To ensure that perverse incentives were not created for departments in order to artificially delay efficiency measures, HM Treasury has agreed that these additional savings would score towards the Department's CSR VfM target. Therefore, in addition to the £7,057 million of savings achieved as part of the SR 2004 Efficiency Programme, the Department delivered a further £820 million of net, cash-releasing savings by March 2008, which will be counted towards its CSR 2007 target.

## NHS productivity

5.76 The Office for National Statistics (ONS) plans to publish the next productivity report in summer 2009. In January 2008, the ONS published its latest report on NHS productivity, *Public Service Productivity: health care*.

5.77 The report distinguishes three separate phases of productivity performance since 1995:

- from 1995 to 2001, productivity was stable, falling slightly by 0.1 per cent;
- from 2001 to 2005, productivity fell by 2.5 per cent per year; and
- from 2005 to 2006, productivity levelled off, falling by only 0.2 per cent.

5.78 The ONS report shows that from 1997 to 2006 NHS output grew by 42 per cent, just under 4 per cent per annum before making any adjustment for quality.

5.79 The ONS report shows falling NHS productivity from 2001 to 2005. This coincides with the period of extra investment focused on improving access to health services and improving outcomes in the big killer diseases of cardiovascular disease and cancer. The upturn in productivity from 2005 reflects levelling off investment, the slowing of workforce growth, and the focused prioritisation of the NHS on improving efficiency.

5.80 The ONS productivity measure excludes cost savings from better procurement and does not measure the outcomes of NHS treatments. The objective of the NHS is not to maximise activity but to maximise the health and well-being of the population, improve access and reduce health inequalities. The Department has commissioned a three-year research project from The Centre for Health Economics (CHE) to improve the measurement of NHS output, input and productivity. Each year, CHE will produce an NHS output and an NHS input index using the latest available data, and will progressively extend the methodology for quality adjustment. The Department continues to work closely with the ONS and others to improve our measurement and understanding of NHS productivity.



# III The NHS – Delivering Better Health and Well-being, Better Care and Better Value for all

- Chapter 6** NHS Finance, Performance and Operations
- Chapter 7** Commissioning and System Management
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# 6 NHS Finance, Performance and Operations

## Role

Facilitates NHS delivery through oversight of all aspects of NHS performance, and supports programmes to enable the NHS to achieve world class services.

### Key achievements in 2008-09 included:

Published the final report of the NHS Next Stage Review, *High Quality Care for All*, and established a clear framework for implementation and governance.

Assisted the NHS to deliver the 18-week referral to treatment target; improved GP access, reduced healthcare-associated infections and ensured performance against the *NHS Operating Framework*.

Published the *NHS Operating Framework for 2009-10*.

Achieved the *NHS Plan* target of 100 new hospital schemes over a year ahead of schedule.

Ensured strong financial governance across the NHS by delivering a sustainable surplus during a time of economic difficulty, ensuring the NHS is well equipped to meet the challenges of future years; and published the national tariff for 2009-10.

Increased the numbers of NHS foundation trusts and reached the halfway point of all eligible acute and mental health trusts becoming NHS foundation trusts.

## Summary

6.1 In this chapter you will find information on:

- NHS Next Stage Review – *High Quality Care for All*
- NHS operating framework
- performance and delivery
- financial governance
- NHS Security Management Service and NHS Counter Fraud Service
- payment by results
- capital investment
- gateway reviews, estates and facilities
- NHS foundation trusts
- the independent sector treatment centres and the Extended Choice Network

## Introduction

6.2 The NHS Finance, Performance and Operations (NHS FPO) Directorate facilitates NHS delivery – through performance monitoring and management – across all aspects of performance, including achievement of national standards and priorities and financial management.

6.3 NHS FPO is a predominantly outward-facing directorate, although it undertakes some policy development responsibilities, and it supports the NHS to deliver on some of the most important national programmes to achieve world class services for patients and users alongside excellent value for the public. NHS FPO works in partnership with SHAs, the NHS leadership team, the wider Department and its arm's length bodies, and other government departments and healthcare bodies, in order to deliver these priorities.



6.4 NHS FPO brings together the following functions within the Department:

- performance and delivery
- NHS Next Stage Review
- NHS financial strategy
- NHS financial control
- Financially Challenged Trusts Programme
- NHS capital strategy
- capital investment, including PFI and LIFT
- Gateway reviews, estates and facilities and ProCure21
- elective care and diagnostics, including the 18-Weeks Delivery Programme
- knowledge and intelligence (specifically supporting NHS delivery)
- Operating framework and business processes
- new performance framework
- Foundation Trust Unit
- counter-fraud and security management
- NHS Business Unit
- NHS contracting

### NHS Next Stage Review – *High Quality Care for All*

6.5 *High Quality Care for All* (DH, June 2008), the final report of the NHS Next Stage Review, set out a vision of an NHS that gives patients and the public more choice, works in partnership with stakeholders, and has quality of care at the heart of everything it does.

6.6 At the heart of the review were the 2,000 local clinicians who engaged with their local communities and examined the best available clinical evidence in order to identify improvements to health and healthcare locally. Their work underpins the ambitious visions for health and healthcare that were published by SHAs in May and June of 2008.

6.7 The NHS Next Stage Review has been a key step in a journey that has improving the quality of care at its core. This journey began with the greatest investment in the history of the NHS, aimed at providing more doctors, more nurses and better facilities. These enhancements to the NHS's capacity and capabilities have delivered improved quality in terms of access and choice, ensuring that the NHS delivers to the standards that the public expect. Expansion in capacity has been followed by a range of reforms to improve the responsiveness of the NHS, including the introduction of NHS foundation trusts and payment by results, coupled with a strong focus on extending patient choice.

6.8 The NHS Next Stage Review builds on this greater capacity and responsiveness in order to embed quality as the organising principle for all NHS services. For the first time, local clinicians, in discussion with patients, NHS staff and their local communities, have determined how quality can best be improved locally, rather than this being agreed in Whitehall or set out in national targets. The commitments made in *High Quality Care for All* are now being taken forward in partnership and co-production with the NHS, ensuring that the spirit and reality of this open and consultative approach is embedded in the relationship between the NHS and the Department.

6.9 David Flory (Director General – NHS Finance, Performance and Operations) is the Senior Responsible Owner for the delivery of the programme set out in *High Quality Care for All*. His role is to assure the successful delivery of the 70 implementation projects, brigaded under 8 work streams across the Department, in order to deliver on the commitments it makes. The Next Stage Review Programme Office supports him in this role and provides the secretariat to the Delivery Overview Board, which brings directors general together to progress programme-level issues.

6.10 Having successfully got the programme up and running, the Department is increasingly seeing



tangible results being delivered. The Department has published the first-ever *NHS Constitution*, launched the 'patients' prospectus' and a coalition for better health, and also placed a legal duty on SHAs to promote innovation in their region. Over the coming months it will continue to drive forward the delivery of the programme.

## NHS Operating Framework

6.11 *The NHS Operating Framework for 2009-10* (DH, December 2008), sets the priorities for the coming year and supports the implementation of the plans laid out in *High Quality Care for All*. The major challenge, of enabling all parts of the NHS to focus consistently and systematically on improving the quality of care, requires long-term transformation that touches all parts of the system, starting from the front line. The NHS should enable this transformation by:

- developing and embedding a new approach to change; and
- putting in place a series of enablers for high-quality care.

6.12 A key element of establishing these enablers was the publication of SHAs' local 'visions' with the NHS Next Stage Review final report, *High Quality Care for All*, in June 2008. The ability of SHAs to start delivering on their visions from 2009-10 will be a critical success factor in implementing the aims of *High Quality Care for All*.

6.13 The purpose of the *NHS Operating Framework*, produced after a series of engagement events across the NHS, is to set out the parameters within which local organisations will operate in 2009-10. This is the second year in the three-year planning cycle established by the 2007 Comprehensive Spending Review (CSR). The *NHS Operating Framework* is about maintaining the momentum on continuous improvement.

6.14 *The NHS Operating Framework for 2009-10* also set out the following leadership challenges for NHS organisations:

- Continue to deliver on the national priorities that matter most to patients and the public, so that progress is sustained and improved in these areas.
- Invest the additional resources wisely in 2009-10 in order to prepare for the need to make substantial efficiency savings in 2010-11, and for a tighter financial climate thereafter.
- Start to put in place the strategic enablers and foundations that will help to deliver the ten SHA regional visions and put quality at the heart of services.
- Develop new ways of working and leading that reflect the evidence base and principles for driving large-scale transformational change.

### Priorities

6.15 The five national priorities established through last year's *NHS Operating Framework* remain. They are as follows:

- Improving cleanliness and reducing healthcare-associated infections.
- Improving access through achievement of the 18-week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services.
- Keeping adults and children well, improving their health and reducing inequalities.
- Improving patient experience, staff satisfaction and engagement.
- Preparing to respond in a state of emergency, such as an outbreak of pandemic influenza.

6.16 These priorities will be delivered using the principles of co-production, subsidiarity, clinical ownership and leadership, and system management. The Department's gateway process will continue to ensure that communications with the NHS are consistent with the priorities and principles set out in the *NHS Operating Framework*.



## Performance and delivery

6.17 NHS FPO has had a key role in monitoring and performance-managing the NHS, through SHAs, against the *NHS Operating Framework for 2008-09* (DH, December 2007) priorities and vital signs, in order to ensure delivery of key targets and milestones in 2008-09. This included delivery of the 18-week referral to treatment target, provision of improved access to primary care and a reduction in healthcare-associated infections.

6.18 The Department also worked with the NHS to ensure maintenance of the existing commitments, including accident and emergency (A&E) performance, performance of ambulance services, and in-patient and outpatient waiting times.

6.19 The *NHS Operating Framework for 2008-09* introduced a new approach to planning and managing our priorities both nationally and locally – the vital signs. The planning guidance for the current three-year CSR cycle was set out in operational plans from 2008-09 and that guidance still holds, and will apply in 2009-10.

6.20 The Department will review the plans for 2009-10 with each SHA. In doing so, the Department will apply key assurance tests to plans in order to ensure that they:

- are based on robust demand-and-activity assumptions that support delivery of the 18-week target and other key targets;
- give assurances on the delivery of national priorities and reconcile these across the three elements of finance, workforce and activity;
- are consistent with contracts agreed locally; and
- are aligned with their Local Area Agreement's (LAA's) priorities for health and well-being.

### Vital signs

6.21 The *vital signs* pull together the commitments made through the 2007 CSR process by the Department to both HM Treasury and other

government departments. The vital signs framework rolls forward for a second year, maintaining the momentum and freedom for the NHS to focus on the national 'must do's' alongside locally determined priorities. The framework provides PCTs, their partners and local communities with information across a range of services with which to inform local planning.

6.22 The *NHS Operating Framework for 2009-10* set out that, as part of this process, performance against the vital signs will be published in 2009-10 to reflect the 2008-09 position. This will allow people locally to understand how well their PCT is performing (compared to other PCTs) across a range of commissioner responsibilities. In turn, this supports a local conversation between PCTs, their partners and their populations in order to inform local priorities.

6.23 Once again, central performance management is limited to the smaller subset of vital signs and, beyond that, to those areas or organisations where performance is weak.

### Local Area Agreements

6.24 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 for the Region) and a local area represented by the lead local authority and other key partners through Local Strategic Partnerships. LAAs have been shown to have great potential in delivering improvements in health and social care outcomes, and have proved to be an important catalyst for improved partnership working. Since April 2007, every area in England has had its own tailored LAA in place. Their profile and importance was raised further from June 2008, when LAAs formed the central delivery contract between central government and local government and its partners. Since then, LAAs have focused on a relatively small number of priorities for improvement.



## Developing the performance regime for 2009-10

6.25 The Department published *Developing the NHS Performance Regime* in June 2008, which outlined its vision for affording greater consistency and transparency in how the NHS identifies under-performance, how the system intervenes to support recovery, and how organisations are managed where services are not clinically or financially viable. The performance regime will establish clear thresholds for intervention in underperforming organisations and a rules-based process for escalation, including defined timescales for demonstrating performance improvements.

6.26 Supporting this work, the Department published *Consultation on a Regime for Unsustainable NHS Providers* (DH, September 2008) in order to engage with the NHS on proposed measures to underpin NHS performance, ensure that patients receive high-quality services and protect patients from failing services.

6.27 The Department is currently developing the performance regime for 2009-10 and it will continue to work with colleagues across the NHS in order to develop this for NHS providers and commissioners.

### Annual health check

6.28 In October 2008, the Healthcare Commission published the 2007-08 'annual health check' assessment scores. For the second year in a row, the overall picture is one of improvement.

6.29 On quality of services in 2007-08:

- Over 60 per cent of trusts were rated either 'excellent' or 'good' (26 per cent 'excellent' and 36 per cent 'good') – the preceding year 46 per cent were in these two categories.
- 34 per cent were 'fair' and 5 per cent were 'weak' – the preceding year 53 per cent of trusts were in these two categories.

6.30 On the use of resources in 2007-08:

- Over 60 per cent of trusts were rated either 'excellent' or 'good' (24 per cent 'excellent' and 37 per cent 'good') – the preceding year 37 per cent were in these two categories.
- 34 per cent were 'fair' and 5 per cent were 'weak' – the preceding year 62 per cent of trusts were in these two categories.

6.31 The Care Quality Commission took responsibility for periodic reviews from 1 April 2009.

### Improving access

6.32 As *High Quality Care for All* set out, once national targets are achieved they will then become national minimum standards for all NHS organisations and will form a national standard for all patients. Therefore, from 1 January 2009, the minimum expectation of consultant-led elective services was that no one should wait for more than 18 weeks from the time they are referred to the start of their hospital treatment, unless it is clinically appropriate to do so or they choose to wait longer. This pledge was reaffirmed in *The Handbook to the NHS Constitution*, published on 21 January 2009.

6.33 Every PCT and trust must strive to achieve this minimum standard across all services and specialties, monitoring waiting times over 18 weeks, so that patients do not wait for reasons other than choice or clinical exception.

6.34 From January 2009, the Department has focused on supporting the NHS in sustaining the 18-week patient pathway. Work has also continued with the small number of trusts and specialties that did meet the target in order to ensure that the target is achieved as quickly as possible for all patients.

6.35 As set out in the *NHS Operating Framework for 2008-09*, performance sharing has been introduced, allowing responsibility for breaches of the 18-week pathway to be shared if a patient's care



has transferred between provider organisations during the referral-to-treatment pathway. From October 2008, provider performance has been measured on a performance-shared basis.

**6.36** Diagnostic tests must be carried out swiftly and accurately in order to enable delivery of an 18-week patient pathway – and maintaining reductions in waits for all diagnostic tests is central to reducing overall waits for elective care.

**6.37** As part of the drive towards a maximum wait of 18 weeks for consultant-led treatment, the NHS has also been working to reduce referral to treatment waiting times for ‘direct access audiology’

treatment, ie services that are not consultant-led and where patients are referred directly to the audiology department to be seen by either audiologists or clinical scientists in audiology.

## Activity trends

**6.38** Figure 6.1 gives details of hospital activity levels for each of the main sectors. The 2007-08 year saw an increase of 5.4 per cent in elective admissions (compared to long run average of 3.3 per cent), while growth in emergency and other admissions was managed to a level of 0.4 per cent growth (compared to long run average of 2.4 per cent).

Figure 6.1: Hospital activity trends, 1997-98 to 2007-08

	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	Annual average% change 1997-98 to 2007-08	% change 2006-07 to 2007-08
<b>General and acute (thousands of episodes)</b>													
Elective admissions <sup>(1)</sup>	4,529	4,955	5,021	5,134	5,170	5,401	5,589	5,705	5,833	5,917	6,236	3.3%	5.4%
Emergency and other admissions (non-elective admissions) <sup>(1)</sup>	3,775	3,896	3,934	3,991	4,010	4,056	4,327	4,552	4,750	4,777	4,795	2.4%	0.4%
Total admissions (first finished consultant episodes) <sup>(1)</sup>	8,304	8,851	8,955	9,125	9,179	9,458	9,916	10,257	10,582	10,694	11,031	2.9%	3.2%
<b>Geriatrics (thousands of episodes)</b>													
Total admissions (first finished consultant episodes) <sup>(2)</sup>	401	399	383	359	347	357	357	368	361	358	357	-1.2%	-0.3%
<b>Maternity (thousands of episodes)</b>													
Total admissions (first finished consultant episodes) <sup>(2)</sup>	827	880	884	896	877	924	970	1,000	1,038	1,039	1,090	2.8%	4.9%
<b>New outpatients (first attendances seen) (thousands)<sup>(3)</sup></b>													
All specialities, provider-based	11,529	11,778	12,136	12,466	12,613	12,879	13,431	13,370	13,692	13,617	14,274	2.2%	4.8%
All specialities, commissioner-based										12,648	13,575	N/a	7.3%
<b>New A&amp;E (first attenders) (thousands)<sup>(4)</sup></b>													
	12,794	12,811	13,167	12,953	12,853	12,945	15,313	16,712	17,775	18,011	18,302	3.6%	1.6%
<b>Average length of spell (ordinary admissions) (days)</b>													
General and acute <sup>(2)</sup>	7.0	6.8	6.7	6.9	7.1	7.0	6.8	6.3	5.9	5.5	5.3	-2.7%	-3.6%
– of which, Geriatrics <sup>(2)</sup>	22.7	22.2	21.8	23.3	23.4	23.1	21.7	20.1	19.0	17.3	16.3	-3.3%	-5.8%

Source: NHS Finance, Performance and Operations Directorate, DH  
Notes:

(1) 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 specialities 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. 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. Figures for years prior to 2007-08 have been re-based to allow direct comparison. Data are presented for financial years and are not adjusted for the differing number of working days per year. There was one less working day (251) in 2007-08 compared with 2006-07 (252).

(2) 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, 2005-06 and 2006-07 which are not yet adjusted for shortfalls. Length of stay is calculated as the difference in days between the admission date and the discharge date, where both are given, and is based on hospital spells and only applies to ordinary admissions, ie day cases are excluded (unless otherwise stated).

(3) KH09, QMOP and QM08/QM08R. Figures for 2007-08 are sourced from Quarterly Activity Return (QAR). Commissioner-based data was first collected in 2005-06, but due to data quality issues only 2006-07 onwards has been used.

(4) QMAE and KH09. From 2003-04, attendances at A&E walk-in centres were included. From 2007-08, attendances at independent sector type 3 services were included.



## Financial governance

### Setting the context

6.39 In the *NHS Operating Framework for 2008-09*, the Department stressed the importance of sustaining the level of NHS surplus forecast for 2007-08 as the NHS went forward to 2008-09.

6.40 The framework built on the principles underlying the management of NHS finances set in the previous year: transparency, consistency, independence, and fairness.

6.41 The key financial objectives for the NHS in 2008-09 were:

- for each SHA area to plan for a surplus at least equivalent to the surplus recorded in 2007-08;
- to plan for sufficient surplus in the NHS trust sector to service working capital loan repayments and recover legacy debt positions; and
- for SHAs to resolve all outstanding legacy debt in PCTs by 31 March 2008, or in exceptional circumstances where agreed by the Department, by 31 March 2009.

6.42 To deliver these objectives, SHAs had the flexibility to determine, within their economies, the level of contingency necessary to ensure the delivery of their financial plans and where this contingency was best held.

6.43 The Department is continuing to tackle the small number of NHS organisations that perform poorly with their finances.

6.44 The draft accounts for 2008-09 show that there were six organisations that ended the financial year with an operating deficit. Those six organisations had a combined gross operating deficit of £58 million.

6.45 The Department is working with SHAs to ensure that all the organisations forecasting an operating deficit in 2008-09 are developing recovery

plans in order to return to financial balance while maintaining and improving services to patients.

### Planning for 2009-10

6.46 The financial strategy for the NHS for 2009-10 and beyond is built on the firm financial foundations laid in the previous two years.

6.47 The aggregate surplus delivered in 2008-09 by SHAs and PCTs will be carried forward to 2009-10. Each SHA area, with the Department, will determine the level of accumulated surplus deployment required for 2009-10 and 2010-11 based on their local planning requirements. Across England, this will probably total some £800 million over the next two-year period, with approximately £400 million deployed in each of the two years.

6.48 This approach once again enables the full deployment of baseline and additional resources that were made available to the service in 2009-10.

6.49 Within these plans, the Department expects all PCT debts caused by previous years' deficits to be fully resolved, except where there has been specific agreement between the SHAs and the Department. There is also an expectation that no NHS organisation will plan for an operating deficit in 2009-10 unless this is part of a planned recovery position agreed between the SHAs and the Department.

6.50 SHAs will continue to have the flexibility to determine, within their economies, the level of contingency necessary to ensure delivery of their financial plans, and where this contingency is best held. SHAs will again also be able to determine and agree locally with PCTs the arrangements for the transfer and lodging of revenue resources with the SHA, within the limit of the overall SHA planned surplus.

### Accounting regime

6.51 The NHS and the Department have finished preparing for the full adoption of the International



Financial Reporting Standards (IFRS) in accordance with HM Treasury requirements that have been in force since April 2009. NHS organisations are expected to produce financial plans for 2009-10 that are fully IFRS compliant, and this has been reflected in NHS financial planning guidance.

## NHS Security Management Service and NHS Counter Fraud Service

**6.52** The Department acts as sponsor for the NHS Security Management Service (SMS) and the NHS Counter Fraud Service (CFS).

**6.53** The SMS has a wide remit but has concentrated primarily on work to reduce violence against staff. Since 2003-04, improved working procedures between the SMS, NHS bodies, the police and the Crown Prosecution Service have been developed. By 2007-08, annual reports showed that the number of physical assaults against NHS staff had fallen by over 4,000 and that the number of criminal sanctions following assaults had risen from a very low level to close to 1,000. However, levels of violence against staff remain high and numbers of prosecutions for violence are still too low. More remains to be done in order to ensure that staff protection and preparedness are maximised and that prompt action follows the cases of violence that do occur. The Department and the NHS look to tackle violence in a variety of ways. For example, in order to improve the personal security of a particularly vulnerable group of staff, a current project is the procurement of lone worker alarm services (with the intention of these being used throughout the NHS).

**6.54** The CFS specifically addresses issues of fraud and corruption in a remit that covers dealing with these issues within the Department as well as throughout the NHS. The CFS focus is therefore on the prevention and recovery of financial losses alongside work on criminal, civil and disciplinary sanctions procedures. A particular objective of anti-fraud effort has been to shift the emphasis of the work, wherever possible, towards prevention of

losses to fraud, while maintaining a robust capacity to undertake reactive work to investigate and prosecute cases when fraud or corruption do occur. Annually published CFS reports provide detailed output statistics from anti-fraud work and also give narrative details of both proactive and reactive work undertaken.

**6.55** The SMS and the CFS are located within a division of the NHS Business Services Authority. Both services work with the police and other agencies as necessary via agreed memoranda of understanding. Additionally, both work with nominated and trained individuals within health bodies who are thus able to lead locally on security management and anti-fraud issues.

## Payment by results

**6.56** 2008-09 was a year of preparation for the introduction, from 1 April 2009, of a new clinical grouping methodology, or healthcare resource grouping (HRG) system, to support payment – known as HRG4. HRG4 has been developed with the help of a large number of clinicians and will enable a better fit between tariff prices and current clinical practice. In addition, it breaks clinical activity down into more specific groupings and therefore allows better targeting of funds to different levels of clinical complexity.

**6.57** The move to HRG4 meant that the process of calculating and checking the tariff for use in 2009-10 was more complicated than it had been previously. Many NHS and other organisations helped with the process and the final tariff was released for use in early February 2009.

**6.58** During the year, work has also been underway to establish and support more than 50 separate development sites as part of a project to enable NHS staff to lead future payment by results (PbR) development in their areas of expertise. These sites act as a mechanism for developing local currencies and funding models for services currently outside the scope of the tariff, or as an alternative to



national currencies for services already within the tariff's scope.

6.59 Following the NHS Next Stage Review, work has also been underway to lay the foundations for an expansion of the scope of PbR into mental health and community services. The development of tariffs set on the basis of best clinical practice has also begun. Four potential areas for best practice tariffs were identified in the review and work on their feasibility, and the challenges of developing them, has been taking place with the help of leading clinicians. The Department aims to introduce best practice tariffs in 2010-11.

6.60 A new collection system for the annual collection of reference costs was successfully introduced in 2008. This simplified the reporting system for more than 400 organisations and was well received.

6.61 As part of continuing efforts to improve the 'building blocks' of PbR, the Department has encouraged NHS organisations to adopt patient level information and costing systems. These have included the development, with the help of NHS finance staff, of costing standards to help the NHS in costing at a patient level.

## Capital investment

6.62 The capital resources available to health are set out in **figure 6.2**. It includes an estimate for the capital funding that will be supplied under the private finance initiative (PFI). As in previous years, there will also be further investment through NHS Local Improvement Finance Trust (LIFT), the public-private partnership vehicle, for redeveloping and modernising primary care premises.

6.63 The increase in public capital funding will not only give the health service scope to further improve the quality of the assets with which services are delivered, but it will allow other important initiatives to proceed. These include increasing the stocks of antiviral medicines in the event of an outbreak of pandemic influenza, and bringing a £100 million programme forward into 2009-10 which will improve the facilities in practices that instruct GP trainees.

### PFI and the 100 hospital schemes target

6.64 During 2008, a further six PFI schemes with a combined capital value of £789 million became operational. A further four reached financial close and commenced building, worth £396 million. In total, 104 hospital schemes (77 of which are PFI) are now operational and a further 28 are under construction; and many others under the ProCure21 initiative. In October 2008, the NHS

Figure 6.2: NHS capital spending, 2007-08 to 2009-10 (resources)

	2007-08 outturn	2008-09 estimated outturn	2009-10 plan
Government spending	3,597	4,410	5,434
<i>Percentage real terms growth<sup>(1)</sup></i>		19.6	20.2
Receipts from land sales <sup>(2)</sup>	507	300	146
<i>Percentage real terms growth<sup>(1)</sup></i>		-42.3	-52.5
PFI investment	1,746	1,525	992
<i>Percentage real terms growth<sup>(1)</sup></i>		-14.8	-36.5
<b>Total</b>	<b>5,850</b>	<b>6,235</b>	<b>6,572</b>

Notes:

(1) Real terms growth calculated using GDP deflators as at 23 April 2009.

(2) The figures for outturn and estimated outturn receipts from disposals include disposals between NHS organisations because these are not separately identified in the accounts of NHS organisations.

(3) Figures may not sum due to rounding.



achieved the *NHS Plan* target (set in 2000) of opening 100 new hospital schemes by 2010.

### **ProCure21**

**6.65** The ProCure21 public-sector capital-build programme, structured in line with HM Treasury and Office of Government Commerce guidance, incorporates best public-sector procurement practice. It is delivering well-designed capital projects in the NHS secondary and primary care sectors that are delivered on time and within budget. To date it has completed 234 schemes at a value of £1.3 billion, of which 22 schemes were completed in 2008-09. Schemes worth a further £2.1 billion are currently in the pipeline to be taken forward by the NHS.

### **Local Improvement Finance Trust**

**6.66** So far, there are 48 NHS LIFT schemes. As at 31 March 2008, 206 facilities were open to patients with 25 under construction and many more being planned. NHS LIFT has now attracted £1.5 billion of capital investment and this level of investment will continue to grow in 2009-10 and beyond.

**6.67** A major development is the significant extension of the geographical spread of the NHS LIFT initiative through the introduction of 'Express LIFT'. This will provide a fast-track route for PCTs and local authorities to set up NHS LIFT companies outside established NHS LIFT areas in order to build primary and social care facilities. This will be achieved through the establishment of a national partnering framework of selected private-sector contractors. Procurement of this framework started in August 2008 and was completed in March 2009, when seven contractors were appointed.

### **Earned autonomy and the Strategic Estates Development Project**

**6.68** Currently 88 PCTs have access to partnering services through NHS LIFT and many more will

have the opportunity to link to partners through the Express LIFT initiative. The partnering relationship is crucial in ensuring that PCTs are supported in making sound value judgements as early as possible in the development of projects.

**6.69** It is not the Department's intention to exercise undue oversight on successful local arrangements. Where it can be demonstrated that partnering arrangements are working well and value for money is being delivered, the Department will consider a process of accreditation to reward PCTs with higher delegated expenditure limits.

**6.70** In support of *Transforming Community Services: Enabling New Patterns of Provision* (DH, January 2009), the Department is also exploring a number of ways in which it can help PCTs to use their estates more effectively and efficiently. This is to enable estates to flex and remodel as commissioners' priorities change and to create a level playing field for all providers, including the third sector.

### **Social care**

**6.71** In 2008, the Department ran a bidding round for adult social care PFI credits. These are paid to local authorities in order to support the capital cost of new social care infrastructure, eg residential care for elderly people, or day services for physically or mentally disabled adults. A total of £210 million was awarded to nine councils, with the awards ranging in size from £4.4 million to £30 million. Total allocation of social care PFI credits is now £670 million. The Department intends to run a further bidding round in 2009.



## Gateway reviews, estates and facilities

6.72 The Department improved its estates and facilities guidance in 2008-09 by producing 24 specialised healthcare-specific technical publications, ranging from mental health to fire safety. The Department has updated and issued all-room data sheets related to clinical activity in the acute setting. The Department has also made good progress in developing a pan-UK content management system, as well as in addressing digital rights management and a successor to its current Knowledge Information Portal.

6.73 Working with health protection colleagues, the Department has undertaken unique research programmes in order to inform the better design of decontamination processes and physical environments to assist the reduction of incidences of healthcare-associated infections. The work informed the production of guidance and standards for the NHS, in addition to aspects of the review and update of the *Code of Practice for the NHS on the Prevention and Control of Healthcare Associated Infections and Related Guidance* (DH, January 2009).

6.74 Climate change legislation set the challenge for the NHS to become a leader and exemplar of a low-carbon public sector organisation with an aim to reduce greenhouse gas emissions by 80 per cent by 2050. In response to this, the Department has continued its work to ensure that the NHS improves performance on sustainability. This work has included the development and publication of a national mandatory tool: BREEAM Health. The Department has supported the NHS Sustainable Development Unit since its establishment in April 2008 and has worked in partnership with it in order to develop a significant programme of work to address the climate change challenge.

6.75 The Health Gateway Team has continued to support the modernisation of facilities across the NHS by organising nearly 30 reviews of construction projects, including PFI, LIFT and ProCure21 schemes. It has also assisted with ten IT projects in the Department, its arm's length bodies (ALBs) and the NHS, as well as a growing number of reviews on policy implementation in the Department and its ALBs. By far the biggest growth area though is the reviews of service reconfiguration schemes in the NHS. In conjunction with the National Clinical Advisory Team reviews, the gateway process is playing a major part in ensuring that these schemes are providing real improvements for the public.

6.76 The completion of around 100 reviews this year, nearly 50 per cent more than in any previous year, demonstrates the increased recognition of the value of the process, the range of schemes that can benefit from its operation and the major role it can play in developing and moving forward the Department, its ALBs and the NHS.

### Asset disposal

6.77 The Department continued with the disposal programme in 2008-09 for the remaining surplus property in the ownership of the Secretary of State for Health. It is expected that a further £10 million, including 'overage' payments from sales completed in earlier years, will be released for reinvestment in 2008-09. In addition, the Department is working closely with the Homes and Communities Agency (formerly English Partnerships) to identify the contribution that the NHS can make towards the Government's target for new housing on surplus public sector land.

6.78 To support the Government's policy on increasing housing supply and quality, the Department has prepared directions for the NHS on using a national register for surplus NHS land and ensuring that homes built on this land achieve a good standard of design as well as meeting sound environmental standards. Additionally, it is



promoting greater integration of health and social care in the town planning system through its work with Communities and Local Government. The development of new legislation, such as the Planning Act 2008, has provided the Department with the opportunity, through the development of the community infrastructure levy, to ensure that contributions will be available for the provision of health and social care facilities when new development is proposed.

### Strategic Health Asset Planning and Evaluation Project

6.79 The Strategic Health Asset Planning and Evaluation application (SHAPE), launched by the Department in November 2007, is a web-based piece of planning software aimed primarily at SHAs and PCTs to inform and support delivery of service reconfiguration. The SHAPE application links clinical analysis and demographic data with healthcare estate performance and facilities' locations in order to inform the strategic planning of services and physical assets across a whole health economy, and to underpin local health inequalities strategies. To date there are approximately 600 SHAPE users.

### Ongoing initiatives

6.80 The Department has worked with a range of organisations – including the King's Fund, the Prince's Foundation for the Built Environment, the Commission for Architecture and the Built Environment, and the Royal Institute of British Architects – in order to improve the environments in which care is provided. Specific initiatives include the following:

- Supporting the Arts in Health network to develop a strategy for delivering the recommendations of the Department's 2007 *Report of the Review of Arts and Health Working Group*.
- Providing support to the Hillingdon Hospital NHS Trust's 'Bevan Ward' pilot project, a brand new 24-bed unit comprising 100 per cent single room accommodation.

- Managing the NHS Design Review Panel in order to help the NHS achieve high standards of design by reviewing major building proposals at key stages of their development.
- Funding for the King's Fund's Enhancing the Healing Environment Programme has continued. The end-of-life care element of the programme has seen 19 NHS trust improvement schemes making excellent progress along with an offender health prison scheme.
- Working in partnership with the Institute of Healthcare Management and the Department's Emergency Preparedness Division to produce a training DVD that will assist the NHS to be better prepared for any future major adverse incident, drawing on lessons learned from the 2007 flooding experiences and adapting these to a wider business continuity model.

### NHS foundation trusts

6.81 The NHS Foundation Trusts (FTs) Programme offers greater autonomy and freedoms to NHS organisations set against a national framework of standards and inspection. FTs are free from central government control. They set their own strategies and make their own decisions to improve services for patients.

6.82 After four years of FT authorisations and an existing 115 FTs, independent evidence suggests that the FT model offers a better way of delivering NHS services to patients.

6.83 It is now generally accepted that FTs are performing well, clinically and financially. The most recent 'annual health check' by the Healthcare Commission showed that, overall, FTs performed significantly better than non-FTs on the use of resources and the quality of services: 38 out of the 42 organisations rated 'excellent' were FTs. The regulator's compliance system and intervention arrangements also offer robust safeguards, allowing actual and potential financial and non-financial problems to be identified and dealt with effectively.



The Care Quality Commission also ensures that FTs meet required levels of safety and quality.

6.84 The halfway mark on FT roll-out has been reached – 50 per cent of eligible acute and mental health trusts are FTs, and the Department is working with SHAs to support the progress of acute, mental health and ambulance trusts towards FT status. A performance framework will also be introduced for all NHS providers that have not yet achieved FT status (acute trusts, mental health trusts, ambulance trusts and PCT provided services) between April and October 2009 and for NHS commissioners from April 2010.

6.85 *High Quality Care for All* recommended that the rate of transition to FT status should be accelerated. In response to this, the Department requested that SHAs undertake a further review of their trust trajectories. SHAs have now confirmed those trusts that will be able to apply to the Secretary of State for FT status by December 2010.

6.86 Some trusts will not be in a position to apply for FT status by the end of 2010. SHAs are working with these organisations to finalise their plans for the future, which may include some restructuring. The aim is that all NHS providers should ultimately offer services to the FT standard.

6.87 The Department is receiving periodic updates from SHAs to confirm progress against trajectory, which will ensure that an up-to-date profile of those applying for FT status is maintained and that the flow of applications continues.

6.88 The Department is also extending the benefits of the FT model to other types of providers. Ambulance trusts can now apply to become FTs and the Department is also exploring a range of options for community services, including approving the use of FT status for providers of community services.

## Independent sector treatment centres and the Extended Choice Network

6.89 The Department involves the independent sector in delivering health services as part of government plans to deliver a patient-led NHS, cut waiting times and offer choice to patients. These services are run by the independent sector but funded through the NHS, and are free to patients.

6.90 The Independent Sector Treatment Centre (ISTC) Programme plays a key role in reducing waiting times and improving patient choice.

6.91 There are now more than 100 mobile and fixed-site ISTCs. In 2008-09, four new centres opened. Nearly 1.5 million operations, diagnostic assessments and primary care consultations have been provided to NHS patients since the programme began, including 439,000 in the 2008-09 financial year to 31 December 2008.

6.92 In 2008-09, ISTC utilisation-to-date was unchanged at 85 per cent in Wave 1 centres. In Phase 2 centres, it had increased from 76 per cent in March 2008 to 88 per cent in December 2008 for elective procedures, and from 12 per cent to 31 per cent for diagnostic procedures.

6.93 This year, responsibility for the ongoing management and operation of ISTC contracts moved to the NHS, so that these centres continue to deliver services that meet the needs of local health economies. The first two Wave 1 ISTC contracts are scheduled to end in 2009, with further contracts scheduled to end from January 2010. As ISTC contracts come to an end, the Department will work with NHS commissioners to make decisions about health services in their communities.



## **Independent sector Extended Choice Network and Free Choice Network**

**6.94** Since April 2008, with the introduction of free choice, patients who require a referral for a consultant-led outpatient appointment have been able to choose from any approved provider. This includes NHS FTs, NHS acute trusts and a large number of independent sector providers who have signed up to the Extended Choice Network or Free Choice Network.

**6.95** Through both these networks, more than 28,000 procedures were performed in the 2008-09 financial year (equivalent to 38,000 a year), an increase of 280 per cent from the previous financial year.

## **Choose and Book**

**6.96** Choose and Book is a national service that combines electronic booking and a choice of place, date and time for first outpatient appointments.

**6.97** Since its introduction, over 12.9 million patients have been referred through Choose and Book, of which over 10.9 million patients have been referred to outpatient care. The end-of-month position for January 2009 represented 54 per cent of all outpatient referrals made through the Choose and Book system.

**6.98** In many areas across England where Choose and Book utilisation is high and where there is strong leadership, it is now the standard method of referral. It gives patients greater involvement in the decisions about their treatment by allowing them to choose their initial hospital appointment, and book it there and then in the GP practice, or later via the internet or by telephone (via the National Appointments Line run by NHS Direct).

**6.99** In May 2008, the Choose and Book application was changed to support the roll-out of free choice policy. This has enabled GPs to search for all secondary care services from across the country (that are provided by NHS and independent providers, under a national contract), alongside all primary care services which are commissioned by their PCT. This change in the application continues to help GPs to navigate through the increasing array of choices that NHS patients can make. In June 2009, important changes will be made to the Choose and Book software that will enable providers to display their services with even greater precision. This involves using standard coded medical terminology to find the correct service quickly.

# 7 Commissioning and System Management

## Role

To develop world class commissioning to add life to years and years to life.

### Key achievements in 2008-09 included:

Worked with the NHS to deliver the World Class Commissioning Assurance Programme.

Developed the NHS Next Stage Review vision and strategy for primary and community services.

Delivered improvements in access to primary care services.

Implemented the arrangements for improved engagement and complaints handling.

Implemented free choice across the NHS.

Created a framework to enable the NHS to stimulate and reward innovation across the NHS.

## Summary

7.1 In this chapter you will find information on:

- commissioning
- primary care
- system management and new enterprise
- patient experience and planning
- service management.

## Commissioning

7.2 The Commissioning Division is responsible for driving improvements in commissioning. It is taking this forward through world class commissioning, which is a challenging and ambitious programme designed to improve health outcomes and reduce health inequalities – adding life to years and years to life.

7.3 Practice-based commissioning is integral to the world class commissioning agenda, which is driving up clinical engagement in commissioning alongside a focus on strengthening PCT commissioning capabilities.

7.4 In addition, the commissioning team have responsibility for the Integrated Care Pilot

Programme, which is promoting greater working together among providers in order to deliver improved health outcomes for patients.

### World class commissioning

7.5 In December 2007 the Department published *World Class Commissioning: Vision*, launched the World Class Commissioning programme, set out what excellent commissioning in the NHS can achieve, and identified the organisational competencies that PCTs would need in order to become world class commissioners.

### Assurance

7.6 In June 2008, the assurance system for world class commissioning was launched following co-production and design of the content and process with the NHS and local government. The assurance system holds PCTs to account and highlights areas for their development as they move towards becoming world class. It is a robust, challenging and developmental system that has nationally consistent content and processes, and it is implemented locally by SHAs.

7.7 The assurance system has been taken forward during 2008-09 with PCTs preparing the evidence



for the process during the summer and panel days taking place in every PCT over the winter.

7.8 The assurance system focuses on three elements: improvements in locally prioritised health and well-being outcomes, commissioning competencies and governance of the PCT organisation.

7.9 Publication of the individual PCT's scores has been led locally by PCTs facing outwards to their populations, and since the end of February 2009 all results have been placed in the public domain.

7.10 The assurance system has been a challenging, fair and valuable process for PCTs. It has supported a focus on commissioning, both outcomes and processes, and is beginning to drive health gain across England.

7.11 There is a high degree of commonality in the choice of health outcomes by PCTs. The top ten outcomes were:

- smoking quitters;
- rate of hospital admissions per 100,000 for alcohol related harm;
- cardiovascular disease mortality;
- percentage of all deaths that occur at home;
- under-18 conception rate;
- childhood obesity;
- cancer mortality rate;
- diabetes controlled blood sugar;
- infants breastfed; and
- percentage of stroke admissions given a brain scan within 24 hours.

7.12 With a focus on these health outcomes, PCTs will be delivering health gain for their local populations, accelerating improvements in health and well-being and driving down inequalities.

7.13 In terms of the achievements against the competency and governance elements, PCTs scored levels one and two (on a four-point scale), indicating slightly higher scores against the first few competencies, around partnership working than the later five competencies which reflect the more technical commissioning skills of market management and procurement. These results are as expected, based on a challenging system that expects improvement towards level four over five years. In terms of governance, PCTs scored red, amber and green across the ratings, with a higher proportion of ambers and greens than had been anticipated, indicating PCTs they have a good basis from which to develop their competencies next year.

### Support and development

7.14 Alongside the assurance system, SHAs have taken the lead on providing PCTs with support and development resources for commissioners to draw upon as they work to improve.

7.15 At a national level, the *Framework for Procuring External Support for Commissioners* (FESC) (DH, February 2007) was launched and is available to help PCTs address gaps in their commissioning capability and capacity. The framework provides access to independent sector suppliers with pre-assessed skills in different aspects of the commissioning cycle. The FESC is being used by a number of PCTs.

7.16 In addition, the *PCT Board Development Framework* (DH, September 2008) was launched to support PCTs to tailor their own development of boards, with an emphasis on their governance arrangements. The framework provides access to suppliers to work with PCTs on an organisational-specific basis. This was supported by the launch of guidance articulating the role of the PCT board in *World Class Commissioning* (DH, November 2008).

7.17 To support PCTs to develop their competencies, a handbook setting out best practice, *How to Achieve World Class Commissioning*



*Competencies. Practical tips for NHS Commissioners* (DH, October 2008), was also published.

### Practice-based commissioning

7.18 Practice-based commissioning (PBC) has the potential to transform care services by putting clinicians at the heart of commissioning. However, there is a widespread view that, with some exceptions, it has not lived up to its potential.

7.19 The NHS Next Stage Review is committed to redefining and reinvigorating PBC, positioning it firmly to provide the clinical leadership that is vital to the long-term success of PCTs as world class commissioners. The Department is working with the NHS to take this forward.

7.20 *Clinical commissioning: our vision for practice-based commissioning* (DH, March 2009) confirms how PBC is an integral part of world class commissioning and fundamental to making commissioning more effective and to improving health outcomes for individuals and communities. It also provides clarity around the roles and responsibilities of PCTs and PBC groups in embedding PBC locally.

7.21 In line with the commitment in the NHS Next Stage Review: *Our vision for primary and community care* (DH, July 2008), PCTs will be expected to provide the levels of managerial and analytical support that is necessary to allow practices to fully engage with PBC. PCTs will be held more to account for the quality of this support through the world class commissioning assurance process.

7.22 A national clinically led PBC Improvement Team has been established to offer focused support and advice on local PBC implementation to SHAs, PCTs and practice-based commissioners through a series of intensive regional visits in 2009. As part of this work, the team will be collecting and sharing examples of best practice and innovative solutions.

7.23 The PBC Development Framework was launched in December 2008 to support to PCTs and practice-based commissioners to strengthen their local arrangements for PBC. The framework provides access to pre-qualified organisations that are quality assured and capable of providing development services on local organisational specific bases. The Department has pump primed its use through a £1 million budget shared across SHAs.

### Integrated care

7.24 The pilot Integrated Care Programme was announced in Lord Darzi's report, *High Quality Care for All* (DH, June 2008).

7.25 *The Integrated Care Pilot Programme: Prospectus for Potential Pilots* (DH, October 2008) is a co-production from the NHS, social care and local government. The prospectus set out the vision and outcomes for the programme and invited applications from the NHS and local government.

7.26 The pilots will test a number of diverse models of integration, and successful pilots will demonstrate a focus on innovation and integration, leading to improvements in outcomes, reductions in health inequalities and improvements in quality and levels of patient and user satisfaction.

7.27 There are certain essential components that all successful pilots will demonstrate as part of the formal programme, including:

- clinically led;
- partnerships across providers in health, social care and beyond, according to local needs;
- based on list(s) of patients registered for medical services – any contract type;
- supported by the PCT and/or local authority as the commissioner of services and confirmed as being in line with the strategic plan for their local community;
- confirmation that the pilot will cooperate fully with a three-year national evaluation programme,



which will include collection of data against local and national measures;

- collaboration and commitment to data sharing across the system, to support care delivery, measurement and evaluation;
- robust project management and good governance;
- within the current legislative framework;
- confirmation that the pilot will give all patients the choice of provider that they are entitled to when they are referred to secondary care, as set out in the *NHS Constitution* and – for patients with long-term conditions – choice of provider, treatment and setting, linked to the agreement of their care plans; and
- clarification if any of the principles and rules of cooperation and competition would need to be waived in order for the pilot to be successful – this will only be agreed in some circumstances.

7.28 More than 100 applications were submitted in November 2008 as part of the first stage of the selection process for the formal programme. These were short listed to a total of 37 sites at stage two. Through a combination of coaching, written responses to clarification questions and a series of site visits, the formal pilots were selected by the end of March 2009. It is expected that there will be around 20 formal pilot sites announced in April 2009.

7.29 The pilot programme will be a two-year programme, with evaluation of the sites taking place over three years. Evaluation will focus on a combination of national and local metrics to provide additions to the evidence base for integrated care, and ongoing learning and sharing for the NHS and local government communities.

### Plans for 2009-10

#### World class commissioning

7.30 Following the results of the assurance system, the programme for world class commissioning in 2009-10 will respond to the

strengths and areas for development that are identified for PCTs as commissioners. The details of the programme, finalised in spring 2009, include:

- agreeing any improvements to the assurance system, including timing, for 2009-10;
- establishing a performance regime, linked to *Developing the NHS Performance Regime* (DH June 2008) and the *Transactions Manual* (DH February 2009), for use in 2010-11;
- working with SHAs to establish a support and development programme; and
- strengthening the assurance system to hold PCTs more to account for their support arrangements for PBC.

#### Integrated care

7.31 The final pilots for the formal integrated care programme will be announced in 2009. The pilots will start the programme following their announcement, including contributing to the national evaluation and ongoing learning and sharing networks that will take place throughout the programme.

7.32 Learning networks will be extended beyond the formal pilots to ensure that the progress and findings from the programme are shared on an ongoing basis.

#### Primary care

7.33 The Department's vision for primary and community care, *NHS Next Stage Review: Our Vision for Primary and Community Care* (DH, July 2008), drew together the main conclusions of the NHS Next Stage Review for primary care and other community-based NHS services. This new vision and strategy for primary care and community services was based on widespread engagement with NHS staff, patients and other stakeholders, and was informed by an expert advisory group that brought together leading GPs, community nurses and other primary care clinicians.



7.34 The strategy focuses on:

- shaping services around people's needs and views;
- promoting healthy lives and tackling health inequalities;
- continuously improving quality; and
- ensuring that change is led locally.

7.35 In addition to the improvements to GP services, dental services and other primary care services described below, the Department is working with the NHS and with stakeholder groups to support improvements in the local commissioning of primary care. This includes supporting better mapping of local health needs, public involvement and patient choice, measuring quality and quality improvement, supporting innovation, tackling poor performance, and using the market to promote innovation and quality.

7.36 In January 2009, the Department published two general guides for PCT commissioners: *Primary Care and Community Services: Improving GP Services* and *Improving Dental Access, Quality and Oral Health*. These are part of a rolling programme of practical guides, tools and regional events to help PCTs to address the strategic, leadership and operational challenges in driving up the quality of primary care commissioning.

### GP services

7.37 There have been major improvements in patient access to GP services following the commitments given in the interim report of the NHS Next Stage Review, *Our NHS, Our Future*, (DH, October 2007).

### Extended GP opening hours

7.38 Public engagement events during the NHS Next Stage Review showed that one of the public's main priorities for improving the NHS was having greater flexibility over when they could see a GP.

7.39 In January 2008, the Prime Minister gave a commitment that by the end of the year at least 50

per cent of GP practices in England would offer extended opening hours for patients. Thanks to the hard work of GP practices and PCTs, the NHS met this commitment three months early. In September 2008, 51 per cent of GP practices were offering routine appointments to their patients outside normal working hours. The latest figures show that 72 per cent of GP practices are now offering this service for patients.

### Additional primary care services

7.40 The interim report of the NHS Next Stage Review gave commitments to:

- correct historic inequalities in the distribution of primary care by establishing at least 100 new GP surgeries in those PCTs that have the fewest GPs and practice nurses and the greatest health needs; and
- give the public greater flexibility and choice in accessing GP services by establishing at least 150 GP health centres that are open from 8am to 8pm, seven days a week, and are open to any member of the public (regardless of which local GP practice they are registered with).

7.41 Following the 2008 Comprehensive Spending Review, the Department announced £250 million of new investment to support the local NHS in establishing these new services. PCTs were asked to undertake open and transparent procurements to enable the full range of potential providers to put forward bids for these new services and to stimulate high-quality, innovative proposals. PCTs were also asked to consider ways of using GP health centres to provide a wider range of co-located services that meet local needs, for instance diagnostic services, pharmacy services and social care.

7.42 The local NHS has made very good progress in establishing these new services. As of the end of February 2009, PCTs had awarded contracts for more than 100 of the new GP health centres and more than 80 new GP practices. The Secretary of



State for Health opened the first fully operational GP health centre in Bradford on 28 November 2008.

### Improving patient satisfaction with GP services

7.43 More than 2 million people responded to the second national GP patient survey in 2008. The results, published in July 2008, showed that:

- 87 per cent of people were satisfied with their ability to get through to their doctor's surgery on the telephone (up from 86 per cent in 2007);
- 87 per cent of people who tried to get a quick appointment with a GP said they were able to do so within 48 hours (up from 86 per cent);
- 77 per cent of people who wanted to book more than two days ahead for an appointment with a doctor reported that they were able to do so (up from 75 per cent);
- 88 per cent said that they were able to see the GP of their choice when they wanted to do so (no change); and
- 82 per cent said that they were satisfied with the current opening hours in their practice (down from 84 per cent).

7.44 These results showed improving levels of patient satisfaction but reinforced the need for the improvements that have since been achieved in GP practice opening hours. The GP patient survey is used in part to recognise and reward those practices that provide a high-quality patient experience. The Quality and Outcomes Framework (QOF) for GP practices now includes financial rewards linked to patient satisfaction with fast access and the ability to book appointments in advance.

7.45 For 2009, the Department has improved the GP patient survey to include a broader range of questions, designed to assess whether GP practices are getting the basics right, for instance whether the reception staff are helpful and whether doctors and nurses listen to and understand patients' problems and involve them in decisions about their care.

7.46 The Department continues to work with patient groups, professionals and the NHS to support general practice in providing services that are responsive to individual patients' needs. This includes building on the recommendations of Professor Mayur Lakhani's 2007 review to help make services more accessible and responsive to people from black and minority ethnic groups.

### Fair GP funding

7.47 In September 2008, the Department agreed significant changes to the General Medical Services contract that will introduce a fairer basic funding system for GP practices, with funding more equitably related to the number of patients each practice serves and their relative health needs. The agreement for 2009-10 will begin to phase out payments under the Minimum Practice Income Guarantee (MPIG) and make payments under the QOF more fully related to the local prevalence of long-term conditions.

### Driving continuous quality improvement

7.48 As part of the NHS Next Stage Review, the Department announced proposals to introduce a more transparent process for reviewing and developing indicators for the QOF, which rewards GP practices for how well they care for patients rather than simply for how many patients they treat. The Department consulted widely on more detailed proposals for this new process and announced its response to the consultation on 18 March 2009. The new process, which is to be led by the National Institute for Health and Clinical Excellence (NICE), will help to ensure that QOF indicators – and rewards for GP practices – are based on the best possible evidence of clinical effectiveness and cost effectiveness.

7.49 For 2009-10, the Department has agreed around £70 million of improvements to the QOF, replacing out-of-date indicators with new or improved indicators that will promote areas such as vascular screening for patients with hypertension, improved sexual health services and better diagnosis



and treatment for depression. The NHS is also now working with GP practices to introduce a range of enhanced services, including health checks for people with learning disabilities, better support for people with alcohol problems, more comprehensive ethnicity monitoring and better care for people with osteoporosis.

### Patient choice

**7.50** The NHS Next Stage Review emphasised the importance of promoting greater and more informed patient choice in relation to GP services and other primary care services. The recent procurements for more than 250 new primary care services, together with the move to a fairer GP funding formula (that better rewards practices that attract new patients), are designed to support wider improvements in patient choice. The Department is also working with the NHS to improve the range and quality of comparative information for the public on primary care services, including that on the NHS Choices website.

### Plans for 2009-10

**7.51** Over the coming year, the Department will continue to work with the NHS and with professional and patient groups to fulfil the NHS Next Stage Review vision for primary care. The Department will, in particular:

- help to embed systems that will achieve continuous improvements in the quality of GP services, including promoting the use of practice accreditation and developing quality accounts for primary care;
- promote further improvements in access to GP services. The Department expects that by the end of 2009 at least three-quarters of GP practices will be providing extended opening hours, and more than 200 GP health centres and new GP surgeries will be open to the public, providing more flexible access to GPs and greater choice for patients;
- help to make services more responsive to individual patients' needs and to extend patient choice. The GP patient survey will run quarterly

from April 2009 to provide more regular information for the public and for GP practices on patients' experiences. NHS Choices will include a greater range of comparative information for the public, including direct patient feedback on the quality of services at their GP practice; and

- make continued progress on improving value for money from the QOF, supported by the new role of NICE, and on phasing out MPIG.

### Dental services

**7.52** Over the past year, there have been encouraging signs of progress in commissioning dental services to improve patient access and to address local needs.

**7.53** As shown in **Figure 7.1**, the number of courses of NHS dental treatment rose by 940,000 (2.7 per cent) during 2007-08 and the number of dentists working in the NHS rose by 655 (3.2 per cent). For 2008-09, PCTs received an average 11 per cent (£209 million) increase in their dental budgets to support further expansion of services. PCTs have received a further average 8.5 per cent increase for 2009-10.

**7.54** The current indicator of access counts the number of people receiving NHS dental services over a retrospective 24-month period. The temporary reduction in service availability in 2006-07, as a result of some dentists refusing to sign new contracts, contributed to fewer people receiving services in the two years up to March 2008 (27.1 million people) than in the two years up to March 2006 (28 million people), as shown in **Figure 7.1**. However, subsequent investment in new services is enabling access to rise again. The most recent data (for the two years up to September 2008) showed a 100,000 increase in the number of people accessing services, and the Department expects further and faster progress in subsequent months.



Figure 7.1: Family health services – key statistics on primary dental care services, England

	1996-97	2003-04	2004-05	2005-06	2006-07	2007-08	% change 1996-97 to 2007-08	% change 2006-07 to 2007-08
<b>Primary dental care services</b>								
Number of general and personal dental practitioners <sup>(1)</sup>	16,470	19,026	19,797	21,111	20,160	20,815	26.4%	3.2%
Number of adults registered (thousands) <sup>(2)</sup>	19,798	17,374	17,237	17,670	N/a	N/a		
Number of children registered (thousands) <sup>(2)</sup>	6,617	6,964	6,891	7,044	N/a	N/a		
<b>Patients seen</b>								
Number of adults seen in previous 24 months (thousands) <sup>(3)</sup>				20,348	20,285	19,435		-4.2%
Number of children seen in previous 24 months (thousands) <sup>(3)</sup>				7,797	7,813	7,615		-2.5%
<b>Courses of treatment</b>								
Adult courses of treatment (thousands) <sup>(4)</sup>	24,580	27,031	26,488	25,844	25,121	25,801	5.0%	2.7%

Source: Dental and Eye Care Services, DH

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Notes:

(1) Numbers as at 31 March. Figures for 1996-97 to 2005-06, relate to dentists working within general dental services (GDS) including salaried dentists, or personal dental services (PDS) pilots. Figures for 2006-07 and 2007-08, relate to dentists with NHS activity in GDS, PDS and trust-led dental services (TDS) and includes some TDS dentists who did not previously work under a PDS or GDS contract in 2005-06.

(2) 1996-97 figures covered adults registered in the previous 24 months and children in the previous 15 months. 2003-04 and later years are numbers of patients registered in the GDS and PDS as at 31 March. GDS registrations lasted for 15 months. PDS schemes had varying registration periods. To ensure comparability with corresponding GDS data, PDS registrations are estimated using 'proxy registrations', namely the number of patients seen by PDS practices in the previous 15 months. PDS proxy registrations were not estimated for periods before September 2003 – actual registrations were used before this date.

(3) Numbers as at 31 March. The figures for 31 March 2007 and 31 March 2008 contain an additional group of patients who were seen by TDS dentists who did not previously work under a PDS or GDS contract in 2005-06. This is thought to have a minimal impact on the figures.

(4) Data on courses of treatment until 2005-06 represent completed treatment claims processed by the Dental Practice Board (Dental Services Division of NHS Business Services Authority from April 2006) within the relevant year. For 2006-07 and 2007-08, the figures are for courses of treatment conducted within the year.

## Plans for 2009-10

**7.55** The Department has recently invited Professor Jimmy Steele, University of Newcastle-upon-Tyne, to carry out a review of NHS dental services. The review will consider how best to build on the 2006 reforms to ensure access to high-quality services with an appropriate focus on preventive services. The review is expected to report in summer 2009.

**7.56** The *NHS Operating Framework for 2009-10* identified access to NHS dentistry as a key priority, stating that PCTs need to continue to develop dental services so that they meet local needs for access, quality of care and oral health. This will include reviewing dental commissioning strategies and ensuring open and transparent procurement for all significant new investments in dental services, in order to provide access to anyone who seeks help in accessing services.

**7.57** The ten SHAs have indicated that they and the PCTs in their areas intend to plan on the basis of achieving the operating framework objective by

March 2011 at the latest. The Department has established a strengthened dental access programme to support the NHS in achieving this objective. This will include supporting PCTs in undertaking open and transparent procurements for new dental services, both to increase access and to stimulate high-quality, innovative approaches to providing NHS dental services.

## Eye care services

**7.58** In April 2008, the Secretary of State welcomed the publication of the *UK Vision Strategy* (RNIB, April 2008). The strategy was developed by a coalition of organisations representing people who are blind or suffer from sight loss, and the professions and organisations that provide services for them. Its key aims are:

- improving the eye health of the people of the UK;
- eliminating avoidable sight loss while delivering excellent support for people with sight loss; and
- inclusion, participation and independence for people with sight loss.



**7.59** The Department has set up an Eye Care Strategy Group, with membership drawn from key stakeholder organisations, to advise on best practice in commissioning eye care services in support of the strategy.

**7.60** As shown in **Figure 7.2**, the number of NHS sight tests rose by 62 per cent between 1996-97 and 2007-08, driven mainly by the Government's decision to extend eligibility for free sight tests to everyone aged 60 years and over from 1 April 1999.

**7.61** NHS optical vouchers provide help for people on low incomes, children and certain other groups, towards the cost of glasses or contact lenses. The number of vouchers rose by 12.2 per cent between 2003-04 and 2007-08 (following a fall of 11.3 per cent between 1996-97 and 2003-04), with a rise of 5 per cent in 2007-08. Numbers tend to fluctuate year on year, reflecting changes in demographic factors and the number of adults claiming Income Support or Jobseeker's Allowance (the main categories of people who qualify for vouchers).

**7.62** There were 9,632 opticians providing NHS services in 2007-08, an increase of 7.7 per cent over the previous year and an increase of 39 per cent over the numbers in 1996-97.

## System management and new enterprise

**7.63** The System Management and New Enterprise Division leads the development of policy and support to the NHS on patient choice, system management (including competition, contracts, procurement, hosting the Cooperation and Competition Panel, and assuring the performance by SHAs of their system management responsibilities), social enterprise, and the Transforming Community Services Programme.

## Choice

### Achievements in 2008-09

**7.64** Choice is fundamental to a truly patient-centred NHS. It can empower patients so that they are able to make informed choices about their healthcare. Choice also gives providers the incentive to tailor services to the needs and preferences of patients, which will lead to better outcomes for patients. Free choice was introduced on 1 April 2008; it allows individuals to choose services from any hospital provider in England that meets NHS standards and costs, including NHS foundation trusts, NHS acute hospitals and many independent sector providers when they are referred for an elective procedure. Through the extended choice network, NHS patients now have a much greater choice of provider and much better access to independent sector facilities. As of February 2009, patients could choose between 170 acute trusts and 150 independent sector sites.

**Figure 7.2: Family health services – key statistics on general ophthalmic services, England**

	1996-97	2003-04	2004-05	2005-06	2006-07	2007-08	% change 1996-97 to 2007-08	% change 2006-07 to 2007-08
<b>General ophthalmic services</b>								
NHS sight tests (thousands) <sup>(1)</sup>	6,808	9,845	10,149	10,355	10,485	11,048	62.3%	5.4%
Optical vouchers (thousands) <sup>(2)</sup>	3,967	3,520	3,624	3,678	3,765	3,951	-0.4%	4.9%
Number of opticians <sup>(3)</sup>	6,939	8,331	8,472	8,639	8,946	9,632	38.8%	7.7%

Source: Dental and Eye Care Services, DH

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Notes:

(1) From 1 April 1999, the eligibility criteria for NHS sight tests was extended to include all patients aged 60 and over. Figures are based on the number of sight test claims where the date of payment fell within the financial year, rather than the date the sight test was conducted.

(2) The voucher scheme was introduced on 1 July 1986 to help certain priority groups with the provision of spectacles. Figures are based on the number of vouchers reimbursed to practitioners in the year, including payments for complex appliances, rather than the date when the vouchers were exchanged by patients for glasses.

(3) Optometrists and ophthalmic medical practitioners at 31 December.



7.65 Awareness of choice is increasing over time as choice becomes a core feature of NHS delivery for patients and providers. Figures for September 2008 show that 48 per cent of patients were aware, before they visited their GP, that they had a choice of hospital. Figures for September 2008 show that 46 per cent of patients recalled being offered a choice by their GP when they were referred to hospital.

7.66 The Department has been using a number of levers to ensure that everyone is aware of their entitlement to choice and of information to support that choice. A campaign was launched in spring 2008 that was designed to raise awareness among adults of their ability to choose the provider of their NHS care. The campaign appeared in the local press, on local radio adverts and interviews, and in videos broadcast on the Life Channel in GP surgeries. Marketing initiatives targeted specific demographic groups, such as the elderly, to ensure that hard-to-reach and vulnerable groups are aware of patient choice.

7.67 The *NHS Constitution*, published on 21 January 2009, brings together a number of rights, pledges and responsibilities for staff and patients. Patient choice is a prominent feature of the *NHS Constitution* and a new right to choice was announced in the document, together with the right to information to support choice.

#### Plans for 2009-10

7.68 From 1 April 2009, the new rights to choice and information will come into force. Effectively this will create a legal right for patients to choose where they have their treatment when they are referred for their first outpatient appointment with a service led by consultants, and to information to support that choice. New, legally binding directions from the Secretary of State to PCTs underpin this new right. PCTs will have to ensure that patients get a choice as set out in the *NHS Constitution* and to publicise that they are entitled to a choice.

7.69 At present, the right to choice only extends to elective referral. The options and entitlements available to the patient will evolve over time. The Department is exploring the areas where patient choice might be extended in the future.

7.70 The Department will be implementing the second phase of a marketing campaign to raise awareness of patient choice throughout 2009. The second phase aims to:

- ensure that patients feel empowered to make those choices;
- develop targeted activity for seldom-heard groups and their influencers; and
- improve the toolkit and collateral that are provided to regional stakeholders to help them implement the national strategy at a local level.

### System management

#### Achievements in 2008-09

7.71 During 2008-09, further substantial progress was made in establishing the infrastructure required to ensure that a 'rules-based' NHS system works in the best interests of patients and taxpayers. There was a particular focus on ensuring fair and transparent commissioning and competition, and effective patient choice. New standard national contracts were co-produced with the NHS, encompassing ambulance services, community services and mental health services, for use from April 2009. The standard contract for acute hospital services was also updated.

7.72 To improve standards of procurement – especially decisions as to whether and when to tender – the *Primary Care Trust Procurement Guide for Health Services* was published by the Department in May 2008, which is mandatory for PCT commissioners. To ensure that commissioners procure transparently, and that all potential bidders are aware of what is being sought, as easily and efficiently as possible, a single national procurement portal – 'Supply to Health' – was developed and launched from October 2008.



7.73 To support the introduction of free choice in elective care, a code was published governing the promotion of NHS-funded services to enable providers to advertise their services. It also provides protection for patients, staff and hospitals from misleading advertisements or information.

7.74 The *Principles and Rules for Cooperation and Competition* (DH, December 2007), designed to set out clear expectations and rules of commissioners and providers in ensuring fair and effective commissioning, fair competition, appropriate cooperation, and foster patient choice, was published as part of the *NHS Operating Framework for 2008-09*. A transactions manual was co-produced and published, providing guidance on 'corporate transactions' – mergers, acquisitions, the 'corporatisation' of PCT commissioning functions, and joint ventures. To help provide effective oversight of cooperation and competition, an independent NHS Cooperation and Competition Panel, chaired by Lord Carter of Coles, has been established. It will advise the Department, SHAs and – where relevant for NHS foundation trusts – Monitor, on alleged breaches of the principles and rules, and proposed mergers, acquisitions and joint ventures.

#### Plans for 2009-10

7.75 The *Principles and Rules for Cooperation and Competition* will be reviewed and revised, if necessary, to ensure that they remain fit for purpose. The new standard national contracts for ambulance services, community services and mental health services will be evaluated and revised, ensuring that they are aligned with the quality framework and the payment framework *Commissioning for Quality and Innovation* (DH, December 2008), for use from April 2010. All independent sector providers who are currently working under the aegis of the extended choice and free choice networks will be transferred to the standard national contract.

7.76 An assurance system will be developed and implemented to assure the effective performance of

SHA system management responsibilities, reflecting their role as regional system managers.

### Transforming community services

#### Achievements in 2008-09

7.77 The Transforming Community Services Programme was set in response to the NHS Next Stage Review and the Primary and Community Care Strategy. Its purpose is to help enable the NHS to develop and provide modern, personalised community services of a consistently high standard. This will require both the reform of the community services system and the transformation of individual services.

7.78 The foundations for this transformation were laid in 2008-09, through a set of enabling policies and guidance. These focused mainly on improving systems and empowering staff, and included:

- launch of the 'right to request' to set up a social enterprise (see Social enterprise);
- establishment of an innovation and leadership fund to support transformational change;
- guidance on currencies and pricing;
- a resource pack to help PCTs commission transformed, evidence-based community services;
- a standard national contract for community services;
- guidance on enabling new patterns of provision to develop 'fit for purpose' provider organisations for community services that:
  - empower staff to use their professional skills to improve patient care
  - focus on quality and innovate focus on quality as their 'organising principle'
  - enable service transformation and are able to perform effectively in contractual relationships with PCTs.



## Plans for 2009-10

7.79 The focus in 2009-10 will be largely on supporting service transformation through developing people and improving services, particularly through defining and measuring quality. This will include:

- co-producing and piloting, for use from April 2010, a national quality framework for community services;
- co-producing six transformational practice guides for clinical team leaders, encompassing *High-quality Care for Children and Families; Services for Long-term Conditions; Acute Services Closer to Home, Rehabilitation long-term Neurological Conditions; End-of-Life Care; and Promoting Health and Well-being and Reducing Inequalities*. Each guide will contain six practical high-impact transformational changes;
- rolling out the Productive Community Services Programme;
- investing in building clinical and managerial leadership and capacity, and encouraging innovation;
- further work and guidance on currencies and pricing for community services, and evaluation and refinement of the standard community contract; and
- developing a strategy for the development of information systems for community services.

## Social enterprise

### Achievements in 2008-09

7.80 The Department's Social Enterprise Unit has been strengthened to support its key role in building the capacity and capability of social enterprises to provide NHS-funded services and contribute to commissioning. This reflects the Department's recognition of the proven record of social enterprises in reaching out to individuals/communities on the margins, providing innovative responsive services and good value for money. The Department also believes that, by giving NHS staff the opportunity

to develop social enterprises under the 'right to request' scheme for community services, it can help empower them to lead, transform services and innovate.

7.81 Practical steps to achieve this have included:

- Using the £100 million Social Enterprise Investment Fund (SEIF) to build capacity and pump prime new social enterprises. The 2006 White Paper included a commitment to set up a Social Enterprise Fund in 2007. In January 2007, funding of £73 million was announced over four years for the SEIF, followed by an announcement in January 2008 of a further £27 million, creating a fund of £100 million over four years. The key objectives of the SEIF are to: stimulate the start-up of new social enterprises in health and social care; enable growth in the delivery by social enterprises of health and social care services and products; develop and offer a range of innovative financial products for start-up funding and longer term investment that are tailored to the needs of emerging and existing social enterprises in the health and social care sectors and that support their financial sustainability; encourage social returns; and leverage investment from external investors. So far, around £15 million has been given to more than 50 social enterprises since March 2007.
- Social Enterprise Pathfinders. The Pathfinder Programme was launched by the Department in 2006-07 to develop social enterprise models for delivery of the health and social care.
- The Innovation for Life Challenge Fund. This came about through a challenge set by Ivan Lewis, in his previous role as Minister for Care Services, to encourage SHAs and commissioners to find collaborative solutions through social enterprise. The fund was developed in collaboration with the Social Enterprise Coalition and is a discrete funding stream from within the Department of Health SEIF. A sum of £450,000 for six innovative projects was awarded in November 2008.



- The NHS PCT staff 'right to request' to set up social enterprise is one of the recommendations of the NHS Next Stage Review. It was launched in November 2008 with the publication of the right to request 'how to' guide (*Social Enterprise – Making a Difference*), which was co-produced with the Social Enterprise Coalition. The guide provides practical information for PCT staff on how to approach the creation of a social enterprise. Information on the right to request, legal issues, pensions, and business planning are all included in the guide, along with a number of case studies to illustrate the different forms of social enterprises and some of the issues that social enterprises face when setting up. It has been followed by a series of national and regional conferences for front-line staff interested in setting up social enterprises. Initial interest has been high.

7.82 Taken together, these measures should help to establish a vibrant social enterprise sector in health and social care by supporting the development of social enterprises delivering innovative, responsive and personalised services; encouraging new entrants to the sector; and, opening up marketing and commissioning to social enterprises.

#### Plans for 2009-10

7.83 The Department will build on this in 2009-10 by:

- Appointing external fund management for the SEIF. The Health and Social Care Act 2008 allows the Secretary of State to delegate the authority to invest in social enterprises to a fund manager. The SEIF will continue to be owned by the Department, but external professional fund management should enable the £100 million fund to be used to optimum effect, including: securing increased leverage through cooperation with other cross-government funders by the fund manager; marketing the SEIF to potential applicants; screening and appraising applications by social enterprises seeking financial assistance and investment; managing the draw-down of

investment funding; monitoring the performance of the SEIF's portfolio of investments (including the SEIF's existing investments); and ensuring that SEIF investees meet their repayment obligations. The fund manager will also be expected to offer business support services to both applicant and investee organisations, and to engage with health and social care service commissioning bodies to test demand among such bodies for the services being offered by social enterprises applying to the SEIF for support.

- Identifying and supporting a viable 'first wave' of new social enterprises under the 'right to request' scheme.

## Patient experience and planning

7.84 The Patient Experience and Planning Division brings together two teams. The Public and Patient Empowerment (PPE) Division is focused on helping to ensure that 'what really matters to patients and the public' is at the heart of the work of the health and social care system. The Analysis Division provides an expert analytical service to the Directorate and the NHS on commissioning and system management work programmes.

### Public and patient empowerment

#### Achievements in 2008-09

7.85 In 2008, the PPE Division focused on placing the message of empowerment and engagement at the heart of the delivery of health and social care. The role of PPE in supporting the delivery of the NHS Next Stage Review was set out at a national conference in July 2008 and, building upon the momentum from both the NHS Next Stage Review and the launch of the constitution consultation process, the profile of the following PPE programmes was raised.

7.86 In 2008, the PPE Division successfully set up new arrangements to create Local Involvement Networks (LINKs) across the country. LINKs were established in all 150 and they have a remit to work with local health and social care organisations.



7.87 The preparatory work for the new national framework for the new complaints procedure was completed in 2008-09. This creates for the first time an integrated two-stage complaints procedure for health and social care that is simpler for patients and service users. The Parliamentary and Health Service Ombudsman and the Local Government Ombudsman started their new duties on 1 April 2009, and new more responsive models to enable local resolution have been developed in 94 pilots across the country.

7.88 New legal duties for PCTs and SHAs about involving patients and the public became law in November 2008, and supporting guidance entitled *Real involvement: working with people to improve health services* (DH, October 2008) guidance has been published.

7.89 Local providers and commissioners have piloted methods of collecting and using patient and public feedback to help improve the design and quality of services. The PPE Division is working with these pilots and with SHAs to stimulate the widespread and systematic adoption of methods of collecting and using real-time patient experience feedback across the NHS.

7.90 The *NHS Constitution* published in January 2009 includes a new duty to provide information to patients. The PPE Division has been working to improve the quality and range of information that is available to patients. In 2008-09 a new set of 'information prescriptions' were made available to the public on the NHS Choices website and a tender to accredit information providers has been launched.

### Analysis teams

7.91 The Analysis Division has ensured that policies that are developed and implemented within the Commissioning and System Management Division have been evidence-based. The team has helped the understanding of the likely costs and benefits, in particular for the primary and

community care strategy, and has developed a range of metrics to assess the emerging effects. Financial modelling was at the heart of giving ministers the confidence to reform the GP contract and plan for improvements in dental access. A model to support the local NHS to analyse changes in the NHS estate stemming from service reconfiguration was produced and widely disseminated.

7.92 The Commissioning Intelligence team has developed, piloted and evaluated analytical products to assist commissioning organisations make the link between expenditure and health outcomes, and to enable PCTs to develop key world class commissioning competencies. The programme budgeting data for 2007-08 was published and stimulated a wider and higher profile discussion than in previous years, and a range of improvements in the data collection for 2007-08 was made and widely appreciated by the NHS. Building on this, the Association of Public Health Observatories was commissioned to develop PCT profiles, and the team has facilitated joint projects on the analysis of the Joint Strategic Needs Assessment and the development of commissioning intelligence data through a roadshow, academic publications and stakeholder groups. The *Second Annual Population Value Review* (NHS National Knowledge Service and DH, October 2008) helps PCTs to produce plans to deliver health gain locally and underpins the local PCT strategies that will be published in 2009.

### Plans for 2009-10

7.93 In 2009 the PPE Division will focus its work on placing what really matters to patients and the public at the heart of the decision-making in the Department and the NHS.

7.94 There are three key sets of work programmes for 2009 that bring together the work of the business teams in the PPE Division that focuses on accountability, experience and empowerment.



7.95 Firstly, the work to support PCTs in the local development of world class engagement will be demonstrated by a step change in the performance on world class commissioning competency 3 (engaging with patients and the public). Work with Local Involvement Networks and other patient and public groups will be complemented by using other mechanisms, such as new digital channels of communication and information exchange, to both empower patients and the public and to enable PCTs to become more responsive to local needs.

7.96 The Division will support the NHS in developing the competencies and capacities that will enable them to become 'world class engagers'. This will be co-produced with the NHS and will access the very best tools and techniques from the private and public sectors in social marketing and research, community development and the use of digital and other technologies.

7.97 Secondly, staff and the public will be empowered through the local NHS, using the *NHS Constitution* to focus on the needs, wants and aspirations of patients and the public and this will enable the NHS to demonstrate its accountability to the public. Specifically, the Constitution recognises the crucial role that good quality, reliable and accessible information has in supporting patients and carers in living healthier and more independent lives. Work will continue to support the NHS and social care in implementing information prescriptions, and in developing an accreditation scheme to quality assure the providers of information. Work to support the NHS in making the Constitution a central component of PCT's engagement strategies will be paralleled by the work with staff in becoming ambassadors for the Constitution.

7.98 Over the past few years, the legislative infrastructure for engagement and accountability has been created, but there remain a couple of further areas for consultation that build on listening exercises from last year, including refreshing

the guidance on the work of the Overview and Scrutiny Committees.

7.99 Thirdly, there is the opportunity to embed patient experience feedback in the quality improvement systems of all NHS organisations and in the national quality framework. Thus the patient experience will be seen alongside clinical effectiveness and patient safety as being at the heart of the work on metrics, of quality observatories and in the quality accounts. The Department will work with the NHS to deliver the commitment that every hospital will be able to demonstrate to its commissioners and the public how it is using real-time patient feedback to transform services in 2009 by publishing guidance on the development of local strategies for patient and customer feedback as part of the organisation's quality improvement system. Building on the requirement to include patient experience metrics as part of the payments made under CQUIN (Commissioning for Quality and Innovation) schemes, work to explore other ways of rewarding providers who deliver high-quality patient experience will be explored. Real-time feedback is one source of insight into what really matters to patients, but this information will need to be triangulated with survey information, patient stories and feedback from complaints.

7.100 The new complaints system will bring a focus to the work locally to improve complaints handling and to learn the lessons from complaints. The new system will enable organisations to provide a more flexible and responsive service that is tailored to the needs of complainants and, as it applies to both health and adult social care, to provide joined-up responses when required. The system also changes the process of independent review: in health through a single process run by the Parliamentary and Health Service Ombudsman, and in adult social care by introducing the Local Government Ombudsman.



## Analysis teams

**7.101** The Analysis Division will be driving forward work to support the Commissioning and System Management Directorate and the NHS in 2009. The work will support the scoping and implementation of key aspects of *High Quality Care for All*, such as the three-digit number for urgent care and the new GP patient survey. The team will be working with SHAs and PCTs to support the development of analytical skills and capacity in commissioners, including a commissioning information portal to provide access to the national analytical resources such as the rolling-out of programme budgeting as part of NHS comparators. Underpinning all this work will be the support to PCTs to drive the achievement of better value through improving the technical and allocative efficiency of the NHS.

## Service management

### Innovation

#### Achievements in 2008-09

**7.102** *High Quality Care for All* puts quality at the heart of the NHS, providing an ambitious shared vision for the future of the NHS. It goes on to describe a reformed system that supports quality improvement. One of the key enablers for this is creating an environment within which innovation can flourish.

**7.103** Communities and people across England have different characteristics and different needs. Yet, too often, the services that they receive are not sufficiently shaped around those characteristics and needs. If the NHS is to live up to its founding principles, it must constantly respond to those it serves, changing to continue to live up to the ambition of high-quality care. This will not happen without a culture in the NHS that supports and rewards innovation.

**7.104** The Department's role will be to set up the conditions that encourage innovation to flourish. This begins with helping to prepare the right

macroeconomic conditions, creating open and competitive markets, and investing in people and knowledge. Focusing on regulation and procurement policies can extend this support, as can implementing measures that are designed specifically to unlock hidden innovation.

**7.105** The main driver for innovation will be the productive relationship between the NHS, research and educational organisations, business, and the third sector. The ways in which the cultures and processes of these players support or hinder the development and diffusion of good ideas is the key determinant to the effectiveness of innovation in healthcare and the successful delivery of the *High Quality Care for All* commitments. Government can help the NHS and its partners realise the benefits of innovation, but can never be a substitute for local action.

**7.106** Over the last 12 months, the Department has worked with stakeholders from the academic, scientific, suitable, voluntary and public sectors to develop suitable conditions and relationships. It has committed new resources for the diffusion of innovation, strengthened support for innovators, improved IT and access to evidence, and through the new legal duty to promote innovation-strengthened leadership.

**7.107** The Health Innovation Council, established in 2007 by Lord Darzi, continues to support the work of the Department and has made a vital contribution to shaping its approach and delivering success – an independent peer review of its work concluded that “it was the most comprehensive effort that has yet been made by a UK government public service department to develop an evidence-based, well-resourced approach to innovation”.

#### Plans for 2009-10

**7.108** NHS Evidence – a new single web-based portal that will allow quick and easy access to authoritative and unbiased evidence to support clinical and non-clinical decision-making – will go



live in 2009 and will provide, in one place, more evidence than has ever been available before. NHS Evidence will continue to develop over time (including an accreditation process) with ever-increasing sources of evidence and more bespoke and personalised search facilities for users. The aim is for NHS Evidence to become the first choice of evidence for all NHS staff.

**7.109** A new £220 million Regional Innovation Fund will be launched in 2009. Aimed at front-line staff and organisations to help with the development and diffusion of ideas, it will be the first time that the NHS has had a dedicated pot of money of this kind.

**7.110** Work to develop the Innovation Challenge prizes will continue, ahead of the first awards in 2010. The prizes will help address some of the key healthcare challenges that the NHS will face over the next five to ten years, and will encourage open innovation – where partners come together locally to problem solve and jointly develop solutions.

**7.111** The new legal duty to promote innovation will act as an enabling tool for SHAs in driving the promotion of innovation locally. In turn, this will promote stronger leadership of innovation and encourage a culture change right across the NHS.

**7.112** Towards the end of 2009-10, each SHA will produce an Annual Innovation Report. This will detail the progress made on innovation in-year, including the amount, and impact, of resource dedicated to and invested in innovation.

## Reconfiguration

### Achievements 2008-09

**7.113** Major service change is about modernising treatment and facilities to improve patient outcomes, developing accessible services closer to home and saving lives.

**7.114** The Department published *Changing for the Better: Guidance When Undertaking Major Changes*

to NHS Services (DH, May 2008) alongside the NHS Next Stage Review interim report. This best practice guidance offered clear advice for patients, the public and NHS staff on the processes underpinning changes to NHS services. It will help to ensure that changes to local services are:

- based on sound clinical evidence;
- made in the best interests of patients; and
- made as part of an ongoing dialogue with local stakeholders about services in the area.

**7.115** The publication of *Changing for the Better* complemented the NHS Next Stage Review Report, *Leading Local Change* (DH, May 2008). This document made five pledges, which demonstrated the commitment to delivering the most effective change possible:

- Change will always be to the benefit of patients.
- Change will be clinically driven.
- Change will be locally led.
- You will be involved – The local NHS will involve patients, carers, the public and other key partners in decisions about service change.
- You will see the difference first – existing services will not be withdrawn until new and better services are available to patients, so that they can see the difference.

## NHS telephone access

A new three-digit telephone number for access to non-emergency healthcare services

**7.116** The NHS Next Stage Review report, *High Quality Care for All*, said: "...we [the Department] should consider options to introduce a new three-digit telephone number to help people find the right local service to meet their urgent, unplanned care needs".

**7.117** In addition to the NHS Next Stage Review, other reports and publications before it reminded the Department that NHS users and patients can sometimes find it difficult to understand what



services are available to them (particularly during the 'out-of-hours' period or when they are away from home), where they are located, the times when they are open, and which are the most appropriate services to use.

**7.118** The three-digit number will improve and simplify access to unplanned/urgent care services by connecting callers to a range of integrated and convenient services – available 24/7, 365 days a year – including primary care, walk-in facilities, A&E, ambulances, pharmacy, NHS Direct, and community and mental health services.

**7.119** The Office of Communications (Ofcom) will undertake a public consultation exercise on the introduction of a three-digit telephone number early in 2009. Subject to a successful outcome from the consultation, the Department plans to pilot the introduction of the three-digit number in the NHS as soon as possible.

#### Review the use of non-geographic '084' telephone numbers within the NHS

**7.120** The Department completed an internal information-gathering exercise, and a subsequent public consultation exercise, looking at the use and cost of 084 numbers in the NHS. The purpose of the consultation was to find out how people felt about using 084 numbers, which functions people valued and why, and how best these could be provided at no extra cost to the patient. The consultation ended on 31 March 2009 and generated a high level of public and media interest.

**7.121** The Department will be taking swift action in response to the outcome of the 084 numbers consultation to ensure that patients, wherever they are in the country, get the same quality of service, improved access, and pay no more than the cost of a local telephone call when contacting the NHS.

#### Long-term conditions

**7.122** During the 2008-09, the Department continued to work closely with all stakeholders to develop a commitment to the improvement of care

services that are delivered to people with long-term conditions (LTCs). These are chronic diseases that cannot be cured but that can be controlled by medication and/or therapies, for example diabetes, asthma, chronic obstructive pulmonary disease and many more. The Department's commitment extends beyond delivering services in the way 'it has always been' and is about putting the person with the condition at the centre of their own care.

#### Personalised care planning

**7.123** An existing commitment that each one of the 15 million people with one or more LTCs should be offered a personalised care plan was reinforced in *High Quality Care for All*.

**7.124** Throughout the last year, the LTC team has continued to work with all stakeholders, including patients and carers, to develop a common understanding of what a personal care plan would be. This resulted in the publication of *Supporting People with Long-term Conditions: Commissioning Personalised Care Planning* (DH, January 2009), a clear guide for commissioners on what is meant by personalised care planning and why it is important.

**7.125** The Department has been monitoring patient views of personalised care planning through the annual GP Patient Survey and by using a monthly patient tracker survey. Early indications from these sources show that more people are having a discussion with their health professional about how they want to manage their LTC and that many have agreed, a written care plan. More importantly, where a care plan has been agreed the vast majority report that this has improved the care that they are receiving.

#### Patients' prospectus

**7.126** At the start of the year, the Prime Minister made a commitment that the Department would produce and publish a patients' prospectus to ensure that people with an LTC were aware of the choices of self-care support that they could expect to help them to make decisions and manage their own care.



This was an important commitment that was developed in partnership with patients, professionals and voluntary groups. *Your Health, Your Way – A Guide to Long-term Conditions and Self-care* was published in November 2008 on the NHS Choices website and has received some very positive feedback.

**7.127** The website provides an interactive approach for people to identify information about their condition, find out about personalised care planning and access information about support arrangements available to them locally. The next stage, currently underway, is to ensure that this approach is embedded locally so that all people can access the information regardless of personal access to the NHS Choices website.

#### Supporting a self-care approach

**7.128** To further support empowerment and self-care for people with LTCs, the Department continues to work with the Expert Patients Programme Community Interest Company (EPP CIC) to raise the profile of the lay-led, self-management programme. The programme supports people to increase their confidence, improve their quality of life and better manage their condition.

**7.129** Establishing the EPP CIC and increasing capacity towards delivering 100,000 course places by 2012 were commitments in the *Our health, Our Care, Our Say* White Paper of 2006. Latest information shows that, between April 2007 and March 2008, the EPP CIC delivered almost 25,000 course places to people with LTC needs.

**7.130** As well as delivering the EPP, the CIC is developing new courses, designed to meet people's different needs, and developing new partnerships with all stakeholders who are involved in self-care support.

#### Use of assistive technology

**7.131** Telehealth (electronic aids to remotely measure vital health signs) and telecare (electronic

aids to support social care needs) are widely available, but there is no robust evidence demonstrating their effectiveness. This year has seen the Department launch the Whole System Demonstrator programme to evaluate the cost and clinical effectiveness of this emerging technology. The programme will involve up to 6,000 patients across three sites in Newham, Cornwall and Kent, all of which have joint health and social care approaches.

**7.132** In total, the Department will be investing up to £30 million over two years in what it believes to be the largest randomised controlled trial of this technology anywhere in the world. The fully evaluated outcomes should be available by late 2010 or early 2011 and will provide the evidence to support potential multi-million-pound investments in this technology across England. There has also been much interest in this programme internationally, and a number of other health systems around the world will benefit from the programme's findings.

#### Plans for 2009-10

**7.133** The main focus of the Department's efforts in the coming year will be to support the delivery and implementation of a personalised approach to the services available to people with an LTC. In particular it will continue to provide guidance and support to the NHS and social care system to:

- embed personalised care planning across the country;
- ensure that patients receive information on what they can expect to receive;
- promote the development of self-care as a real option for patients; and
- identify opportunities to support the workforce to deliver a service based on one-to-one support where needed.

**7.134** For example, work is in train to develop an e-learning tool and guidance to support the workforce and a targeted support programme to



help local PCTs to deliver personalised care planning locally.

**7.135** There is also a need to identify arrangements that can help support people who have not yet developed an LTC but may do so in the future. This means identifying the risk factors that prevail and what, if anything, can be done to help delay the onset of LTCs. Therefore, the Department will work with the Prime Minister's Strategy Unit to consider the feasibility of developing an approach for a 'personalised prevention strategy' for people who are most likely to develop LTCs in the future.

### **Urgent and emergency care**

**7.136** During 2008-09, the Department made significant progress in developing the framework required for the NHS to make sustained and effective improvements in urgent and emergency care services. The aim is to help PCTs, as commissioners of services for unscheduled care, to deliver excellent services to their local communities.

**7.137** In April 2008, the new 'call connect' target was introduced. Ambulance response time targets are more challenging than ever before. The measurement clock starts once the call has been connected to the ambulance control room, rather than after key information has been obtained from the caller. Telephones are being answered more quickly, advice and reassurance are given to the caller earlier, ambulances are dispatched faster and the patient is reached sooner.

**7.138** The Department published a good practice document *Changing Times: Sustaining Long-term Performance Against 'call connect' for NHS Ambulance Services* (DH, July 2008). This provides ambulance services with a suite of performance improvement tools and best practice examples for sustainable performance improvements against 'call connect', and also helps to further enhance the delivery of service to patients through improved quality of care.

**7.139** Patient access to services is a key element within the new *NHS Constitution*. The pledges include the national waiting time target for A&E (four hours) and the national ambulance response time targets for category A (immediately-life threatening) and category B (urgent, but not life-threatening) calls.

**7.140** In 2008, the Healthcare Commission published the results of its Emergency department survey. The results show that patient satisfaction was high: 88 per cent of patients rated it 'excellent', 'very good' or 'good'. This compares with 85 per cent in 2002-03. The same survey indicates that patients rated ambulance services at 97 per cent – the highest ratings received by any NHS service.

**7.141** The Healthcare Commission also reviewed urgent and emergency care services by PCTs during 2008. Some 60 per cent of PCTs scored 'better' or 'best performing' and 82 per cent of PCTs were rated as 'fair performing' or better. The review highlighted areas where improvements can be made, and the Department is working with the NHS to make these improvements a reality as soon as possible. For example, the Department held three national events for the NHS in autumn 2008 to explore the Healthcare Commission's findings and to highlight effective practice.

**7.142** Following the introduction of the national quality requirements, the Healthcare Commission reported that the NHS has made significant progress on performance for primary care out-of-hours services. To continue to drive this trend, the Department commissioned the Primary Care Foundation to develop a benchmarking tool for out-of-hours services to help improve quality, performance and value for money. PCTs are already securing benefits from this tool.

**7.143** The number of critical care beds in England on 15 January 2009 was 3,637, some 164 more than in January 2008. This maintains a continuing increase in capacity to meet the needs of some of

the sickest patients in hospital and is the highest number of critical care beds in England since the Department started to record the numbers in 1999-2000. The 2008-09 winter period has been particularly challenging for critical care services throughout the country, with high demand leading to high occupancy levels in most hospitals. The increase in capacity since 2000, along with effective local planning, has helped manage this situation.

### NHS Direct

7.144 The Healthcare Commission reported that NHS Direct's performance against call-handling targets was excellent. It continues to report good performance results to the Department. A number of changes to NHS Direct's operations are underway to drive further improvements. A review of their finance and contracting arrangements is being carried out, which will lead to financial allocations that are better linked to costs, activity and performance. The Department is also delegating responsibility for management of the Department's contract with NHS Direct to NHS East of England, to ensure that planning and commissioning of NHS Direct's services are better linked to the NHS's own delivery plans.

### Plans for 2009-10

7.145 The review of the future operational form of NHS Direct, its fit with the emerging Department of Health digital strategy, and use of NHS Pathways call operator model.

7.146 The Department will support the NHS to deliver 24/7, integrated, convenient, accessible and high-quality urgent and emergency care services by producing commissioning guides and tools for PCTs and by removing barriers in the system, eg pricing and tariff anomalies. The Department will also:

- develop and consult on proposals to allow paramedics to prescribe a specified range of drugs to patients;

- research and consider the development of quality indicators across the full urgent and emergency care system, including indicators to replace ambulance category B response time targets; and
- continue to work with authoritative professional bodies and organisations on the development of a range of quality metrics to support quality accounts and still further improve the quality of care delivered to critically ill patients.



# 8 Workforce

## Role

To provide system leadership on people matters so that NHS and social care staff can serve the health needs of their communities.

### Key achievements in 2008-09 included:

Published the *NHS Constitution*, *A High Quality Workforce*, and NHS talent and leadership guidance.

Established the NHS Leadership Council and gained approval to establish a National Skills Academy for Social Care.

Agreed a three-year pay deal for Agenda for Change staff and introduced a new NHS Pension Scheme.

Completed the implementation of the Electronic Staff Record.

Passage of new legislation to reform professional regulation and promote patient safety.

Established a new Modernising Medical Careers Programme Board and improved recruitment to medical training posts.

## Summary

8.1 In this chapter you will find information on:

- the NHS journey;
- the NHS Constitution and values;
- staff engagement and social partnership;
- developing and strengthening talent and leadership in the NHS;
- meeting NHS workforce needs;
- modernising education and training;
- modernising regulation of healthcare workers;
- NHS pay and pensions modernisation; and
- social care workforce.

## Introduction

8.2 It is the role of the Department to create the conditions nationally that will enable the workforces who deliver health and social care across England to succeed.

## The NHS journey

8.3 For the last ten years, the development of the NHS workforce has been informed by the *NHS Plan: A plan for, investment, a plan for reform* (DH, July 2000), which set out to expand services across the country. This required more staff and the modernisation of pay systems, including improved pay for the majority of staff. The NHS has delivered this with over 270,000 more staff, including over 42,000 more doctors, almost 85,000 more nurses and more than 42,000 scientific and therapeutic staff. The latest workforce census (published in March 2009, covering the prior year) showed that there were 1,368,200 staff compared with the headcount of 1,071,562 in 1998. This represents an increase of over 27 per cent.

8.4 This expansion has enabled front-line staff to provide better services and to reduce waiting times and waiting lists, including delivery of the Government's commitment that no-one will now wait over 18 weeks from GP referral to the start of their treatment. Now that the Department has achieved the expansion required by the *NHS Plan*,

any further expansion will be targeted at specific areas such as the introduction of the European Working Time Directive or the planned development of midwifery services. The Department's primary focus has therefore moved on to enabling the ambitions laid out in the review of the NHS led by Lord Darzi, *High Quality Care for All: NHS Next Stage Review Final Report* (DH 2008). The workforce implications of the review and the Department's commitments are set out in the document *A High Quality Workforce* (DH, 2008), which accompanied the review. These commitments are designed to put quality at the heart of all that the Department does.

## The NHS Constitution and values

8.5 Although the NHS is constantly changing in order to respond to public and patient expectations, the fundamental purpose, principles and values of the NHS are more enduring. The Department therefore set out to consult on the development of an NHS constitution to set out the rights and responsibilities of patients, the public and staff. The first *NHS Constitution* was subsequently published on 21 January 2009.

8.6 The *NHS Constitution* establishes the principles and values for the NHS in England. It sets out the rights to which patients, the public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies, private and third sector providers supplying NHS services will be required by law to take account of the Constitution in their decisions and actions. The Constitution will be reviewed every ten years and is supported by a detailed handbook that will be reviewed at least every three years to ensure that the principles and values that underpin the NHS are subject to regular review and recommitment.

8.7 The *NHS Constitution* was developed following extensive consultation with trade unions, NHS providers and commissioners, staff, the public and patients. The commitments that it makes to staff reflect extensive research into:

- what matters to patients:
  - get the basics right – don't leave it to chance;
  - fit in with my life – don't force me to fit in with yours;
  - treat me as a person – not a symptom;
  - work with me as a partner in my health – not just a recipient of care;
- what matters to staff:
  - the resources to deliver high-quality care;
  - a worthwhile job with the opportunity to develop;
  - the opportunity to contribute and to improve the way we work; and
  - the support to do a good job; and
- what matters to the public:
  - Financial support for the NHS and care for its staff;
  - users treated fairly based on need, not ability;
  - money not wasted; and
  - that its there when we need it.

8.8 The *NHS Constitution* is also underpinned by the publication of six values that inform how organisations across the NHS work together in the interests of patients. Alongside this, organisations in the NHS will develop and refresh their own values, tailored to their local needs. The NHS values provide the common ground to achieve our shared aspirations:

- respect and dignity – we value each person as an individual and respect their aspirations and commitments in life;
- commitment to quality of care – we earn the trust placed in us by insisting on quality and striving to get the basics rights every time;



- compassion – we respond with humanity and kindness to each person’s pain, distress, anxiety or need;
- improving lives – we strive to improve health and well-being and people’s experience of the NHS;
- working together for patients – we put patients first in everything we do; and
- everybody counts – we use our resources for the benefit of the whole community and make sure nobody is excluded or left behind.

8.9 The Constitution is also supported by four pledges to staff which commit the NHS to strive to provide:

- well-designed, rewarding jobs that make a difference to patients, families, carers and communities;
- personal development, access to appropriate training, and line management support to succeed;
- support and opportunities to keep staff healthy and safe; and
- the engagement of staff in decisions that affect them and the services they provide.

8.10 The Department has backed these up with concrete actions involving regions and employers:

- The current arrangements for education funding in the NHS will be reviewed to ensure that they are fairer, more transparent, provide improved value for money and are responsive to the feedback from trainees.
- The Department has commissioned a comprehensive review to gather evidence on the health of NHS staff, and the provision of support for their health and well-being at work. This joint Department/NHS review will build a comprehensive evidence base to allow effective system-wide improvements in the health and well-being of the NHS workforce. It will be carried out in partnership with employers and staff.
- To recognise the achievements of the best-performing organisations, the Department will

work with key partners to ensure that annual competitions identify the best NHS employers.

8.11 The *NHS Constitution*, values and pledges recognise that the NHS cannot deliver high-quality services without high-quality staff and high-quality workplaces. To inform continuous improvement and allow the Department to track progress, the 2008 NHS Staff Survey was amended to be better aligned to the pledges. The inclusion of these questions is designed to enable individual NHS employers to understand how well they are performing in those areas that matter most to staff. Taking action in these areas should have a positive impact on staff motivation and morale, with direct benefits for the quality of patient care. In addition, the Care Quality Commission will measure staff satisfaction from the staff survey in their annual report on trusts.

8.12 Over the next few months, individual organisations will develop and refresh their own values, tailored to their purpose and local needs. To support them to do this, the Department has commissioned the NHS Institute for Innovation and Improvement to identify best practice and make it available to organisations.

## Staff engagement and social partnership

8.13 Staff engagement was crucial to the success of developing *High Quality Care for All*, and needs to be maintained and expanded during implementation. If the Department gets it right, the quality agenda has great potential to mobilise and empower staff across the system. All the evidence suggests that the way to succeed is to build on the genuine engagement begun during the NHS Next Stage Review process. This applies just as much to local organisations where staff engagement is fundamental to high-quality care on the ground. On healthcare-acquired infections, mutual support and engagement with the trade unions helped to



increase staff action and make a real difference to quality of care.

**8.14** The national Social Partnership Forum, which is chaired by Ann Keen, Parliamentary Under-Secretary of State for Health Services, and includes representation from SHAs, trades unions, NHS Employers and the Department, is an exemplar of what can be achieved. During 2008-09, it has gone from strength to strength and has provided valuable advice to ministers on the workforce implications of proposed changes in policy, such as the recent guidance on the transformation of community services.

**8.15** Over the next 12 months, the aim is to promote the benefits of partnership working and staff engagement and to support their development throughout the NHS. To support this, in November 2008 Ann Keen announced a partnership fund of £500,000 to develop partnership working between employers and trade unions.

## Developing and strengthening talent and leadership in the NHS

### Talent and leadership

**8.16** *High Quality Care for All* also emphasised the importance of leaders and leadership. It established a shared vision of an NHS that has quality of care at its heart – quality that spans safety, effectiveness and the patient experience. This has provided a common language, a way of talking about quality across the system, focused on improvement for the benefit of patients and service users.

**8.17** Providing high-quality care is a source of professional pride, energising and motivating all NHS staff, clinical and non-clinical alike. It requires professionals to be empowered to make the daily decisions that improve quality, combined with a new and stronger accountability to the people that the NHS is there to serve.

**8.18** In January 2009, the Department published *Inspiring Leaders: Leadership for Quality*. This guidance for SHAs on talent and leadership planning was developed in partnership with the NHS and outlines accountability at all levels of the NHS – for individuals, organisations, regionally and nationally – to develop leaders and leadership. Every individual in healthcare has a responsibility to continuously learn and seek development. Providers and commissioning organisations at local level have a responsibility through their boards of directors to create conditions for talent and leadership development.

**8.19** In a system where leaders frequently move between organisations and sectors, employers also have a key role as stewards of talent and leadership, ensuring that there is a range of aspiring leaders to choose from when filling new opportunities. All organisations are also responsible for participating in leadership improvement efforts across their region.

**8.20** SHAs play a key role at regional level. They foster investment and collaboration in order to support leadership development, assuring themselves that the right conditions are in place across their regions for improving talent and leadership development. SHAs will also add value at a regional level through the commissioning and provision of development programmes for senior leaders.

**8.21** There is also a role nationally. *High Quality Care for All* committed the NHS to the establishment of a National Leadership Council (NLC) to sit alongside the Quality Board.

**8.22** The NLC is being created to challenge the new priority being attached to leadership in the NHS – to ensure that the system and culture support the development of leaders and leadership for high-quality care, and to challenge them where they do not.



## Appointments Commission

8.23 The Appointments Commission is an executive non-departmental public body with particular expertise in relation to public appointments. It is responsible for the recruitment, selection and appointment of the best people, from a diverse range of backgrounds, to public appointments in the NHS and to national bodies and groups established by the Department.

8.24 The Commission also provides a year-long induction programme for new non-executives, oversees performance appraisal for non-executives, and provides recruitment and selection services to a growing number of NHS foundation trusts and other government departments.

8.25 In January 2008, the Commission published *Adding Value to a 21st Century Health Service – A Review of the NHS Public Appointments Process*. The review, commissioned by the Department, engaged stakeholders and looked at the range of services the Commission provides to the NHS. Substantial progress has been made in implementing its recommendations. The Commission has:

- introduced an online recruitment system and an electronic customer survey;
- developed a new national induction programme and a streamlined appraisal system;
- supported the Commission's Independent Public Appointment Assessors, who are all now accredited by the office of the Commissioner for Public Appointments; and
- developed a detailed recruitment strategy for each campaign through initial discussion with chairs.

8.26 The Department and the Commission have also reformed the process by which an appointee can be removed from office, including the introduction of a new process for suspending non-executives in PCTs and NHS trusts.

8.27 The second annual Chairs Conference, held in January 2009, included the Secretary of State for

Health and the Chief Executive of the NHS as speakers. Over 300 chairs representing trusts from across England attended the event, the only one of its kind in the UK. The conference focused on leadership and governance, sparking lively debate on performance culture, while a session from representatives of the private sector offered an alternative perspective on effective board management. The new *NHS Constitution* and challenges for the future were also discussed in detail.

## Meeting NHS workforce needs

### Improving workforce planning

8.28 Consistently delivering high-quality care requires a more transparent workforce planning system which is based on clearly articulated patient care plans and integrated with curricula design, education commissioning and financial plans.

8.29 The Department has committed to put in place improved architecture to achieve this vision. It is also establishing national and regional advisory boards, including Medical Education England (MEE), to ensure appropriate professional and clinical input to workforce planning, and creating a centre of excellence to support workforce strategy and planning across the health and social care system in England.

8.30 MEE represents a unique opportunity to build a new consensus between the Department and the professions on getting the right numbers and types of doctors, dentists, pharmacists and healthcare scientists that the NHS will need for the future. This new body will bring a coherent professional voice on education and training matters as they relate to those four professional groups, and will advise the Department on policy.

8.31 The Department is also creating a new centre of excellence providing strategic oversight and leadership to improve on the quality of workforce planning across the health and social



care system. It will achieve this by exercising its responsibilities across three functions:

- aligning the overall system around shared goals for improving data analysis and modelling;
- prioritising for horizon scanning and using the best evidence to identify workforce models to support new care pathways; and
- providing leadership for capability building in workforce planning at all levels.

## Modernising education and training

8.32 *A High Quality Workforce* set out a vision not only for improvements in workforce planning, but also for the modernisation of education and training, and education funding. This included the need to review and restate the unique contribution of different professional groups, including responsibilities not just as expert practitioners but also as partners and leaders, and the development of clearer career frameworks to support workforce planning and help staff and prospective staff to understand how they can develop their careers.

### Education and training for doctors

8.33 The need to make changes to the historical structure of the recruitment and training of doctors has been widely recognised and is supported by many in the medical profession. The Modernising Medical Careers (MMC) England Programme was therefore developed in order to introduce a range of integrated measures to improve the recruitment and selection process for entry to the various stages of postgraduate medical education. It also aimed to enhance the arrangements and outcomes for that education and training.

8.34 Serious problems were encountered during implementation in the early part of 2007, but the Department responded to these with a series of independent reviews culminating in a detailed report by Professor Sir John Tooke, *Aspiring to Excellence* and the Health Select Committee report on MMC, *Modernising Medical Careers: Third*

*Report of Session 2007–08, Volume 1* (The Stationery Office, 2008). In 2008, the Department published its official response to those reports (*The Government Response to the Health Select Committee Report 'Modernising Medical Careers'*, (The Stationery Office, 2008) setting out the way forward for the modernisation of medical education and its supporting systems. This has included the establishment of a new MMC England Programme Board and stronger service and professional representation in policy development and workforce planning.

8.35 In the meantime, national recruitment has continued to improve. The traditional junior doctor changeover in August 2008 was completed without incident and a national average fill rate of 92 per cent was achieved, the highest rate ever recorded.

8.36 The MMC England Programme Board continued its successful focus on improving recruitment and the MMC team held a series of successful stakeholder workshops during the summer, allowing those involved in the process to talk about their experiences and suggest where further improvements could be made.

8.37 Improved advanced planning also allowed the early release of information about how the application process was going to work for 2009. This included confirmation that, while there will not be any national IT system, all applications may be made electronically. There will also be a standard Part 1 application form rather than doctors being faced with a number of different forms to complete. Moreover, nearly all deaneries will use the same IT system for their local recruitment, which will help with data reporting.

8.38 Also for 2009, nearly half of all recruitment is being coordinated nationally by Royal Colleges or specialties working closely with deaneries. This should help consultants by reducing the time spent short listing and interviewing. It should also increase the chances of appointing trainees who want to



work in a particular specialty, and help to achieve a higher fill rate – a key consideration for the NHS.

### European Working Time Directive

8.39 The NHS has continued to make progress on implementation of the European Working Time Directive. By September 2008, more than two-thirds of doctors in training were working an average of 48 hours a week or less, and the North West Strategic Health Authority, which piloted early implementation, had achieved 94 per cent compliance by August 2008.

8.40 The United Kingdom remains committed to delivering compliance with the August 2009 requirements and is confident that this can be achieved in most areas. However, a number of significant challenges remain in some services, especially those delivering 24-hour immediate patient care, some supra-specialist services and some small, remote and rural units. The UK has therefore notified the European Commission of its intention to request a limited derogation that can be applied to doctors in training in particular services or areas. The derogation would apply for up to three years and would allow a 52-hour working week for those to whom it applied.

### Education and training for nurses

8.41 Within nurse education, the main focus is on successfully implementing the Nursing and Midwifery Council's (NMC's) recent decision to raise the minimum standard for the future registration of new nurses from diploma to degree. The Department is working with the NHS and the NMC to maximise the opportunities and minimise the risks to successful implementation.

8.42 The NMC has also proposed a new national framework for preceptorship to help the transition from newly registered nurse to fully confident practitioner. Full details are expected to be announced in autumn 2009; however, the Department has already supported the concept of preceptorships by investing £10 million in 2008-09,

and by committing to invest £20 million in 2009-10 and £30 million in 2010-11 to support this important initiative and pilot good practice.

8.43 The Department is also developing a new career framework for nurses and proposals for a marketing campaign for nursing careers.

### Education and training for midwives

8.44 For midwifery, the Department has begun working with education providers to ensure that undergraduate and postgraduate curricula support high-quality patient care and deliver choice. The Department will also be working to develop more high-quality clinical placements, ensuring that future education is aligned to the maternity care pathway and that clinicians have the support to ensure that their skills keep pace with service reforms.

### Education and training for the allied health professionals

8.45 During 2008, the Department also published *Modernising Allied Health Professions (AHP) Careers: A Competence-Based Careers Framework* (DH and Skills for Health, July 2008), which provides the basis for a flexible, responsive approach to developing the AHP workforce of the future. The competences themselves have been developed by starting with the patient/client need and have been field-tested with professionals across the country. The Skills for Health web-based tools provide the health and social care system with the means to maximise AHPs' potential to transform the health and social care system by highlighting their ability to perform a variety of new and extended roles that will enable service redesign. The second phase of the Modernising AHP Careers Programme will build on the competence-based career framework to put in place those educational levers necessary to build and maintain a flexible and responsive workforce. The Department is also establishing a Professional Advisory Board that will meet the commitments it made in the NHS Next



Stage Review to provide professional oversight of both the Modernising AHP Careers Programme and workforce planning to ensure that these are interlinked. The Professional Advisory Board will be chaired by the Chief Health Professions Officer.

### Education and training for healthcare scientists

**8.46** For healthcare science, the aim of the UK-wide Modernising Scientific Careers Programme, being led by the Chief Scientific Officer, will be to transform the education, training and career pathways of the Healthcare Science workforce across over 50 scientific disciplines. The Department recognises the vital contribution to be played by healthcare scientists in the delivery of improved benefits for patients, for employers and health commissioners, for the workforce itself, and for health services, and the integral part they play in multi-professional teams delivering high-quality innovative patient care in a range of settings.

### Continuing professional development

**8.47** *A High Quality Workforce* also set out proposals to strengthen educational governance and ensure that all staff have equitable opportunities to update and develop their skills. The Department is reviewing the education contracting arrangements

between it, SHAs and individual employers in order to support this. The Department is also developing financial and non-financial metrics, which can be made available to employers, employees, patients and the public to improve transparency about the availability of continuing professional development. This includes working with NHS Employers and the trade unions and service to promote the use of the Knowledge and Skills Framework development review in identifying individuals' development needs. The Department is also accelerating plans to double its investment in apprenticeships in order to provide those staff who do not have a professional qualification with the opportunity to develop their skills and progress their careers, and to provide improved access to NHS careers for those outside the service, including the unemployed and socially excluded.

### Education, funding and investment

**8.48** During 2008-09, the Department has continued to increase its investment in education and training, allocating over £4.5 billion to SHAs to support existing and new commissions. **Figure 8.1** shows significant investment in new commissions, for the last four years. **Figure 8.2** shows this year's commissions including a further 6,471 new places

Figure 8.1: Commissions of pre-registration training places

	2005-06	2006-07	2007-08	2008-09 planned commissions
Nurses	23,230	21,199	19,352	21,732
Midwives	1,559	1,523	1,719	1,777
Allied health professionals	6,744	7,103	6,650	6,714
Scientists <sup>(1)</sup>	874	1,059	1,078	1,140
Technicians <sup>(2)</sup>	2,965	2,847	2,750	2,972

Source: Workforce Directorate, DH

Notes:

(1) Scientists data includes child psychotherapy and clinical psychology commissions.

(2) Technicians data includes pre-registration pharmacists, pharmacy technicians, operating department practitioners and dental care professions commissions.

Figure 8.2: Numbers in medical training

	2006	2007	2008
Medical school intake	6,401	6,292	6,471
Doctors in training and equivalent	45,394	45,855	
Medical F1s	4,879	5,223	

Source: Workforce Directorate, DH



at undergraduate medical school and over 34,000 new places on non-medical professional training courses, bringing the total population in undergraduate professional training to over 90,000.

8.49 The Department has also strengthened the accountability arrangements in respect of the Multi Professional Education and Training (MPET) budget, and has begun to review education funding policy as set out in *A High Quality Workforce*, including the fundamental review of the way it incentivises and rewards quality in education and ensure value for money. This includes the review of the funding for tuition in higher education, student support funding, and the introduction of a tariff-based approach for clinical placements where funding will follow the trainee. This work is complex but is progressing well and will continue in 2009-10.

## Modernising regulation of healthcare workers

### Professional Standards Programme

8.50 The Professional Standards Programme is a critical component of the Government's drive to improve NHS services, as set out in the NHS Next Stage Review. It will help to deliver the high-quality workforce needed to ensure the safe, respectful and effective care that patients expect. Similarly, in social care, it seeks to ensure that users of social care services are served safely and respectfully by qualified and high-quality staff.

8.51 The Department is leading this initiative by working in partnership with the devolved administrations, patients, service users, the public, professionals, regulators and employers to deliver a wide-ranging programme of reform to the UK systems of professional regulation and employers' and commissioners' systems of local professional management. These are set out in the 2007 White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (The Stationery Office); the Department's response to the

Shipman Inquiry, *Learning from tragedy, keeping patients safe* (The Stationery Office, 2007) and related documents; and the Department's strategies for raising the quality of provision of social care.

8.52 The programme works on the general principle that risk to patients is most effectively managed at the point closest to those risks, and that it is for national organisations to work together to provide the leadership, legislative framework, systems and resources to enable that risk management to work well.

### Legislation

8.53 The Health and Social Care Act 2008 received Royal Assent in June 2008. This Act sets out a number of reforms for professional standards, which are now being taken forward, including:

- the creation of a new body to be called the Office of the Health Professions Adjudicator, which will have adjudication functions in relation to the professions regulated by the Medical Act 1983 and the Opticians Act 1989;
- provisions to enable the General Pharmaceutical Council to separate pharmacy regulation from professional leadership;
- the removal of restrictions that prevented there being a lay majority on the councils of the regulatory bodies;
- imposing the civil standard of proof by healthcare professions regulators in proceedings relating to fitness to practise;
- amendments to the constitution and functions of the Council for Healthcare Regulatory Excellence and the way in which members are appointed;
- regulations to require designated bodies in the UK to nominate or appoint 'responsible officers' who will have responsibilities relating to the regulation of doctors; and
- the creation of a general responsibility on healthcare organisations, and other specified bodies in England and Wales, to share information regarding concerns about the conduct



and performance of healthcare workers, and to agree the actions needed to protect patients and the public.

8.54 The Department has also introduced legislation to make changes to the structure and appointment of the councils of the regulatory bodies.

### Revalidation

8.55 The publication of *Medical Revalidation – Principles and Next Steps: The Report of the Chief Medical Officer for England's Working Group* (DH, July 2008) set out the principles and next steps for implementing revalidation in the UK. While the General Medical Council (GMC) retains overall responsibility for the introduction of medical revalidation in the UK, since the report was published the Department has established an internal project board, chaired by the Chief Medical Officer, to oversee the introduction of an effective appraisal system to underpin revalidation in England, and has established an NHS Revalidation Support Team.

8.56 The Department is working with the Academy of Medical Royal Colleges and has provided funding to them to enable the development by the Medical Royal Colleges of standards and tools for re-certification.

8.57 The Working Group for non-Medical Revalidation published its report *Principles for Revalidation – Report of the Working Group for non-Medical Revalidation* in November 2008. The non-medical regulatory bodies will now develop their models of revalidation and proposals for pilots, and will report to the Department early in 2009.

### Health for health professionals

8.58 The Department has been working with the National Clinical Assessment Service to commission a prototype Practitioner Health Programme (PHP) for registered medical and dental practitioners working in the London SHA. Practitioners accessing

the PHP have health concerns that relate to a mental health or addiction problem and/or a physical health problem. The pilot was officially launched by the Chief Medical Officer in November 2008 and will receive funding of £3.6 million over the next two years.

### Postgraduate Medical Education and Training Board

8.59 In order to ensure that medical education is a seamless process from undergraduate training through to continuing professional development, appraisal and revalidation, work is under way to merge the Postgraduate Medical Education and Training Board (PMETB) into the regulatory structure of the GMC.

8.60 A draft Order supporting this merger is being prepared for public consultation in 2009. The GMC – PMETB merger is due to be completed by April 2010.

### Extending professional regulation

8.61 During 2008, the Extending Professional Regulation Working Group considered the process by which regulation should be extended to further professional roles and groups. Emphasis has been placed on considering the alternatives to statutory regulation in order to find the most suitable mechanism for managing professional standards for unregulated groups, without introducing unnecessary regulatory burdens. The group commissioned two pieces of research and held two stakeholder events to help inform their recommendations. They expect to report shortly. In order to ensure that regulation in the health arena is consistent with developments within the social care workforce, the Professional Standards Programme is also working in partnership with social care policy staff and the General Social Care Council to progress proposals regarding the registration of domiciliary/home care workers.

8.62 A separate report on introducing regulation for acupuncture, herbal medicine and traditional



Chinese medicine was produced in May 2008, and a public consultation will be launched in 2009, once the report from the Extending Professional Regulation Working Group has been published.

**8.63** The Department has commissioned, and funded, the Prince's Foundation for Integrated Health to develop voluntary self-regulation among a range of currently unregulated complementary therapies, and the Complementary and Natural Healthcare Council opened its register in January 2009.

### Improving workforce systems

**8.64** In the past, the NHS was disadvantaged by the lack of consistency in its payroll and human resources (HR) systems. Over the last five years, the Department has therefore been developing a new integrated payroll and HR system, the Electronic Staff Record (ESR). Implementation of the ESR was completed in April 2008, on time and within budget. This represented one of the world's largest information technology implementations as the ESR has replaced at least 29 payroll and at least 38 HR systems that were previously used in the NHS, and is now successfully paying over 1.3 million employees across England and Wales.

**8.65** The focus for the ESR Programme has now shifted to ensure full-system utilisation and benefits realisation. The Oracle Learning Management (OLM) functionality within ESR is now being implemented in 62 per cent of organisations, and there is a steady increase in organisations piloting the manager self-service functionality. Work has also progressed to enable ESR to provide NHS employees with access to learning content online (NLMS project), and for organisations to better manage NHS employees' access to patient care systems (the interface between ESR and the Care Records System). Confirmed benefits to date have already exceeded the ESR business case target by 32 per cent and continue to grow.

**8.66** Over the coming year, attention will also be focused on capturing the potential of ESR as a strategic HR tool able to support board-level decisions. The Department will also continue to improve the consistency and completeness of workforce information, and to deliver system-wide efficiencies through further integration with existing workforce solutions.

## NHS pay and pensions modernisation

**8.67** The Department has continued to reform pay and pensions policy to ensure that they are fit for the 21st century. From 1 April 2008, following a root and branch review of the NHS Pension Scheme, changes were made to the scheme for existing staff and a new, more flexible NHS Pension Scheme was introduced for new entrants with a higher normal pensionable age of 65.

**8.68** During the summer of 2009, the 1.3 million staff who were members of the old pension scheme in April 2008 will begin to be offered the opportunity to move to the new scheme if they wish. This process will be managed by the Pensions Division of the NHS Business Services Authority, which is responsible for the scheme's administration in England and Wales. However, due to the large scale of the project, the exercise will be implemented over three years and will be phased in one strategic health authority region at a time, starting with staff aged over 50.

### NHS pensions for social enterprises

**8.69** The Department was also pleased as part of *High Quality Care for All* to be able to confirm that staff transferring under TUPE from the NHS to social enterprises would be able to retain membership of the NHS Pension Scheme while they continue working wholly on NHS-funded services. This announcement addressed an important concern for staff and should help promote the development of social enterprises.

## Pay modernisation

8.70 During 2008-09, the Department continued its process of pay modernisation, including the successful introduction of a new three-year pay deal for 1.1 million Agenda for Change (AfC) staff. This provides a package of pay and non-pay improvements worth 7.99 per cent over the three years to 2010-11, with extra help targeted at the lowest paid. Moreover, the deal is subject to annual review by the NHS Pay Review Body to ensure that it remains appropriate in light of changing circumstances. The NHS Pay Review Body reviewed data from the trade unions, employers and the Department in December 2008 in order to assess whether the uplifts for years two and three should be reviewed. They decided that the deal should not be reopened at the moment. The deal will therefore continue into its second year, which will include the removal of the bottom pay point of AfC, increasing the NHS minimum hourly wage to £6.77, 18 per cent above the national minimum wage.

8.71 In the meantime, the National Audit Office has conducted its own review of AfC and published its report, *NHS Pay Modernisation in England: Agenda for Change*, on 29 January 2009. The report acknowledged the successful implementation of the AfC agreement, but highlighted that there is more to be done if its full benefits are to be realised. In particular, the NHS needs to make full use of the NHS Knowledge and Skills Framework (KSF).

8.72 The report reinforced the commitment that the Department has already shown to ensure that the KSF is fully implemented. Indeed, the Parliamentary Under Secretary of State for Health Services, relaunched the NHS KSF during 2008-09 and reviewed progress in October 2008. This showed that about 70 per cent of trusts now have a board member with responsibility for KSF; 60 per cent of staff have a KSF outline; and more than 40 per cent have had a KSF review. The relaunch has raised awareness of this important tool, but more needs to be done. The Department has therefore

commissioned the NHS Staff Council (comprising NHS Employers and NHS trade unions) to take this forward, including an independent review of what is required and the production of improved guidance to employers.

8.73 The Department has also worked with the NHS Staff Council throughout the year to continue to modernise other NHS pay systems, including the introduction of a harmonised system for unsocial hours and revised mileage rates for staff on AfC terms and conditions. It has also begun introduction of a new contract for speciality doctors and associate specialists from 1 April 2008; and it has completed an independent evaluation of the pay framework for very senior managers (VSMs), with the Department accepting the main recommendations, which include the introduction of a job evaluation system designed to bring greater clarity and fairness to NHS VSM pay.

8.74 Looking ahead to 2009-10, the Department will implement the findings of the review into VSM pay and will continue to support the delivery of benefits from the consultants' contract and AfC, including improving productivity and securing value for money.

## Social care workforce

8.75 For information on the developments happening in the adult social care workforce, please refer to chapter 12.



# 9 NHS Medical

## Role

To drive the engagement of the health service in improving the care of patients.

### Key achievements in 2008-09 included:

- Established Medical Education England, incorporating doctors, scientists, dentists and pharmacists.
- Launched Measuring for Quality Improvement, taking forward one of the key commitments from High Quality Care for All and established the National Quality Board.
- Published *Pharmacy in England* White Paper and the End-of-Life Care Strategy.
- Agreed a new Pharmaceutical Price Regulation Scheme with the pharmaceutical industry.
- Fully implemented antenatal screening programmes for sickle cell disease and thalassaemia; newborn screening for medium chain acetyl dehydrogenase deficiency (MCADD); initiated screening programme for abdominal aortic aneurysm; and successful further roll-out of bowel cancer screening.
- Published *Putting Prevention First*, and launched a new initiative in preventive care with NHS health checks to reduce risk of diabetes, heart disease, stroke and kidney disease for all aged 40 to 74.

## Summary

9.1 In this chapter you will find information on:

- enhancing clinical and scientific leadership in the NHS;
- pharmacy;
- making quality the organising principle of the NHS;
- ensuring value for money from the NHS drugs budget and by promoting cost-effective clinical practice;
- implementing the Pathology Review; and
- adding years to life and life to years through leading programmes to reduce premature mortality and morbidity.

## Introduction

9.2 The NHS Medical Directorate was established in November 2007 with the appointment of the NHS Medical Director, Sir Bruce Keogh. The Directorate has four objectives:

- enhancing clinical and scientific leadership in the NHS;
- making quality the organising principle of the NHS;
- ensuring value for money from the NHS drugs budget and by promoting cost-effective clinical practice; and
- adding years to life and life to years through leading programmes to reduce premature mortality and morbidity.

## Enhancing clinical and scientific leadership in the NHS

### NHS Medical Director

9.3 The NHS Medical Director has established a network of medical directors under his leadership, largely completed during 2008-09. Each strategic health authority (SHA) now has a medical director post at senior level to oversee medical leadership in primary care trusts (PCTs) and NHS trusts. A major conference for NHS medical directors in

November 2008 brought together for the first time medical directors from SHAs, PCTs, NHS trusts and NHS foundation trusts, together with other professional colleagues and Department staff.

### Medical Education England

9.4 Following the Tooke Report into the implementation of the Modernising Medical Careers Programme, the Department established a new board to oversee medical education, Medical Education England. Sir Christopher Edwards has been appointed as Chairman, and Dr Patricia Hamilton took up post in January 2009 as Director of Medical Education.

### Healthcare science

9.5 The consultation on the UK-wide Modernising Scientific Careers (MSC) programme, led by the Chief Scientific Officer (CSO), to deliver a world class Healthcare Science (HCS) workforce, closed on 6 March 2009. Following the closure of the consultation the Department anticipates publishing a future direction document, including a new regulatory framework, in summer 2009, with piloting from autumn 2009 and full implementation from 2012.

9.6 The programme will provide enhanced benefits for patients:

- delivering high-quality diagnostic and therapeutic patient services; and
- developing and using technology to improve care for priority groups, and finding scientific and technological solutions.

9.7 An HCS Programme Board has been established under the umbrella of Medical Education England. The board will provide advice to inform and enable the delivery of integrated workforce planning, on the implementation of MSC in England, and on leadership and academic career pathways.

9.8 This year the Department established the £4 million CSO Research Fellowships over three years in order to enhance the research capacity and capability of the HCS.

9.9 A series of good practice guides for physiological measurement in diagnostic services have been produced, in conjunction with the 18-week team, aimed at transforming the way in which services are provided for patients. Further guidance on physiological measurement is planned for publication later in 2009. A guide to good practice in perfusion, including a medicines management framework, will be published in 2009.

9.10 There have been a number of projects supporting the cross-government Science and Society initiative, for example the development of a collaborative framework with the Specialist Schools and Academies Trust, and Healthcare Science Awareness Week. In 2009, the Department will further develop its contribution to this area.

9.11 The fifth annual CSO conference was held in November 2008 and included awards to recognise the contribution of healthcare scientists. The *CSO Bulletin* was relaunched at this event, and is aimed at delivering key policy messages to the NHS scientific workforce.

### Pharmacy

9.12 Last year's White Paper, *Pharmacy in England: Building on Strengths – Delivering the Future* (The Stationery Office, April 2008), set out the Government's vision for further developing quality services for patients and consumers through pharmacies in England, and a programme of work is now under way to implement its proposals.

9.13 To support this programme, the Department has appointed two National Clinical Directors for Pharmacy to champion change and to promote better patient experience and pharmaceutical outcomes in hospitals and in the community.



Figure 9.1: Family health services – key statistics on pharmaceutical services, England

Pharmaceutical services <sup>(1)</sup>	1997-98	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	% change 1997-98 to 2007-08	% change 2006-07 to 2007-08
Prescription items dispensed (millions) <sup>(2)</sup>	462.2	566.3	596.5	623.2	659.0	688.4	725.8	57.0%	5.4%
Number of contracting pharmacies <sup>(2)(3)</sup>	9,785	9,748	9,759	9,736	9,872*	10,133	10,291	5.2%	1.6%
Average number of prescription fees per pharmacy <sup>(2)</sup>	47,899	59,530	62,691	65,854*	68,808*	70,121*	72,818	52.0%	3.8%
Average net ingredient cost per fee (£) <sup>(2)(6)</sup>	8.53	10.87	11.23	11.29	10.50	10.36*	9.89	15.9%	-4.5%
Percentage of all prescription items which attracted a charge <sup>(4)(5)</sup>	14.6%	14.3%	13.7%*	13.1%	12.4%	12.0%	11.3%		

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\* Indicates figure has been revised from the 2008 Departmental Report.

Notes:

(1) Pharmaceutical services include the supply of medicines and appliances prescribed by NHS practitioners.

(2) Includes prescriptions dispensed by community pharmacists; excludes personally administered items and items dispensed by appliance contractors and dispensing doctors.

(3) Figures refer to 31 March (eg 2007-08 is number as at 31 March 2008).

(4) 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 exempt prescription forms submitted to the Prescription Services Division of the NHS Business Services Authority. The analysis is based on prescriptions submitted by community pharmacists and appliance contractors and excludes dispensing doctors and personally administered items.

(5) Figures in reports prior to 2007-08 were presented in calendar years, not financial years.

(6) Cash-based figures 1997-98 and resource-based figures 2002-03 to 2007-08.

## NHS pharmaceutical services

9.14 **Figure 9.1** provides key information on pharmaceutical services in England. In particular:

- the number of community pharmacies continues to increase, with 10,291 at the end of 2007-08 (there were 10,133 at the end of 2006-07); and
- the number of prescription items dispensed by community pharmacies in 2007-08 rose to 726 million – an increase of 5.4 per cent on 2006-07.

9.15 The review of the arrangements for the provision of stoma and incontinence products – and related services – in primary care under Part IX of the Drug Tariff has concluded. The new arrangements, which look to standardise services for patients and improve care, will be implemented from 1 April 2010, subject to amendment regulations being laid in due course and amendment directions being made.

9.16 The Pharmacy in England White Paper put forward a number of proposals for changing the current structure of pharmaceutical services. A public consultation on these proposals was held in the autumn of 2008. A full report is being prepared for publication in 2009. However, the Government's response concerning those proposals,

which would require changes to the NHS Act, was published in January 2009.

9.17 As part of the Health Bill 2009 currently before Parliament, the Department proposes to:

- replace the current 'control of entry' system for community pharmacies in England with one determined by reference to local pharmaceutical needs assessments (PNAs) prepared and published by PCTs;
- introduce new powers so that PCTs can take more effective action where providers are not delivering services to an acceptable level of quality, as part of a wider quality and performance programme for providers of NHS pharmaceutical services; and
- amend the current legislation to allow PCTs to provide local pharmaceutical services themselves in prescribed circumstances, such as national emergencies.

9.18 As part of the World Class Commissioning Programme, the Department published *Improving Pharmaceutical Services* on 31 March 2009.

This provides further information for PCTs on how to commission these services. NHS Employers also published guidance on PNAs in January 2009 as part of this programme, at the request of the



Department. More resources will follow later in 2009.

### Community Pharmacy Contractual Framework

9.19 Under the contractual framework, community pharmacies are providing more services than ever:

- In 2007-08, PCTs commissioned 23,551 local enhanced services providing, for example, minor ailment schemes, stop smoking services, needle and syringe exchange and supervised administration schemes. This was a 12 per cent increase on the 20,996 services commissioned in 2006-07.
- Repeat dispensing continues to increase gradually. Over 8.2 million items (almost 2 per cent of all items dispensed) were dispensed via repeat dispensing in the first half of 2008-09.
- Over 950,000 medicines use reviews were conducted by pharmacists in 2007-08, making a total of 2.4 million since the service was introduced in 2005.

9.20 The Department is discussing with key stakeholders how additional services identified in the White Paper may best be introduced within the contractual framework, such as minor ailment schemes and support to people in the early stages of taking a new course of medicine to treat a long-term condition, while taking account of the local enhanced services PCTs already commission.

### Hospital pharmacy

9.21 The Pharmacy in England White Paper continued the development of hospital pharmacists' clinical and patient safety roles. It saw hospital pharmacists increasingly using their clinical expertise in the most appropriate settings, including closer to people's homes in health community clinical pharmacy teams.

9.22 In addition, the Government considers that chief pharmacists of NHS organisations should take the lead in ensuring that safe medication practices

are embedded in patient care. To support this, and at the request of the Department, the National Patient Safety Agency (NPSA) hosted an event for senior pharmacists in October 2008. This resulted in the agreement by senior pharmacists to take on this role, and the recommendation that a virtual medication safety forum should be established where best practice can be shared.

### Pharmacy and public health

9.23 The Department continues to promote the contribution that pharmacy can make to the wider public health agenda by providing services for stopping smoking, sexual health and alcohol reduction. For example, educational resources on sustainable development were distributed to over 10,000 pharmacies in England, with further resources on sexual health and mental health services being developed.

9.24 Following on from the Pharmacy in England White paper:

- the Public Health Leadership Forum for Pharmacy is leading a work programme to accelerate pharmacy's contributions to public health, reducing health inequalities, and promoting community leadership and sustainable development;
- the Department is working with pharmacy bodies and employers on how pharmacy staff can be supported to become health trainers; and
- community pharmacies have been identified as ideal locations for delivering the Government's vascular risk assessment programme.

### Pharmacy workforce and professional regulation

9.25 Amendments to the Medicines Act 1968 have been made, which will come into force from October 2009. These remove the requirement that each registered pharmacy must be under the personal control of a pharmacist. Instead, each pharmacy is to have a responsible pharmacist with a statutory duty to secure the safe and effective



running of the pharmacy where this concerns the sale and supply of medicines to the public. At the same time, regulations will come into force, setting out in more detail how the responsible pharmacist is to carry out this duty.

**9.26** These changes are the first stage in updating the legislative framework to make better use of the skills of those working in pharmacies while maintaining public safety. There will be further public consultation on proposals relating to the requirement on pharmacists to supervise the preparation, dispensing and sale of medicines.

**9.27** The draft Pharmacy Order 2009 will take forward the recommendations in the Government's 2007 White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* to establish a new regulator for pharmacists, pharmacy technicians and pharmacy premises in England, Scotland and Wales – the General Pharmaceutical Council (GPhC). The Department's consultation on its proposals for setting up this new body ended in March 2009. The GPhC is expected to be functioning in 2010.

**9.28** The Chief Pharmaceutical Officer for England has established the Modernising Pharmacy Careers Programme Board to provide professional advice and scrutiny on workforce plans where these concern pharmacists and other pharmacy staff (eg pharmacy technicians) providing NHS services. The Pharmacy Professional Advisory Board will work closely with Medical Education England, which will provide professional, high-level scrutiny of, and advice on, the quality of workforce planning at a national level for doctors, dentists, pharmacists and healthcare scientists.

## Communications

**9.29** In line with the developments outlined elsewhere in this chapter, the Department is

undertaking a programme of communications that seeks to:

- highlight the breadth of services and skills available in pharmacies;
- illustrate the role that pharmacies can play in promoting good health;
- raise awareness and knowledge of the role pharmacy can play in managing long-term conditions and reducing health inequalities; and
- increase the use of pharmacy services among target audiences.

**9.30** The Department commissioned an extensive piece of qualitative consumer research, to be published in 2009, which gives insight into the profiles of pharmacy users and their use of pharmacy services. Further qualitative research is being commissioned by the Department on the opinions of the pharmacy profession towards delivering the services outlined in the Pharmacy in England White Paper. This research is expected to be completed by summer 2009.

**9.31** The National Clinical Directors for Pharmacy have been charged with helping to improve communications between pharmacy and other health professionals, and NHS Employers has been commissioned by the Department to convene and lead a working group of pharmacy, medical and public representatives to formulate a series of actions to promote more effective professional relationships.

## Making quality the organising principle of the NHS

### High Quality Care for All

**9.32** In June 2008, leading cancer surgeon and health minister Lord Darzi's report, *High Quality Care for All*, was published. This was the final report of the NHS Next Stage Review, co-produced with the NHS during a unique year-long process, which involved more than 2,000 clinicians and 60,000 NHS staff, patients, stakeholders and members of the public.



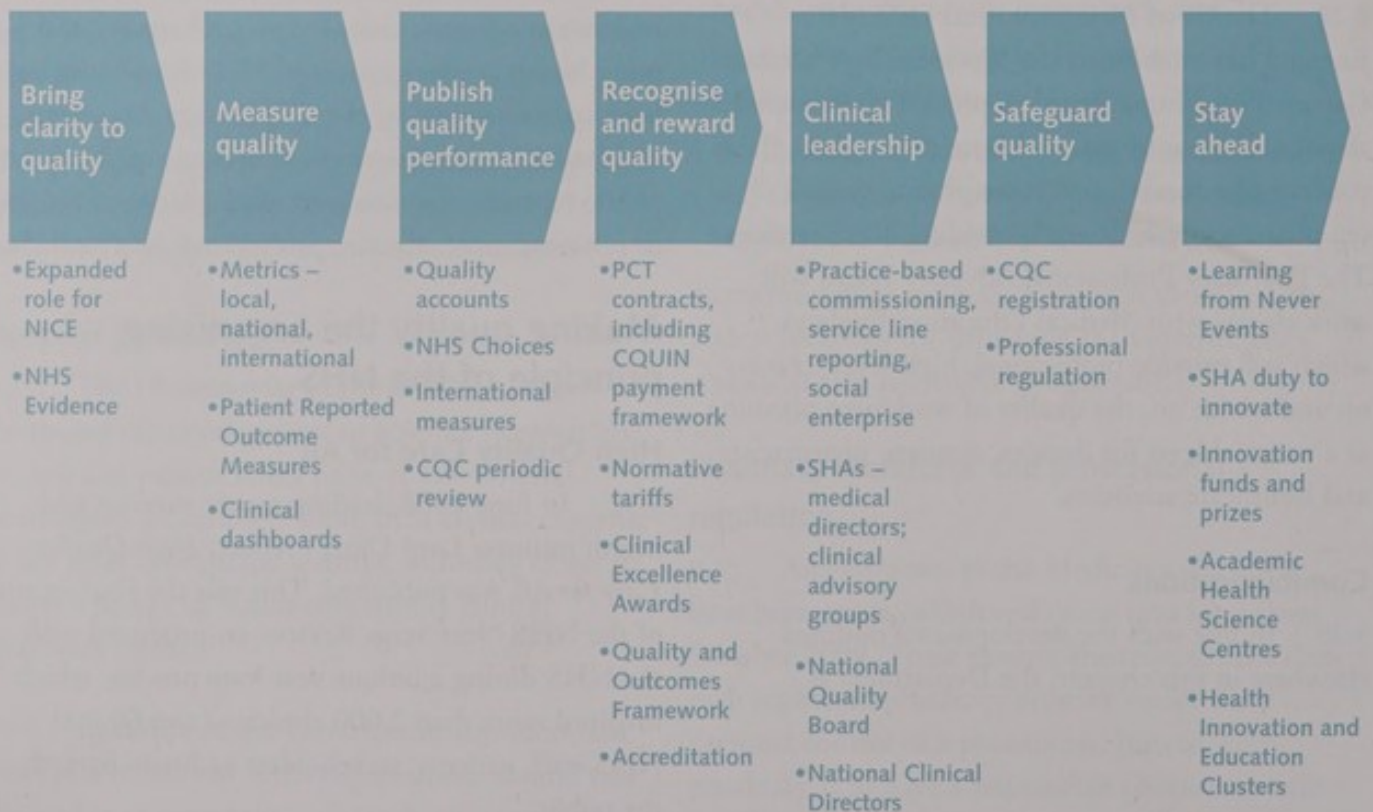
9.33 The strong message from everyone who took part in the review was that providing high-quality NHS care has always been a guiding principle for staff in the NHS. Lord Darzi recognised that, building on investments in the NHS and reforms to the NHS, the time is right to explicitly align systems in order to support the delivery of high-quality care and ensure that staff are able to deliver high-quality care with the system instead of despite the system.

9.34 Lord Darzi defined the three domains of quality in healthcare as: patient safety; effectiveness of care; and patient experience. This means protecting patient safety by eradicating avoidable accidents and healthcare-acquired infections. It means ensuring the effectiveness of care from the clinical procedure the patient receives to their quality of life after treatment. Finally, it means improving the patient's entire experience of the NHS and ensuring that people are treated with compassion, dignity and respect in a clean, safe and well-managed environment.

9.35 *High Quality Care for All* set out a quality framework (refer to **figure 9.2**) to support local clinical teams to improve the quality of care, by:

- bringing clarity to quality – making it easy to access evidence about best practice through a single portal called NHS Evidence and by asking The National Institute for Health and Clinical Excellence (NICE) to develop and kite-mark quality standards;
- supporting clinicians to measure quality in order to support improvement;
- requiring quality information to be published, in quality accounts, making it available to the public and making it as important to NHS chief executives as it has always been for NHS staff;
- recognising and rewarding the delivery of high-quality care, including through the Commissioning for Quality and Innovation (CQUIN) payment framework;
- recognising the role of clinicians as leaders and giving them the freedom to drive improvements in quality of care;

Figure 9.2: Quality framework





- safeguarding basic standards through a new independent regulator, the Care Quality Commission (CQC); and
- staying ahead by ensuring that innovation in medical advances and service design is fostered and promoted.

9.36 Improvements in quality will be primarily delivered at a local level, with support from the centre only where necessary. The Department is asking the NHS to help it shape the framework in a way that works for them.

### Quality metrics

9.37 In November 2008, the Measuring for Quality Improvement process was launched in a letter from NHS Chief Executive David Nicholson, NHS Medical Director Sir Bruce Keogh and Chief Nursing Officer Dame Christine Beasley. This letter asked SHAs to shape the local and regional elements of the quality framework by engaging actively with commissioners, clinical teams and provider organisations across each region to co-produce a set of metrics that will enable each SHA to measure improvement as its vision is implemented. SHAs reported on progress at the end of January 2009 on:

- the local measures identified for use in quality accounts;
- proposed regional measures;
- suggestions or recommendations for national indicators and benchmarking measures; and
- suggestions or recommendations for national support to develop quality improvement skills and capacity.

9.38 Nationally, the Department will support this work by integrating national cross-cutting initiatives, and by identifying and sharing supporting materials and resources to ensure that they are readily available to staff across the NHS, including the development of a quality-assured 'menu' of existing measures from which local teams can choose indicators that meet their needs.

### National Quality Board

9.39 The National Quality Board (NQB) was established and met for the first time on 30 March 2008. Its membership includes representatives from the system as well as six expert and six lay members. The key functions of the NQB are:

- ensuring the overall alignment of the quality system;
- delivering on specific technical responsibilities, including those set out in *High Quality Care for All*. These are:
  - to oversee the work to improve quality indicators;
  - advise the Secretary of State for Health on the priorities for clinical standards set by NICE; and
  - make an annual report to the Secretary of State on the state of quality in England; and
- assuming a wider leadership responsibility for driving the quality agenda and acting as a 'powerhouse for change'.

### Patient safety

9.40 Patient safety is a central element of quality in health services, as identified by Lord Darzi's review *High Quality Care for All*. Increased reporting of critical incidents and near misses will lead to better identification of patient safety risks and allow dissemination of lessons learned, leading to reduced harm to patients. The Department tasked the NPSA with the design and delivery of a simpler and more accessible way of reporting incidents. As part of this work, the NPSA will combine reporting of serious untoward incidents to SHAs and PCTs through Patient Safety Direct in order to reduce duplication and link organisational effort.

9.41 The Central Alerting System, a more robust web-based technology for distributing safety alerts, drug alerts and other variants of emergency alert, went live on 8 September 2008, replacing former separate systems. This new, flexible system enables



alerts and urgent patient safety specific guidance to be accessed by clinical staff at any time.

**9.42** *High Quality Care for All* identified two specific patient safety initiatives for early implementation. Firstly, the NPSA will develop lists of 'Never Events', avoidable occurrences that should not feature in modern healthcare, to inform NHS trusts, NHS foundation trusts and NHS commissioners. The lists, specific to the acute sector, primary care and mental health, will draw on international experience and be validated using the National Reporting and Learning System (NRLS), serious untoward incidents and other relevant data sources. Secondly, the NPSA will promote a centrally led initiative to replicate 'Matching Michigan', a US-born project aiming at reducing central line-associated bloodstream infections in intensive care units in England.

### International and European patient safety activities

#### European Union Network for Patient Safety (EUNetPaS)

**9.43** The UK is an associate member of the EuNetPaS initiative, which is looking at facilitating member state exchange of information and collaboration on reporting and learning systems, education for patient safety, medication errors and safety cultures. The UK plays a key role in the development of guidelines for professionals and the design of a rapid alert mechanism.

#### WHO Surgical Safety Checklist

**9.44** On 26 January 2009, the NPSA disseminated through the Central Alerting System an alert which requires healthcare organisations in England and Wales to implement the World Health Organization (WHO) Surgical Safety Checklist (adapted for England and Wales) for every patient undergoing a surgical procedure. The alert is part of the WHO second Global Patient Safety Challenge, 'Safe Surgery Saves Lives'. The goal is to strengthen

the commitment of clinical staff to address safety issues in the surgical setting.

### World Alliance for Patient Safety

**9.45** The Director-General of the World Health Organization launched the World Alliance for Patient Safety in October 2004. Sir Liam Donaldson, the Chief Medical Officer for England, is the Chair of the World Alliance for Patient Safety. As part of the WHO's work on the International Classification for Patient Safety, the NPSA works closely with the organisation so that the UK is considered in any developments that could assist in the integration of the classification into the NRLS. The NPSA will implement the WHO's High 5s initiative by recruiting acute hospitals in England and Wales from early 2009, and ensure that there is support for them over the five years of the initiative.

### National Clinical Audit

**9.46** The Department has acted on the Chief Medical Officer's 2006 report *Good Doctors, Safer Patients* in its call for the reinvigoration of clinical audit. Clinical audit offers a rich source of information to support service improvement, other activities such as the revalidation of clinicians, and better choices for patients. As of 1 April 2008, a consortium comprised of the Academy of Medical Royal Colleges, the Royal College of Nursing and the Long-term Conditions Alliance has hosted the expanded programme, known as the Healthcare Quality Improvement Partnership. An additional £3.2 million a year was allocated to the National Clinical Audit and Patient Outcomes Programme (NCAPOP) so that its role as a commissioner of clinical audits can be expanded to include wider support activities and increase the use of this valuable service improvement tool.

**9.47** The National Clinical Audit Advisory Group has been created to drive the reinvigoration programme and to provide a national focus for discussion and advice on matters relating to clinical audit. The group provides advice and guidance to



the expanded NCAPOP. It advises on the overall programme of work, in particular considering proposals for new audits and for discontinuing existing audits.

### Healthcare Commission

9.48 As sponsor of the Healthcare Commission, the Department worked to support the Commission in continuing its statutory functions at the same time as it worked towards its replacement by the Care Quality Commission.

9.49 The Healthcare Commission has made a significant contribution to improvements across the NHS in relation to tackling healthcare-associated infections, such as those identified in the investigation of Maidstone and Tunbridge Wells NHS Trust.

9.50 The report of this investigation (*Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*, Healthcare Commission), published in October 2007 highlighted considerable failings in care and led to significant change. The Commission published its *One Year On* report on 9 January 2009, reporting on the progress made in the 12 months since the investigation. The report is positive, highlighting the trust's change in attitude and commitment to infection control and the implementation of the recommendations from the original report.

## Ensuring value for money from the NHS drugs budget and by promoting cost-effective clinical practice

### The NHS drugs bill

9.51 In 2007-08, the NHS spent around £11 billion on drugs and medicines. This represents 12 per cent of the total NHS expenditure for that year.

### Primary care – family health services

9.52 The primary care drugs bill gross expenditure is the amount paid to contractors (pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for prescribed medicines and certain listed appliances. Net drugs bill expenditure is the total gross expenditure minus Pharmaceutical Price Regulation Scheme (PPRS) receipts.

9.53 The 2007-08 primary care gross drugs bill outturn for England was £7,663 million (refer to **figure A.21** in annex A); this represents an increase of 0.9 per cent over 2006-07. Price reductions from the Category M scheme have helped to keep the drugs bill growth modest.

9.54 **Figure 9.3** shows the top ten British National Formulary (BNF) sections with the highest expenditure in 2007-08, which represent around

**Figure 9.3: Top ten British National Formulary (BNF) sections with the highest expenditure in 2007-08**

BNF section name	Actual cost (£ million)	Items (million)	Cost – % growth from 2006-07	Items – % growth from 2006-07	Section cost as a % of total expenditure
Drugs used in diabetes	541.1	30.8	3.5%	6.7%	7.3%
Lipid-regulating drugs	528.4	48.4	-7.2%	11.0%	7.1%
Corticosteroids (respiratory)	487.3	15.2	10.9%	3.2%	6.6%
Hypertension and heart failure	450.0	54.6	-3.7%	10.7%	6.1%
Analgesics	402.1	51.8	4.0%	5.3%	5.4%
Antiepileptics	250.8	10.8	14.8%	8.4%	3.4%
Bronchodilators	248.2	25.2	1.5%	0.3%	3.3%
Antidepressant drugs	242.9	34.0	-5.7%	8.4%	3.3%
Drugs used in psychoses and related disorders	238.9	7.5	9.9%	6.5%	3.2%
Nitrates, calcium-channel blockers and other antianginal drugs	232.8	37.6	-14.0%	6.3%	3.1%



50 per cent of the total expenditure on medicines in primary care.

9.55 Drugs used in diabetes consumed the highest amount of expenditure in 2007-08 – around £541 million – which is an increase of 3.5 per cent compared with the previous year. This is largely due to the increased use of insulins, including shifts to the higher-cost human analogue insulins.

9.56 The second highest group was lipid-regulating drugs such as statins (£528 million). Expenditure on this group of medicines reduced by 7.2 per cent from 2006-07.

9.57 In terms of the number of items prescribed, hypertension and heart failure drugs grew by the highest number, by 5.3 million items to 54.6 million items (a 10.7 per cent increase), while lipid-regulating drugs recorded the second highest item growth with an increase of 4.8 million items (representing an 11.0 per cent increase).

9.58 The growth in the primary care drugs bill is affected by a combination of factors including cost and volume changes. Using hypertension and heart failure drugs as an example, while the average cost per item has fallen, the volume of items dispensed has seen a substantial increase in recent years, resulting in this group having the fourth highest expenditure.

#### Secondary care – hospital and community health services

9.59 The secondary care drugs bill is made up of expenditure on drugs and medical gases used in hospitals and drugs prescribed in hospitals but dispensed in the community.

9.60 **Figure A.22**, in annex A shows the trend of the secondary care drugs bill. Expenditure for 2007-08 was £3,274 million – an increase of 10.3 per cent from the previous year.

9.61 Many of the drugs and treatments recommendations by NICE are for specialist treatments in hospitals, for example cancer treatments, and this has an impact on drugs expenditure in secondary care.

#### Branded medicines

9.62 A new PPRS has been agreed with the pharmaceutical industry so that UK patients will continue to benefit from cost-effective innovative drugs. The new scheme took effect from 1 January 2009.

9.63 Following the Secretary of State for Health's decision in summer 2007 to renegotiate the PPRS, a new 2009 PPRS was agreed with the industry and companies were invited to join this scheme in December 2008. The new PPRS seeks to achieve a balance between reasonable prices for the NHS and a fair return for the industry in order to enable it to research, develop and market new and improved medicines.

9.64 The PPRS controls the prices of branded medicines by regulating the profits that pharmaceutical companies can make on these sales. The new PPRS includes a price cut of 3.9 per cent in the first year of the new agreement, with a further price cut of 1.9 per cent and, subject to discussions with affected parties, the introduction of generic substitution – allowing pharmacists to substitute a branded product with a generic one when dispensing prescriptions – in January 2010.

9.65 The new PPRS also recognises the importance of the pharmaceutical industry to healthcare and the development of medical advances, and it was recognised that it is in everyone's interest to encourage research and reward innovation. That is why a package promoting the uptake of cost-effective innovative treatments forms a key part of the PPRS for the first time.

9.66 The new PPRS includes two specific measures to increase patients' access to medicines



and ensure that value is better reflected in pricing as identified by the Office of Fair Trading in its 2007 report on the PPRS:

- New and more flexible pricing arrangements will enable pharmaceutical companies to supply drugs to the NHS at lower initial prices, with the option of higher prices if value is proven at a later date.
- The more systematic use of patient access schemes will allow companies to offer discounts or rebates, which reduce the effective cost of a drug to the NHS.

### Generic medicines

9.67 The long-term arrangements for generic medicines reimbursement continue, in line with the arrangements agreed as part of the community pharmacy contractual framework. Category M generic medicine prices continue to be adjusted in line with market prices and to take account of the findings of the medicines margins survey.

### Improving access to medicines

9.68 One of the core aims of the NHS Next Stage Review was to support the uptake of cost-effective innovative technologies, including medicines and medical devices. The Department has worked closely with the NHS, the pharmaceutical and medical technology industries and NICE to introduce a number of measures to increase patients' access to innovative new treatments.

### The PPRS innovation package

9.69 The new PPRS agreement includes, for the first time, an innovation package to help increase the uptake of cost-effective, innovative drugs and treatments and encourage the pharmaceutical industry to develop innovative new medicines. This package includes:

- setting up a single horizon scanning process for new drugs in development, with more systematic industry involvement, to support better forward planning; and

- developing new metrics for the uptake of clinically cost-effective medicines and publishing comparative international data.

### The National Institute for Health and Clinical Excellence

9.70 NICE continues to help many thousands of NHS patients to benefit from innovative treatments while ensuring that the NHS gets value from the money it spends. In recognition of this, *High Quality Care for All* set out an extended role for NICE, building on its success. This included:

- a commitment to publish consistently timely NICE guidance on significant new drugs. In November 2008, the Secretary of State for Health announced that, in 2009, draft or final guidance will be available within six months of licensing for about half the drugs that are being appraised through the fast-track single technology appraisal process. In 2010, the average time taken by NICE to produce draft or final guidance on new cancer drugs is expected to fall below six months after licensing;
- new roles for NICE in setting quality standards and priority setting and in developing and reviewing Quality and Outcomes Framework (QOF) indicators;
- a fellowship programme to improve local NHS engagement with NICE; and
- a new NHS Evidence service hosted by NICE, which will provide the NHS with a single source of authoritative evidence-based clinical and non-clinical best practice.

9.71 In March 2009, the Department and NICE announced four further measures designed to speed up access to modern, clinically cost-effective treatments in the NHS:

- A consultation on a new and faster system for referring drugs to NICE for appraisal – proposals will enable NICE to issue more timely guidance, in turn giving patients faster access to drugs and treatments.



- An additional new appraisal committee – to ensure that NICE has the capacity it needs to appraise new drugs and treatments as promptly as possible.
- Increased investment in horizon scanning – to ensure that new drugs are identified early on for appraisal.
- A guidance document for the NHS – detailing good practice on how decisions on new drugs should be made by PCTs where there is no existing NICE guidance. This will be supported by a programme of training and support to assist the NHS to implement the guidance.

9.72 In addition, on 2 January 2009, NICE announced changes to the way in which it appraises treatments that may be life-extending for patients with short life expectancy, and which are licensed for indications affecting small numbers of patients with incurable illnesses.

9.73 The *NHS Constitution* sets out the right of patients to treatments which NICE has recommended in its technology appraisals, along with a right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence.

#### Non-medical prescribing

9.74 There are now over 13,000 qualified nurse independent prescribers and over 600 pharmacist independent prescribers in England. In addition, there are many thousands of community practitioner nurse prescribers, and the number of allied health profession supplementary prescribers (physiotherapists, chiropodists/podiatrists, radiographers and optometrists) is growing steadily.

9.75 Prescribing by nurses, pharmacists and allied health professionals continues to help improve NHS services and choice for patients, as well as making maximum use of the skills of NHS staff. Many nurse and pharmacist independent prescribers now manage their own caseloads in dedicated clinics.

They may help patients to manage their long-term conditions, or treat them in GP practices or in walk-in centres. However, patient safety remains paramount and robust professional and clinical governance arrangements are in place to ensure that non-medical prescribers act within their competence.

## Implementing the Pathology Review

9.76 Pathology services underpin clinical care: most decisions on diagnosis or treatment involve pathology investigations and, frequently, expert interpretation of the results. Services need to meet the challenges of rising demand, workforce pressures and technological developments, while maintaining their current high quality; and also to achieve greater cost effectiveness and improve their responsiveness to both patients and clinical service users.

9.77 The *Report of the Second Phase of the Review of NHS Pathology Services in England*, chaired by Lord Carter of Coles, was published by the Department in December 2008 alongside the Department's response. The report focused on three main themes:

- improving quality and patient safety;
- improving efficiency; and
- identifying the mechanisms for delivering change.

9.78 The review estimated that significant savings could be realised by the NHS through consolidating pathology services, and made some specific recommendations for change.

9.79 The Department welcomed the broad thrust of the review's approach and its vision for an NHS pathology service which is clinically excellent, responsive to users, cost effective and fully integrated with the Government's strategy on NHS reform. The Department will work with three SHAs – East of England, South East Coast, and Yorkshire and the Humber – to understand in more detail the implications of service consolidation. This will



feed in to the impact assessment being developed by the Department, which will be published in 2009 for consultation.

## Adding years to life and life to years through leading programmes to reduce premature mortality and morbidity

### Prevention and screening

**9.80** National programmes to prevent ill-health and to detect and treat illness before it progresses, based on good evidence of clinical and cost effectiveness, have significant potential to reduce unnecessary suffering and avoid premature mortality. The Department has led both the introduction of substantial new prevention and screening programmes and the extension of existing ones.

### NHS Health Check Programme

**9.81** The introduction of systematic checks for all aged 40 to 74 years in order to assess and reduce individual risk of diabetes, heart disease, stroke and kidney disease is a significant opportunity to reduce mortality and morbidity and close health inequalities. *Putting Prevention First* was published on 1 April 2008, setting out the basis of this new initiative and the evidence supporting its introduction. The Department has been working with its key stakeholders, including the NHS, its front-line workers and the private and voluntary sectors, to support implementation and roll-out of the NHS Health Check Programme, beginning in 2009-10. Following publication of a final impact assessment, *Next Steps* guidance for PCTs was released on 13 November 2008 to inform and support PCTs in their implementation. This guidance was developed in consultation with PCT commissioners, those carrying out the checks, and the learning network, which has been set up to share learning across the NHS on vascular risk assessment and management. Other practical tools developed to support commissioning of the

necessary services include a Primary Care Service Framework.

### Antenatal screening for sickle cell and thalassaemia

**9.82** Antenatal screening for sickle cell and thalassaemia has now completed roll-out to offer tests to all pregnant women in England. This complements the successful roll-out of newborn screening for sickle cell, which is the first such joint initiative worldwide.

**9.83** Newborn screening identified some 350 babies with sickle cell in England in 2008 who will benefit from early diagnosis. Antenatal screening for sickle cell and thalassaemia is important, especially in high-prevalence areas, covering almost half of England, where:

- some 1 in 25 women are carriers of haemoglobin disorders;
- these women have a 1 in 20 chance that their partner will also be a carrier; and
- this means that a carrier woman in a high-prevalence area has a 1 in 80 chance of having a baby with sickle cell or thalassaemia in each pregnancy.

### Newborn MCADD screening programmes

**9.84** The roll-out of newborn screening for medium chain acyl dehydrogenase deficiency (MCADD), completed in January 2008, is expected to prevent avoidable deaths and minimise childhood morbidity among the 70 children with MCADD born each year in England. It is estimated that screening will reduce infant mortality by preventing two to three deaths due to MCADD in infants less than 12 months old in England each year.

### Abdominal aortic aneurysm screening

**9.85** Since the ministerial announcement in January 2008, the Department has led the initiation of a screening programme for abdominal aortic aneurysm (AAA), including establishing a new



programme team and funding six early implementation sites.

**9.86** The introduction of a screening programme for AAA for men aged 65 will save approximately 700 lives within the first ten years of screening eventually rising to 1,600 a year. The national programme team has been working with stakeholders to plan implementation, including putting in place quality assurance and monitoring, setting national standards and training staff.

**9.87** Six early-implementation sites have been identified and will commence screening during early 2009. The sites are: West Sussex, Leicester, Gloucester, South Manchester, South Devon and Exeter and South West London.

### Bowel screening

**9.88** Bowel screening continues to be extended to men and women aged 60 to 69. Men and women over 70 can self-refer every two years. Roll-out of the NHS Bowel Cancer Screening Programme began in April 2006, with full roll-out across the country expected by December 2009. As at November 2008, 40 screening centres were operational. When fully implemented, around 2 million men and women will be screened. So far, nearly 2,000 cancers have been detected and over 7,000 people have had polyps removed as a result of screening.

**9.89** The phased expansion of the Bowel Cancer Screening Programme to people aged 70 to 75 is under way and has started in six sites. Learning from the sites will be shared across the programme to ensure that screening is available to this age group from 2010. By the end of 2010, the Department will assess whether or not to extend the programme to people in their 50s.

### Breast screening

**9.90** Currently, women aged between 50 and 69 are invited routinely and women over the age of 70 can request free three-yearly screening. Work on the

age extension of routine breast screening to women aged 47 to 73 is in progress, with the full roll-out planned by end of 2012. The work is being managed by the NHS Cancer Screening Programmes in partnership with local health services, and pilots in six sites commenced in January 2009. The pilots will meet strict quality and performance criteria and inform the service model for full roll-out.

**9.91** Work is ongoing to ensure that the NHS Breast Screening Service converts to direct digital mammography in order to improve breast screening. This equipment is now available in a number of sites, and a national framework agreement has been negotiated to enable easier acquisition of the equipment by the remaining services.

### Cervical screening

**9.92** Women aged 25 to 49 are invited for free cervical screening every three years, and women aged 50 to 64 are invited every five years. Women over the age of 65 are invited if their previous three tests were unclear or if they have never been screened. Liquid-based cytology (LBC) was recommended by NICE in 2003 as the preferred technology for cervical screening. In October 2008, roll-out of LBC across the country was completed in line with national guidance. Prior to the introduction of LBC, rates of inadequate samples were over 9 per cent, resulting in about 300,000 women a year being screened again. With the rolling out of LBC, the rate of inadequate samples has fallen each year and is now at a record low of just under 3 per cent, or fewer than 100,000 women. Recent work has shown that in 2007-08, 200,000 women did not have to go through the anxiety of having a repeat test because their original sample could not be read.

**9.93** Cervical screening coverage has been falling steadily in women aged 25 to 35 for some years. In order to tackle this, NHS Cancer Screening Programmes have commissioned the Improvement



Foundation to undertake work at a local level targeting this group. The lessons learned from this work, due later in 2009, will be shared with SHAs and local screening programmes to develop best practice.

9.94 The Department is now in the implementation phase of human papillomavirus (HPV) triage for women with borderline or low-grade abnormalities, using HPV testing. Work has begun in six screening services to target services more appropriately, reducing the need for significant numbers of repeat tests.

### Cancer services

9.95 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.

9.96 On 3 December 2007 the Department launched the Cancer Reform Strategy (CRS), which builds on progress made since the *NHS Cancer Plan* and sets out plans to further improve and develop cancer services across England over the next five years. It includes measures to improve cancer prevention, speed up the diagnosis and treatment of cancer, reduce inequalities, improve the experience of people living with and beyond cancer, ensure care is delivered in the most appropriate settings, and ensure that patients can access effective new treatments quickly.

9.97 Good progress is being made on delivery of the objectives of the CRS, as highlighted in the annual report *Cancer Reform Strategy: Maintaining Momentum, Building for the Future – First Annual Report*, published on 1 December 2008.

9.98 Priorities for the year ahead include:

- ensuring that primary care is fully engaged;
- tackling the issues raised by the National Confidential Enquiry into Patient Outcome and

Death (NCEPOD) report on systemic anti-cancer therapy;

- ensuring that radiotherapy capacity is being developed in line with the requirements of the 2010 waiting time standards;
- using implementation of the *Improving Outcomes* guidance and peer review as levers to improve quality; and
- putting patient experience at the heart of our measurement of quality services, particularly by moving forward on the patient experience survey programme.

9.99 The report highlights a number of key achievements which are summarised below. Further information on these and future priorities is available on the Department's website.

### Awareness and early diagnosis

9.100 The National Awareness and Early Diagnosis Initiative (NAEDI), announced in the CRS, was formally launched in November 2008. NAEDI is co-chaired by the Department's National Cancer Director, Professor Mike Richards, and the Chief Executive of Cancer Research UK, Harpal Kumar, and will co-ordinate a programme of activity to increase cancer symptom awareness, encourage people to seek help early, and work with primary care to diagnose early. The initiative is bringing together representatives of the NHS, local authorities, the Department, the National Cancer Research Institute, professional bodies, cancer charities and patient representatives. There are eight work streams:

- review of the evidence base on links between early diagnosis and survival;
- measuring awareness of cancer symptoms and introducing regular assessment surveys;
- interventions to promote early presentation, focusing on evaluation and dissemination;
- interventions in primary care and understanding the nature of primary care delay;



- international benchmarking against countries with better outcomes for selected cancers;
- prospective research to identify and fill gaps in the knowledge base;
- key messages which use language consistently and effectively; and
- measures to further primary care access to diagnostics.

**9.101** The Healthy Communities Collaborative work on cancer awareness in ten pilot areas has been running for the past year, and work has now started with a further ten areas (wave 2). All the teams are based in spearhead PCTs and have been delivering targeted interventions in order to improve awareness of the signs and symptoms of breast, bowel and lung cancer among the public, and to encourage those with symptoms to visit their GP.

**9.102** The Department has commissioned the Office for National Statistics to carry out a national baseline cancer awareness survey, using the validated cancer awareness measurement tool developed by a research team funded by Cancer Research UK. The early results from the survey were set out in the first annual report of the CRS, and full results from the survey will be published in 2009.

#### Survivorship initiative

**9.103** A specific commitment was made in the CRS to work closely with Macmillan Cancer Support in developing a survivorship initiative, in order to ensure that cancer survivors receive the integrated, quality services they need.

**9.104** The initiative is co-chaired by Professor Mike Richards and Ciarán Devane, the Chief Executive of Macmillan Cancer Support, and was formally launched at a conference in September 2008. Seven work streams have been established and have already started work on:

- assessment, care planning and immediate post-treatment approaches to care;
- managing active, progressive and recurrent disease;
- late effects of treatment;
- children and young people who have survived cancers;
- work and finance; and
- self-care and self-management; and research.

**9.105** The plan is for the work streams to have reached initial conclusions in time for a vision and implementation plan to be published in the autumn of 2009.

#### Cancer waits

**9.106** Excellent progress has been made on reducing cancer waiting times:

- 99 per cent of patients are seen within two weeks of urgent GP referral to outpatient appointment;
- 99 per cent of patients with cancer receive their first treatment within one month of diagnosis for breast cancer; and
- 97 per cent of patients are treated within 62 days from urgent GP referral, for all cancers.

**9.107** The Department is going further on cancer waits by extending the existing cancer waiting times standards to more patients. This will include extending the 31-day standard to cover all cancer treatments, not just the first, and enabling hospital specialists to place patients, where appropriate, on the 62-day treatment pathway. All patients whose cancer is detected through national screening programmes will also enter the 62-day pathway.

**9.108** Implementation of the extension to the 31-day treatment standard commenced from the end of December 2008 and currently applies to all surgery and drug treatment. Implementation of the 62-day treatment standard began from the same period and applies to all patients referred from the NHS Cancer Screening Programmes (breast, cervical and bowel), and patients deemed urgent by their consultants or their GPs.



## Cancer treatment

**9.109** The National Cancer Director undertook an evaluation of NICE-approved cancer drug usage in 2003 and in 2006. This evaluation was repeated in 2008 and the findings were published in the first annual report of the CRS. Based on drug usage in 2007-08, the analysis again shows an increase in overall usage (a median 72 per cent increase for 13 of the 14 NICE-approved drugs in the analysis) and a further reduction in geographic variations in the usage of these drugs.

**9.110** On 20 January 2009, the Department announced that everyone undergoing treatment for cancer, the effects of cancer or the effects of cancer treatment is entitled to apply for an exemption certificate for free prescriptions valid from 1 April 2009.

## Cancer equality

**9.111** The Department has a cancer-specific Public Service Agreement target to substantially reduce mortality rates from cancer by 2010, by at least 20 per cent in people under 75, with a reduction in the inequalities gap of at least 6 per cent between the fifth of the areas with the worst health and deprivation indicators and the population as a whole. The Department is on course to meet this target. Recent figures show that cancer mortality in people under 75 fell by over 18 per cent between 1996 and 2006, and the inequalities gap was reduced by 13.2 per cent. Data from *Health Profile of England 2008* (DH), published on 27 January 2009, reveals that over the last 30 years premature mortality rates from cancer for males have fallen substantially faster than the EU-15 average, and are now among the lowest in the EU-15; for females, rates which were once substantially higher than the EU-15 average are now rather closer to the EU-15 average.

**9.112** The National Cancer Equality Initiative (NCEI) has been set up to take forward a series of actions in order to continue to reduce these inequalities in cancer care. The NCEI is co-chaired

by Professor Mike Richards and Joanne Rule, a member of the CRS Advisory Board, and will initially focus on optimising data collection in order to enhance understanding of the inequalities that exist, promoting research to fill gaps in the evidence, and spreading good practice, sustaining and embedding it in NHS organisations.

## National Cancer Intelligence Network

**9.113** The National Cancer Intelligence Network (NCIN) was officially launched on 18 June 2008, to develop, build, maintain and quality assure a new repository of national cancer data. It will bring together millions of NHS cancer records to create the largest patient-based cancer research resource in the world by 2012. Information on cancer prevalence was published for the first time in July 2008 by the NCIN and covers diagnosis from 1971 to 2004, with predictions to 2008. The first annual report of the NCIN is scheduled for publication in 2009.

## Cancer Commissioning Toolkit

**9.114** A Cancer Commissioning Toolkit has been launched to provide a one-stop source of cancer information which commissioners need in order to commission effectively for their populations. The development of the toolkit has been led by the National Cancer Action Team (NCAT), with the NCIN and the National Cancer Services Analysis Team. NCAT and the NCIN will support PCTs, cancer networks and other stakeholders to use the toolkit and continue to work with them on further refinements and developments.

## Vascular disease

**9.115** Four related groups of conditions – diabetes, heart disease, stroke and kidney disease – are the largest single cause of premature mortality and disability, and account for the largest part of the gap in health between deprived and better-off people and between ethnic groups.



## Diabetes

**9.116** The Department is ensuring support and leadership for improvement of diabetes services and implementation of the Diabetes National Service Framework. A new National Clinical Director for Diabetes has been appointed, Dr Rowan Hillson. Dr Hillson will be filling this post on a part-time basis to enable her to keep her up to date on clinical practice. The National Diabetes Support Team has been redeveloped to ensure that there is front-line support for diabetes services and the development of diabetes multi-disciplinary networks. It is now part of a larger team also providing support to kidney services, known as NHS Diabetes and Kidney Care.

**9.117** The QOF has been successful in continuing to help the NHS to identify people with diabetes early, which is vital to prevent or delay the complications of the condition. Over 320,000 extra people with diabetes have been recorded on practice registers since the QOF was introduced.

**9.118** The Department is continuing to drive forward the national screening programme to detect sight-threatening diabetic retinopathy, the leading cause of blindness in working-age people in the UK. By September 2008, over 93 per cent of people with diabetes had been offered retinopathy screening in the previous 12 months.

## Heart disease

**9.119** New guidance on treatment of heart attack in England was published – *Treatment of Heart Attack National Guidance: Final Report of the National Infarct Angioplasty Project* (DH, October 2008). It is based on a feasibility study from which it was concluded that roll-out of primary angioplasty across England would be feasible, that a 24/7 service was likely to lead to best outcomes, and that acceptable times to treatment were 120 minutes from a patient's call for help and 90 minutes from arrival at hospital. An impact assessment suggested that roll-out would be feasible in three years for 97 per cent of the population.

**9.120** In December 2008, a Department funded national database for cardiac pathologists was launched. The database will provide epidemiological data on the frequency of sudden cardiac death as well as important demographic information. The database will also provide information on geographic variation in the uptake of specialist cardiac pathology services. In the long term, it is hoped that the database can be linked to other clinical databases in order to facilitate assessment of the families of young sudden death victims.

## Stroke

**9.121** Stroke is a top priority for the NHS and an indicator measure has been included in the NHS Performance Framework's Vital Signs. Since the launch of the National Stroke Strategy in December 2007, stroke networks have been established to pull together and coordinate expertise; 27 networks cover the whole of England.

**9.122** In addition to extra funding that has gone to NHS primary care trusts, central funding is helping to support implementation of the strategy through:

- local demonstration sites to help accelerate improvements in acute and local authority community services;
- continuing to support a programme of work that develops all staff who are involved in providing care for people who have had a stroke, including stroke physicians, nurses, allied health professionals and care workers; and
- the Act F.A.S.T. (Face, Arm, Speech, Time to call 999) public and professional awareness campaign.

**9.123** The UK Forum for Stroke Training has developed an educational framework, the primary objective of which is to create nationally recognised standards for stroke training which will ensure that education and learning programmes in stroke at pre-registration and postgraduate level can be quality assured and transferable. The Department intends to issue this framework for consultation in 2009.



## Kidney disease

**9.124** In April 2008, a Kidney Care team was established, an extension of the National Diabetes and Kidney Support Team, to support front-line staff in delivering care that meets the Renal National Service Framework.

**9.125** The Information Standards Board has approved the new kidney care dataset – the first speciality to have a mandated dataset for the whole patient pathway. The dataset will be collected from May 2009.

**9.126** Changes in the measurement of kidney function, and the introduction of chronic kidney disease (CKD) into the QOF (since April 2006), means that the UK is now a world leader in the identification of CKD.

## New and additional clinical programmes

**9.127** The Department's approach to determining whether or not to propose work on a national clinical strategy has been guided by an examination of epidemiological evidence, mortality and comorbidity rates, spend against international comparators, and best practice. In the past, where the Department has identified conditions where variability in performance has become a significant issue for the NHS, it has proposed work on a national service framework or national clinical strategy in order to help the NHS close the gap. These strategies have been developed with the assistance of clinicians, professional groups, patients and the voluntary sector. In future, the newly established National Quality Board will take on responsibility for advising ministers on clinical priorities, including whether or not there is a need for the Department (or any other body) to develop a catalytic initiative or strategy. During 2008-09, the Department undertook further work on the case for a national clinical strategy for liver disease and decided that senior specialist advice on trauma services was needed. Decisions about next steps will be taken in 2009-10, guided by the National Quality Board.

## Chronic obstructive pulmonary disease

**9.128** The Department has worked closely with patients, clinicians, professional groups and the voluntary sector to develop proposals to improve services for those with chronic obstructive pulmonary disease (COPD), looking in detail at the entire patient journey from prevention through to end-of-life care. Based on this work, the case for publishing a national strategy for COPD will now be considered by the National Quality Board. Subject to recommendations made by that body, a consultation on final proposals would be expected to start in summer 2009.

## Allergy service improvement

**9.129** The Department commissioned Skills for Health to publish the *National Occupational Standards for Allergy* in 2008. These provide e-learning for all clinicians involved in the care of allergy patients.

**9.130** The North West SHA was selected in 2008 as national lead for allergy services, to champion innovation and improvements in allergy services across the NHS. It has also been asked to develop a pilot allergy clinic, bringing together primary, secondary and tertiary care for allergy services. The success of the clinic will be evaluated to inform models adopted by other SHA regions.

## Organ Donation Taskforce

**9.131** The Department has appointed Chris Rudge as the first National Clinical Director for Transplantation, to champion change within the NHS. A Programme Delivery Board, chaired by Professor Sir Bruce Keogh, has been established to oversee the implementation of the Organ Donation Taskforce recommendations. The board brings together the Department and NHS Blood and Transplant with key professional bodies and representatives from all four UK countries.

**9.132** Work on implementation of the Organ Donation Taskforce report is progressing well, with



several recommendations already fully implemented such as reimbursing trusts for organ donor management activity. In addition, at the end of March, there were 73 clinical donor champions in place in acute trusts across the UK and 63 new local donor transplant coordinators will be in post. The Department allocated over £11 million in 2008-09 to the implementation work.

### End-of-Life Care Strategy

9.133 The Department published its *End-of-Life Care Strategy: Promoting high quality care for all adults at the end of life*, the first for the UK, on 16 July 2008. The strategy is the means by which the Government will meet the manifesto commitment to increase choice and investment in palliative care and the commitments in the White Paper, *Our Health, Our Care, Our Say*, to improve co-ordination of services, extend the roll-out of existing good practice tools and invest in community-based specialist palliative care. It builds on and supports the visions for end-of-life care developed by SHAs as part of the NHS Next Stage Review. The emerging findings from the strategy informed the work of the SHAs, and they in turn contributed to the development of the national strategy.

9.134 The strategy's aim is to improve care for people approaching the end of life whatever their diagnosis and wherever they are, including enabling more people to be cared for and die at home if they wish. It covers all adults with advanced, progressive illness and care given in all settings. The strategy is backed by an additional £286 million of government funding, to be invested over the two years up to 2011. It has been well received by both the NHS and the voluntary sector.

9.135 The NHS Next Stage Review asked PCTs, working with local authorities, to develop local strategic plans for the eight pathways identified in the review, including end-of-life care.

9.136 The Department has begun taking forward the strategy at a national level. Work is in hand on establishing two important national groups – a national coalition, led by the National Council for Palliative Care, to raise the profile, and public awareness of end-of-life care issues; and a National Implementation Advisory Board to help oversee the implementation of the strategy, and contribute to the annual progress report.

9.137 At their request, the Department has worked with SHA clinical leads to develop quality markers for end-of-life care, against which PCTs and providers can assess themselves and be assessed by regulators. Consultation on the quality markers concluded in February 2009.

9.138 Work has been initiated to support workforce training and development in this area. The Department has commissioned Skills for Health and Skills for Care to develop competences and core principles in end-of-life care to underpin workforce training and commissioning. It has also commissioned e-Learning for Healthcare to develop an e-learning programme for health and social care staff. This will be aimed at all staff and volunteer groups working in health and social care sectors across all settings, within and beyond the NHS, who might be involved in looking after people near the end of life. The Department also plans to start a number of Advanced Communication Skills training pilots from spring 2009.

9.139 The Department is funding the national End-of-Life Care Programme. This will be the national implementation team for the strategy and will be the main means by which the good practice and other improvements highlighted in the strategy will be promulgated.

### Commissioning of specialised services

9.140 All specialised commissioning groups (SCGs) have adopted the unified commissioning approach set out in *Target Therapies for the Treatment of Pulmonary Arterial Hypertension in Adults* (NSCG,



2008). Adoption of this national policy by all SCGs will mean substantial increases in investment by some of them to raise standards to those of the best, providing parity of access and quality for pulmonary hypertension patients across England.

**9.141** Ministers have supported the National Commissioning Group's recommendations to add ten new services to the portfolio of nationally commissioned specialised services at a total cost to the NHS of around £53 million. These include deaf child, and adolescent mental health services, and the treatment of patients with Paroxysmal Nocturnal Haemoglobinuria. This will manage the risk of high-cost treatments, ensuring the high quality of clinical care and equity of access for patients.

### Professional Standards Programme – Tackling Concerns Locally

**9.142** Tackling Concerns Locally (TCL) is a key part of the wider Professional Standards Programme, which is charged with taking forward the White Paper *Trust, Assurance and Safety* which sets out how the Department will reform and modernise the system of professional regulation. The TCL programme brought together key stakeholders to advise on how best to put into place proposals for improving local systems for dealing with concerns about professional performance and behaviours. The Department's Clinical Governance Team managed and supported the work of the programme through a main working group and six sub-groups.

**9.143** The work of the TCL programme was largely completed during 2008 (the exception is areas such as death certification where the work of the sub-group continues in order to oversee implementation), and resulted in the production of the main TCL report along with reports from three of the sub-groups. The reports contain over 100 individual recommendations to the Department and were formally submitted in November 2008. Primary legislation implementing a number of elements of TCL (responsible officers, duty of

cooperation) was included in the Health and Social Care Act 2008.

### Prescription charges and exemptions

**9.144** On 23 September 2008, the Prime Minister announced that, over time, people in England suffering from cancer and other long-term conditions would no longer have to pay prescription charges.

**9.145** Exemption from prescription charges for people undergoing treatment for cancer, including the effects of cancer or the effects of cancer treatment, was introduced from 1 April 2009. Work is under way to extend this to people with other long-term conditions over the next few years.

**9.146** Ministers asked Professor Ian Gilmore, President of the Royal College of Physicians, to undertake a review to seek the views of the public, clinicians and patient representative bodies on how exemption for people with other long-term conditions should be progressively phased in over the next few years. Professor Gilmore is due to report back to ministers in summer 2009.

# 10 Nursing

## Role

To provide leadership for nurses, midwives and allied health professionals, and strategic policy direction on healthcare-associated infections and children, families and maternity.

### Key achievements in 2008-09 included:

Supported the NHS to deliver the target to halve MRSA bloodstream infections and to maintain this reduction.

Supported the NHS to reduce *Clostridium difficile* infections in patients aged 65 and over.

Published *Healthy Lives Brighter Futures*, the joint DH/DCSF Child Health Strategy.

Rolled out the Healthy Child Programme and Family Nurse Partnership pilots.

Launched Modernising Nursing Careers and Modernising Allied Health Professions Careers.

## Summary

10.1 In this chapter you will find information on:

- developments in children's and maternity services;
- professional leadership; and
- activity to tackle healthcare-associated infections.

## Developments in children's and maternity services

10.2 In February 2009, the Department and the Department for Children, Schools and Families (DCSF) jointly published the Child Health Strategy, *Healthy Lives, Brighter Futures*. Building on the National Service Framework for Children, Young People and Maternity Services, Every Child Matters, and the SHA clinical visions developed through the NHS Next Stage Review, it set out a long-term strategy to improve health outcomes for all children and young people from pre-birth to 19.

10.3 Key aims are to achieve world class health outcomes and minimise health inequalities, offering services of the highest quality and an excellent experience for the young people and families who use them. The strategy builds on work already in train to improve the quality and consistency of

services, support and opportunities that families and children can expect in their local areas.

10.4 Services already aim to promote healthy lifestyles, intervene early where health problems arise, and deliver support tailored to families' needs:

- easily accessible support in pregnancy and the early years of children's life through Sure Start Children's Centres and GP practices;
- helping children to take increasing personal responsibility for their health during their school years and helping young people to deal with the health challenges of adolescence;
- good access to urgent care; and
- specialist support for children with complex and long-term conditions, so that every child can reach their full potential.

10.5 The strategy draws together recent and new commitments to improve services, including the specific health commitments set out below.



## Healthy Child Programme and Family Nurse Partnership pilots

**10.6** These are being rolled out to systematise support for children in their early years and to test new support for the most vulnerable young families.

**10.7** In 2008, the Department published an updated guide to the implementation of the Healthy Child Programme covering pregnancy and the early years. Work is now beginning on a parallel guide covering school-age children. The programme offers early intervention and public health programmes, to support every family in helping their children towards optimum health and well-being. It is intended to provide services tailored to the individual needs of children and families, acting as a best practice guide for health and social services.

**10.8** The programme aims to:

- deliver services tailored to individual needs, risks and choices with a focus on reducing inequalities;
- provide greater emphasis on promoting the health and well-being of children early – in pregnancy and the beginning of life;
- encourage partnership working between different agencies on local service development (eg general practice and children's centres); and
- focus services on changing public health priorities – obesity, breastfeeding, and social and emotional development.

**10.9** The Family Nurse Partnership (FNP) Programme offers a structured, intensive home visiting programme for vulnerable, first-time, young parents from early pregnancy until the child is 2-years-old. Specially trained nurses build close and supportive relationships with families, and guide young first-time mothers so that they adopt healthier lifestyles for themselves and their babies, provide good care for their babies and plan their future life goals. The programme has been developed in the United States for over 30 years, where research has demonstrated consistent long- and short-term benefits for children and their mothers.

**10.10** The Department has been testing the FNP Programme in England since April 2007, expanding to 70 test sites by 2010-11. Evaluation from the first year of testing is promising. From April 2009, the Department will test the impact of FNP compared with usual services through a randomised controlled trial.

## Response to the independent Child and Adolescent Mental Health Services Review

**10.11** The independent Child and Adolescent Mental Health Services (CAMHS) Review, commissioned by the Department and DCSF ministers, reported in November 2008 and 20 recommendations for changes over the next three to five years, in order to improve children and young people's mental health and psychological well-being.

**10.12** The Government welcomed the review's recommendations, and has demonstrated its commitment to implementing change by the immediate implementation of a number of these recommendations. In particular:

- a National Advisory Council has been set up, to champion children's psychological well-being and mental health issues, advise Government on implementing the recommendations that have been set out in the report, and hold Government to account on delivery; and
- a National Support Programme is in development, building on the work already being delivered by the National CAMHS Support Service and other field forces to facilitate and support sustainable cultural change at national, regional and local levels, across all organisations and staff working in this area.

## Response to the Bercow Review of speech, language and communication needs

**10.13** A review of speech, language and communication services was published in July 2008 (the *Bercow Review*). The Government's response, *Better Communication: An Action Plan to Improve Services for Children and Young People with Speech,*



*Language and Communication Needs* (DH, DCSF, 2008) published in December 2008, commits the Department, along with DCSF, to develop a joint commissioning framework for children's and young people's speech, language and communication services. The Department will lead a programme to develop up to 20 local area pathfinders during 2009-10 to identify best practice and evidence of effective interventions to inform the development of this framework.

### Development of improved services for disabled children

**10.14** The Child Health Strategy confirmed that £340 million has been included in PCT allocations for the three years 2008-09 to 2010-11, to support children with disabilities and their families. This includes £30 million to improve palliative care services. This is in addition to the £340 million revenue over three years already announced by DCSF to support implementation of *Aiming High for Disabled Children* by local authority children's services. This funding will enable local areas to work together in partnership to support children with disabilities and their families and invest in palliative care and end-of-life services, short breaks, community equipment and wheelchair services.

### Maternity services

**10.15** Work continues to improve maternity services within the framework set by *Maternity Matters* (DH, April 2007), which focuses on improving the quality of care and ensuring that women have access to safe services that respond to their needs. This is supported by £330 million for maternity services within PCT allocations for the period 2008-09 to 2010-11. The Secretary of State for Health announced a package of measures in February 2008 to recruit an extra 1,000 midwives by 2009, rising to around 4,000 by 2012, dependent on the birth rate continuing to rise. The 2008 NHS Workforce Census data shows that by September 2008 there were an additional 1,195 (headcount) midwives since the baseline in

September 2006 (with the full-time equivalent increase of 778 or 4.1 per cent since 2006), so the first recruitment goal has been achieved. There are now over 25,600 midwives and 5,200 obstetricians and gynaecologists, almost 1,600 of whom are consultants.

### Action to strengthen NHS arrangements for safeguarding children

**10.16** The *NHS Operating Framework for 2009-10* highlights that all NHS organisations have statutory responsibilities in relation to safeguarding and promoting the welfare of children.

**10.17** Following the tragic death of Baby P in Haringey, the Chief Executive of the NHS wrote on 1 December 2008 to ask all NHS organisations to review their arrangements for child protection. At the same time, the Healthcare Commission was asked to undertake a swift analysis of whether or not health organisation boards are applying national child protection standards as vigorously as they should be.

**10.18** Action to strengthen NHS arrangements for safeguarding children will be informed by the outcomes of this analysis and by the recommendations of the independent report by Lord Laming of child protection arrangements. As part of the Government's initial response to Lord Laming, the Secretary of State for Health confirmed that a new Action on Health Visiting Programme, would take forward commitments from *Healthy Lives, Brighter Futures*, and also respond to challenges from Lord Laming to increase the number, competence and confidence of health visitors. In parallel, the Secretary of State has asked Dr Sheila Shribman, the National Clinical Director for Children, Young People and Maternity Services, to work closely with NHS and professional leaders in order to respond to the report's recommendations on other areas of training, development and support for staff.



## Support for local action to improve services for children

**10.19** Driving these changes for children and families in every area will need stronger joint leadership to plan, commission and monitor the delivery of excellent services. The Child Health Strategy sets out a clear expectation that Children's Trust partners are to provide children and families with accessible and comprehensive information about the services, advice and support available locally. New commitments to support local provision include action to:

- promote stronger joint leadership and local accountability arrangements, with statutory Children's Trust Boards to include GP members as well as PCTs;
- ensure that all organisations with responsibility for child health and well-being are fulfilling their statutory responsibilities for safeguarding children;
- develop the child health workforce, with a particular early focus on health visitors;
- deliver a support programme for local authorities and PCTs to commission child health services;
- strengthen the information available to help, plan, monitor and improve services; and
- give a stronger voice for children and young people in assessments of healthcare organisations, and robust arrangements to promote and ensure the quality of health services.

## Professional leadership

**10.20** The year 2008-09 has seen a number of important workforce and service developments, building on the themes of the NHS Next Stage Review.

### Modernising nursing careers

**10.21** *Modernising Nursing Careers: Setting the Direction* (DH, September 2006) was subject to discussion and consultation across the profession and debated in the context of Lord Darzi's intentions in *A High Quality Workforce* (DH, 2008).

The consultation response report, *Towards a Framework for Post Registration Nursing Careers*, was published by the Department in July 2008.

**10.22** The next phase of modelling the five proposed career pathways in order to establish their utility in practice is now in the planning stage with NHS and higher education colleagues and other stakeholders.

### Modernising allied health professionals careers

**10.23** This competence-based career framework was launched in July 2008, as heralded in *A High Quality Workforce*.

**10.24** The framework provides service managers and planners, clinicians and support staff, and education planners and commissioners with the tools to support a more flexible and responsive workforce.

**10.25** The first Modernising Allied Health Professionals (AHP) Careers Education Summit held in December 2008 identified the following priorities for further action:

- advanced practice;
- preceptorship;
- practice education;
- clinical academic careers;
- support workers; and
- an AHP Professional Advisory Board.

### Degree-level registration for nurses

**10.26** A debate about pre-registration nursing was held during summer 2008, within discussions on the role of the nurse in the context of Lord Darzi's NHS Next Stage Review. *Nurses in Society: Starting the Debate*, was commissioned by the Department of Health and published in October 2008 by the National Nursing Research Unit at King's College, London.



**10.27** In September 2008 the Nursing and Midwifery Council confirmed in principle to support a new framework for pre-registration nursing education with the minimum award being registration with a degree.

**10.28** Department teams are now working with stakeholders to plan the implementation of degree-level registration.

### Clinical Academic Research Training Pathways

**10.29** This is a new endeavour, launched in the autumn of 2008. It will enable nurses, midwives and allied health professionals to opt for research careers following a fully funded pathway of training, from masters degrees in research methods to doctoral degrees by research, culminating in post-doctoral clinical research opportunities which will enable the professions to become principal investigators and attract significant research grants. The latest phase (clinical doctorate research fellowships) was announced in January 2009. The scheme is being run by the Co-ordinating Centre for Research Capacity Development (part of the National Institute for Health Research).

**10.30** Selection of individual applicants will start in late spring 2009 and their programmes of study will start in September 2009.

### Quality of nursing care

**10.31** Improving the quality of nursing care is predicated on developing, understanding and using metrics to measure the quality of care. To establish a baseline for this, the Department commissioned the National Nursing Research Unit at King's College London to undertake a review of the evidence. This was published as *State of the art metrics for nursing: A rapid appraisal* (Griffiths, P. et al) in 2008, and informed the work of the NHS Next Stage Review. Further work continues, as part of the wider development of quality metrics.

**10.32** The Essence of Care Programme, a national benchmarking system covering 11 fundamental

aspects of care such as nutrition, record-keeping and communication, has undergone an updating of the original toolkit so that it keeps pace with evolving evidence. A 12th benchmark has been added on the subject of pain management. Essence of Care continues to be widely used across the NHS and increasingly, in social care settings. People value its approach of putting patients' perspective at the centre of quality improvement, and of empowering front-line staff to lead change.

### NHS Next Stage Review – nursing and AHP contributions

**10.33** *High Quality Care for All*, the final report of the NHS Next Stage Review, highlighted the role of health service staff. This was developed further in *Framing the Nursing and Midwifery Contribution: Driving up the Quality of Care* (DH) in July 2008, and in *Framing the Contribution of Allied Health Professionals – Delivering High-Quality Healthcare*, launched by the Department in October 2008. The AHP framework detailed an improved AHP service offer to the public and patients, focusing on services in primary care and the community and building on the work achieved by AHPs who work in the acute sector. The offer has three aspects:

- mandating the collection of referral to treatment data for AHP services and support for service redesign to improve services for patients;
- improving accessibility to physiotherapy and other AHP services through self-referral where clinically appropriate; and
- improving the quality of services and empowering patients through ensuring that work to develop an integrated set of quality metrics has a clear focus on metrics related to services provided by clinical teams, including AHPs; but highlighting the benefits of personal health budgets and integrated care organisations, and through the use of information prescriptions for allied health professionals and their services.



## NHS Next Stage Review – primary and community services

10.34 The NHS Next Stage Review Primary and Community Care Strategy includes key opportunities and challenges for nurses and AHPs. These will be taken forward through the Transforming Community Services Programme, which is being co-produced with clinicians and managed from across health and social care commissioning and provider organisations. A suite of system improvement products was launched by the Department in January 2009, including *Transforming Community Services* and *World Class Commissioning: Resource Pack for Commissioners of Community Services*.

10.35 The programme is focusing on six clinical improvement areas:

- promoting health and well-being and reducing inequalities;
- children and families;
- services for long-term conditions;
- acute services closer to home;

- services for rehabilitation and long-term neurological conditions; and
- End-of-life care.

### Transformational guides

10.36 These are being developed for each of the six areas. They will identify six high-impact transformational changes in each area and six transformational attributes, to inform future development of AHP and nursing services. Other components of the programme include:

- a literature review of evidence of effectiveness in community services; and
- developing a productive community services programme with the NHS Institute, including:
  - a community services diagnostic tool to identify key opportunities for improvement;
  - tools and modules to support staff in maximising their time for effective patient care;
  - testing ‘care bundles’ to support improvement and maximise patient outcomes with an

Figure 10.1: Transforming community services





initial focus on wound care, stroke care and continence services; and

- leadership development empowering front-line managers and strengthening relationships between front-line and senior leaders.

**10.37** Figure 10.1 summarises the programme's aims and delivery streams.

### Commission on the Future of Nursing and Midwifery

**10.38** In March 2009, the Prime Minister established a Commission to further enhance the role of nursing and midwifery in health and social care. The Commission will specifically focus on how to:

- engage with the professions, patients and the public in an interactive and robust dialogue which will identify challenges and opportunities for nurses and midwives;
- identify the competences, skills and support that front-line nurses and midwives need to take a central role in the design and delivery of 21st century services for those who are sick and to promote health and well-being. In particular, to identify any barriers that impede the pivotal role that wards sisters/charge nurses/community team leaders provide; and
- identify the potential and benefits for nurses and midwives, particularly in primary and community care, leading and managing their own services.

**10.39** The Commission will report back to the Prime Minister in March 2010.

### Activity to tackle healthcare-associated infections

#### Background

**10.40** Healthcare-associated infections (HCAIs) are infections acquired in hospitals or due to healthcare interventions. They are caused by a wide variety of micro-organisms, often by bacteria that normally live harmlessly in or on our bodies.

**10.41** For most people, the risk of acquiring an infection is very low. However, for those who acquire infections such as meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*), considerable pain and suffering can be caused both to patients and their families. In many cases, they are preventable.

**10.42** HCAIs can also present a significant additional cost to the NHS: evidence suggests that patients with an MRSA bloodstream infection spend on average an additional ten days in hospital and those with *C. difficile* an extra 21 days.

**10.43** Tackling HCAIs is a top priority for both the Department and the NHS. The Department has a strategy it knows will reduce infection, and has equipped the NHS with the guidance to deliver it – all backed by substantial investment and a legal requirement to maintain proper infection control. It was one of the five top priorities in the *NHS Operating Framework for 2008-09*.

**10.44** Under the 'ensure better care for all' Public Service Agreement the Department has a commitment to:

- reduce the number of *C. difficile* infections by 30 per cent from the 2007-08 baseline by 2010-11; and
- maintain the number of MRSA bloodstream infections below 50 per cent of the 2003-04 baseline.

#### What has been achieved so far

**10.45** MRSA and *C. difficile* infections have been significantly reduced. Latest Health Protection Agency data show the following:

- MRSA bloodstream infections are down 13 per cent on the previous quarter (April to June 2008), down 33 per cent on the same quarter in 2007, and down by 62 per cent compared with the quarterly average in 2003-04. (Data covering July–September 2008.)



- The NHS has delivered the target to halve MRSA bloodstream infections, and is on course to maintain this reduction.
- *C. difficile* infections in patients aged 2 and over are down 33 per cent on the same quarter in 2007. (Data covering July – September 2008.)

10.46 Figures 10.2. and 10.3 show how MRSA bloodstream infections and *C. difficile* infections have been reducing.

- Cleanliness across the NHS has been improved:
  - All hospitals had completed a deep clean by May 2008.

Figure 10.2: MRSA bloodstream infections – quarterly totals between April 2003 and September 2008

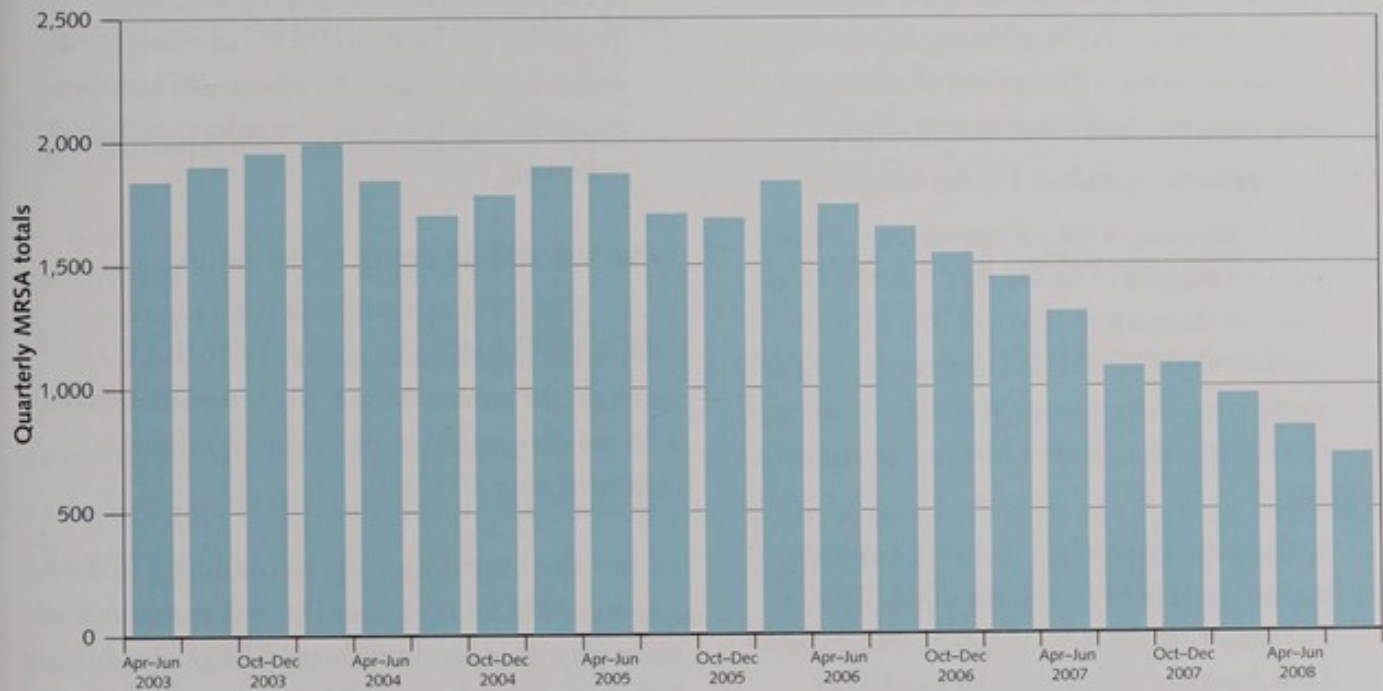
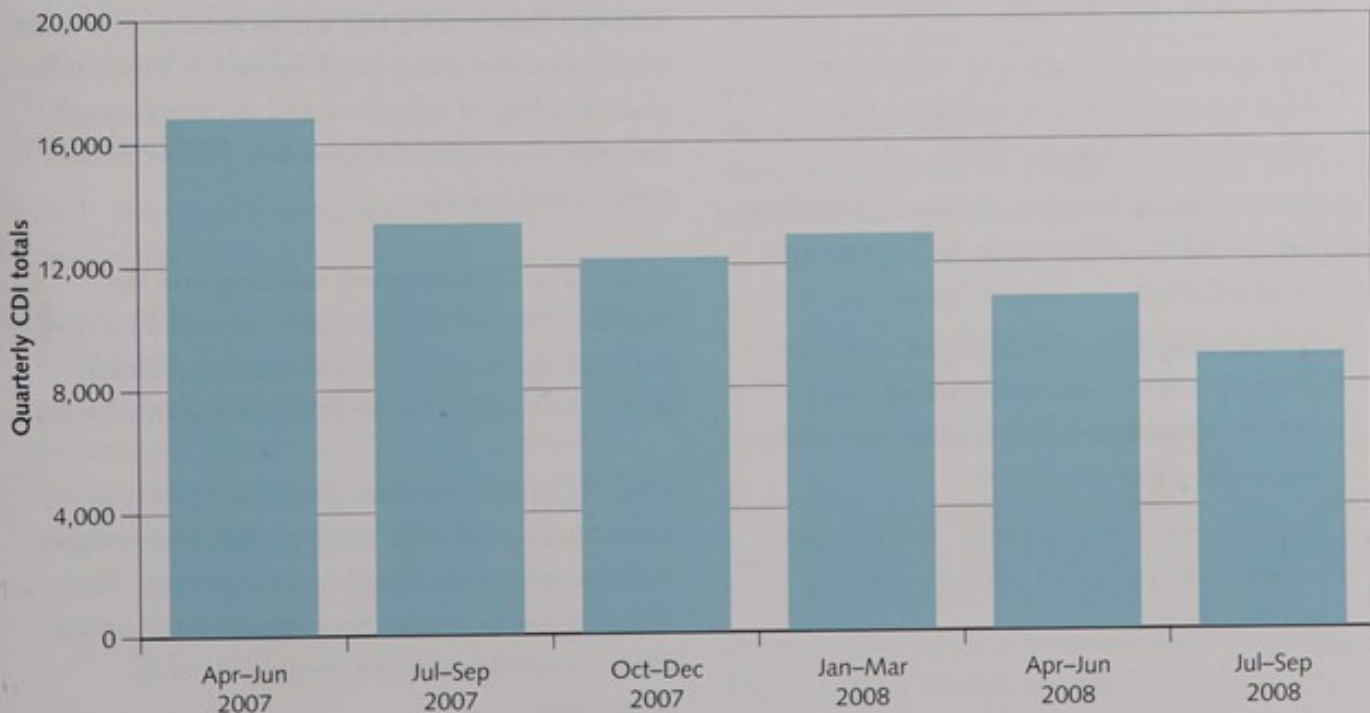


Figure 10.3: *C. difficile* cases aged 2 or more – quarterly totals between April 2007 and September 2008





- Working with SHAs, the Department published a compendium of good practice arising from the national deep clean programme (*From Deep Clean to Keep Clean*) in October 2008.
- 98.5 per cent of hospitals were rated acceptable, good or excellent in the 2008 Patient Environment Action Team Scores published in July 2008 (compared with 2000, when a third were rated ‘red’).
- The latest Healthcare Commission inpatient survey shows the NHS achieving its highest ever cleanliness rating – 93 per cent of adults said that their ward was fairly clean or very clean.
- Other initiatives to address HCAs comprise:
  - The Department’s HCAI Improvement Team provides support to ensure that trusts develop and own their action plan and oversee their implementation for HCAI improvement. The teams take a long-term view of behavioural and cultural change to embed best practice to reduce rates.
  - Acute trusts are required to comply with the hygiene code (*The Health Act 2006: Code of Practice for the Prevention and Control of Health Care Associated Infections*). The Healthcare Commission undertook infection control specialist inspections of all acute trusts against the hygiene code this year.
  - The nationwide campaign to raise awareness about appropriate use of antibiotics was relaunched in November 2008.
  - Comprehensive Spending Review (CSR) funding includes £270 million a year by 2010-11 to tackle HCAs.
  - CSR funding allowed local organisations to invest up to £45 million on specialist staff. Also, there has been an increase in the number of matrons to more than 5,000.
  - Matrons and clinical directors report to trust boards every quarter on infection control and cleanliness.
- The HCAI Technology Programme and Design Bugs Out are designed to accelerate the development and uptake of new ideas for the prevention and control of HCAs.
- The National Patient Safety Agency’s cleanyourhands campaign was expanded in July to primary care, mental health, ambulance and care trusts.
- The NHS has introduced MRSA screening for all relevant routine hospital admissions. Screening will be extended to cover emergency patients on admission by March 2011 at the latest. Screening will help to reduce the spread of infections.

### What we will be doing in the future

**10.47** The NHS needs to maintain progress to achieve the targets for the period to 2010-11 – to maintain the current MRSA target, and to deliver a 30 per cent reduction in *C. difficile* infections compared with 2007-08.

**10.48** The Department will be consulting to define a national MRSA objective. This will ensure that all trusts play their part in reducing MRSA bloodstream infections as much as possible.

**10.49** A new patient empowerment campaign starting summer 2009 will aim to make people more confident about going into hospitals, to broaden the understanding of infections, and to carry forward messages about shared responsibility between staff, patients and visitors.

**10.50** The Department is working with the National Patient Safety Agency to produce a new national standard to assess hospital cleanliness, under the auspices of the British Standards Institute.

**10.51** The new regulator (the Care Quality Commission) will have tough powers to investigate and intervene, with HCAI as a top priority. They will continue to oversee the programme of annual infection control specialist inspections of all acute trusts.



# 11 Informatics

## Role

To develop and deliver the Department's overall information strategy and integrate leadership across the NHS and associated bodies, including NHS Connecting for Health and the Information Centre.

### Key achievements in 2008-09 included:

- Growth in Choose and Book hospital appointments.
- Increased use of the Electronic Prescription Service.
- Expansion of the NHS National Network.
- Increased NHSmail traffic volumes.

## Summary

11.1 In this chapter you will find information on:

- health informatics;
- digital information and health policy;
- supporting the NHS to implement the National Programme for IT;
- supporting patient choice;
- supporting the NHS;
- the NHS Information Centre for health and social care; and
- the National Information Governance Board for Health and Social Care.

## Introduction

11.2 The Chief Information Officer for Health is responsible for:

- health informatics for the NHS and social care in England. This includes overall digital health strategy and the development of national and local information systems and IT-enabled business change processes through the effective application of information technology (IT);
- NHS CfH, including supporting the delivery of the National Programme for IT and maintenance

of existing national business-critical NHS information systems; and

- being a sponsor within the Department for:
  - the NHS Information Centre for health and social care; and
  - the National Information Governance Board, a non-departmental public body providing independent advice to the Secretary of State for Health on information governance issues.

## Health informatics

11.3 The need for high-quality information in the NHS and social care in England has never been greater. The NHS Next Stage Review highlighted the challenges faced in meeting rising patient expectations for greater choice and better control over their care and the way it is delivered in an age of expanding IT and growing connectivity. Patients want to understand the choices they can make and be confident that the healthcare professionals they see have access in order to all necessary information in order to provide care effectively and safely.

11.4 The *Health Informatics Review* report (DH, July 2008) was carried out at the same time as the NHS Next Stage Review and was jointly commissioned by the Permanent Secretary at the Department of Health and the NHS Chief



Executive. The review looked at the supply and demand for information across the NHS and social care in England. More than 1,400 stakeholders were consulted, including patients, the public, clinicians, and health and social care professionals.

**11.5** Addressing the need to develop NHS services in order to support high-quality personalised care for patients, the review's conclusions focused on the need to ensure that appropriate information systems architecture for the future is in place, supported by clear leadership and accountability arrangements that strengthen local ownership and develop the strategic links with emerging new policies.

**11.6** The first phase of the review's recommendations has already been completed. In September 2008, a Chief Information Officer (CIO) for Health was appointed. A member of the NHS Management Board, reporting to the NHS Chief Executive the CIO for Health is responsible for providing professional leadership to the key informatics organisations inside and outside the Department. The CIO for Health also assumed responsibility for information governance and assurance, taking forward the new mandatory requirements from the Cabinet Office around the handling of personal information and ensuring that these requirements are met across the NHS.

**11.7** Key to implementation will be the supporting and influencing roles of the NHS Information Centre for health and social care as an enabler organisation, actively promoting access to national and other information sources such as Secondary Uses Services (SUS), benchmarks and comparisons, publications and analytical reports; and the National Information Governance Board, as the top-level independent governance body for health and social care.

## Digital information and health policy

### Information Governance Assurance

**11.8** The Digital Information Policy Team has led work on information governance assurance in order to reinforce the steps taken to strengthen information security in 2007-08 and to align NHS information handling with the standards now expected of the public sector. This has included the development and deployment of online learning modules available free to all NHS staff, and the publication of comprehensive guidelines on managing information risk, tailored to NHS requirements. NHS Connecting for Health has also purchased 1 million licences for encryption in the NHS and provided the means for NHSmail users to transfer bulk data securely.

**11.9** An Information Governance Assurance Programme reported in June 2008 with recommendations to extend the NHS Information Governance Performance Assessment Framework to all bodies that provide or support the delivery of care. The new statutory National Information Governance Board will oversee the framework and help to drive improvements. The national contracts for care services and *Operating Framework for 2009-10* now include information governance performance requirements for all NHS bodies. Work is continuing to ensure that all parts of the Department's wider delivery chain are brought within the framework.

**11.10** The NHS Chief Executive has written to all NHS chief executives to ensure that robust data handling remains a priority for the NHS. Accountability arrangements have been strengthened, with all serious data loss incidents reported to the Department. Guidance has been provided to ensure that misconduct is dealt with appropriately.

### International developments

**11.11** The European Commission has begun a three-year project to support the continuity of care



for citizens travelling or working away from home in Europe. The project is a first step in addressing the problems faced by doctors when treating patients from other member states.

**11.12** The Department is one of 12 European member state health administrations now working together on the development of a practical solution that will enable clinicians to have secure access to patient summary health and medication information from within European healthcare systems with the consent of the patient. At the same time, the Department continues to represent the UK in international policy development relating to the use of information and communications technology in the delivery of healthcare services.

## Supporting the NHS to implement the National Programme for IT

**11.13** Modernising IT in order to underpin service transformation and so enable better, safer care is the main aim of the National Programme for IT (NPfIT). NHS CfH draws on its core strengths of managing large national IT programmes through third party suppliers to assist local NHS organisations in the implementation of systems and exploitation of benefits. Those benefits will increase as the number of front-line and clinical systems and services are delivered according to local needs and priorities.

**11.14** The NPfIT has a number of key individual programmes, each with its own purpose and contributing to the overall goal of linking a patient's health information, which in turn will support their use of NHS services and assist those providing them with care. The benefits include enabling choice, providing faster diagnosis and reducing waiting times for patients. IT alone will not deliver those benefits, but it can enable change across processes and organisations.

**11.15** During 2008-09, the introduction of the Summary Care Record (SCR), providing a summary

of a person's important health information (initially allergies, current medication and adverse reactions to medication), continued as planning for implementation began in the first PCTs beyond the early adopter sites. Some 258,000 patients across England now benefit from having their SCR securely accessible to hospital and community health professionals, so that informed care can be provided when needed, 24 hours a day, 7 days a week.

**11.16** The progress of NPfIT can be seen from the growth in use of the new systems, improving the quality of care to patients. During 2008-09:

- over 6.5 million hospital appointments were made using the Choose and Book service, with bookings now exceeding 28,000 a day;
- over 104 million prescription messages were issued electronically using the Electronic Prescription Service (EPS), with the number now in excess of 536,000 a day;
- over 640 million digital images were stored on the Picture Archiving and Communications System (PACS);
- over 40,000 connections, including virtually all GP practices, except those currently in the process of moving or new builds, are now connected to the New National Network (N3); and
- on average, 1.2 million e-mails a day are now transmitted using NHSmail (the secure NHS e-mail and directory service), serving 197,000 active users.

**11.17** New IT and information systems are being designed and delivered to meet 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 systems that make patient information available across the health and social care community in order to track and record a patient's care in the NHS.



**11.18** Clinical assurance is provided by the Office of the Chief Clinical Officer, focusing on patient safety such as safer patient handover and safer prescribing. The Clinical Content Assurance Programme is supporting the implementation of the SCR by reducing the potential variability of records and the consequent risks to clinical safety. The NHS Clinical Leaders Network Programme engages with over 1,000 senior NHS clinicians in order to improve leadership engagement, improve NHS service reform delivery and influence policy.

**11.19** The National Integration Centre (NIC), part of the Technical Assurance Group, works to ensure systems interoperability and safety. Robust assurance processes are in place to govern suppliers' product development, testing and integration into the national infrastructure. During 2008-09, the coordinated assurance approach across national, local and existing service providers has been further strengthened using a process approach. To date the NIC has:

- assured 23 national Spine (the system on which patient SCR are stored) and SUS releases (15 major and 8 minor);
- assured 24 Choose and Book national releases (5 major and 19 minor);
- assured 761 versions of 183 different products outside of the Local Service Provider (LSP) contracts;
- released 180 Clinical Authority to Release certificates to suppliers outside of the main LSP contracts; and
- assured 203 separate systems under the LSP contracts.

**11.20** The challenges and resources required to assure a new national release are significant and the established assurance standards are critical to maintaining service integrity. Information exchange has become ever more important, and clear standards have been developed and integrated into the national infrastructure, adding even more value to the established applications and services for

patient care across the NHS. There has also been a significant additional level of assurance introduced, including usability support for end users, wider volume and performance assurance, expanded monitoring of service availability, proof of concept of virtual test environments, and wider support for test data.

### NHS Care Records Service

**11.21** The NHS Care Records Service (NHS CRS) is a secure service that links patient information from different parts of the NHS electronically so that authorised NHS staff and patients have the information they need in order to make care decisions. There are two elements to the NHS CRS: detailed records, held locally; and the SCR, held nationally. In due course, the NHS CRS will enable each person's detailed records to be securely shared between the different parts of the local NHS, such as the GP surgery and the general hospital. Patients will also be able to have an SCR available to authorised NHS staff treating them anywhere in England. Patients will be able to access their SCR using the secure website HealthSpace ([www.healthspace.nhs.uk](http://www.healthspace.nhs.uk)). Following roll-out to early-adopter sites, 'fast follower' NHS trusts are now implementing the SCR. By the end of March 2009, over 250,000 SCRs had been created.

*"I have complex health needs ... so to have a record like this available will mean that the health professionals will know my medication and the levels I'm taking, will be aware of my long list of allergies and will be able to see if I had any bad reactions to the drugs they might want to give me."*

*Jill Grant, patient  
Ridge Medical Practice, Bradford*

### Choose and Book

**11.22** The process for booking first hospital appointments for patients has been revolutionised by the introduction of the Choose and Book system, which combines electronic booking and a



choice of place, date and time for first outpatient appointments.

**11.23** Patients are provided with more choice and involvement in the decisions made about their care, supporting the Government's health policy on choice. The local NHS is now able to identify the 'clock start' time at the beginning of the patient's care pathway, supporting the implementation of the Government's 18-week wait target.

**11.24** Two new software updates of Choose and Book went live in May and October 2008. The first enabled patients to book appointments at any suitable service of their choice, anywhere in England, supporting the Department health policy on choice. The second update introduced a series of enhancements to the service based almost exclusively on feedback from users.

**11.25** By the end of March 2009, 88 per cent of acute hospitals had a Choose and Book compliant patient administration system that had received an electronic referral, and 96 per cent of all GPs had used Choose and Book to send an electronic referral. Over 50 per cent of first outpatient referrals are now being made through Choose and Book.

**Figure 11.1** shows Choose and Book bookings from 2004 to 2009.

**11.26** Choose and Book has enabled trusts to make significant improvements in operational efficiency, with did not attend (DNA) rates being significantly reduced:

- Newark Hospital reported that DNAs reduced by more than 35 per cent when patients were referred electronically through Choose and Book

in comparison to the old paper referral method; and

- five trusts from the South East Coast SHA reported an average reduction in DNAs of more than 45 per cent when patients were referred electronically rather than via the old paper method (from April 2007–March 2008).

*"[Choose and Book] really has felt like a service that can accommodate my needs as an individual and not something where I have to fall in line with systems that I haven't had a say in."*

*Ken Odoki-Olam, patient  
Hillsborough Health Centre, Sheffield*

**11.27** A further update to the Choose and Book software in 2009 will allow referrers to search for services using a form of coded medical terminology known as SNOMED. This will allow healthcare providers to set out their directory of service entries with greater accuracy and clarity, and will allow referrers to help the patient to be booked into the most appropriate service that best meets their healthcare needs.

### Electronic Prescription Service

**11.28** Primary care prescribers can create and transmit prescription messages electronically using the EPS. A dispenser with an upgraded computer system can then download the prescription message from the EPS.

**11.29** Once the service is fully introduced, patients will not need to visit the GP for repeat prescriptions and GP practices will be able to save significant amounts of time as patients will be able to choose, or 'nominate', a pharmacy to receive their electronic

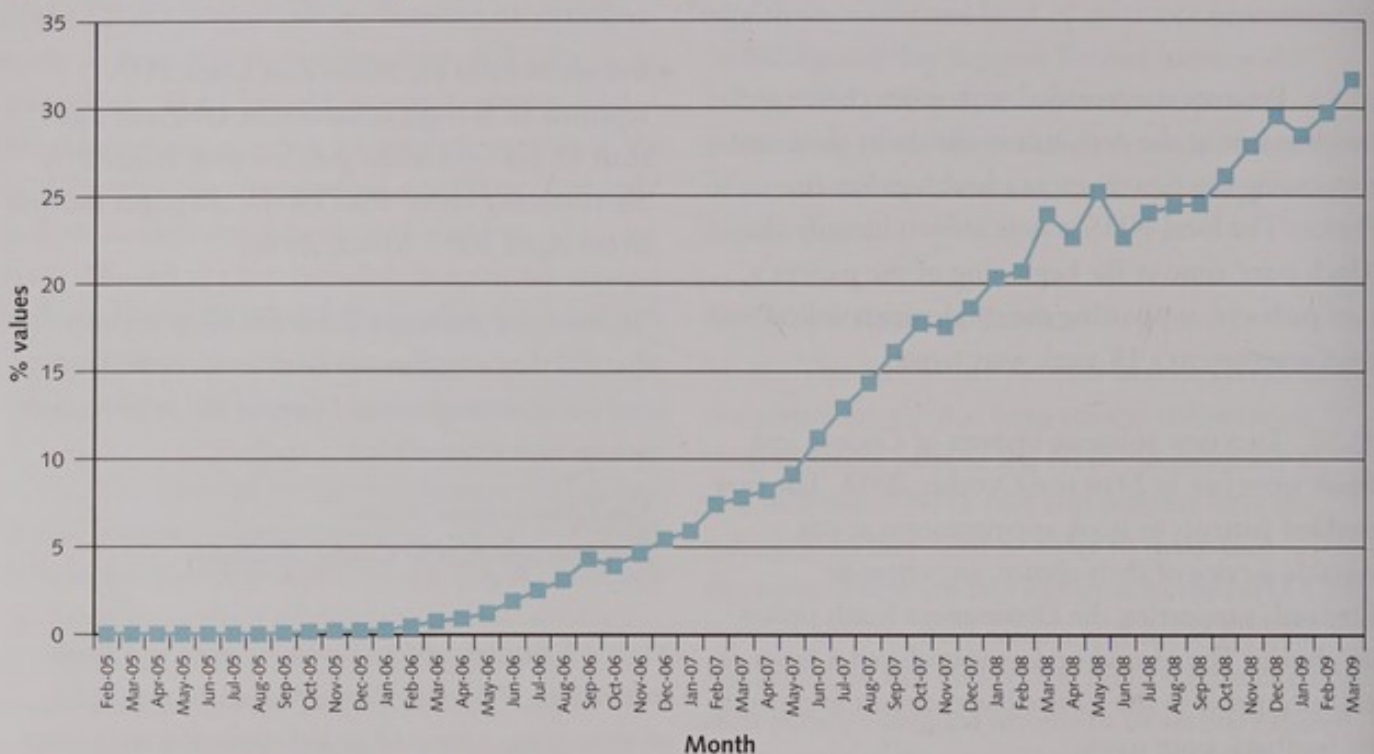
**Figure 11.1: Choose and Book system bookings, 2004 to 2009**

	2004	2005	2006	2007	2008	2009
Quarter 1	N/a	268	176,752	1,036,901	1,406,398	1,847,302
Quarter 2	N/a	1,096	384,399	1,059,912	1,516,000	
Quarter 3	9	7,254	666,283	1,150,449	1,625,906	
Quarter 4	63	62,119	820,716	1,194,604	1,616,444	
<b>Total</b>	<b>72</b>	<b>70,737</b>	<b>2,048,150</b>	<b>4,441,866</b>	<b>6,164,748</b>	<b>1,847,302</b>

Source: NHS Connecting for Health



Figure 11.2: Percentage of prescriptions through EPS



prescription automatically. The risk of transcription error between what was prescribed and dispensed will be reduced by the improved accuracy in dispensing medication. Pharmacists will benefit from improved workflow and stock control, as prescriptions may be received in advance of the patient collecting them, and also from a reduction in the number of times they have to physically collect prescriptions from a GP surgery.

**11.30** The first stage (Release 1) of the EPS has been rolling out over the past three years, with nearly 80 per cent of GP practices and community pharmacies now having the technology required to operate the service. Over 2.6 million prescriptions are issued every working week in England, and one-third of these are now issued using the EPS.

**Figure 11.2** shows the percentage of EPS prescriptions.

**11.31** The last quarter of 2008-09 saw the final preparations for the implementation of EPS Release 2. This will deliver major new advancements for prescribers and dispensers, including the introduction of advanced electronic signatures and the option for patients to nominate dispensing

pharmacies. Once Release 2 is fully operational, the need for paper prescriptions will reduce dramatically.

*"It's clear to see that Release 2 [of the Electronic Prescription Service] will bring huge benefits for my pharmacy. Gone will be the days of sorting masses of paper scripts at the end of each month to send to the reimbursement agency and it will really help with planning daily workload."*

*"Nomination will help to manage stock as, in most cases, we will receive the electronic prescription before the patient arrives. All in all, the Electronic Prescription Service gives us scope to really enhance the service we offer to patients."*

*Richard Dean, independent pharmacist and Pharmacy User Group member  
South Staffordshire PCT*

### Picture Archiving and Communications System

**11.32** Digital imaging using PACS is in place in all English acute trusts. Work is now under way to design, implement and rollout solutions that will



allow sharing of images across NHS sites and with the independent sector. Full Care Record Guarantee compliance has been developed and will be deployed over the next two years. Work is under way to develop PACS support to stroke and breast screening programmes.

*"PACS has made a huge difference and transformed the way in which we work for the better. Now that we have previous films electronically archived on PACS, the system is fantastically easy to use! Everything you need is there at the click of a button... [and] the turnaround time for reporting is much quicker."*

*Deborah Cunningham,  
Clinical Director of Radiology  
St Mary's Hospital Imperial College Healthcare  
NHS Trust*

### **NHS New National Network (N3)**

**11.33** N3 delivers the systems and services that enable the fast, secure exchange of information, files and data between NHS sites in England. Following completion of the initial implementation, additional services are being developed to ensure that the network continues to meet the needs of all sites to be connected to it. Over 40,000 N3 services are now deployed, which include 11,000 Mobility Services for mobile/community workers.

**11.34** Over 7,000 GP sites have migrated to a new rate-adaptive service which delivers significantly higher bandwidth at a lower cost. Community of Interest Network (COIN) designs, serving both national and local networking needs and providing both significant economies of scale and the potential to make major savings, have been implemented in 2008-09 at 30 per cent of N3 connected sites covering more than 60 NHS communities. Voice over Internet Protocol telephony services are now being well received, with 80 NHS organisations using the services nationally. More than 1.5 million telephone calls had been made using the service by 31 March 2009.

### **Local implementation**

**11.35** Individual SHAs, in partnership with NHS trusts are responsible for defining requirements and for the local implementation of NPfIT as well as the realisation of benefits from the new systems. NHS Connecting for Health supports local NHS organisations in the planning, development and deployment of the systems locally.

**11.36** During 2008-09, the LSPs deployed new patient administration systems (PASs) or upgraded existing PASs in 13 acute trusts, bringing the total covered to 45 acute trusts.

**11.37** The next generation of secondary care systems, with Cerner Millennium Release 1 in the South and London, and iSOFT Lorenzo Release 1 in the North, Midlands and East (NME), are currently being developed. All three early adopter trusts – University Hospitals of Morecombe Bay, South Birmingham PCT and Bradford Teaching Hospitals NHS Foundation Trust – have gone live with elements of the first version of the new Lorenzo system.

**11.38** In London, 7 mental health trusts have taken the RiO planning, scheduling and reporting software application deployed by BT. In the south, 1 mental health trust and 7 primary care trusts have taken the Cerner Millennium system. In NME, 17 mental health trusts have taken the iSOFT iPM system deployed by the Computer Sciences Corporation, and in primary care trusts there have been 47 such deployments.

**11.39** NHS Connecting for Health is working closely with the NHS to ensure that staff have the right skills to benefit from the new systems being deployed. The Essential IT Skills Programme, which has been developed specifically for the NHS and replaces training formerly provided by the European Computer Driving Licence service, the Microsoft Skills Academies and the Local IM&T self assessment tool, are examples of the new training which has been made available.



## National Audit Office review of the NPfIT

**11.40** In January 2009, the Public Accounts Committee (PAC) published a further report on progress made by the NPfIT in the NHS since 2006. This followed a second review conducted by the National Audit Office, which had been published in May 2008. Although the PAC recognised that good progress had been made on the delivery of many components of the programme, it concluded that recent progress in deploying the new care records systems had been disappointing, particularly in the case of iSOFT's Lorenzo product that was contracted to be deployed in NME. There were also issues with the deployment of Cerner's Millennium product in London, and progress had stopped altogether in the south following the termination of the contract with the LSP.

**11.41** In responding to the PAC, the Department accepted the main conclusions. The Lorenzo product is now being tested thoroughly in the early adopter sites and the PAC itself recognised that national implementation should not begin until the components had proved to work satisfactorily. The Department is also taking action to improve the situation in London and is developing a new strategy for the provision of the NHS CRS in the south.

**11.42** The Department expects these actions to bring demonstrable improvements to the deployment of the NHS CRS and it committed to providing the PAC with a progress report by the end of 2009. The national contracts provide for payment only on delivery, which has protected the taxpayer and ensured that costs are kept under control. See annex E for more information.

## Supporting patient choice

### HealthSpace

**11.43** HealthSpace is a secure website providing an online personal health organiser, a diary and calendar, an address book, access to Choose and

Book, and access to SCRs for patients who live in PCT areas where SCRs have been created. Since October 2008, patients in Salford have been using HealthSpace to access their local diabetes care record, enabling them to take a more participative role in their care. For the future, HealthSpace could provide a wider range of online services, focusing on personal transactional and selfcare services, providing patients with their own personal health-care record and the ability to link more closely with other NHS services.

### The 18-week Patient Pathway Programme

**11.44** NHS Connecting for Health has helped NHS organisations and their IT systems suppliers to develop and deploy systems to support the delivery of the Government target that nobody should wait longer than 18 weeks from GP referral to the start of treatment.

## Supporting the NHS

### NHSmail

**11.45** There are direct, quantifiable benefits to clinicians and patients from the increasing number of NHS organisations using NHSmail, the secure, encrypted e-mail and directory system for the NHS. It is the only NHS e-mail service secure enough for transferring patient information and is endorsed by the British Medical Association and the Royal College of Nursing. The organisations using the service are making savings through decommissioning local e-mail services in favour of NHSmail.

**11.46** The number of active NHSmail users has increased by 38 per cent over the year to date to 197,000, and there was a 115 per cent increase in the number of SMS text messages sent per month in 2008 as patient appointment reminders rose from 350,355 in January to 754,997 in December.

**11.47** In January 2009, the NHSmail core service technology began to move to a platform based on Microsoft Exchange 2007. This makes migrations



from local NHS trust exchange e-mail services much simpler. It will also, in a single step, give existing users a significantly enhanced set of features and functionality – giving NHS organisations further impetus to switch to NHSmail.

*“We have a lot of staff who deal with the same clients and the secure functions of NHSmail mean they can quickly and safely share client information without compromising confidentiality.”*

*“A large number of our staff are community-based, without fixed work stations, and it’s very helpful for them to be able to access their e-mails from different PCs.”*

*Andrew Lavender, IM&T lead  
Torbay Care Trust*

### Primary care support

**11.48** NHS Connecting for Health supports primary care practitioners by developing and supporting systems that are used to provide management information, make payments to GPs and deliver improved patient care.

**11.49** These include the Quality Management and Analysis System, a national IT system that gives GP practices and PCTs objective evidence and feedback on the quality of care delivered to patients. It supports the Quality and Outcomes Framework element of the GP contract by calculating the payment due to GPs, and has been in operation since 2004.

**11.50** The average time taken to transfer patients’ records when they register at a new GP practice has been reduced from several weeks for paper records, to within minutes for electronic records for the more than 5,000 practices that are GP2GP enabled. GPs can now have almost immediate access to the medical records of new patients, improving the quality of the patient treatment, patient diagnoses and records available, since data does not have to be re-entered at the new practice and nearly all the historical data can be retained. Over 500,000

records have been transferred to date. The project team is now working with two further suppliers with the aim of increasing the number of practices eligible for GP2GP by 1,500, thus bringing coverage up to 75 per cent of practices in England.

*“Patients didn’t understand why we didn’t know about them when they had just registered. Now, we do know and they are much happier. GP2GP is helping the practice provide a much better service for our patients.”*

*Jayne Dewhurst, Practice Manager  
Padiham Group Practice*

**11.51** GP Systems of Choice is the contractual mechanism for the delivery of NPfIT applications from existing suppliers to a common set of standards and performance metrics. This programme improves the hosted services available to practices, improving the security of patient records. It also facilitates the delivery of key NPfIT functionality such as the SCR and Release 2 of the EPS.

### Business-critical NHS systems

**11.52** NHS Connecting for Health continues to manage a portfolio of some 40 existing national NHS IT services, including the National Cancer Screening Services, the Bowel Cancer Screening Service, the Cancer Waiting Times Service and a range of national management information systems such as the Ophthalmic Payments System.

**11.53** During 2008, a number of key development projects have been delivered, including software enhancement systems that integrate to the Personal Demographics Service (PDS), allowing the PDS to be searched for patient matches and for NHS numbers to be allocated directly. The Secure File Transfer service, providing a secure method to transfer files between NHS organisations and the Message Handling Service which provides a simple and effective means to connect to the PDS, have also been introduced.



### Secondary Uses Service

**11.54** The SUS, which provides management information for the NHS, is being delivered incrementally through a series of releases. It captures, processes and enables access to and reporting on all data relating to NHS-commissioned activity. Data capture is automatic from operational systems and enables the generation of summary reports. This is reducing the burden of data collection for the NHS, and enabling a full range of reporting to support healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance at local and national levels, through the use of anonymised and pseudonymised data, which protects patient confidentiality.

**11.55** Additional features will become available at the start of 2009-10 containing a wide range of data collection and reporting functionality including, amongst others, 18-week reporting, Choose and Book, mental health management information and payment by results pricing for GPs for the 2009-10 financial year.

### Research Capability

**11.56** The Research Capability Programme aims to reduce the need for the use of patient identifiable data by increasing the quantity and quality of data routinely available for research, drawing on expertise from the pharmaceutical industries, academic researchers, research charities and councils, public and patient groups and representatives from the other UK home countries. The programme is currently piloting the Health Research Support Service, utilising research data and real-life research questions from a number of stakeholder organisations, including the Association of the British Pharmaceutical Industry, the National Cancer Intelligence Network, the Health Protection Agency and Imperial College London.

### The NHS Information Centre for Health and Social Care

**11.57** The NHS and social care system increasingly needs timely, good-quality benchmarking and comparative personal data at a local rather than a national level. The NHS Information Centre for health and social care (NHS IC) helps local organisations to plan better local care and thereby reduce the burden on NHS and social care front-line staff. The NHS IC supports the front line by:

- delivering products and services that address key issues and priorities in NHS and social care;
- being the recognised source of data for secondary use in the health and social care system;
- leading on the development of data and information standards and ensuring that data quality is fit for purpose in terms of consistency, relevance, timeliness and accuracy; and
- acting as an 'honest broker' and a 'safe haven' managing the authorised disclosure of information to users.

**11.58** Further information about the NHS IC is on its website: [www.ic.nhs.uk](http://www.ic.nhs.uk).

### National Information Governance Board for Health and Social Care

**11.59** The National Information Governance Board for Health and Social Care (NIGB) is an advisory body that was established in October 2007. It supports improvements in information governance practice and monitors information governance trends in both the NHS and adult social care. It became a statutory body as part of the Health and Social Care Act 2008. On 1 January 2009, it took over the responsibilities of the Patient Information Advisory Group.

**11.60** The role of the NIGB is to promote consistent standards for information governance across health and social care. It also administers applications made under section 251 of the NHS Act 2006, which permits the Secretary of State for



Health to set aside the common law duty of confidentiality in certain exceptional circumstances in order to allow information that identifies the patient to be used without their consent.

11.61 The board reports annually to the Secretary of State for Health and publishes the NHS Care Record Guarantee for England. Further information about the NIGB is on its website: [www.nigb.nhs.uk](http://www.nigb.nhs.uk).



The NHS is a public body that provides a wide range of health services to the population of the United Kingdom. It is funded by the government and is not-for-profit. The NHS is a large and complex organization, and its structure and operations are constantly evolving. The NHS is a public body that provides a wide range of health services to the population of the United Kingdom. It is funded by the government and is not-for-profit. The NHS is a large and complex organization, and its structure and operations are constantly evolving.



# IV Care and Support – Social Care, Older People, Mental Health, Disability and Offender Health

## Chapter 12 Social Care, Local Government and Care Partnerships

# 12 Social Care, Local Government and Care Partnerships

## Role

Sets the direction for adult social care, mental health services and health services for offenders, and takes the lead in developing the Department's relationship with local and regional government.

### Key achievements in 2008-09 included:

Care and Support Green Paper, the *Case for Change* consultation.

Improving Access to Psychological Therapies Programme roll-out.

Dignity in Care Campaign progress.

Publication of the National Dementia Strategy; the Valuing People Now Strategy; the Carers Strategy; and the *Evaluation of the Individual Budgets Pilot Programme: Final Report*.

## Summary

12.1 In this chapter you will find information on:

- the Care and Support Green Paper;
- transforming adult social care;
- improving social care capacity and capability;
- mental health;
- offender health;
- New Deal for Carers;
- Valuing People Now;
- autistic spectrum conditions;
- older people and system reform;
- dignity and safety; and
- local government and regional policy.

## Introduction

12.2 Social care is the wide range of services designed to support people in order to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and work with complex relationships. Advances in public health, healthcare and changes in society mean that people are living longer and, as communities become more diverse, the challenges

of supporting the increasing demand and diversity become more apparent.

12.3 People have higher expectations of what they need to meet their own particular circumstances, wanting greater control over their lives and the risks they take. They want dignity and respect to be at the heart of any interaction, so that they can access high-quality services and support closer to home at the right time, enabling them and their supporters to maintain or improve their well-being and independence rather than relying on intervention at the point of crisis. Social care cannot meet these challenges without radical change in how services are delivered.

12.4 In the longer term, the Department is committed to publishing a Green Paper in 2009 on reforming future care and support services in England. In the meantime, to address the challenges faced now and to make best use of resources available, *Putting People First: A shared vision and commitment to the transformation of Adult Social Care* (DH, December 2007) sets the direction for adult social care over the next ten years and beyond.



## Policy overview

**12.5** The Social Care, Local Government and Care Partnerships Directorate focuses its efforts on the development of policy across three broad interlinked themes: adult social care, mental health and offender health. There are also some cross-cutting areas of work which underpin this, particularly in the development of relationships across Whitehall and local government focused on ensuring the best outcomes for people in these groups. Although the Directorate has a specific role in relation to adult social care, it is also involved in the development of policies which span both health and social care for particular client groups, eg older people and mental health.

### Adult social care

**12.6** The Government's vision for adult social care was set out in the White Paper, *Our Health, Our Care, Our Say* (DH, January 2006). *Putting People First* sets out a unique public service reform programme to be co-produced. It recognises that real change will only ever be achieved through the engagement of staff and of people using services and their carers, at every stage.

**12.7** The intention remains that every council will aim to develop a single community-based support system focused on the health and well-being of the local population, including those who fund their own support. The local performance framework covers the delivery of all services by local government, working alone and in partnership.

**12.8** Adult social care will be transformed through working with partner organisations in local government, the NHS, other statutory and non-statutory agencies, local communities and individuals giving and receiving support. The transformation will harness the requirements of the new local performance framework, such as the duty of local authorities and primary care trusts (PCTs) to undertake a joint strategic needs assessment in order to drive through reform that really delivers for local people.

**12.9** A personalised adult social care system will ensure that people are supported, irrespective of illness or disability to:

- live independently;
- stay healthy and recover from illness;
- exercise maximum control over their own life and, where appropriate, the lives of their family members;
- sustain a family unit which avoids children being required to take on inappropriate caring roles;
- participate as active and equal citizens, both economically and socially;
- have the best possible quality of life, irrespective of illness or disability; and
- retain maximum dignity and respect.

**12.10** Local government will continue to need to spend some existing resources differently, and the Department has provided specific funding to support system-wide transformation through the Social Care Reform Grant. From 2008 to 2011, the Department committed to contributing over £3.5 billion into adult social services specific revenue grants and the Area Based Grant (ABG). This is an average increase of over 10 per cent per year. In addition, a further £70 million of capital grants were committed in 2008-09 to further support investment in the delivery of social care policies. The ABG is not ring-fenced, which enables authorities to determine locally how best to spend monies in order to deliver local and national priorities specific to their needs.

**12.11** Local authorities reported a continued increase in social care expenditure. In 2007-08, provisional data shows that authorities reported gross current spend on adult social care services of £15.3 billion. Local authorities continued to work to achieve their 3 per cent efficiency targets set by government. The Department is working closely with local authorities through its sponsored Care Services Efficiency Delivery Team to meet this target and ensure that care services deliver value for



money quality outcomes. Refer to **figure A.24** in annex A.

## Mental health

**12.12** The *National Service Framework for Mental Health* (DH, September 1999), which has acted as a catalyst for progress across the whole spectrum of mental health services since 1999, will draw to an end in 2009.

**12.13** The New Horizons Programme, which has already involved an extensive process of engagement with mental health stakeholders over the course of 2008, is about the development of a new and reinvigorated vision to maintain the momentum of the National Service Framework. Its focus this year will be on fostering broad consensus about both the way forward, and the practical ways of embedding new priorities and agreed principles into services, alongside a wider public mental health approach.

## Offender health

**12.14** The NHS holds budgetary and commissioning responsibilities for health services in all publicly run prison establishments in England and Wales. The strategy remains that prison health services should be broadly equivalent in range and quality to the wider NHS.

**12.15** 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. The Government remains committed to reducing inequalities.

## The Care and Support Green Paper

### Background

**12.16** The existing social care system in England is facing some major challenges: demand is rising rapidly as the population ages (the number of people over 85 will double in the next 20 years);

and people's expectations are rising, as people want more personalised and flexible services.

**12.17** Care and support should not only be about social services. As one person using care and support said,

*"It means I can have a normal life, which sounds a bit odd, but it means I do go shopping and I do get the housework done, and I am in charge of all those kind of little things that people take for granted."*

**12.18** Care and support should therefore be about appropriate housing, work opportunities, benefits for those who cannot support themselves, health services, and information about how to access all of these.

**12.19** In order to address the major challenges outlined above, the Department will publish the Care and Support Green Paper in spring 2009. In preparation for this, the Department ran an extensive engagement programme between May and November 2008.

**12.20** The Department knew that there was limited understanding about existing care and support services. Often people think that these are part of the NHS, whose services are free at the point of delivery to all who need them, regardless of their financial position. Care and support services are not. People need to better understand how the funding system works, and the need to save for future care and support.

### Policy issues

**12.21** The fundamental question that the Green Paper needs to resolve is 'How can the Department ensure that care and support are delivered, to a high standard, for everyone who needs them, and on an affordable, sustainable basis?'



12.22 The Government has set out three principles to underpin any reformed system. It must:

- promote independence, choice and control for all users;
- ensure that all users receive high-quality care and support, that everyone gets some support from the Government, but that funding is targeted at those most in need; and
- be affordable for the Government, individuals and families in the long term.

### Public engagement

12.23 For the public engagement, the Department:

- ran a dedicated website, which had nearly 47,000 visits;
- held events for stakeholders in each of the Government's nine regions;
- held five citizens' events for members of the general public;
- invited people to send us their views – more than 1,000 were received;
- conducted separate work to reach those people who it knows are often seldom heard in these circumstances; and
- encouraged stakeholders to run their own events. The Department knows that over 100 events were held, some using materials the Department developed for this purpose.

12.24 To keep the public debate focused, the Department introduced a key theme every few weeks. These included:

- promoting equality and human rights through care and support;
- joining up care and support (integration);
- private finance;
- fair and clear access;
- families and communities; and
- working together to meet costs.

12.25 Prominent stakeholders and commentators worked with the Department on the themes. Some experts contributed articles for the website in order to maintain interest and inspire further discussion.

### Engagement findings

12.26 The Department is in the process of analysing the responses and plans to publish a report alongside the Green Paper. The engagement demonstrated a real appetite for change. One citizen said:

*"I didn't realise the scale of the problem or that it would happen so soon."*

12.27 Three areas of common concern were immediately apparent from the engagement:

- fairness – people felt that the new system has to be based on principles of fairness and consistent standards;
- partnership – stakeholders and the members of the public recognised that care is a responsibility shared by individuals, families, the community and the state; and
- funding the system – people agreed that there is a need for change and that more money needs to be available for future services. They found it difficult to say where this money should come from, but there was broad support for a collective approach.

### Next steps

12.28 There is a real opportunity to improve the quality of people's lives by radically reforming the care and support system. This will make for a better experience for service users, carers, families and service providers.

12.29 The Department will move towards achieving this by publishing the Green Paper in spring 2009. Publication will be followed by a period of consultation, during which the Government will give staff, stakeholders and the public the chance to respond to the reform options proposed in the Green Paper.



## Transforming adult social care

12.30 The direction of travel for adult social care is set out in *Putting People First*. This cross-sector document provides a consensus on the ambitions for the future. It emphasises and commits all partners to work together in order to find ways that will enable people to retain their independence and exercise choice and control over the support they need.

12.31 *Putting People First* is holistic in its approach to delivering social care services for all individuals in the community. It envisages:

- communities where universal services (including information and advice) have taken into consideration the issues affecting people who may have or be at risk of having social care needs;
- that people are offered interventions preventing them from needing ongoing social care support as well as advice where this is appropriate;
- that people who have longer-term social care needs are able to exercise choice and control over how these needs are met with an understanding of the funds available to do so; and
- communities where people have the opportunity to participate in activities and influence decisions about their neighbourhoods that affect their lives.

12.32 The Department recognises that, in order to meet this goal, the system will need to undergo significant redesign in process, practice and culture. To support this transformation, the Social Care Reform Grant is providing councils with £520 million over three years, for investment in the necessary system and process development.

12.33 Over the last year, the Department and its partners, at all levels, have been working together to start the process of transforming social care into a system capable of delivering support tailored to individuals and local populations, irrespective of their circumstances or level of need. To ensure that this is delivered in a coherent and co-ordinated manner at national level, the Department has

established a Transforming Adult Social Care Programme Board, chaired by the Department's Director of Social Care Strategic Finance. This brings together key stakeholders, including users of services, carers, delivery partners and the regulator.

12.34 To ensure that co-production is at the heart of what the Department does, it has worked with people who use services in order to establish a user reference group for the programme. The group is drawn from a wide range of individuals of all ages, with the aim of embedding the experiences of people who use services, carers and the wider population into every aspect of the work.

12.35 In order to support the link between national and regional delivery, a National Director for Social Care Transformation has been appointed by local government representatives to lead their contribution. The Department's deputy regional directors also provide strong lines of accountability, with one of their key responsibilities being to work with councils and their partners to ensure delivery of *Putting People First*.

### Self-directed support – enabling people to exercise choice and control over the support they receive

12.36 People who have longer-term social care needs need to understand what is available to them. This means having access to information and advice, or advocacy where appropriate, and having choice and control over the support they get so that it can be flexible and personalised to them. To make this work, systems need to be easy to follow and everyone involved should work together with the person at the centre of the plan. This is true whether the council is providing the support or people are buying the services themselves.

12.37 The Department is undertaking a range of work to support councils to make this a reality. These include the following:



## The Individual Budgets Pilot Programme

*"I would say that direct services allow you to survive at home, direct payments give you more choice and control over your life, but individual budgets allow you to live!"*

*Individual budget recipient*

**12.38** Individual budgets were piloted in 13 areas for two years, ending in December 2007. Individual budgets give people who have care needs the power to decide the nature of their own support, and the evaluation report showed that most groups liked this. People can choose to use the money to fund the care that suits them best and fits in with their lifestyle – for example, by having someone support them at home rather than going into residential care.

**12.39** The summary report evaluating the pilots (*Evaluation of the Individual Budgets Pilot Programme*, Social Policy Research Unit, University of York) was published on 21 October 2008. The report found that individual budgets had particular benefits for mental health service users and younger disabled people. While there were no important differences in overall cost, there were indications that individual budgets have the potential to offer greater value for money.

**12.40** Mental health service users in the individual budget group reported a significantly higher quality of life. Younger physically disabled people were more likely to report higher quality of care, were more satisfied with the help they received and the choice and control they experienced, and felt that they had the opportunity to build better-quality support networks. People with learning disabilities were more likely to feel that they had control over their daily lives.

**12.41** The report found that older people did not find the individual budget system used during the pilot as easy to use as the other groups, and many did not appear to like the idea of managing their

own support. Since the evaluation, councils involved in the pilot have started to put new systems in place to support older people with individual budgets. They are now reporting very positive developments and many examples of older people and their carers gaining real benefits. The Department is doing further research to see whether or not this improves older people's experience of using individual budgets.

**12.42** Running the pilots involved major changes from the way in which community care had been provided previously, posing challenges for those commissioning and providing social care services. Practical learning from the pilots was captured and is available in a Personalisation Toolkit. It also involved working with other agencies to streamline assessment and reporting systems to allow for a bundling together of disparate income streams in order to meet common and agreed outcomes for the individual. Although the pilot sites had some success in aligning different funding streams, it was not possible to integrate them as envisaged at a local level in the limited lifetime of the pilots.

**12.43** The Department's plans to take services forward in the coming year include the development of person-centred services offering support while allowing choice and control over the shape of that support in all care settings. This is being delivered through the Transforming Adult Social Care Programme.

**12.44** As part of this, the Department will continue to promote the uptake of personal budgets and to contribute to various initiatives relating to personalisation, such as personal health budgets, working closely with colleagues in other government departments who are piloting individual budgets and keeping developments in general under review.

### Fairer contribution guidance

**12.45** The Department has undertaken a review of the *Fairer Charging Policies for Home Care and other non-residential Social Services* (DH, September



2003) guidance in relation to personal budgets as part of the work to help local authorities transform their social care systems. The aim of the review is to design a new local authority personal financial contribution regime that is appropriate for personal budgets and which will accommodate any other funding streams that ministers might wish to include in any future roll-out of individual budgets.

12.46 A 12-week national consultation began on 26 January 2009. Any necessary revisions to the guidance will be made following the consultation, with a view to issuing the final *Fairer Contributions* guidance to local authorities in summer 2009.

### Extension of direct payments

12.47 The Government is committed to increasing the uptake of direct payments and to enabling previously excluded groups to benefit. The Health and Social Care Act 2008 provided for the extension of direct payments to people who lack capacity to consent, including some adults with head injuries, some people with dementia, and severely disabled children moving into adulthood.

12.48 This delivers on the commitment given in *Our Health, Our Care, Our Say*. Following recent public consultation, regulations allowing direct payments to be made to adults lacking capacity and also to groups previously excluded by mental health legislation will come into force in 2009.

### Fair Access to Care Services Review

12.49 In January 2008, the Minister for Care Services asked the Commission for Social Care Inspection (CSCI) to undertake an independent review of the application of eligibility criteria for social care and their impact on people. This review was commissioned in recognition of the need to ensure fairness and transparency in the assessment of needs and allocation of finite resources.

12.50 CSCI published their review of eligibility criteria for social care, *Cutting the Cake Fairly*, in October 2008. The report was welcomed by the

Department, and in light of its recommendations the Department is now working with stakeholders to strengthen the *Fair Access to Care Services* guidance within the context of *Putting People First*, and to support councils to use the resources available to them in the most fair, open and effective way. This work will also look at implementation support issues for councils, service users and carers.

### Transforming community equipment services

*“Every step from beginning with assessor to retailer, everyone has been so kind. Wonderful service.”*  
Equipment service user, Manchester

12.51 Since 2006, the Department has been working with stakeholders, including users and carers, front-line staff, local authorities and their health partners, to develop a new model of delivery for community equipment. The retail model demonstrates a way of delivering personalised services for service users and their carers/personal assistants supported by the state and those who self-fund, which aligns powerfully with health and social care policy and vision.

12.52 The testing of the primary elements of the retail model has proved that the concept can work for both organisations and users. Users supported by the state were able to access the equipment they were assessed as needing, in addition to being able to top up their prescription to a product that better suited their lifestyle and pay the difference to the retailer. A national catalogue and tariff support the prescription system. The programme has also highlighted opportunities to provide a more effective home delivery service for complex aids to daily living, and is working through regional structures to develop solutions which leverage the strengths of current good services.

12.53 Around 60 local authority and health partners have engaged with the national programme and used the national toolkit to create their local business cases, including financial models to support their local implementation decision.



**12.54** The programme has increased the profile of the market for community equipment and generated an impetus for developing into a mainstream consumer market. This benefits the whole population and empowers individuals to self-help, which is one of the key components of *Putting People First*.

**12.55** In 2009, the national programme will continue to support local authorities and their health partners to implement the model within their localities. The team will continue to work with national and multi-store retailers to support their entry into this market, in order to provide more access and choice for individuals.

### User-led organisations

**12.56** For the Department, the priority of the Government's report *Improving the Life Chances of Disabled People* (January 2005) is to deliver the recommendation that, by 2010, each locality should have a User-led Organisation modelled on existing centres for independent living. User-led organisations will play a vital part in implementing a new approach to supporting independent living. The Department has instigated a range of work in partnership with disabled people, their families and relevant organisations in order to map the current position, identify barriers to delivery and develop proposals to deliver this objective.

**12.57** Achieving the *Life Chances* recommendation is dependent on the initiative and commitment of disabled people across the country. To support this, the Department has set up the User-led Organisations Development Fund, offering user-led organisations the opportunity to become a User-led Action and Learning Site. Up to £850,000 was made available in 2007-08, with a further £900,000 available for 2008-09. The emphasis is on user-led organisations themselves developing practical solutions locally, and sharing these with others to ensure that every locality has the chance to develop and have access to a User-led Organisation.

This will be complemented by targeted capacity work in the regions during 2009.

### Common Assessment Framework

**12.58** To support the wider development of *Putting People First*, the Department has consulted on how to improve information sharing between health, social care and wider community support services, such as housing. All these have a role to play in multi-disciplinary assessment and information sharing under a Common Assessment Framework (CAF) for adults, which is also expected to assist the personalisation agenda. It will also help people to choose services and support better suited to their individual needs. In order to inform developments, the Department has also set up a number of CAF demonstrators and local authority-led partnerships, to test out some of the practicalities and provide it with evaluated evidence on benefits, costs and cost effectiveness.

## Improving social care capacity and capability

### Adult Social Care Workforce

**12.59** Approximately 1 million staff work in paid employment across the core areas of social care, including social work, residential, day and domiciliary care. This includes staff in all sectors, agency staff and some in the NHS. The wider social care workforce is estimated to be 1.6 million, including childcare and early years, additional NHS staff, foster carers and adopters, and some school staff.

**12.60** Of these, in the adult social care workforce about 61 per cent work with older people, 19 per cent work with people with disabilities and 7 per cent work with those with mental health conditions. The balance, about 12 per cent, work with children and are accountable to the Department for Children, Schools and Families.

**12.61** Approximately 30 per cent of the social care workforce have a relevant qualification and some



76,000 are professionally qualified social workers, of whom approximately half work in adult social care.

12.62 Recruitment, retention and service quality remain a concern in some areas of social care. The Department has therefore embarked on a fundamental reform of adult social care services in *Putting People First*.

### Interim statement on the Social Care Workforce Strategy

12.63 The Department has established an Adult Social Care Workforce Strategy Board and an Executive Group to identify priorities for workforce development. The Board, which comprises key delivery partners, supported the publication on 23 June 2008 of an interim statement on the workforce strategy development, *Putting People First – Working to Make it Happen*. The report mapped the enablers from *Putting People First* and identified the key priority areas for the workforce as:

- leadership, management and commissioning skills;
- workforce development;
- recruitment, retention and career pathways;
- remodelling the workforce;
- regulation of the workforce (quality improvement); and
- integrated and joint cross-sector working.

12.64 The interim report formed the basis of a 12-week engagement exercise with a wide range of stakeholders. The feedback was comprehensive and enabled a better understanding of what stakeholders expect the strategy to address and how it should be positioned. The feedback will be used to inform the Department's adult workforce strategy.

### National Skills Academy for Social Care

12.65 In the meantime, the Department has supported social care employers to develop proposals for National Skills Academy status from the Learning and Skills Council. In particular, ministers appointed David Sherlock (Director of Beyond

Standards) to chair a steering group to oversee the development of a bid for a National Skills Academy for Social Care.

12.66 On 7 October 2008, following a competitive bidding process, John Denham, Secretary of State for Innovation, Universities and Skills, announced that "The National Skills Academy for Social Care will be the first welfare-related skills academy and will target training and development support to the 1.5 million social care workers in England. There will be a particular emphasis on small and medium-sized organisations with limited training and development budgets."

12.67 The National Skills Academy will be an independent organisation led by social care employers, and will focus on commissioning, leadership and management. It is currently developing the following programmes:

- Leadership and commissioning: extending the scope of leadership programmes from senior levels to the rest of the social care workforce.
- Accreditation and evaluation: building a model for the Academy of endorsing programmes, materials and training providers in order to support employers in making wise choices when spending their training, learning or development budgets.
- Social care training scheme: developing a scheme for trainees in social care, to appeal particularly to graduates, taking account of existing models such as those in local government, health management and the Civil Service.
- Personalisation: reaching out to micro-employers (those managing their own staff with their own budgets) and identifying with them the best ways of supporting their learning needs as employers, and those of their staff.

12.68 In addition, the National Skills Academy is developing a business plan to meet the requirements of the Learning and Skills Council, a communications strategy and a membership



scheme. It is envisaged that the Academy will be launched in autumn 2009.

### Raising the status of social care

12.69 Supporting the development of a National Skills Academy for Social Care was one part of a ministerial five-point plan to raise the status of social care, announced by ministers in April 2007. Progress is also being made on the other four priorities. In particular, the Department is working with the Social Care Institute for Excellence (SCIE) to develop:

- a good-quality professional social care journal;
- a new awards scheme, the Social Care Accolades, which is jointly sponsored with Skills for Care;
- improved e-learning capacity and capability within social care; and
- an extended programme to identify and disseminate good practice.

12.70 Taken together with the National Skills Academy, these measures should do much to raise the profile and status of social care.

### Review of delivery organisations

12.71 The Department of Health and the Department for Children, Schools and Families (DCSF) have also jointly commissioned a review of the three delivery organisations for social care workforce issues:

- the General Social Care Council (GSCC);
- SCIE; and
- Skills for Care.

12.72 These organisations are collectively responsible for managing the Department's investment of £95 million in social care workforce development. It therefore seems right to review whether or not this money is being used to best effect to deliver on the Department's overall objectives, and to ensure that the roles and remit of each organisation are fit for purpose in the new policy context of increased personalisation.

12.73 The review, which will report in spring 2009, will cover:

- the role and purpose of the three organisations;
- their statutory functions;
- their governance and funding arrangements;
- the relationships between them;
- their relationships with the Department; and
- their relationships with stakeholders.

12.74 In considering the role of the GSCC, the review will ensure continuing assurance of public protection and the read across to the health sector. In addition, the review will ensure consideration of the UK-wide system of regulation and the need to align regulation across the four countries of the UK. DCSF have also commissioned a review of the delivery partners on children's services.

## Mental health

### Access to care

12.75 Since the publication of the *National Service Framework for Mental Health*, mental health services in the community have continued to be strengthened. There are now more than 740 new specialised mental health teams in place to ensure that people with serious mental health problems get the right treatment, at the right time.

12.76 As at the end of March 2008, there were around 344 crisis resolution, 249 assertive outreach and 150 early intervention teams established in England (refer to the case study example overleaf). In the first two quarters of the financial year 2008-09, crisis resolution teams provided 58,100 home treatment episodes, and at September 2008 some 20,130 people had been seen by assertive outreach teams.



*Lifting the cloud of doom – a personal experience of early intervention.*

*All her life, Jill from Kent has lived with people with mental illness. Her father and her two brothers had schizophrenia, so when her son Ed started to hear voices and hallucinate she despaired that his life was over, in the way that she felt her brothers' lives had been cut short, and that he would never play an active role in society.*

*"After getting involved with the early intervention team, all of our lives changed for the better. A chain was broken in our family that had gone on for many years, the doom cloud was lifted and we all learned how to live again.*

*"The things that have really helped have been the whole-family support, learning how the brain and body works and how important it is to take care of it all like a well-oiled machine. We understand the need to have goals in life and to chill out and relax as well.*

*"We communicate better as a family and we're able to look out for all the early warning signs, so if Ed does slip we can nip it in the bud, talk about it and move on. Ed is a very active and motivated young man. He has passed his GCSEs, is continuing his studies and has become horticulture student of the year at college."*

## Suicide rate

12.77 The 2000 Public Service Agreement (PSA) Mortality Targets set out to reduce the mortality rate from suicide and undetermined injury by at least 20 per cent by 2010. The suicide rate for 2007, the most recent data available, is the lowest recorded level ever and among the lowest in Europe. The latest suicide monitoring data for the three-year period 2005 to 2007 shows a reduction of 13.9 per cent from the baseline to 7.9 deaths per 100,000 population. This is now part of PSA Delivery Agreement 18 (refer to annex C).

12.78 Significant progress has been made in reducing the number of suicides in our prisons,

and the Department continues to see a welcome reduction in the rate of suicide among young men.

12.79 Following publication of *Sensitive Coverage Saves Lives* (The MediaWise Trust) in June 2007, the SHiFT initiative has published a handbook and web resource entitled *What's the Story?*, designed to help journalists report mental health and suicide stories in a more responsible way.

12.80 Other key priorities in 2009 will be:

- to publish a toolkit for acute mental health in-patient staff to use in order to reduce the incidents of in-patients dying by suicide while off the ward without permission;
- to improve mental health care for older people; and
- to take forward the findings of the review, published in 2008, of suicide risk among lesbian, gay and bisexual people.

## Delivering race equality

12.81 *Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services* is a five-year plan launched by the Department in January 2005 to tackle the inequalities in access to services that people from some black and minority ethnic (BME) communities experience. Delivering race equality (DRE) is now a well-established priority for mental health services, supported by significant new resources – for example, by March 2008 over 400 community development workers (CDWs) were in place. CDWs help to build bridges between services and their local BME communities, and support those communities in helping to plan and provide mental health care.

12.82 DRE is identifying new models for commissioning and provision that better meet individual needs, engage communities and make more effective use of resources. For example, the pilot project in Newham, East London, of the programme Improving Access to Psychological Therapies (IAPT) has demonstrated that Asian



and other BME communities can have equal access to, and from, the new services. The challenge now for DRE is to transplant that sort of experience and learning from the confines of the programme into mainstream local commissioning, so that the NHS can offer equal access to a full range of effective services that are appropriate to the ethnicity or culture of service users. DRE will remain a top-tier priority until then.

### Older people

**12.83** Policy on older people's mental health (OPMH) has been consistently developing since publication of the *National Service Framework for Older People* (DH, May 2001). This framework has a strong focus on meeting the needs of older people and contains a standard on older people's mental health care and a service model for dementia. The start of a wider OPMH Programme was marked by publication of *Securing Better Mental Health for Older Adults* (DH, 2005) and *Everybody's Business*, the Department's service development guide for integrated mental health services for older adults, in 2006. This was followed by the Let's Respect campaign and toolkit.

**12.84** The Department is committed to developing policy and practice which is robustly assessed for its potential impact on older people, so that services meet everyone's needs equally well, whatever their age.

**12.85** The Department introduced a new Healthcare Commission indicator for the Commission's *Annual Health Check 2006-07*. This indicator assesses PCTs on the existence and content of the latest local assessments of older people's mental health needs. Results for 2007-08 showed that 74 per cent of PCTs achieved the criteria set against this indicator – an increase from 65 per cent in 2006-07.

**12.86** It is expected that implementation of the National Dementia Strategy will be a lever for driving further improvements. More detail on this strategy can be found in paragraph 12.181.

### Strengthening the workforce

**12.87** Since 1997, there have been significant increases in the numbers of consultant psychiatrists (64 per cent), mental health nurses (21 per cent) and clinical psychologists (71 per cent), based on whole-time equivalent numbers.

**12.88** Work is continuing to support and embed the New Ways of Working Programme across all practitioners in order to promote flexible working, based on competences and capabilities. This initiative has been carried out using best practice guidance and the creating capable teams approach that enables multi-disciplinary teams to review their function, to define the needs of service users, and carers, and to look at what skills and competences they need in order to meet those needs. This work has taken place in partnership with stakeholder professional and regulatory bodies representing psychiatrists, psychologists, nurses, social workers, pharmacists and allied health professions as well as the NHS Confederation.

**12.89** A specific programme on Medicines Management (MM) in Mental Health has been developed that covered:

- the Mental Health Spread Programme that looked at the potential for pharmacy to impact on the delivery of medicine-related services to service users of mental health by developing staff roles;
- publication of a leaflet entitled *Medicines Management: Everybody's Business – A guide for service users, carers and health and social care practitioners* (DH, 2008);
- an MM best practice Self Assessment Toolkit to help trusts to review their MM;
- an MM Leadership Collaborative Learning Set covering 16 trusts;
- guidance on mental health pharmacy service level agreements; and
- publication of a consultation document on extending the roles of pharmacy technicians.



12.90 The Mental Health Act 2007's new clinical roles offer the flexibility and opportunity for a wider range of mental health professionals to develop their careers by undertaking the roles of approved mental health professional and approved clinician.

### Reducing stigma and discrimination

12.91 The Department is working closely with Time to Change, the Big Lottery Fund and Comic Relief-funded charity sector Anti-stigma and Well-being Campaign, and is continuing to support SHiFT, which focuses on two key audiences – employers and the media.

12.92 The work in employment is aimed at improving the recruitment and retention of people with mental health problems. More than 30,000 copies of a guide for line managers on handling mental health problems in the workplace have been distributed, and a panel of experts has been set up at the Sainsbury Centre for Mental Health in order to signpost employers to other best practice guidance. Three short, humorous films about managing mental health problems at work have been made as a way of engaging employers and staff with the issue. SHiFT is also playing a central role in developing Dame Carol Black's cross-government strategy on mental health and employment.

12.93 SHiFT's other focus has been on improving media reporting, encouraging more positive representations of people with mental health problems and challenging stigmatising coverage. The SHiFT 'Speakers' Bureau' – a bank of people willing to talk about their real-life experiences of mental illness in the media – has become an essential resource for journalists and a way of ensuring that service users' voices are heard. Apart from their handbook on best practice for reporting mental health, SHiFT publishes an annual analysis of media coverage to see if it is improving.

12.94 SHiFT also conducts research to measure how effective anti-stigma work is. It conducts the annual Attitudes to Mental Illness survey, and has

commissioned annual surveys of people's experience of discrimination. This research will also be used to evaluate the overall impact of the Time to Change Programme.

### Tackling social exclusion

12.95 The discrimination that surrounds mental health can make it more difficult for people with mental health problems to get the job they want, or the education and services that they need. The Department knows that the majority of people with mental ill-health want to work, and that social inclusion is also assisted by supporting people with mental health problems to access and use mainstream community services.

12.96 PSA Delivery Agreement 16, which exists to increase the proportion of social excluded adults in settled accommodation and employment, includes those people in touch with secondary mental health services. In 2008-09, the National Social Inclusion Programme (NSIP) has worked with the Department for Work and Pensions and the Cabinet Office on delivery plans along with its associated national indicator on adults in contact with secondary mental health services in employment.

12.97 The Department is indebted to the work of the NSIP which published its fourth *Annual Review* in January 2009, highlighting its key progress. Its achievements this year include increasing the levels of support to socially excluded adults who want to learn, and the publication of *Connect and Include – An Exploratory Study of Community Development and Mental Health* in June 2008. Secretary of State for Health Alan Johnson launched the training package 'Open to All' on 16 September 2008 at the Wallace Collection. This was developed to help museums and galleries to be more inclusive for people with mental health problems through arts participation, access to galleries and museums, and employment and volunteering opportunities in the sector.



## Choice in mental health

**12.98** The Department knows that there are significant inequalities in both access to mental health services and mental health itself, and that giving mental health service users more choice and control over their treatment can benefit them more than any other group.

**12.99** The Department is committed to giving people with mental health problems choice and a more personalised service, and there is encouraging evidence that choice can work in reducing inequalities in access. For example, the IAPT pilot site in Newham, East London, found that removing the GP 'gateway' and allowing people to self-refer improved the ethnic mix of those using the service so that it more closely matched that of the local population.

**12.100** The way in which mental health services are organised, and the fact that referrals are not normally elective, means that mental health services have not been included in Free Choice policy. This exclusion extends to the legal right, from 1 April 2009, to choose the organisation that provides NHS care when referred for a first outpatient appointment.

**12.101** The focus has been on the personalisation of services. For example, mental health has been included in the pilot projects for new individual budgets for healthcare, and it may be possible to offer some service users a choice in the form of cognitive behavioural therapy they are offered.

**12.102** Choice is also important in secure settings, and the Mental Capacity Act 2005 clearly states that the least restrictive option should be employed wherever possible, giving people the maximum opportunity to make their own choices, for example about food and activities.

## Personalisation

**12.103** Personalisation means making sure that people get a service as closely tailored to their

individual needs as possible, and much of the Departments' activity on mental health will continue to be based around work on equalities, which comprises significant work streams on race, gender and age.

**12.104** A key part of the New Horizons work will entail a framework for public mental health and well-being, which recognises the important contribution that mental well-being makes to promoting physical well-being and addressing inequalities in health. Additionally, cross-government work will take place on addressing the wider determinants that affect well-being. These include addressing risk factors, for example substance misuse and violence prevention, and promoting protective factors, including improvements in parenting.

## Improving Access to Psychological Therapies

**12.105** The IAPT Programme is already contributing to better well-being around the country in the first stage of its nationwide roll-out.

**12.106** Some 35 PCTs launched IAPT services during the year, sharing £33 million of funding. More will do so over the next two years as a further £140 million is released.

**12.107** The NHS embraced the programme enthusiastically, with many PCTs choosing to add their own money to the programme funding so that their new services could develop further and faster than originally planned. Between 60 and 70 per cent of England's population is now expected to have access to local psychological therapy services by 2011, against a plan for 50 per cent.

**12.108** The first wave of new services recruited more than 800 trainees between them. Around 400 qualified therapists are supervising the trainees' work with patients.

**12.109** A key aim for the IAPT Programme is to help people get back to or stay in work if their



mental health has put their job at risk or prevented them getting one. The opportunity to have 12 job retention pilot projects, funded by the Department for Work and Pensions, in some of the IAPT areas is welcome.

**12.110** IAPT services are working hard to help local employment and health services work well together in order to meet their patients' individual needs by adding case managers to their multi-disciplinary teams in the next financial year. Top-up training will also be offered to some qualified therapists so that they are equipped to provide the required level of supervision to trainees and support the more rapid expansion of new services across the NHS.

### **Mental Health Act 2007**

**12.111** The Mental Health Act 2007 extensively revised the Mental Health Act 1983 (the 1983 Act) in order to modernise and improve the legislative framework within which compulsory measures can be taken, when necessary, to ensure that people with mental disorders receive the treatment they require. The changes include greater flexibility about the practitioners who may carry out important statutory roles under the Act, and the introduction of supervised community treatment to allow patients to be discharged from detention in hospital and continue their treatment in the community, subject to the possibility of recall to hospital if necessary.

**12.112** During 2008-09, the Department, working with the National Institute for Mental Health in England, the Ministry of Justice, the NHS, and local social services authorities, completed the preparations necessary for the implementation of the majority of the amendments to the 1983 Act from 3 November 2008. This included the publication in May 2008 of a comprehensively revised code of practice to the 1983 Act.

### *Jake's Story*

*"For the last 20 years, I have not done a job I actually enjoy – money was my only incentive. I was a husband, a doting father of two beautiful daughters, all safe in our home. Until redundancy strikes and mortgage rates over-double. Worried beyond belief, I had to sell the house. We moved in with my mother-in-law, short-term. I found a job and started to pay back debts.*

*"I started to get pains in my chest but then my world turned upside down when my granddad, who was my friend, passed away. When I went back to work, I was asked to go on shifts, to get me out of the way I think. My wife's grandpa died. A month or two later, I started having problems with my heart again.*

*"Again, I was off work and I started to get really low, fed up with life itself, I suppose. Back at work, I was given a different job – a heavy job, which I did for about a month. I went off sick again – it was just too much and I was frightened of it all happening again. Then I got made redundant.*

*"My wife eventually made an appointment for me to see the doctor. Turned out I'd got depression and was referred to an organisation called Rethink. I saw an IAPT therapy worker, who somehow got all sorts of things off my chest. Then Lynn, a support worker, whose job is to get someone with low to moderate mental health issues back to 'normal', helped us to get our own house again.*

*"I don't want to speak too soon, but things seem to be sorting out just nicely. We are closer as a family and I am doing some voluntary work."*

### **Future direction of mental health services**

**12.113** Significant gains in mainstreaming and modernising services for people with severe mental health problems have been made. Many people have been enabled to stay in their own homes while being cared for by community teams, avoiding unnecessary hospital admission and resulting in better access to care, and better outcomes for users.



The development of community services is continuing and improvements are being made in the way in which hospital and community services work together, especially for those requiring emergency support and treatment.

**12.114** Building on this work, through the New Horizons Programme, the priority of the Government is to meet the mental health needs of the community as a whole by working with stakeholders to establish a vision of how to embed new priorities and agreed principles into services; alongside a public mental health strategy which identifies root causes of poor mental health and provides cost-effective interventions to promote mental well-being.

**12.115** The Department also intends to:

- develop, in partnership with the NHS, a payment system for mental health services coupled with better monitoring of patient outcomes so that good practice is incentivised; and
- provide stronger primary care for mental health, and ensure that the principles of world class commissioning are applied to the commissioning of mental health services, making integrated health and social care commissioning the key to delivering excellent services.

## Offender health

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

### Smoking

**12.117** Following the passing of the Health Act 2006, smoke-free provisions have been introduced throughout prisons. All indoor areas are now smoke-free, with the exception of cells occupied solely by smokers aged 18 and over. The young person's prison estate is now entirely smoke-free.

## Drug misuse

**12.118** At December 2008, all of the 53 first- and second-wave Integrated Drug Treatment System (IDTS) prisons were operational, providing the key elements of clinical IDTS service. Some 29 of the 53 received additional National Offender Management Service funding for counselling, assessment, referral, advice and throughcare (CARAT) resources; the other 24 did not and were considered 'clinical only' sites. All of the 29 fully funded sites were operational.

**12.119** In 2008-09, PCTs received a third wave of funding for enhanced clinical drug treatment in a further 38 prisons. The IDTS is designed to provide:

- improved clinical management with greater use of maintenance presenting;
- intensive psychosocial support during the first 28 days of clinical management; and
- greater integration of clinical and psychosocial treatment services with renewed emphasis on throughcare.

## Blood-borne virus prevention

**12.120** Prevention work includes:

- continued distribution of disinfecting tablets throughout prisons to aid prevention and control of the transmission of blood-borne viruses such as HIV, hepatitis B and hepatitis C; and
- distribution of a DVD entitled *Hep C: inside and out*, developed for use by people in prison, providing primary prevention information on the risks of the hepatitis C virus. This DVD won a gold award at the New York International Film and Video Awards, the top accolade in the 'Society and Social Issues' category. Earlier in the year, it won a gold award from the International Visual Communications Association for the category 'Best Documentary' in 2008.



## Health trainers

**12.121** The health trainer service in offender settings is an integral part of the National Health Trainer Programme and thus aligns with the national model. Prisoners are trained to identify and support their peers with lifestyle issues, and to signpost them to available services appropriate to their needs following training to National Level 2 (Royal Society of Public Health, Health Trainer Champions).

**12.122** Those who have been trained to Level 3 (City & Guilds – Health Trainers) are able to help others with changing their patterns of behaviour. This programme has a high profile and is now producing explicit evidence, through PCT-owned data collection systems, that the outcomes are positive.

## Physical Activity and Health Referral Programme

**12.123** This programme offers prisoners physical activity/exercise on prescription for specific physical and mental health conditions and runs in partnership with Offender Health (Department of Health), Her Majesty's Prison Service Physical Education College and the University of Central Lancashire.

**12.124** Physical education officers undertake training models at University Certificate level in order to become expert practitioners in exercise referral. The qualification is assignment-based and runs alongside the mainstream exercise referral provision which was built on *Exercise Referral Systems: A National Quality Assurance Framework* (DH, April 2001).

## Walking the Way to Prison Health

**12.125** Walking the Way to Prison Health is integral to the mainstream provision of the National Walking the way to Health Initiative (WHI). Prisoners who may be at risk of ill-health as a direct result of unhealthy/sedentary lifestyles are offered the chance to join walking groups in order to

improve their levels of physical activity and therefore their health.

**12.126** Prison staff are trained to the national standard, in line with the national programme. Work is currently under way to ensure further integration with the national programme in order that existing WHI staff (usually PCT-based) can deliver training in their local prisons.

## Learning disability

**12.127** A proportion of prisoners (estimated at between 3 and 7 per cent) have a learning disability. Initiatives to improve the health and well-being of this group include:

- national one-day learning disability awareness training for prison officers on how to identify and address the challenges presented by learning-disabled offenders; and
- piloting a screening tool for use by non-clinicians to identify the probability of a learning disability in a prisoner (three pilots to commence during 2009-10).

## Older prisoners

**12.128** There is an increasing number of older prisoners in the system. They present challenges to the prison regime with regard to health and well-being. Initiatives to address this include:

- the implementation of an Older Prisoners Care Pathway based on community standards but within a prison setting;
- the development of Older Prisoner Forums in prisons with a significant number of older prisoners (more than 50 prisoners over the age of 55); and
- the establishment of a generic end-of-life policy for prisoners in partnership with the National Offender Management Service.

## Enhancing the healing environment

**12.129** The Department's Offender Health Team has worked in partnership with the King's Fund and



with teams from five London prisons on a pilot project to improve their healthcare environment. In 2009-10, the King's Fund, in partnership with Offender Health, will extend this initiative across prison and PCT partnerships to a cohort drawn from all public and private sector prisons in England. It is anticipated that a maximum of a further 20 projects will be undertaken over a period of 18 months.

### Helping to improve performance at a local level

**12.130** In 2008, Offender Health issued the first set of voluntary Prison Health Performance Indicators. These indicators were designed in close collaboration with Offender Health regional teams, SHAs, PCTs and prisons. All public sector prisons returned information, allowing for the first ever national detailed overview of prison health services to be undertaken based on NHS standards.

**12.131** While all indicators are being used annually by all SHAs and PCTs with prisons, many have extended their use and are collecting elements of the indicator set quarterly, and a number of PCTs have begun to use them as commissioning tools in tendering new, or monitoring existing, prison services.

**12.132** Building on this success, an amended set of indicators has been developed for 2009 with the ultimate intention to merge prison health performance into the main performance framework of PCTs in due course.

**12.133** These indicators, led locally by the regional offender health leads working alongside their PCT and SHA colleagues, have had a significant effect on promoting the relationship between service developers, providers and commissioners. The independent sector, which currently provides 12 per cent of prison places, is using them to monitor its service provision.

### Improving Health, Supporting Justice

**12.134** Work on developing the national strategy has continued; however, the extension to Lord Bradley's review on diversion from the criminal justice system for people with mental health and learning disabilities has meant that publication of the final strategy will not take place until the end of the first half of 2009. This extension has allowed Offender Health to ensure that regional delivery plans for 2009 are fully integrated into national and regional strategic objectives.

### Women offenders' health

**12.135** The Department is responding positively to the health recommendations contained within the Corston Report, *A Review of Women with Particular Vulnerabilities in the Criminal Justice System* (The Home Office, 2007). The Offender Health and Social Care Strategy will have a distinct pathway for women in contact with the criminal justice system, and will look at improvements in health provision throughout the process, including at arrest and in court, as well as more generally in the community. This strategy will provide the vehicle for taking forward the Department response to Baroness Corston's recommendations relating to women's healthcare.

### Escorts and bed watches

**12.136** Offender Health is leading a three-year project to transfer the commissioning responsibility for the security activity relating to escorting prisoners to NHS hospitals, for appointments or in-patient stays, from public sector prisons in England to PCTs.

**12.137** In April 2008, HM Prison Service transferred £19.96 million to the Department of Health. It was then allocated to PCTs to manage this activity via the SHA bundle.

### Children and young people

**12.138** The vision for the Children and Young People Programme Team in Offender Health is to



embed improvements to services for this very vulnerable group of children and young people into the wider children's agenda rather than into the wider offender agenda. In order to achieve change, these children must be seen as children first and offenders second, where the latter applies. With this aim in mind, the team works in partnership with the Youth Justice Board (YJB), the Ministry of Justice, the Home Office, HM Prison Service (HMPS), and colleagues in the Department of Health and the Department for Children, Schools and Families (DCSF). DCSF will be undertaking a key role in this project as the legislative lead for developments for the Children and Young People Programme, as laid out in the Children Act 2004 and Every Child Matters (2005).

12.139 The management of health and social care policy for children and young people in contact with the criminal justice system has recently been the subject of a review. This has led to the development of a senior-level programme board with membership from the YJB, HMPS, Offender Health, the Department of Health, Children, Families and Maternity Teams and, in future, DCSF. The board is focusing on the development of more formalised partnership working, and a prioritised joint programme of work with the development of an Offender Health Strategy for Children and Young People at its centre.

### Prison health IT

12.140 The Department commissioned NHS Connecting for Health to deliver the first national clinical IT system across the entire Prison Service estate. Deployment across the prison estate is planned for 2009-10.

12.141 The introduction of such a system will deliver a wide range of benefits, including:

- enabling clinicians to have 24/7 access to prisoners' medical records, so that they can make more informed decisions and deliver better quality care; and

- ensuring better continuity of care as prisoners transfer between prisons, and between prison and the community, and improving patient safety.

## New Deal for Carers

12.142 Following consultation with over 4,000 carers, the Department published the Government's Carers Strategy, *Carers at the Heart of 21st Century Families and Communities*, in June 2008. The strategy, signed by eight Secretaries of State, sets out a ten-year vision and plans for improving support for carers. It contains both short- and longer-term commitments for the Department, working in partnership with other government departments, health and social services, the third sector and carers themselves.

### Carers Strategy

12.143 The Carers Strategy makes clear that carers of all ages should not have to ignore their personal concerns and needs – whether in respect of their well-being or health – because their caring role does not allow time to address them. Services and support available to carers should be such to enable them to stay well throughout their caring role, from young carers through to older carers.

12.144 Key components of the new strategy will ensure that carers have increased choice and control, and are empowered to have a life outside caring. Key commitments include:

- providing access to information for all carers;
- training for carers;
- an additional £150 million in PCT allocations over two years from April 2009 to support breaks from caring;
- the establishment of national demonstrator sites to develop evidence of effective ways of providing health checks and breaks for carers and better support from the NHS;
- training for professionals in order to provide better support for carers; and



- supporting the third sector to develop its capacity to support carers.

### Standing Commission on Carers

12.145 The Standing Commission on Carers, announced by the Prime Minister in 2007, played a significant role in advising on the development of the strategy, particularly the strategic vision. In the initial stages of its work, the chair and members were personally invited by the Minister for Care Services to form the Commission. For the longer term, the Commission will be appointed in accordance with guidance from the Office of the Commissioner for Public Appointments. Advertisements seeking applications were placed in February 2009. The appointment exercise will be completed by summer 2009.

### Implementing the strategy

12.146 The chair and members of the Standing Commission addressed nine regional events organised by the Department in September and October 2008. In all over 1,000 delegates attended. The primary purpose of these events was to engage with those delivering services to carers. The Department wanted to hear about their experiences and how they had developed innovative approaches and good practice. A summary of key messages from the regional events is available at: [www.coievents.co.uk/carersstrategy/summary.asp](http://www.coievents.co.uk/carersstrategy/summary.asp).

12.147 In February 2009, the Department sought expressions of interest from PCTs, local authorities and the third sector to establish national demonstrator sites.

### Carers Direct

12.148 Previously known as the information service/helpline for carers, Carers Direct fulfils commitments made in *Our Health, Our Care, Our Say*.

12.149 Carers need accessible and reliable information that enables them to access services and support for themselves and the people they care

for. To date a number of local and national services have provided such support. While the value of these services cannot be overstated, they are often available for only a few hours a week, poorly resourced or limited geographically. What has been lacking is a well-funded and comprehensive nationally available information service.

12.150 Working with carers, the national carers' charities and other stakeholders, the Department has established such a service – Carers Direct. Carers Direct will provide, via a website, a single, national freephone number, e-mail and postal access to the information so needed by carers. The Department expects that carers will be provided with assistance by the service directly, or referred on to an existing service that would be more appropriate.

12.151 Carers Direct will also work with other similar services to develop the integration and, through that, the value of information services for carers generally.

12.152 The web component of the website, hosted on NHS Choices – [www.nhs.uk/carersdirect](http://www.nhs.uk/carersdirect) – went live in June 2008 in limited form. Working with national carers' charities to develop the website's content, NHS Choices completed the site in April 2009. The complementary help resource, available by phone, e-mail and post, went live in April 2009.

12.153 The Department is making up to £2.8 million a year available to support Carers Direct.

### Caring with Confidence

12.154 Previously known as the Expert Carer Programme, Caring with Confidence delivers another commitment in *Our Health, Our Care, Our Say*.

12.155 The Government acknowledges the huge contribution that carers make to society, but it is a role that is often taken on suddenly and without



preparation, leaving carers to struggle with the vital responsibilities that they have assumed. In recognition of this, the Department has established Caring with Confidence. It will provide training to carers, empowering and enabling them. It will inform them of their rights and the services available to them, and develop their advocacy skills and their ability to network with other carers in order to support their needs.

**12.156** Working with stakeholders, the Department developed a comprehensive model for the training and its delivery – which will be available face to face and on a distance-learning basis.

**12.157** In December 2007, the Department awarded a contract to a consortium comprising the Princess Royal Trust for Carers, Carers UK, Crossroads, Partners in Policymaking and the Expert Patients Programme, to lead the delivery and ongoing development. The contract commenced on 1 January 2008.

**12.158** The first face-to-face training for carers took place in August 2008, and the distance-learning version is currently being piloted. Full capacity of Caring with Confidence provision will be achieved during summer 2009.

**12.159** The delivery of Caring with Confidence will be through existing local providers of services – whether from the third or statutory sectors.

**12.160** The Department is making up to £4.6 million a year available to fund the programme.

## Valuing People Now

**12.161** *Valuing People Now: A New Three-year Strategy for People with Learning Disabilities* (DH) was launched on 19 January 2009 by Secretary of State for Health, Alan Johnson, Minister for Care Services Phil Hope, and National Director for Learning Disabilities Anne Williams.

**12.162** This cross-government strategy aims to deliver real change for all people with learning disabilities, including those with complex needs, people on the autistic spectrum, learning-disabled parents and people from minority ethnic communities, so that all people with learning disabilities are supported to live independently and as equal citizens. In particular, the strategy sets out key action at government, regional and local level to set the environment to enable change to happen, and grow capacity and capability for local delivery.

**12.163** The strategy:

- is written from a human rights perspective;
- focuses on what people have told us about the support people with learning disabilities and their families need – over 10,000 people were involved in responding to consultation on the strategy;
- sets out action across government to transform the relationship between people with learning disabilities and public services; and
- provides a further response to the Joint Committee on Human Rights report, *A Life Like Any Other?*

**12.164** The strategy also includes the Government's response to the recommendations in *Healthcare for All* (HM Government, 2008) the report of the independent inquiry into access to healthcare for people with learning disabilities, chaired by Sir Jonathan Michael. The Inquiry was set up following Mencap's report *Death by Indifference* about six people with learning disabilities who died in the care of the NHS and/or social services. The Ombudsman reported in March 2009 on the investigation of complaints made by the families of the same six people.

**12.165** The strategy is firmly rooted within the Government's personalisation agenda and links with other national strategies and initiatives, including *Aiming High for Disabled Children*, the Carers Strategy and *Putting People First*. It will support more people to commission their own services in



order to live independently and have choice about the way they live their lives, including supporting people to get jobs and a home of their own, and to have relationships and social lives.

**12.166** The delivery plan, published alongside the strategy, sets out roles and responsibilities, and action for 2009-10. Making it happen requires leadership at all levels and across all agencies, a greater focus on understanding needs locally, and developing commissioning strategies to support choice. Key deliverables in the year include:

- having an effective Learning Disability Partnership Board in every local authority area;
- publication of a cross-government employment strategy in 2009, which will help to meet the PSA Delivery Agreement 16 indicator on getting more adults with learning disabilities known to councils into employment;
- a joint programme of work between the Department of Health and the Department for Communities and Local Government, in order to increase housing options which will help to meet the PSA Delivery Agreement 16 indicator to get more people with learning disabilities known to councils into settled accommodation; and
- new guidance on commissioning services for people with learning disabilities in spring 2009.

## Autistic spectrum conditions

**12.167** The Government has announced a range of measures to help people with autistic spectrum conditions and their family carers. The Department has appointed a national advisor on autistic spectrum conditions and established an external reference group, which is chaired by the Chief Executive of the National Autistic Society. The Department is working closely with the external group to engage stakeholders in a programme of work in 2009-10 to improve public services for people with autistic spectrum conditions in order

to enable independent living and inclusion in society. Key deliverables in the year include:

- published good practice guidance on commission services for people with autistic spectrum conditions in April 2009;
- consultation on a new national strategy for autism from April 2009;
- a final strategy to be published in December 2009;
- statutory guidance, subject to consultation and assessment of benefits, to support delivery of the strategy; and
- a research study on the prevalence of autism in adults, to commence later this year.

## Older people and system reform

### Partnerships for Older People Projects

**12.168** The Partnerships for Older People Projects (POPPs) programme was launched in 2005 and the Department invested £60 million ring-fenced funding in 29 pilot projects led by councils with social services responsibilities, in partnership with PCTs and the voluntary and community sector.

**12.169** The pilots have been testing and evaluating approaches aimed at creating a sustainable shift in resources and culture away from institutional and hospital-based crisis care for older people towards targeted interventions within their own homes and communities.

**12.170** Nearly 100,000 older people in the 29 pilot sites have benefited so far from the schemes. They are helping to keep older people in their homes and out of hospital and residential care.

**12.171** The national evaluation of the programme is due to report in autumn 2009 and will contribute to the evidence base on the effectiveness of prevention and early intervention for older people, and will provide learning and best practice to support the implementation of the *Putting People First* agenda.



12.172 The wider lessons from the programme are being disseminated alongside evidence from the Link-Age Plus pilots. A comprehensive resource pack and a DVD were launched at the National Children and Adult Social Services Conference in October 2008.

12.173 The majority of interventions funded through the two-year POPPs grant indicate that they have been, or are in the process of being, sustained through mainstream commissioning processes, with, in many cases, significant investment provided by PCTs. To date only 15 (4 per cent) of the total 470 projects across the programme have indicated that they do not intend to sustain their service after the end of Department funding.

12.174 The recent interim report from the national evaluation of the POPPs programme on progress demonstrated that older people using POPPs services have found that their quality of life (mobility, washing/dressing, pain and anxiety) has improved. POPPs has strengthened and accelerated developments around joint commissioning, and contributed to a culture change with more emphasis on early intervention. In particular, the report found that:

- for every £1 spent on POPPs interventions, there is an average benefit of £1.73, made up of the £1 value of the service delivered (eg complex case management, handyperson support or re-ablement) plus an additional benefit in the form of an average 73p saving in emergency hospital bed days; and
- because POPPs services have led to fewer days in hospital, the overall cost of care has been reduced by £410 per person.

### Prevention package for older people

12.175 Since May 2008, the Department has been taking forward a package of measures to empower older people in their access and use of prevention

services that built on the *National Service Framework for Older People*. The main measures are:

- improved prevention, early intervention, health and well-being;
- reduced emergency bed days (National Indicator 134) and reduced delayed discharges (National Indicator 131); and
- reduced admissions to long-term care from acute hospitals.

12.176 There are plans to extend the scope of the initial prevention package for older people to look at improving other services as part of the cross-government Ageing Strategy.

12.177 The aim of the package is to provide a renewed focus within the NHS at local level to work in partnership with social care, local government and older people in order to provide services that promote the delivery of better outcomes for older people and greater value for money through supporting and informing service redesign.

12.178 The current phase of the prevention package is focused on bringing together existing health entitlements for older people, such as flu vaccination, cancer screening, eye checks and integrated care planning, and work to support, encourage and communicate improvements in services in 'new' areas such as foot care, falls and fractures, intermediate care, telecare and audiology. The final outputs are due to be published later in 2009.

12.179 The National Service Framework was instrumental in rooting out age discrimination in health and social care, reaffirming the principle that access to treatment and services should be based on clinical need, not age. People over the age of 65 are increasingly likely to take up opportunities for disease prevention, and the Department is already seeing increasing numbers of older people accessing



treatments and services; for example, in elective care:

- the number of knee replacements among those aged 65 and over rose from 27,242 in 2000-01 to 45,737 in 2006-07; and
- the number of cataract procedures rose from 203,240 in 2000-01 to 254,669 in 2006-07.

**12.180** The Department also worked to influence the Local Area Agreement's (LAA's) process to help ensure that indicators around the health and well-being of older people were included in the LAAs and are continuing to support delivery, particularly where performance is currently poor.

### National Dementia Strategy

**12.181** The first National Dementia Strategy (NDS) to improve dementia services, announced in 2007, was published in February 2009 (*Living well with dementia: A National Dementia Strategy*, DH, 2009). It recognises the growing impact of dementia as one of the main causes of disability later in life, ahead of some cancers, cardiovascular disease and stroke.

**12.182** There are currently 570,000 people with dementia in England, and an increasingly aged population means that numbers are set to rise to over 750,000 by 2020. Some 65 per cent of people in long-term residential care and many of the people delayed in general hospital care have dementia.

**12.183** In 2008, the Department provided £500,000 to fund the Alzheimer's Society *Worried About Your Memory?* Campaign, making available advice and information leaflets, booklets and posters to every GP practice in England. The campaign aims to prompt and help people to consider if their forgetfulness, or that of a friend or relative, is just due to poor memory or is the beginning of a medical problem, and to encourage them to seek medical advice.

**12.184** The NDS is targeted largely at commissioners and service providers.

Implementation has begun and will continue into 2009-10. Activity has already been taking place in every region and implementation sites have been set up by regionally based Department staff.

Example sites include:

- developing a dementia care pathway with local authority and PCT partners in the South East and East Midlands regions; and
- setting up a regional commissioning network in the north west to help with strategic needs assessments, identifying priorities and financial planning.

### NHS continuing healthcare

**12.185** NHS continuing healthcare is a complex and highly sensitive area, which can affect people at a very vulnerable stage of their lives. In order to make the system fairer for everyone, the Department published new national guidance in June 2007 that sets out a single, national system for determining eligibility for NHS continuing healthcare.

**12.186** The *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (DH, 2007), which was implemented from 1 October 2007, provided tools and guidance to assist the PCTs, working with local authorities, to identify individuals who have an NHS continuing healthcare need, and to assess that level of need. The intention was to promote a more consistent, fair and transparent approach to the provision of NHS continuing healthcare.

**12.187** Introduction of the framework has led to greater consistency and has increased the number of people eligible for NHS continuing healthcare (refer to **figure 12.1**). A review of the operation of the framework is under way and is due to be completed by spring 2009.



Figure 12.1: Number of people receiving NHS continuing healthcare in England, April 2007 to September 2008

Year	Quarter	Number
2007-08	1	24,952
	2	27,619
	3	29,092
	4	38,168
2008-09	1	37,920
	2	40,449
	3	43,455

Source: 2008-09 Vital Signs Monitoring Return; 2007-08 Local Delivery Plan Return Commissioner

## Dignity and safety

### Safeguarding Vulnerable Groups Act implementation

12.188 The Department has worked closely with the Home Office and the Department for Children, Schools and Families to introduce a new scheme, which requires those who work with vulnerable people to be vetted and, if necessary, barred from work that brings them into contact with vulnerable people.

12.189 To ensure the smooth transition from the current barring arrangements to the new Vetting and Barring Scheme, from 1 April 2008, the Independent Safeguarding Authority (ISA) began to give advice to the Secretary of State for Health on referrals to the Protection of Vulnerable Adults (POVA) scheme. From 20 January 2009, the ISA has made decisions on all new referrals to the POVA scheme under the provisions of the Safeguarding Vulnerable Groups Act.

### Review of No Secrets

12.190 The review of the *No Secrets* guidance was launched in order to strengthen safeguarding vulnerable adults. Working with the Home Office, the Ministry of Justice and the Attorney General's office, and many other stakeholders, a challenging consultation document was published (*Safeguarding Adults: A consultation on the Review of the 'No Secrets' Guidance*, DH, 2008).

12.191 One of the most extensive national consultations followed. Together with a document that had perhaps the largest number of questions in a consultation, the Department led the national consultation process involving participation in some 50 national events.

12.192 The consultation events began a public dialogue with stakeholders on strengthening and re-positioning safeguarding policies and practices. Participants included the Director of Public Prosecution, human rights lawyers, chief executives of PCTs and local authorities, some 800 people with mental health needs and several hundred with learning disabilities, as well as the professionals involved in safeguarding.

12.193 The Safeguarding Adults consultation asks how the Department needs to change and develop the *No Secrets* guidance – the key piece of policy guidance on safeguarding vulnerable adults – and how the Department combines keeping people safe with three sets of wider government policy goals. These are the vision of increasing:

- independence, choice and control for users of services;
- access to meaningful community empowerment and safer housing in wider society; and
- access to criminal justice for all.

12.194 The Government takes safeguarding issues very seriously. The Department leads on much of Safeguarding Adults and is committed both to strengthen safeguarding and to transform it into a much more effective, person-led process. It will work closely with a whole range of stakeholders to achieve this aim.

12.195 The Safeguarding Adults consultation has elicited a huge amount of information, from both service users and professionals, which is being considered very carefully by all four government ministers. The Department is determined to make safeguarding more effective, more preventive and



much more person centred. The Government will respond to the consultation in due course.

**12.196** The final word on safeguarding should come from one of our older citizens who told us in one of our events:

*“Forcing older people to do something against their will is abuse. Professionals should think about that when they move people out of their homes against their wishes. Some abuse is done by bad people, and some by professionals who simply think they know best.”*

### **The Mental Capacity Act – Deprivation of Liberty Safeguards (MCA DOLS) Implementation Programme**

**12.197** To ensure compliance with the European Convention on Human Rights, the Mental Health Act 2007 has introduced the Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) into the Mental Capacity Act 2005. The MCA DOLS provide a framework for the lawful deprivation of liberty of people who lack capacity to consent to arrangements made for their care or treatment (in a hospital or care home), but who need to be deprived of liberty in their own best interests. The MCA DOLS came into force on 1 April 2009.

**12.198** The new statutory framework puts in place processes to prevent unlawful deprivation of liberty occurring. These processes include a requirement for hospitals and care homes to seek authorisation from their PCT or local authority if they believe that they can only care for a person in circumstances that amount to a deprivation of liberty. The processes also include a provision for people deprived of liberty to challenge their deprivation in a court of law, as well as requiring a robust assessment process to be undertaken to determine whether or not it is appropriate to deprive a person of their liberty under a standard authorisation.

**12.199** In order to support the assessment process, the Department estimates that 2,000 best interests assessors, 4,000 mental health assessors and 500 independent mental capacity advocates may need to be trained. Discussions continue with key organisations including the NHS Confederation, the Association of Directors of Adult Social Services and the Royal College of Psychiatrists.

### **Dignity in Care Campaign**

**12.200** The Dignity in Care Campaign has created a nationwide social movement of people committed to taking action to improve dignity and respect in health and social care services. More than 5,000 people have signed up as Dignity Champions.

**12.201** Dignity and respect are now a right in the new *NHS Constitution*, will be one of the key areas of inspection and regulation for the new Care Quality Commission, and many national organisations that represent staff, care providers and the public are taking forward their own programmes of work and campaigns to help promote dignity in care.

### **Local government and regional policy**

**12.202** Local government is a key delivery partner for the Department’s health and well-being priorities, and the delivery of adult social care services in particular. Supporting local councils and their partners to work together to improve outcomes for local communities is key to the Department’s work across its strategic objectives. During 2008-09, the Department has progressed work in a number of areas in order to improve how it manages the relationship with local government.

### **Improving the Department’s regional presence**

**12.203** The Regional Presence project was established in order to improve the way in which the Department does business through local government and its partners, and to realise the benefits from increasing investment in regional



partnerships with public, private and third sector organisations. Significant progress has been made on all key objectives of the project:

- In October 2008, new Deputy Regional Directors for Social Care and Partnerships (DRDs) were appointed in each of the nine regional Government Offices. These new roles have made an immense impact on the regional landscape, providing new social care expertise in Government Offices and playing a leading role in managing the relationship between the Department and local councils.
- A new Committee for the Regions was established in September 2008 to hold the Department's regional presence to account for the delivery of the Department's strategic objectives. The Committee also provides governance for the Department's approach to working with local government and the work of the Place Forum.
- The Department continued to provide leadership to establish regional Joint Improvement Partnerships to coordinate social care improvement activity on a regional basis, and to invest resources in poorly performing councils as part of a wider coordination of Department interest in local government performance.

**12.204** The new DRDs will play a key role in implementing *Putting People First* and other national policy priorities on a local level and driving service transformation. They will also support improvement of adult social services by building local capacity and capability, in order to continue the year-on-year success seen in the Commission for Social Care Inspection Star Ratings. In 2008, there were more councils whose adult social services were rated as three and two stars, and fewer rated as one star, continuing the trend seen since the ratings were introduced in 2002. For the third year running, there were no councils zero-rated in 2008.

## Implementing the new Local Performance Framework

**12.205** The new Local Performance Framework for local authorities and their partners, signalled in the 2007 White Paper *Strong and Prosperous Communities* (The Stationery Office, 2006), came into operation for the first time in April 2008. The framework sets out a new approach to managing the performance of local councils and their partners, allowing for local decision-making and priority-setting based on the local circumstances and the Joint Strategic Needs Assessment.

**12.206** The Department has provided strong support for this process – both from central policy and implementation teams and from regional health and social care teams operating from the Government Offices – to enable local partners to develop an evidence-based approach to selecting indicators for their Local Area Agreements (LAAs).

**12.207** In June 2008, 150 LAAs setting out priorities for every locality in England were agreed for the three years from 2008 to 2011. Out of a total of 5,813 indicators chosen by localities across England, 2,750 either contribute to or are determinants of health and well-being. This equates to around 47 per cent of all indicators chosen and is a sign of the degree to which local partners wish to pursue and deliver health and social care priorities for their communities. **Figure 12.2** shows the health and well-being indicators that have been selected as either an LAA or local target in at least one-third of localities.

**12.208** Responding to the new performance framework's National Indicator Set (NIS), the Department initiated a new proactive project to consider how future iterations of the NIS may be developed in order to improve the representation of adult social care and better reflect the outcomes that matter to service users. This project is being led by the Department with the work co-produced by regional Association of Directors of Adult Social Services networks, local councils and other stakeholders.



Figure 12.2: Health and well-being indicators

NI	Vital sign	Indicator	Selected as LAA target	Selected as local target	Total
112	VSB08	Under-18 conception rate per 1,000 females aged 15-17	106	11	117
56	VSB09	Obesity among primary school age children (Year 6)	99	12	111
123	VSB05	Smoking prevalence among people aged 16 or over in routine and manual groups	89	12	101
8	N/a	Adult participation in sport and active recreation	80	16	96
130	VSC17	Proportion of service users receiving self-directed support	81	11	92
135	VSC18	Proportion of carers receiving needs assessment or review and a specific carer's service, or advice and information	80	11	91
120	VSB01	All age all cause mortality rate per 100,000 population	86	4	90
39	VSC26	Rate of hospital admissions per 100,000 for alcohol-related harm	75	11	86
40	VSB14	Number of drug users recorded as being in effective treatment	74	9	83
141	N/a	Percentage of vulnerable people achieving independent living	70	6	76
121	VSB02	Under-75 cardiovascular disease mortality rate per 100,000 population	49	7	56
136	VSC03	Proportion of adults (aged 18 and over) supported directly through social care to live independently at home	46	6	52

Source: Social Care, Local Government and Care Partnerships, DH







# V Protecting and Improving the Health of the Nation and Reducing Health Inequalities

**Chapter 13** Health Improvement and Protection

**Chapter 14** Research and Development



# 13 Health Improvement and Protection

## Role

To develop policy and lead on planning for emergency preparedness, scientific development, bioethics and sexual health, international health, protection of the population from risks of infectious diseases and environmental hazards, health and well-being, and public health delivery.

### Key achievements in 2008-09 included:

Implemented on an ongoing basis smoke-free public places and workplaces, which are expected to demonstrate their impact in due course.

Commenced implementation of *Healthy Weight, Healthy Lives* and launched Change4Life, a groundbreaking social marketing campaign to encourage parents to make healthier choices for their children.

Launched the new national Human Papillomavirus Vaccination Programme, and improved and updated public health legislation for dealing with infectious diseases and other hazards.

Doubled the size of the stockpile of antivirals for an influenza pandemic, and strengthened the NHS's ability to manage the consequences of major incidents.

Ensured record numbers of misusers entering drug treatment programmes.

The Human Fertilisation and Embryology Act 2008, keeping the UK at the forefront of developments in treatment and research.

## Summary

13.1 In this chapter you will find information on:

- Health Challenge England – Next steps for Choosing Health and Ambitions for Health;
- providing strong leadership across government at national and local levels, and joining up policy;
- focusing on key priorities for delivery;
- information for health – information for the public;
- information for health – information for service providers;
- health protection;
- global and EU developments – towards a stronger and more strategic vision; and
- scientific development and bioethics

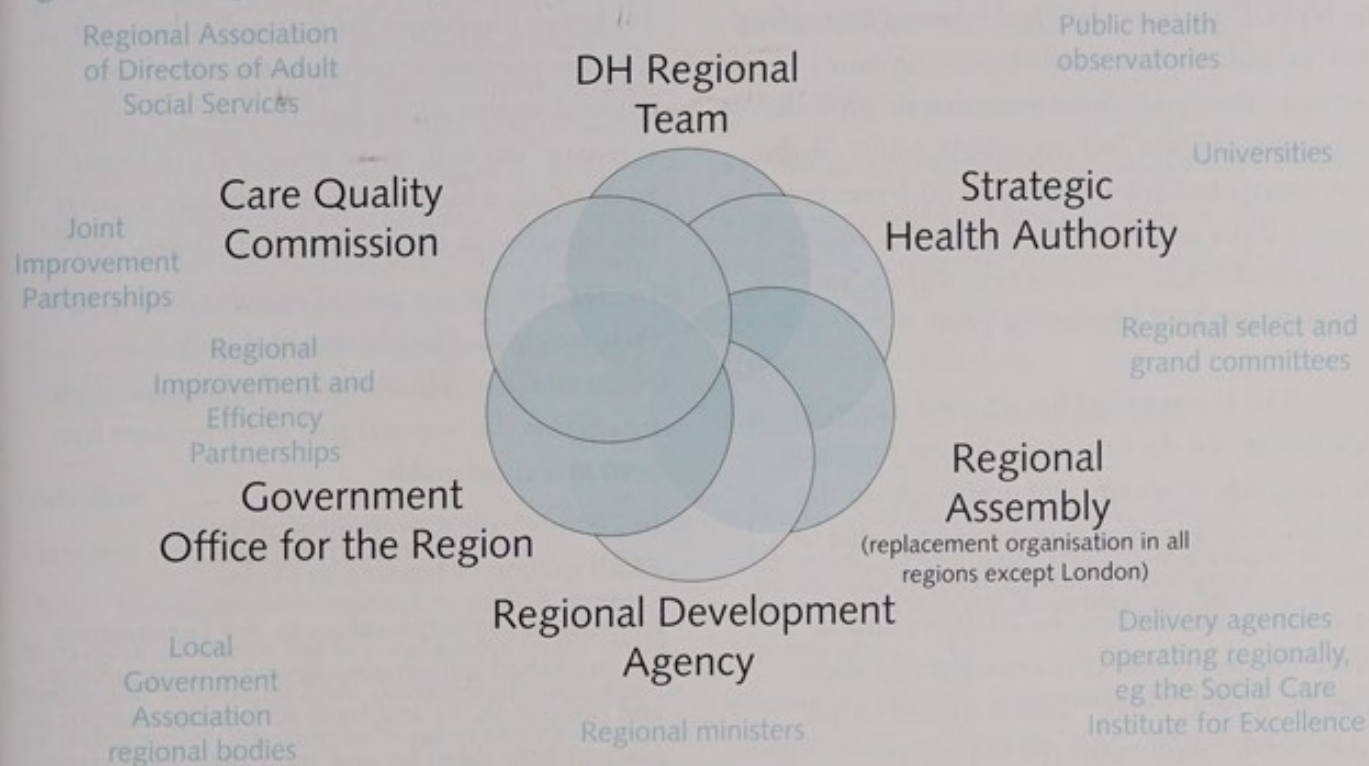
## Introduction

13.2 This chapter reports progress against health improvement and protection in England. However, where appropriate, it also covers developments further afield, including global and EU developments, as well as related topics such as emergency preparedness, scientific development and bioethics.

13.3 Although this chapter focuses on national policies and programmes, delivery of these depends crucially on actions taken at other levels, including the regional tier whose business role includes (refer to **figure 13.1**):

- strategic leadership;
- policy delivery;
- performance management and improvement;
- commissioning; and
- corporate and department of state functions.

Figure 13.1: Regional landscape



## Health Challenge England – Next steps for Choosing Health and Ambitions for Health

13.4 *Ambitions for Health – A Strategic Framework for Maximising the Potential of Social Marketing and Health-related Behaviour* was published by the Department in July 2008. This strategic framework, which complements the vision for the NHS outlined in *High Quality Care for All* (DH, July 2008), sets out:

- how the Department will embed social marketing principles and create health improvement tools in order to promote better health and support behaviour change;
- how the Department wants to work in partnership across government, industry and the voluntary sector in order to support the changes that people need to make to enjoy the best possible health; and
- how the Department plans to take action on the key learning that was gained from the Health Challenge England roadshows, and to keep the momentum going by building social marketing capacity and expertise in the public health system.

13.5 The new framework for social marketing is based on four key areas:

- Health capacity – increasing the skills and knowledge of public health professionals through a series of conferences, seminars and research materials.
- Health insight – what motivates people to change their behaviour.
- Health innovations – putting social marketing into action locally, regionally and nationally.
- Health partnerships – building the capacity of the NHS by arming it with the practical tools to work in partnership with business and voluntary organisations, in order to benefit the health and well-being of members of local communities in England.

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

### Tackling obesity

13.6 Obesity is one of the biggest health challenges that this country faces. Obese and



overweight individuals place a significant burden on the NHS. Data from the *Health Survey for England 2007* provide the latest information on how common obesity is. These show that in 2007 the proportion of obese and overweight adults (ie the 'prevalence') had fallen slightly to 60.8 per cent, from 61.6 per cent in 2006; and obesity among 2 to 10-year-olds had increased very slightly, to 15.4 per cent from 15.2 per cent in 2006.

13.7 The Government has set itself a new ambition to "be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. Our initial focus will be on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels." This is aligned to the Public Service Agreement (PSA) Delivery Agreement 12, which aims to improve the health and well-being of children and young people. The Department for Children, Schools and Families (DCSF) is responsible for delivery of this PSA, though the Department of Health is a key partner.

13.8 *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* includes a framework for action in five key areas:

- Children – healthy growth and healthy weight.
- Promoting healthier food choices.
- Building physical activity into our lives.
- Creating incentives for better health.
- Personalised advice and support.

13.9 Good progress has already been made:

- The Government is investing £30 million in 'Healthy Towns'. Local authorities were invited to become Healthy Towns to lead the way in changing their communities' built environment in order to support people to become more active and promote healthy eating. Nine Healthy Towns have been selected.

- Change4Life was launched, a £75 million social marketing campaign that is aimed at bringing together partners – from grassroots level to national supermarkets and charities – to help everyone "eat well, move more and live longer". In addition, a high-profile advertising campaign was launched at the beginning of January 2009.
- In 2007-08, 88 per cent of eligible children had their weight and height recorded under the National Child Measurement Programme. This means that the national goal of 85 per cent has been met comfortably.
- In 2008-09, the Government allocated £65.9 million of funding to PCTs.
- In order to support local areas, the Government has published information on what programmes and policies PCTs and local authorities can put in place to help them set and meet their local targets on healthy weight. A toolkit was published on 6 October 2008, and gives advice on how local health professionals can support and help people in their areas to eat more healthily and be more active.
- Obesity is now a priority for many local areas. The Local Area Agreement National Indicator Set now includes two childhood obesity measures or 'indicators'. Some 122 local areas have chosen a child obesity indicator (either at Reception or Year 6) as one of their 35 targets.
- A summit was held in October 2008 with representatives of the food and drink sector, as well as health and consumer groups, in order to discuss in more detail how to take forward the *Healthy Food Code of Good Practice* (Food Standards Agency, July 2008).

13.10 The Department published *Healthy Weight, Healthy Lives: One Year On* in April 2009. The report reviews progress on the delivery of *Healthy Weight, Healthy Lives* and sets out priorities for the future.



The Childhood Obesity National Support Team (NST), although focused on childhood obesity, also looks at the aspects of the environment that encourage obesity, and works with parents and families. Visits have been undertaken in every region but the team is now focusing on targeting the top 30 per cent of areas selected on the basis, for example, of breastfeeding, healthy schools and school meals, as well as on the prevalence of childhood obesity locally.

## Nutrition

### Maternal and child nutrition

13.11 'Prevalence of breastfeeding at 6–8 weeks from birth' is one of the key indicators in the child health and well-being PSA. Additionally, it is also an indicator for assessing local government performance and it plays a key role in reversing the rise in childhood obesity.

13.12 Though breastfeeding take-up rates have been increasing steadily over the past few years, many women give up in the early weeks. This suggests that they need to be supported in order to maintain breastfeeding. The main challenge is therefore to focus on interventions that will encourage more women to begin and continue breastfeeding for as long as they wish. The Department is supporting interventions that will contribute to the delivery of the breastfeeding indicator. These include the investment of £4 million in 2008-09 and a further £2 million in 2009-10 for PCTs to promote breastfeeding, including:

- implementing the principles of UNICEF's 'Baby Friendly' initiative in hospitals and the community;
- training of front-line staff; and
- the provision of easily accessible and timely advice to breastfeeding mothers through the national breastfeeding helpline, and the provision of practical support through a breastfeeding DVD – *From Bump to Breastfeeding* (Best Beginnings,

2008) – given to all new mothers in England by their midwives and health visitors.

13.13 Other key activities include:

- provision of commissioning guidance for PCTs;
- engagement of Children's Centres to offer accessible services to promote breastfeeding;
- establishment of a regional and local network to promote breastfeeding;
- establishment of peer support groups for breastfeeding mothers;
- provision of support materials, through Change4Life and national campaigns such as the annual National Breastfeeding Awareness Week; and
- following the introduction of new Infant Formula Regulations in 2008, an independent review is currently underway, focusing particularly on aspects of promotion and marketing of Infant and Follow-on Formula. The review is assessing whether the new measures are working as expected, and what further measures are required to ensure that breastfeeding is not undermined.

### Healthy Start

13.14 The Healthy Start scheme is managed by the Department on behalf of the four UK countries, with each contributing proportionately to the costs of delivery. Information and advice on breastfeeding and healthy eating is included in written materials and is provided by health professionals. Over time, the scheme will be increasingly used as a way to deliver key messages about other relevant public health policies and initiatives, such as 5 A Day (see paragraph 13.16) and Change4Life. Healthy Start vitamin supplements, meeting Government recommendations for women and young children are produced for the scheme and made available through NHS organisations.

13.15 The longstanding Nursery Milk Scheme pays early years and childcare providers the daily cost of one-third of a pint of milk for each child



under five years attending the setting for two hours or more. This scheme is managed on behalf of the three countries of Great Britain by the Department of Health, with each country contributing to costs.

### Fruit and vegetable consumption

13.16 Eating at least 400 grams (around five portions, 5 A Day) of fruit and vegetables every day could lead to an estimated reduction of up to 20 per cent in overall deaths from long-term illnesses such as heart disease, stroke and cancer (*The NHS Plan*, DH, July 2000).

### Physical activity

13.17 Further to the HM Treasury-led review of sport and physical activity, which took place in the spring of 2008, the Government published an action plan: *Before, During and After: Making the Most of the London 2012 Games*. This included a commitment to a cross-government target to help at least two million adults in England become more active by 2012. The Department for Culture, Media and Sport (DCMS) will lead on encouraging more people to be active through sport. Other departments, led by the Department of Health, will deliver programmes that contribute to increasing physical activity, including the following:

- Change4Life launched across England in January 2009 with an initial focus on pregnant women, parents of babies and toddlers, and parents of pre-school and primary school children. Future years will see the development of programmes aimed at young people and adults.
- The Fit for the Future Scheme, which offers 5,000 16 to 22-year-olds subsidised gym memberships linked to frequency of use, is being piloted by the Department in partnership with the Fitness Industry Association. The pilot that commenced in April 2009 will run for 12 months in targeted areas across five local authorities (Manchester, Bristol, Newcastle-upon-Tyne, Torbay and Suffolk).
- A national care pathway for physical activity – based upon the Let's Get Moving resource and the

2007-08 London pilots – that identifies those who are inactive and offers a patient-centred brief intervention to encourage sustained behaviour change.

- A £140 million investment in the Free Swimming Programme, a cross-government initiative that builds on innovation at a local level and supports local authorities existing commitment to swimming. Since 1 April 2009, almost 300 local councils have been providing swimming free of charge for people aged 60 and over – and more than 200 local councils are additionally offering free swimming to those aged 16 and under.

13.18 The Government published a new strategy for physical activity in February 2009. The physical activity, *Be Active, Be Healthy*, sets out a framework for the delivery of physical activity for adults, alongside sport and based upon local needs, with particular emphasis upon the physical activity aspect of the 2012 London Olympic and Paralympic Games. The plan includes further specific announcements on the promotion of physical activity, including the expansion of the successful Walking the Way to Health Initiative and the creation of a high-level working group for dance.

13.19 County Sports Partnerships (CSPs) have already proven their worth in coordinating local delivery and unlocking investment into physical activity. To strengthen the framework for local delivery, the Department announced new funding of £1 million for 2008-09 to help CSPs develop ongoing plans for the promotion of physical activity. *Be Active, Be Healthy* announced a further £3 million in 2009-10 to support CSPs, which will be redesignated as County Sport and Physical Activity Partnerships.

13.20 *Be Active, Be Healthy* also announced the Department's support for the creation of an alliance of organisations that share the common aim of increasing participation in physical activity. This is a significant and groundbreaking development, which brings together private and voluntary sector



organisations from across the three major areas of physical activity (indoor, outdoor and active travel) and beyond.

### Olympics and Paralympics Health Programme (OPHP) – London 2012

13.21 The Department has a significant role to play in relation to the national responsibilities for the health implications of the 2012 Olympic and Paralympic Games. August 2008 marked the start of the Olympiad and a new phase of increased focus on planning for the Olympics. A programme within the Department has been established to provide focus and coordination for the Olympics-related work across the Department and the NHS, and is expected to exist until March 2013.

13.22 The overriding objective of the programme is to ensure seamless planning and delivery related to the safe and secure provision of fit-for-purpose health services for the Games, while creating a legacy of improved health across the nation.

13.23 In order to achieve this, three work streams have been set up, each with discrete objectives:

- Health legacy – using the Games to stimulate long-term benefits for the nation's health and well-being.
- Health resilience – ensuring that the NHS is prepared to deal with any threat to the security of the Games.
- Health services – working with the NHS and London Organising Committee of the Olympic Games (LOCOG) to ensure that appropriate emergency, primary and other medical services are in place for both the Olympic family and visitors to the Games.

13.24 The work streams report to the central programme management office (PMO), which reports on progress directly to the OPHP board, chaired by Professor David Harper, Director-General of Health Improvement and Protection. The OPHP PMO coordinates the programme and

is the key point of contact for all three work streams, other government departments, LOCOG and regional, national and international stakeholders.

### Alcohol

Reducing the rate of alcohol-related hospital admissions

13.25 Annual healthcare costs related to alcohol misuse are estimated to total about £2.7 billion a year for the NHS alone. The social impacts – on individuals, the family, public services and the economy – are greater still.

13.26 New and more accurate hospital admissions statistics released in 2008 show that, in England in 2006-07, there were an estimated 799,000 hospital admissions directly related and attributable to alcohol, which accounted for 6 per cent of all NHS hospital admissions. This is an increase from 510,000 in 2002-03, and the figure is estimated to rise by around 70,000 per year.

13.27 However, real progress is being made in addressing these problems:

- A new NHS Vital Signs indicator has been developed in order to reduce the rate of alcohol-related hospital admissions from April 2008. The NHS indicator is also included in the Home Office PSA Delivery Agreement 25 (reduce the harm caused by alcohol and drugs) and in the Communities and Local Government National Indicator Set for local authorities and their partners.
- The indicator has succeeded in focusing the attention of the NHS and its local partners on alcohol. Ninety-nine PCTs and 75 Local Area Agreements (LAAs) have included this as a local priority, including 46 of the 50 areas where problems are the greatest.
- On 5 November 2008, Dawn Primarolo MP, the Minister for Public Health, announced a new Alcohol Improvement Programme. This brings together new and existing guidance, data, good



practice and training materials for PCTs and alcohol practitioners. This will include:

- the Hub of Commissioned Alcohol Projects and Policies (HubCAPP) examples of local good practice;
- North West Public Health Observatory local data profiles, to help PCTs assess needs and develop plans;
- the National Alcohol Treatment Monitoring System, which provides details on the number of patients receiving specialist alcohol treatment and waiting times; and
- the Screening and Interventions in Primary Settings (SIPS) Trailblazer Research Programme, which provides evidence and training materials on effective identification and brief advice.

The Alcohol Harm Reduction NST offers support to local partnerships in achieving the Government's key target of a minimum of a 1 per cent reduction in the rate of hospital admissions per 100,000 people for alcohol-related harm. A partnership approach at a national, regional and local level is key to the successful delivery of this target. Diagnostic visits started in September 2008. The NST focuses on adults and on areas with the highest hospital admission rates due to alcohol use.

13.28 In addition to this:

- Some 20 early implementer (EI) PCTs have been selected to 'go further a little bit faster' in implementing improvements in order to reduce alcohol-related admissions. EI PCTs will be supported by NST visits and a programme of healthcare collaboratives and learning sets. Funding of £11 million is expected to be allocated to the EI programme over three years; each PCT has received £150,000 for 2008-09. Funding for 2009-10 and 2010-11 is still to be confirmed.
- The NST visited 10 PCTs in 2008-09 and will visit 18 PCTs in 2009-10 to assist them in

making improvements. All of the PCTs have a high level of alcohol-related hospital admissions.

- Regional alcohol managers are being established in the Regional Public Health Directorates in order to strengthen the Department's regional presence. They will: provide linkage between strategic health authorities (SHAs), Government Offices of the Regions (GOs), regional directors of public health and the central Department; assure local delivery and performance monitoring; and provide regional and local advocacy/championing.

13.29 This action is increasingly making a difference 'on the ground'. An article in *Nursing Times* in November 2008 included interviews with nurses who are now – in response to the Department's initiative – using the screening tools to warn people who are at risk, but who would previously have gone undetected, to help them change their behaviour.

13.30 On 3 December 2008, Alan Johnson MP, the Secretary of State for Health, jointly announced with Jacqui Smith MP, the Home Secretary, a package of measures to tackle excessive drinking and reduce alcohol-related harm:

- New legislation that will give the Government a new 'enabling power' to enforce a compulsory code of conduct on the drinks industry. The Government will consult on a range of retailing conditions in 2009.
- £4.5 million of investment in an enforcement campaign to tackle alcohol-related crime and anti-social behaviour.

13.31 On 2 June 2008, DCSF, the Department of Health and the Home Office launched the Youth Action Plan, which sets out how the Government will address the issues surrounding young people's alcohol consumption.

13.32 Sir Liam Donaldson, the Chief Medical Officer (CMO), has developed draft guidance for children, young people and their parents to help



them become aware of the risks of drinking alcohol – particularly at a young age (ie those under 18 years). The guidance is based on the latest research available on the effect of alcohol on young people's intellectual development and health; a consultation was jointly launched on 29 January 2009 by the Secretary of State for Health and the Secretary of State for Children, Schools and Families.

## Pharmacy and public health

**13.33** The White Paper *Pharmacy in England: Building on Strengths – Delivering the Future*, published in April 2008, set out the Government's plans to accelerate and enhance pharmacy's ongoing contribution to improving the health of the population and to helping reduce health inequalities, focusing particularly on developing its community leadership role and contributing to the sustainable development agenda.

**13.34** It sets out a vision for service development with pharmacies being repositioned, recognised and valued by all as healthy living and health promoting pharmacies, offering healthy lifestyle advice and support on self-care, and engaging in a range of public health initiatives. Plans are being developed to make this a reality.

**13.35** In addition, pharmacy is already contributing to improving wider public health with more pharmacies providing, for example, stopping smoking, sexual health and weight management services. The intention is to build on this so that pharmacies are routinely providing such services across the country, not just in some pharmacies in some parts of the country.

## Children and young people

### Healthy Schools Programme and further education

**13.36** Universal health improvement for school-aged pupils is being promoted through the joint Department of Health and DCSF Healthy Schools Programme. An enhanced programme will be rolled

out from September 2009 in order to build on the well-being element of a 21st-century school. An enhanced programme will be rolled out from September 2009 to build on the well-being element of a 21st Century school as outlined in: *21st Century Schools: A World-Class Education for Every Child* (December 2008, DCSF).

### Young people friendly services

**13.37** The Department has taken a number of steps to transform services so that they are young-people friendly:

- The Department has supported the Royal Colleges' development of an adolescent health e-learning programme for doctors and nurses in order to ensure that they have the skills and knowledge to meet the needs of adolescents. This is the first time that the Royal College of Paediatrics and Child Health and the Royal College of General Practitioners have had such a holistic adolescent health programme within their core curriculum.
- The Teenage Health Demonstration Site Programme has shown how health services can be improved to better meet young people's needs and support positive behaviour change. Learning from the programme will be disseminated widely.
- National roll-out of the *You're Welcome* quality criteria, providing a framework for service providers and commissioners to work towards all health services being young-people friendly, began in early 2009. Under the *NHS Operating Framework for 2009-10*, local areas are encouraged to implement *You're Welcome*.

### Healthy Child Programme

**13.38** Building on the updated Healthy Child Programme for early years (formerly known as the Child Health Promotion Programme), the guidance is now being extended to focus on 5 to 19-year-olds. The Department has committed to publishing the guidance by the end of 2009. This will set out the good practice framework for the full range of services so that a universal preventive service



promoting health and well-being is available to all, with the delivery of progressive services for those with additional needs and risks.

### Local Area Agreements

13.39 New Local Area Agreements covering every area in England were published in June 2008. These set out priorities and targets chosen by local areas to achieve improvements on key issues from 2008 to 2011. Out of 5,813 indicators chosen by localities, 2,684 contribute to, or are determinants of, health and well-being. This represents around 47 per cent of overall priorities and shows the willingness of localities to tackle their communities' health and well-being problems.

### Public health leadership and workforce

13.40 The programme on Public Health Leadership and Workforce is currently under review in order to ensure full integration with the NHS Next Stage Review and additions and priorities requested by the CMO, for capacity building for public health and dual accreditation.

13.41 In 2008-09 the key successes were as follows:

- A successful national launch of Climate Connection was managed with wide engagement from public health partners and stakeholders. This was supported and led by the Director-general for Health Improvement and Protection, with a key contribution from the CMO.
- Commissioning education programmes, training and professional development for the workforce and increasing the skills and knowledge of the expert workforces at practitioner and specialist levels.
- An increasing emphasis upon not just the NHS but also upon local government and the third sector.

13.42 Renamed as Public Health Leadership and Workforce, a new team has been established to scrutinise every area, working with key stakeholders to ensure that the policy context, purpose and

strategic direction of the programme fit with the above requirements and within the new structures. This will ensure a renewed focus upon delivery of projects and activities that spread public health leadership and workforce development, in order to enable better services for patients and the public.

13.43 Key projects for the coming year will include:

- a complete review of processes, priorities and targeting of funds in order to deliver CMO and NHS Next Stage Review priorities;
- a review of regulatory issues affecting the public health workforce, ensuring that the focus on patient safety and protection of the public is maintained;
- the provision of strategic coordination and expert advice on approaches to leadership and workforce development, in order to increase public health capacity and capabilities in key workforces; and
- ensuring an integrated and cohesive approach across key departmental policy areas.

### Guidance on health and strategic environmental assessment

Health impact assessment across government

13.44 Health impact assessment (HIA) is now one of the specific impact tests in the revised Government Impact Assessment process, which means it is more visible. Research on how it is being implemented is being commissioned.

13.45 The Department is planning a series of measures to support the delivery of HIA, both internally and in other government departments. The HIA gateway has been transferred to West Midlands Public Health Observatory and is operational and developing HIA resource materials. The Department is revising the HIA policy guidance, particularly to strengthen consideration of health inequalities, to develop public health training for civil servants and to scope the type of tools and resources needed for carrying out HIA across government.



## Strategic environmental assessment

13.46 Following consultation on the draft guidance on health in the strategic environmental assessment (SEA), Communities and Local Government has agreed, in principle, to make one health organisation into a consultation body. It is proposed that the Department operates a gateway function to ensure national, regional and local SEAs consider human health impacts. This is a major opportunity for health to influence plans and programmes that shape the wider determinants of health.

## National Institute for Health and Clinical Excellence public health guidance

13.47 The value of putting evidence about 'what works' into practice in making more consistent progress in public health was highlighted by the Healthcare Commission in its *State of Healthcare 2008* report, published in December 2008. During 2008-09, the National Institute for Health and Clinical Excellence (NICE) issued new public health guidance on a wide range of topics, including:

- workplace physical activity promotion;
- prevention of smoking by children and young people;
- identifying and supporting people most at risk of dying prematurely;
- mental well-being and older people;
- promotion of physical activity in children;
- needle exchange schemes for injecting drug users; and
- management of long-term sickness and incapacity.

13.48 As part of the new topic selection process for NICE guidance, the Department also asked NICE to develop new guidance that is concerned with the prevention of:

- obesity;
- unintentional injury;
- skin cancer;
- HIV transmission;

- domestic violence; and
- type 2 diabetes mellitus.

13.49 In addition, it asked NICE to develop guidance on:

- promotion of physical activity for children;
- promotion of well-being among children;
- reducing infant mortality;
- weight management following childbirth;
- spatial planning; and
- contraceptive services for socially disadvantaged young people.

13.50 New public health guidance on these topics is expected to be issued by NICE from 2010. During 2009-10, the Department will continue working with other government departments in order to facilitate government support for the implementation of NICE public health guidance across sectors, and to promote effective engagement with NICE's topic selection and consultation processes. The Department will also work in partnership with NICE, the new Care Quality Commission, regional partners and others, to consider how NICE's public health guidance can best be incorporated into the new quality standards and the NHS evidence service as part of implementation of *High Quality Care for All*.

## Accident and injury prevention

13.51 Throughout 2008-09, the Department has continued to work with other government departments and other organisations in developing policy and taking forward initiatives for injury prevention and safety promotion. This includes support for the DCSF-led cross-government PSA Delivery Agreement 13, to improve children and young people's safety, and the agenda outlined in *Staying Safe: Action Plan*, which covers reducing child death and hospital admissions due to accidental injury.



13.52 The Department has also contributed funding and support to a Royal Society for the Prevention of Accidents research project, in partnership with the Electrical Safety Council and Intertek, to look at injury data collection.

13.53 The Department announced, in May 2008, a prevention package for older people. The package will provide more and better preventative care for older people, involving health and social care providers working together to ensure that all older people have access to the treatment they need to maintain independence and well-being. This will build on existing work and develop a commissioning framework for falls, fractures and osteoporosis. NICE also published, in October 2008, clinical guidance on preventing fractures due to osteoporosis.

## Focusing on key priorities for delivery

### Reducing the number of people who smoke

13.54 The Department is on target to reach the PSA 18: Promote better health and well-being for all national target of reducing overall adult smoking rates to 21 per cent or less by 2010. Latest data on smoking from the *General Household Survey 2007* (Office for National Statistics, 2009) show that the rate for all adults is now at 21 per cent, a drop of 1 percentage point on the previous year. Progress has also been made towards meeting the second part of the national target: to reduce smoking prevalence among routine and manual groups to 26 per cent or less by 2010. Encouragingly, in the last year there was a larger drop among the routine and manual group than had previously been the case. Smoking rates with the routine and manual group dropped by 3 percentage points, from 29 per cent to 26 per cent.

13.55 The Department has continued to deliver an ambitious programme of tobacco control, with achievements this year including:

- introducing hard-hitting picture warnings on all tobacco products from 1 October 2008;

- introducing smoke-free requirements for residential mental health units in England;
- conducting an extensive consultation on the future of tobacco control, which prompted almost 100,000 responses from stakeholders and members of the public;
- committing to developing the evidence base on plain packaging of cigarettes;
- mainstreaming the pioneering joint Department of Health/Ministry of Defence pilot project to provide stop smoking services to the Armed Forces, which won a Military and Civilian Health Partnership Award; and
- implementing a new marketing communications strategy, which won the Communication Award at the 2008 Civil Service Awards, and which has already generated hundreds of thousands of responses from smokers seeking support to go smoke-free.

13.56 Ten years after the publication of the *Smoking Kills* White Paper in 1998, the UK has developed a reputation as a leader in Europe and across the world in effective tobacco control. During 2009, the Department will be taking forward legislative proposals on tobacco displays and cigarette vending machines and will work closely with key stakeholders to develop regulations in these areas. It will also publish a new tobacco control strategy in order to reduce the impact of smoking on our communities. Through the NHS, it will continue to support smokers who want to quit through quality, evidence-based services.

The Tobacco Control NST provides effective local tobacco control action (including, but not limited to, stop smoking interventions), targeted at areas with the highest adult smoking rates and/or the greatest challenges in tackling health inequalities caused by smoking. The NST uses a holistic model of tobacco control (based upon the Department's 'six strands' approach) to evaluate local strategy at population, community and individual levels.



### Department of Health North West delivery

Smoking remains the single biggest contributor to poor health, reduced life expectancy and health inequalities in the North West (NW). In addition to the Department-funded core tobacco control work, PCTs have invested £1.8 million in a collaborative region-wide programme, in recognition of the scale of the challenge in the NW for 2008-09. Leaders from across the region have pledged their support to the Make Smoking History for Children and Young People campaign because every child in the NW is entitled to a tobacco-free future.

Smoke free Northwest's focus is to work towards a healthier, tobacco-free future for the North West's children and young people and to help break the inter-generation cycle of smoking-related health inequalities.

### Sexual health

13.57 In July 2008, the Independent Advisory Group on Sexual Health and HIV published its review of the Sexual Health Strategy, *Progress and Priorities – Working Together for High Quality Sexual Health*. The document contained a thorough and detailed analysis of progress in implementing the 2001 strategy and highlighted successes and challenges. It contained a number of recommendations at national, regional and local level. The Department is finalising its response.

### Genito-urinary medicine

13.58 Improving access to genito-urinary medicine (GUM) clinics was a priority for the NHS between 2005-06 and 2007-08. The focus is now shifting to sustaining and maintaining delivery. Data for February 2009 showed that 99.7 per cent of first attendees were offered an appointment within 48 hours and 87.2 per cent of people were seen within 48 hours. This compared with 92.7 per cent offered an appointment within two working days and 80.6 per cent of people seen within 48 hours in November 2007.

### Chlamydia

13.59 The *NHS Operating Framework for 2009-10*, which sets out the priorities for the NHS next year, renews the commitment in *High Quality Care for All*: to improve commissioning for sexual health in order to improve health and well-being (as one of six key goals for the NHS).

13.60 There are two sexual health indicators included in the national planning guidance. These are reducing chlamydia prevalence (currently measured through screening volumes) and reducing under-18 conceptions, which are both 'tier two' indicators for 2008-09 to 2010-11 (action on reducing teenage conceptions is highlighted in paragraph 13.69).

13.61 On chlamydia, PCTs have been asked to plan to screen at least 17 per cent of their population aged 15 to 24 in 2008-09. Rapid progress needs to be made to increase screening volumes in most areas in order to enable these plans to be delivered. The Health Protection Agency (HPA) National Chlamydia Screening Programme Team and regional facilitators are working closely with programme areas to develop and support progress in delivering the target.

### HIV

13.62 During 2008-09, the Department reviewed its national HIV health promotion programmes for men who have sex with men and African communities – the groups most at risk of HIV in the UK. Following the review, new contracts have been awarded to the Terrence Higgins Trust and the African HIV Policy Network. Additionally, the Department is funding eight pilot projects aimed at increasing the uptake of HIV testing in a range of healthcare and community settings.



## Contraception

**13.63** A number of actions are underway to improve access to contraception and reduce the number of teenage pregnancies and abortions. To help accelerate delivery on reducing rates of teenage pregnancy, in February 2008 it was announced that there would be £26.8 million of new investment for 2008-09 to improve women's knowledge of, and access to, contraception. The funding is concurrent for 2009-10 and 2010-11. It is being used to look at innovative ways of delivering services that meet the needs of those at highest risk, and also to train more health professionals to provide all methods of contraception, particularly the more effective long-acting methods. Good practice guidance for the commissioning of contraception and abortion services is currently being finalised for publication. This will help commissioners to use the additional funding effectively in order to redevelop their contraception and abortion services.

**13.64** The *NHS Standard Contracts for 2009-10* were published in December 2008, alongside the *Operating Framework*. The contract includes a new clause to ensure that abortion providers improve access to contraception. It also specifies that providers must draw up plans to improve access for women to the full range of contraception advice and treatment during attendance for medical or surgical abortion, including follow-up arrangements for women who do not receive contraceptive advice or treatment at the time of abortion.

**13.65** In addition, in October 2008 it was announced that the agreement between the General Practitioners Committee and NHS Employers for a package of changes to the Quality and Outcomes Framework for 2009-10 includes a reallocation of ten points to sexual health – specifically advice on contraception (particularly long-acting methods). This adds considerable strength to the Department's current effort on improving access to the full range of contraceptive methods in order to reduce

unintended pregnancies, particularly teenage pregnancy and abortions.

**13.66** Improving the quality of data and information is crucial in order to improve commissioning of contraceptive services and to examine the quality of service provision. Six sites have been piloting a revised data collection scheme for community contraception services. Analysis of the data is nearly complete and a submission to the Information Standards Board for approval will follow.

**13.67** In addition, the Department has provided £1 million of funding (£100,000 to a community service in each region) in order to develop systems that can collect the new data and drive forward appropriate use of IT in community services.

**13.68** The Department has also commissioned the South West Public Health Observatory to develop an electronic balanced scorecard for sexual health. This scorecard will aid the development and performance management of sexual health and will act as a source of information for public health, sexual health commissioning and performance management at a local, regional and national level. This will use the indicators developed through the review of the sexual health strategy and some additional indicators related to monitoring the impact of the new contraception funding. The first phase of the scorecard will be available in 2009-10.

The Sexual Health NST provides a whole-systems approach, focusing specifically on:

- supporting PCTs to achieve and maintain 100 per cent 48-hour patient access to GUM services;
- supporting the HPA's National Chlamydia Screening Programme to improve chlamydia screening rates; and
- helping PCTs to improve access to contraceptive services, focusing on the provision of long-acting reversible contraception.



The Sexual Violence NST developed pilots to focus on ensuring that all areas across England and Wales have access to appropriate sexual assault referral centres. These are 'one stop' locations where victims of sexual assault can receive medical care and counselling while at the same time having the opportunity to assist the police investigation into alleged offences, including the facilities for a high standard of forensic examination. The NST first piloted in November 2008 and is due to be rolled out in June 2009.

## Teenage pregnancy

13.69 There has been steady progress on reducing the under-18 conception rate. Within this decline, there has been a steeper reduction of 232 per cent in conceptions leading to births. However, the rate of progress is still below that needed to achieve the challenging target in this area, and the most recent quarterly data from 2007 indicates a worrying reversal of this downward trend. This is entirely accounted for by a rise in conceptions leading to abortion. Urgent action is needed in order to strengthen delivery of the key factors of effective strategies, which have been set out in guidance to PCTs and local authorities. 106 areas chose this indicator as one of their LAA indicators, which signals the very high priority being attached to this issue at local level.

13.70 A number of further actions are being taken at national level to support local delivery: firstly, new funding to improve access to contraception as highlighted above, which includes funding to expand on-site contraception and sexual health services in further education colleges; and secondly, a new media campaign to raise awareness of the full range of effective contraceptive methods, including long-acting reversible contraception. The importance of promoting choice from all the available contraceptive methods in order to reduce teenage pregnancy was highlighted in the *NHS Operating Framework for 2009-10*.

13.71 In addition, the Government's intention to make both personal, social and health education and sex and relationships education (SRE) statutory (announced in October 2008 in response to a national review of SRE) will raise the profile of contraception in schools and will ensure that all young people receive more consistent advice and support.

13.72 There is also a range of support available to PCTs and local authorities from GOs and SHAs in order to help strengthen local delivery. For areas facing the greatest challenge in meeting their targets, this includes support from the Teenage Pregnancy NST.

The Teenage Pregnancy NST aims to facilitate a conception rate reduction in line with planned trajectory – to achieve a 50 per cent reduction by 2010, with visits targeted initially at the 22 areas with the highest or fastest-increasing rates (as reported in 2004-05 using Office for National Statistics (ONS) data). The NST works closely with the National Teenage Pregnancy Unit in DCSF, and consultancy and support for performance improvements continues to be offered to local areas using a range of approaches. Support is also now being offered and developed at regional and national levels.



## Drug treatment

### Overview

13.73 Tackling drug misuse is a major priority for the Government. The expansion of the availability of effective drug treatment has been acknowledged as being key to this. The Department has increased the numbers of people entering drug treatment, as well as the proportion of those whose treatment is assessed as having a long-term, positive impact in tackling their addiction.

13.74 An estimated £604 million is being spent in 2008-09. Drug treatment offers extremely good value for money, with independent research estimating that every £1 spent on drug treatment saves the rest of society £9.50.

### Key statistics

13.75 The number of drug misusers receiving treatment expanded from 85,000 in 1998 to 203,000 in 2007-08. These figures mean that there were 138 per cent more people in treatment than in 1998, considerably in excess of our previous PSA target (refer to annex C, DSO 1 indicator 1.15) to double the numbers in drug treatment by 2008.

13.76 In addition, 83 per cent of those in drug treatment in 2007-08 were recorded as having an effective treatment episode, which meant that the Department also met the effectiveness element of its drugs PSA target.

13.77 Drug-related deaths have fallen by 2 per cent between 2000 and 2007, which represents substantial progress given that they doubled in the 1990s. In addition, data published by the ONS have shown a reduction of over 20 per cent in drug-related crime since 2003.

### Drug strategy

13.78 The Government published *Drugs: Protecting Families and Communities* in February 2008. It sets out a ten-year vision and a raft of new measures to enforce, educate and intervene on drugs, and to

support those who need treatment, which is a key plank of government policy. It sets out the following priorities for the next three years:

- Greater emphasis on treatment outcomes, completion and planned exit.
- More individually tailored care packages, rather than a one-size-fits-all approach.
- Reducing the negative impact of parental drug use on families.
- More user-friendly treatment for parents and other groups who are under-represented in treatment.
- The need for drug misusers to contribute to society through work, helped by better support to enable them to access training and employment.

### Progress on health inequalities

13.79 Health inequalities has been retained as a key priority for the NHS, as set out in the *NHS Operating Framework for 2009-10*. All-age all-cause mortality, a proxy for life expectancy, is an indicator in both the *NHS Operating Framework's Vital Signs* and in *The New Performance Framework for Local Authorities and Local Authority Partnership: Single Set of National Indicators*.

13.80 The most recent data (2005-07) for infant mortality and life expectancy show that while some progress has been made, more needs to be done in order to achieve the challenging national target on inequalities in life expectancy and infant mortality.

13.81 Infant mortality rates are falling in all socio-economic groups. The 2005-07 data show a further slight narrowing in the gap between the 'routine and manual' group (the target group) and the population as a whole, for the third successive year, although it remains wider than at the baseline. This means that if the gap continues to narrow at the rate observed since 2002-04, the infant mortality element of the target will be met.

13.82 Life expectancy in England is the highest it has ever been, including in the spearhead group of



areas – the 70 local authority areas with the worst health and deprivation indicators, and the 62 PCTs mapping to them. The spearhead areas are a focus for the life expectancy element of the target. However, because the increase in spearhead areas is not as great as in non-spearheads, the gap has not narrowed. The latest 2005-07 data show no change in the gap in female life expectancy, and a widening gap in male life expectancy, compared to 2004-06.

13.83 Some spearhead areas are making good progress – 47 per cent are on track to narrow their own life expectancy gap with the rest of England by 10 per cent by 2010, compared to the 1995-97 baseline for males, females or both. There is also encouraging news on the absolute gaps in under-75 cancer and cardiovascular disease (CVD) death rates between spearheads and the rest of England. There has been a 36 per cent reduction in the CVD absolute inequality gap since the 1995-97 baseline. For cancer, the corresponding reduction is 13 per cent from the same baseline.

13.84 *Systematically Addressing Health Inequalities* (June 2008), published by the Health Inequalities NST, draws on the learning from visits to spearhead areas. *Health Inequalities: Progress and Next Steps* (DH, June 2008) identifies how efforts will be increased to meet the 2010 target.

13.85 The Department's focus is to provide tailored, intensive support to spearhead areas and areas with high infant mortality rates. For example, *Progress and Next Steps* announced £34 million in additional spending for inequalities programmes in 2008-09. The Department is investing more in the NST, and it is also enhancing the Tobacco Control NST and has established new NSTs for alcohol and infant mortality – all with an inequalities focus.

Health Inequalities National Support Team (NST) – focused on reaching all spearhead areas by summer 2009, supporting local partners to undertake local analysis and assessment to assist disadvantaged communities. The approach systematically identifies and addresses the local factors that will lead to improving effective health outcomes, following a tailored diagnosis of the leading contributors of the local health inequalities gap. It includes the use of workbooks and workshops with key local partners in the NHS and beyond. More on the approach and methods of the NST can be found at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086570](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086570).

Infant Mortality National Support Team (NST) – building on the review of the infant mortality aspect of the 2010 national health inequalities target, and the *Implementation Plan for Reducing Health Inequalities in Infant Mortality*, the NST aims to reduce inequalities in outcomes for families, mothers and children. The review identified 43 local areas with relatively high numbers of infant deaths in the routine and manual (target) group and the NST will help deliver the infant mortality target by working in partnership with local authorities and local health organisations and promoting good practice. This will include working with non-spearhead areas as well as spearhead areas, and other disadvantaged groups such as single mothers, teenage mothers, the unemployed and homeless and women in black and minority ethnic groups. The first NST pilot was in December 2008 and the full programme of visits across the 43 areas started in January 2009. A national conference to launch the NST and the implementation plan was held in April 2009.



**13.86** An enhanced version of the Health Inequalities Intervention Tool was launched in June 2008, and builds on the previous tool (which provided information for spearhead areas only). It now includes all local authorities, and allows them to focus on within-area health inequalities. Jointly developed by the Department and the Association of Public Health Observatories, both tools support PCTs and local authorities in local priority setting, planning and commissioning of services.

**13.87** The Healthy Communities Programme was delivered by the Improvement and Development Agency for local government in order to support and develop the capacity of local authorities to work alongside PCTs, and to lead local action on tackling health inequalities. The Department has commissioned the programme for a further three years. In addition, the Improvement Foundation's Programme to improve early detection of cancer and CVD in poorly performing spearhead areas has been extended.

### Communities for health

**13.88** Across 83 local authorities, the programme is encouraging and supporting people in the most disadvantaged communities to adopt healthier lifestyles and therefore reduce health inequalities. It is promoting action across local organisations and encouraging partnership-working across sectors and with communities themselves. Many communities, including those often considered hard to reach, have benefited from collaborative approaches, with over 300 local activities. A second report will be published later in 2009.

### Looking ahead

**13.89** *Progress and Next Steps* set out the direction of travel for tackling health inequalities. This includes:

- making action on health inequalities relevant to the whole population, while maintaining a focus on disadvantaged groups and areas;

- reflecting quality of life as well as length of life; and
- addressing changes across the whole of the social gradient of health.

**13.90** In November 2008, the Government announced a post-2010 strategic review of health inequalities to be chaired by Professor Sir Michael Marmot, Chair of the World Health Organization (WHO) Commission on Social Determinants of Health. The review, taking place during 2009, is:

- looking at how the recommendations from the Commission's report can be adapted to the English context;
- identifying new evidence that is most relevant to future policy and action for reducing health inequalities in England; and
- making recommendations to the Government.

### Health and work

Government response to *Working for a healthier tomorrow*, a review of the health of the working age population

**13.91** In November 2008, the Government published its response, *Improving Health and Work: Changing Lives*. The response has three key areas of focus: creating new perspectives; improving work and workplaces; and supporting people to work. A wide range of initiatives will be delivered in 2009 and beyond, including:

- a new Fit for Work Service;
- further development of the Business HealthCheck tool; and
- development of an electronic 'fit note' and a national education programme for GPs.

**13.92** The Secretary of State for Health also announced, in January 2009, a joint Department of Health and NHS review of the health and well-being of the NHS workforce, in partnership with both employers and staff.



## Investors in People (IiP): The health and well-being at work project

13.93 In 2008-09, pending the outcome of a review of IiP by the Department for Innovation, Universities and Skills (DIUS), the Department of Health funded the project to incorporate health and well-being into the IiP standard for a further year (for minor development, gathering good practice and continued piloting). IiP piloted with a further 90 organisations across the public, private and voluntary sectors. Reflecting a new and more flexible way of working with IiP, pilots were tailored around client needs that resulted in many organisations developing health and well-being issues. IiP also built on existing health and well-being good practice, expanding its portfolio of case studies, revising a free database of health initiatives and continued work with the Health and Safety Executive, and the Chartered Institute of Personnel and Development on a proactive response to stress management. IiP has also commenced work on a good practice award for health and well-being that will be available both as a stand-alone assessment or alongside another IiP assessment, thereby reaching a wider group of UK employers. The award, which will be supported by a new publication guide and online resource, is scheduled for launch in September 2009.

## Healthier Food Mark

13.94 *Food Matters: Towards a Strategy for the 21st Century* was published by the Prime Ministers Strategy Unit in July 2008. The Department and the Food Standards Agency are now leading on developing a new benchmark for the standard of catering and nutrition in the public sector. The vision is to establish a voluntary 'healthier food mark' in the public sector to ensure that its food is of a universally high standard and makes a positive contribution to a nutritionally balanced diet. All public bodies in England will be encouraged to sign up. The mark will be pitched at a level that is challenging but achievable and, at the same time, is 'fit for purpose'. Guidance will be issued to assist

participating caterers in the application of the standards. Following agreement on the criteria for the mark, piloting will begin late in 2009.

## NHS Plus Programme

13.95 The NHS Plus Programme has made significant advances over the last year. This includes the following:

- The launch of the Durham Business School NHS Occupational Health Business Development Programme in May 2008.
- The launch of a national marketing strategy for smaller businesses in September 2008.
- The investment of £21million in the development of 11 nationwide innovation sites. The first opened in York in January 2009 and all but one of the remaining centres will open during 2009.
- The development of a national model of service delivery to multi-site organisations using a 'hub and spoke' approach and successful tendering by NHS Plus Network, and the launch of contracts from the Environment Agency and NHS Direct during 2008.
- The launch of the South West Occupational Health social enterprise pilot.

13.96 In 2009, NHS Plus will work with others to further develop clinical and occupational standards, and to further test and promote innovative ways of offering NHS Plus occupational health services cost-effectively to small and medium-sized enterprises.

## Pathways to Work (Department for Work and Pensions (DWP) Green Paper, 2003) and Department of Health Condition Management Programmes

13.97 The Department continues to work in partnership with DWP, Jobcentre Plus, the NHS and the private and voluntary sector to deliver the successful Condition Management Programmes (CMPs), one of the voluntary choices offered as part of the DWP *Pathways to Work* Green Paper. A CMP, developed and led by the Department, is:



- a cognitive educational intervention aimed at helping individuals to understand and manage their health condition in order to move towards a return to work; and
- commissioned by PCTs and delivered in partnership between Jobcentre Plus and the NHS by multi-disciplinary healthcare professionals to 40 per cent of Incapacity Benefit claimants. The remaining 60 per cent of the Incapacity Benefit population service is delivered by provider-led services and the Department contributes to the contractual, training and audit process.

13.98 CMP programmes have been positively evaluated. DWP's White Paper, published in December 2008, *Raising Expectations and Increasing Support: Reforming Welfare for the Future* also includes CMPs.

#### Vocational rehabilitation

13.99 The Vocational Rehabilitation Task Group held its final meeting in March 2009. UKRC gave a presentation to the group on the vocational rehabilitation standards, which are due to be launched in 2009. The three standards are voluntary and are aimed at providers, customers and purchasers. The Department has granted UKRC innovation/excellence funding for the next three years.

#### Public sector leading by example

13.100 From April 2008, the Cabinet Office began collating quarterly reports on performance, once human resource directors had agreed a common reporting format. These are sent to permanent secretaries' meetings in order to monitor progress. In 2009, the National School for Government, working with the Cabinet Office, will increase the emphasis on employee engagement within its range of training programmes.

#### Department of Health – Health, Work and Well-being Programme

13.101 The Department, as an exemplar employer, established a Health, Work and Well-being Board and launched its own Health, Work and Well-being Programme in December 2008. A health promotion pilot established workplace champions. This included workplace health challenges, motivating team physical activity, and nutrition workshops and focus groups in order to facilitate positive changes to both the working environment and to health and well-being. The lessons learned from the pilot are now informing the Health and Well-being Board, and health-promoting activity challenges are now being trialled across the Department.

13.102 The Department and the NHS, as exemplar employers, are committed to implementing the *NHS Constitution* pledge to keep their workforce healthy and safe; ten pilot sites are currently trying out new health and well-being programmes for front-line staff. The Department has commissioned a systematic review of how the health and well-being of the NHS workforce is supported, led by Dr Steve Boorman (on secondment from Royal Mail). It will look at the evidence for where the priorities for whole-system improvement should be and will recommend action that will enable local delivery. It will reaffirm our commitment that good workplaces should be in place for the entire NHS workforce.

13.103 Public sector managers also need to have the competences to address the health and well-being of their workforces. The National School of Government has developed a range of services in support of the Cabinet Office initiative to promote employee engagement approaches in the public sector. As part of the emerging work in this area, a network of practitioners will be established in 2009.

13.104 Across the public sector, there are many other examples of good and proactive work. For example, the Department is developing web-based resources for school staff in England in order to



help them to identify the real risks in teaching environments and then to take sensible and proportionate action to address these when working with children and young people.

### Mental health and employment

**13.105** An expert steering group, under Dame Carol Black's chairmanship, was established in July 2008 to oversee the development of a new national strategy on mental health and employment. Its remit is to ensure a coordinated response across government to the challenges faced by people of working-age with mental health conditions, and to subsequently improve their employment chances. Publication of the strategy is planned for July 2009.

### National Support Teams

#### What they do

**13.106** Their key purpose is to work with the NHS, local government and other partners to support delivery of public health national and local goals and targets, as part of the Department's overall role to improve health and well-being. They do this by providing key local partners with the knowledge, confidence and practical measures to work together to improve health outcomes for their local populations.

**13.107** There are teams dedicated to each national public health priority: on alcohol harm reduction, childhood obesity, health inequalities, infant mortality, sexual health, sexual violence, teenage pregnancy and tobacco control.

#### How they do it

**13.108** Each team provides free consultancy-style, intensive, tailored support to individual local health partnerships. They do this through a programme of structured visits and follow-up actions designed, in relation to the specific public health objective being examined, to:

- identify local strengths and good practice; and

- examine local leadership, partnership, data analysis, strategy, commissioning and communications arrangements.

#### Visits

**13.109** By March 2009, they had undertaken 249 structured visits across all nine English regions.

#### Communications through publications and events

**13.110** They have also provided support nationally to local areas through the publication of a number of documents outlining lessons learned and offering guidance. These include:

- *Sexual Health – GUM 48 hour access target – Quick wins and sustainable services: Hitting the target without missing the point.*
- *Excellence in Tobacco Control: 10 High Impact Changes to Achieve Tobacco Control.*
- *Systematically Addressing Health Inequalities.*

**13.111** They are currently embarking on a programme of regional workshops in order to spread learning from their work to those areas that have not received direct support from the NSTs.

### Information for health – information for the public

#### Social marketing and health-related behaviour

**13.112** The Department is widely recognised as leading the way across government and internationally in embedding social marketing-led approaches. One of the key principles of social marketing is to develop programmes that are based on a deep insight into people's behaviour, including their:

- motivations for change;
- environment;
- social network;
- peers; and
- life experience.



13.113 These multiple sources of information complete a picture of customer needs and are used to design services around the needs of the user.

13.114 In 2009, the Department will continue to develop its social marketing through a range of initiatives, such as:

- deploying ten regional social marketing managers to offer strategic social marketing advice to PCTs;
- supporting the Change4Life anti-obesity programme; and
- launching a new 'life stage strategic segmentation model' that will go live in 2009, and will provide a '360-degree picture' of the population and individual behaviour across issues including obesity, drug and alcohol misuse, sexual health and smoking.

13.115 The National Social Marketing Centre works with and alongside local people in order to support them in understanding and applying effective social marketing principles. For example, it has supported ten learning demonstration sites, based in local PCTs and local authorities, which address a range of health challenges and issues. Each local site takes responsibility for decisions on how to develop and progress work, thereby creating a 'learning footprint'. One of the first demonstration sites to complete its work won a *Health Service Journal* award for the best social marketing project in 2008.

### NHS health trainers

13.116 The NHS Health Trainers Programme has achieved the objectives set out in *Choosing Health: Making healthy choices easier*. By the end of 2008, this included the following:

- More than 3,000 health trainers in post or in training.
- Some 88 per cent of PCTs covered by a health trainer service, including all those in spearhead areas.

- In total, more than 58,000 clients have been seen by health trainers.
- The Health Trainer Data Capture Reporting System shows that 46 per cent of clients came from the 20 per cent most deprived local authority areas, and 67 per cent of clients fall within one or more deprivation indicators.
- Nearly 2,500 health trainers in the British Army and some 80 health trainers in offender health settings.

13.117 A robust evidence base is developing, showing the effectiveness of health trainers and drawing on data supplied by the 126 local health trainer services now in operation or development.

13.118 The programme is a successful example of national policy and strategy implemented through local delivery and partnership working. The programme has strong connections within the Department and is an important tool for implementing and enhancing other policies, including health literacy, NHS LifeCheck and the health inequalities strategy. The programme has also been able to link to and work with a number of other government departments and public sector organisations.

### NHS LifeCheck

13.119 NHS LifeCheck is a simple, user-friendly, online health service designed to help people assess and manage their own lifestyles and to give them the information that they need in order to make positive choices to improve their health outcomes. It is designed to play a crucial role in helping the Department to achieve its overall objectives for health and social care reform by developing services that are truly responsive to people's needs, promote healthier lifestyles, and reduce health inequalities.

13.120 The Communities for Health areas have been provided with a marketing support pack and funds to help them plan and implement NHS LifeCheck launches locally. The aim is to embed the



use of LifeCheck in their everyday working processes.

## Health literacy and Skilled for Health

### Skilled for Health

13.121 A *Choosing Health* commitment, Skilled for Health (SfH) is the national programme that combines Skills for Life with health improvement in order to address the low skills and health inequalities traditionally common within disadvantaged communities. Common themes that characterise an SfH intervention include:

- flexibility;
- focus on users; and
- reaching out to people who experience barriers in accessing 'conventional' learning and healthcare provision and services.

13.122 SfH secured the participation of over 3,000 individuals by March 2009, and key emerging evaluation findings show that health-related outcomes include greater understanding of the health impact of being smoke-free, eating a healthy diet, participating in physical activity and safer sex. There is also an increased ability to use services such as GP surgeries.

### NHS Choices

13.123 Use of the NHS Choices website has grown from 250,000 visits per week at the beginning of 2008 to in excess of 7 million visits for March 2009 (over 1.5 million visits per week). NHS Choices is now the most used online health information service in the UK. It is developing an increasingly personalised experience for visitors, with new content and features added on a regular basis. A series of NHS guides have been published in order to help people with long-term conditions such as diabetes and asthma to understand their disorder and make best use of services. In January 2009, a new Carers Direct Service was launched on NHS Choices, including advice on keeping well for carers and those they support.

13.124 Information on NHS Choices ranges from which preventative measures to take, through to advice on living with a condition, with links to 'information prescriptions'. NHS Choices has an important part to play in supporting healthier lifestyles. It is making a key contribution to delivering the *Healthy Weight, Healthy Lives* strategy through provision of personalised advice on diet and activity. This includes making NHS LifeCheck available via NHS Choices, and pilots in local communities using digital technologies such as kiosks and mobile phones in order to support local health improvement priorities. NHS Choices also now provides the channel for online health campaigns, including the launch of Change4Life in December 2008.

## Information for health – information for service providers

### Informing Healthier Choices

13.125 Informing Healthier Choices is the Department's information and intelligence strategy for improving public health. Key outputs so far include:

- establishment of the National Library for Public Health;
- local authority health profiles;
- the *Health Profile of England 2008*; and
- a career framework for information staff.

### Health profiles – local authority

13.126 Health profiles are four-page summaries of the health of the local population, produced on an annual basis by the Association of Public Health Observatories. Local partners make use of the profiles to inform decisions on improving health. The 2008 profiles were launched in June 2008, the third year of production. This year, there were further improvements, with a new and definitive design, the addition of five new indicators, and new regional profiles. They continue to be very well received. The media coverage was once again



considerable and there have been a large number of hits to the website. A new interactive website was launched at the same time as the paper profiles, which displays the indicators using dynamic mapping (see [www.healthprofiles.info](http://www.healthprofiles.info)). New supporting indicators have been added in the November 2008 refresh of the website.

13.127 The profiles for 2009 are now in production and will incorporate further improvements. An external company was recruited to undertake an evaluation of the health profiles and it reported its findings in March 2009.

### Health Profile of England 2008

13.128 The Department published *Health Profile of England 2008* in January 2009. It is a collation of national and regional data for indicators of public health and well-being and their determinants in England, including social and lifestyle factors. It can be used as a benchmark against which local areas can compare their own local health profile data. The 2008 report updates tables showing regional comparisons and national ten-year trends for indicators presented in the local health profiles. A wider range of indicators is included in a health snapshot of England, and there is a section on international comparisons.

## Health protection

### Pandemic influenza

13.129 The Pandemic Influenza Programme aims to ensure that the nation is as prepared as possible for responding to the challenges of an influenza pandemic. *Pandemic Flu – A National Framework for Responding to an Influenza Pandemic* assists all public and private organisations in planning and preparing for an influenza pandemic. The Department has issued a wide range of guidance to health and social care organisations and others. In addition, it has supported other guidance issued, for example to GP services by the Royal College of General Practitioners and the British Medical Association.

13.130 An assessment of all NHS plans took place in 2008 in order to inform priorities and help prepare services for a pandemic. The 2008-09 *NHS Operating Framework* required PCTs, together with local partners, to produce robust pandemic plans by December 2008. These plans have been assessed and reviewed across each SHA during the first three months of 2009. A summary of results will be made public. The 2009-10 *NHS Operating Framework* requires PCTs to continue to test, review and improve these plans.

13.131 The Department continues to make progress in stockpiling clinical countermeasures and other medicinal products for the response to a pandemic. In August 2008, it launched public procurement exercises for the provision of additional antivirals to enable treatment during a pandemic of 50 per cent of the population (the 'worst-case scenario'). Orders have been placed for these antivirals. This procurement has been completed. It also launched a public procurement of 15.3 million treatment courses of antibiotics to treat the complications arising from pandemic influenza.

13.132 The contract for the development of the National Pandemic Flu Line system was signed in November 2008. This will provide the gateway for the public to access antivirals in the event of a pandemic. The Department continues to work closely with the other UK countries on these and other planning issues to ensure consistency of approach.

13.133 A further campaign was launched in autumn 2008 to help reduce the spread of cold, influenza and other viruses and to embed the good hygiene practices that would also help protect people during a pandemic. Further communications research has also been undertaken in order to build on the public engagement research programme that was used to learn more about public attitudes and behaviour with regard to pandemic influenza.



**13.134** The independent expert Scientific Pandemic Influenza Advisory Committee (SPI) was created in 2008, for which the Department holds the secretariat. This replaces the former Scientific Advisory Group. The changes ensured a wider range of scientific disciplines was included and that the group was more flexible and independent. The modelling, clinical countermeasures, and behaviour and communications sub-groups have been taking specific areas of interest forward. Papers, minutes and final advice of SPI are available on its website: [www.advisorybodies.doh.gov.uk/spi/index.htm](http://www.advisorybodies.doh.gov.uk/spi/index.htm).

**13.135** In 2008, the Department along with the Cabinet Office and others produced the first cross-government UK Pandemic Flu International Preparedness Strategy, setting out the Government's aims and objectives from a global perspective for the coming five years. The Department also played a leading role in discussions in Europe, the Global Health Security Initiative (the G7 countries plus Mexico), and the WHO to aid the sharing of best practice and the preparations of less developed countries. The ongoing WHO influenza virus sharing and access to benefits negotiations, in which the UK played a key role, were an important part of these preparations by ensuring that all influenza viruses are shared with the WHO, and that poorer countries have better access to the benefits, such as vaccines.

### **The national immunisation programme**

**13.136** Vaccination policy is based on advice from the Joint Committee on Vaccination and Immunisation (JCVI), an expert committee that advises the Secretary of State for Health.

**13.137** The investment made in vaccination programmes continues to ensure that babies and young children can be protected against a wide range of serious diseases. For example:

- In 1998-99 – the year before the UK became the first country in the world to introduce meningitis C vaccine – 78 children under 19 years of age

died from this much-feared disease. In 2008-09, there were no deaths in this age group. It is estimated that over 500 deaths and a similar number of long-term disabilities have been prevented by the meningitis C vaccination. This is a tremendous achievement.

- The Department is continuing to see a reduction in young children of Hib disease (*Haemophilus influenzae* type b), a serious disease that can cause meningitis. This demonstrates the success of the Hib catch-up vaccination campaign, and an improvement in the routine vaccination schedule for babies.

**13.138** The Department's commitment to immunisation was further strengthened with the publication of the *NHS Constitution*, which established the principles and values of the NHS in England. The Constitution sets out a new right to vaccinations:

- “You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme”; and
- “You should participate in important public health programmes such as vaccination”.

**13.139** The new right is supported by Health Protection (Vaccination) Regulations 2009 that came into force on 1 April 2009. These regulations place a duty on the Secretary of State for Health to accept and implement recommendations from JCVI to introduce new cost-effective national vaccination programmes or amend existing ones.



## Human papillomavirus (HPV) vaccination

**13.140** September 2008 saw the launch of the new routine national HPV vaccination programme. This is a major vaccination programme, which offers young women protection from cervical cancer. It signals the determination of the Secretary of State for Health to make the NHS a service that prevents ill-health and prioritises keeping people well. This vaccination programme may not have immediate effects but will prevent more serious illness, and much bigger costs, in years to come, and the benefits will be felt by women and their families for generations.

**13.141** Girls in school Year 8 (aged 12 to 13) are being offered the vaccine as part of the routine HPV vaccination programme. It is a complex programme as three doses of vaccine need to be given over a six-month period to complete the vaccination course. In addition to the routine programme, a catch-up programme has been rolled out which will ensure that all young women up to 18 years of age can benefit from the HPV vaccine being offered. Due to the success of the vaccine procurement process, the Department was able to extend the catch-up programme to an additional annual cohort of young women.

**13.142** The HPV vaccination programme has been supported with television and radio advertising, a dedicated telephone helpline, leaflets, posters, and web-based information channelled through social networking sites. This approach is focused on ensuring that the girls and young women being offered the vaccine, and their parents, are aware of the programme and have access to clear factual information.

**13.143** Provisional data show that the programme has started very well. Data available in December 2008 showed that more than 70 per cent of 12- to 13-year-old girls across the country had already had their first dose of HPV vaccine. Some PCTs are reporting coverage of 90 per cent and above. This is a tremendous achievement and shows the

commitment and skill of the NHS staff in delivering programmes that will save lives.

**13.144** The drive to improve protection against vaccine-preventable disease across the country will continue in the year ahead. There will be considerable resources invested in delivering the HPV routine and catch-up programmes. In addition, the Department is concerned about the rise in the number of children catching measles, and the potential for a serious measles outbreak. The Department will continue to work with PCTs on the MMR catch-up campaign to help drive up uptake rates, and drive down the risk of a measles epidemic.

## Tuberculosis

**13.145** The number of new cases of tuberculosis (TB) in England has risen from a low of around 5,000 in 1987 to over 7,700 in 2007. Using a mobile X-ray unit (MXU), the Find and Treat (F&T) team has improved uptake of TB screening by around 40 per cent among residents of hostels for the homeless. The programme has also improved the loss to follow-up of people screened on the MXU from around 1 in 3 to fewer than 1 in 20. Currently, the F&T team is helping over 300 people with TB who have challenging lifestyles to complete their treatment.

## Viral hepatitis – hepatitis C

**13.146** Chronic hepatitis C infection can progress to cirrhosis, primary liver cancer or liver failure after many years. There is effective drug therapy that can prevent this which has been recommended by NICE.

**13.147** To continue to help reduce the level of undiagnosed hepatitis C infection, a new phase of the Department's hepatitis C awareness campaign for healthcare professionals and the public was launched in 2008-09.



13.148 For healthcare professionals, the campaign includes:

- public relations and collaboration with professional bodies;
- advertising in the trade press for general practitioners and practice nurses; and
- a new educational video, hosted on NHS Choices.

13.149 For the general public campaign, activities include:

- advertising across national newspapers and on regional radio;
- posters in bars and nightclubs across the country;
- a public relations campaign targeting the national and regional media; and
- a series of videos involving real people who have lived with hepatitis C, and in many cases cleared it, hosted on NHS Choices.

13.150 There is also a separate targeted campaign aimed at raising awareness in South Asian communities in view of emerging epidemiological evidence that they are at increased risk of infection.

13.151 There were 7,540 laboratory diagnoses of hepatitis C reported to the HPA in 2007 (the latest year for which figures are available); this is a 36 per cent increase compared with 5,529 diagnoses in 2003, the year before the campaign began. NHS expenditure on drugs to treat hepatitis C has increased from about £17 million in 2004 to about £28 million in 2007.

### Health protection legislation

13.152 Globally, infections cause over one-quarter of all deaths. They account for approximately 7 per cent of deaths in the UK. The world faces greater than ever risks of chemical or radiological contamination, whether by accident or by deliberate act. Legislation is necessary to enable public authorities to step in to apply protective measures to control the public health risk from infection or contamination of any kind.

13.153 The passage of the Health and Social Care Act 2008 introduced provisions on public health protection. These update the Public Health (Control of Disease) Act 1984 and give the Secretary of State for Health new powers to tackle threats of this nature.

13.154 During 2009, the Department intends to draft and consult on regulations concerning:

- requirements for reporting cases of infectious disease or contamination which present, or could present, significant harm to human health;
- safeguards to be applied to orders made by a Justice of the Peace in order to protect the public from infection or contamination;
- powers and duties of local authorities and other agencies relating to their health protection role; and
- provisions to prevent the spread of infection or contamination which could be a risk to public health internationally.

13.155 These regulations will play a key role in protecting the health of the population, while clearly taking into account the needs and rights of all individuals who might be affected by them.

## Global and EU developments – towards a stronger and more strategic vision

### Health is global

13.156 In September 2008, the Secretary of State for Health launched *Health is Global: a UK Government Strategy 2008-13* with ministers from the Foreign and Commonwealth Office and the Department for International Development. The strategy is an international first. It identifies ten principles for the way in which government as a whole will work to improve global health (including setting out to do no harm), and describes actions in five areas:

- better global health security;



- stronger, fairer and safer systems to deliver health;
- more effective international health organisations;
- stronger, freer and fairer trade for better health; and
- strengthening the way in which we develop and use evidence to improve policy and practice.

### International health organisations

**13.157** The Department's engagement with the WHO is stronger than ever. The Department is currently on the Executive Board, one of the organisation's principal decision-making bodies, with the CMO as a vice-chair. Last year the Department sponsored a hugely important resolution on climate change calling on the WHO and all countries of the world to do more to tackle the health effects of such change. The Department has worked very closely with the WHO and its Commission on Social Determinants of Health over the last year, and in November 2008 held a large international conference in order to share the results of their work and agree how to work together to take this agenda forward. Last year the WHO's Regional Office for Europe called a meeting in Estonia of health ministers in order to discuss ways of improving health systems.

**13.158** Over the last year, the Department has been working with other government departments to finalise the Government's strategy for the way in which it works with the WHO. This was published in early 2009 and is an important document in helping to get value for money from the funding it puts into the organisation. The Department has continued its work with other international agencies and partnerships, such as the Council of Europe, the Commonwealth Secretariat, the Global Health Security Initiative and the Commonwealth Fund. They all make a vital contribution to improving global and domestic health and tackling global and regional health risks. The effectiveness of international organisations in preventing the spread of infectious diseases was the subject of a House of Lords report last year. The Department led the

production of the Government's response at the end of 2008.

**13.159** Over the next year, the Department will be looking more closely at lessons it can learn from colleagues working in the Organisation for Economic Co-operation and Development. This agency can help the Department do more to benchmark the effectiveness of the health system, and the health and well-being of the population of England, against other countries.

**13.160** As the Department moves towards greater strategic direction in its international activities, it is looking to publish later in 2009 a short paper that describes its own objectives for working internationally and ways in which it can work most effectively.

### Linking health and overseas trade

**13.161** The role of the Department's International Specialist Team is to forge close bilateral relations in health and healthcare, and to promote and support the healthcare industry and the NHS internationally. Most of its work is with a few priority countries. These include Brazil, China, South Africa and Libya where formal umbrella agreements provide the framework for continuing collaboration. Last year the Prime Minister, Gordon Brown, launched the innovative Partners in Health Innovation, which has inputs from both the private and the public sector. More recently, the Department has been looking to step up its partnership with India and anticipates agreeing its strategic approach with the Indian government. The Department has continued its support to Iraq, with the UK-based training programme for Iraqi clinicians and policy-makers. This has led to a number of requests for support from the UK healthcare industry.



## Partnerships between UK health and healthcare institutions and developing countries

**13.162** Over the last year, there has been a good deal of interest in developing partnerships between the NHS and academic institutions in the UK and counterparts in developing countries. In 2008, the Department of Health and the Department for International Development set out the agreed strategic approach in a document called *Global Health Partnerships: The UK Contribution to Health in Developing Countries*. This was in response to an independent report written in 2007 by Lord Nigel Crisp.

## Health in the EU

**13.163** In 2008, the European Commission proposed two new draft Directives in the field of health, in relation to the application of patients' rights in cross-border healthcare and on standards of quality and safety of human organs intended for transplantation. The Commission also proposed two Council Recommendations, on European action in the field of rare diseases and on patient safety, including the prevention and control of healthcare-associated infections. In 2009, these proposals are being negotiated between the 27 member states of the EU, and in relation to the draft Directives, also with the European Parliament.

**13.164** The Department has responsibility for developing and taking forward the UK negotiating position on these proposals, in discussion with other government departments and the devolved administrations. In negotiations, the Department works to ensure that new Commission proposals strike the appropriate balance between adding value through EU level action, and respecting member states' responsibilities for running their own health systems. In the coming year, the Department will also contribute to forthcoming EU-level discussions in other areas of health policy, such as health workforce and health security, in order to determine

whether EU-level action could bring additional benefits to the health and well-being of UK citizens.

## European Commission's draft Directive and current EU Regulations on cross-border healthcare

**13.165** On 2 July 2008, the European Commission published a draft Directive clarifying and codifying the rules in this area. The Directive is intended to cover a narrow field relating to patient mobility, but has potentially profound consequences for the NHS and contains complex provisions. Case law from the European Court of Justice gives UK patients the right to access healthcare in other member states under the EU freedom to obtain services, and to be reimbursed for this under certain circumstances. However, how this would work for NHS-type systems has been unclear.

**13.166** The Department believes that a Directive in this area could codify case law, which would provide clarity to patients and member states. As a result of careful background work by the UK and other member states, the draft Directive contains various helpful principles. It is now under discussion in the EU institutions and a final Directive is not expected until late 2009 at the very earliest. After it is adopted there will be one year for member states to implement the changes required.

**13.167** The Department of Health is the lead negotiator for the UK (although it consults with colleagues from the other UK countries). The Department is working with other member states on further necessary changes to the Directive, and it will continue to push for the best outcome for UK patients and the NHS. In order to help inform the Department's negotiating position it undertook a public consultation in late 2008. Throughout 2009 the Department will be required to:

- continue negotiations in Council;
- brief key members of the European Parliament on potential amendments;



- support UK ministers through UK Parliamentary Scrutiny;
- respond to the consultation;
- consider necessary updates to the current advice to the NHS on handling requests for patient mobility; and
- begin planning the implementation of the Directive and preparing for its impact on the NHS.

13.168 There are also long-standing EU regulations covering how British citizens who work, visit or retire to other European Economic Area member states can access healthcare. The Department manages a central budget in support of these costs.

### Emergency preparedness

13.169 In 2008, work concentrated on the issue of standardised second-generation personal protective equipment (PPE) to NHS first-responders, the advancement of the delivery of medical care into the 'hot zone' of an incident (the most dangerous area, eg a tube tunnel or platform) by the phased national roll-out of Hazardous Area Response Teams. Guidance was published on business continuity in the NHS and the provision of scientific and technical advice during major incidents, and work on the longer-term psychosocial impact following disasters (eg following flooding) was also undertaken. The expert Emergency Planning Clinical Leadership Advisory Group continued to provide specialist advice to the Department on issues relating to the NHS delivery of clinical care during a major incident.

13.170 In 2009, the Emergency Preparedness Division's (EPD's) work will focus on developing further a number of the projects begun in 2008. EPD will continue to input and action the development and implementation of the 2012 London Olympics security strategy. Through 2009, the NHS Resilience Project will continue to develop business continuity management policy for the NHS, including the development with the British

Standards Institute of a new Health Resilience standard. The next ministerial meeting of the Global Health Security Initiative is to be hosted by the UK, and EPD officials will lead on its preparations. Other action includes:

- further work on the National Capability Survey in order to develop and improve capacity, capability and resilience across the health sector in the face of significant disruptive challenges; and
- the publication of guidance on evacuation, sheltering and lockdown, which is planned for autumn 2009.

## Scientific development and bioethics

### Stem cells

13.171 Progress continued on the UK Stem Cell Initiative's recommendation 1 (the public-private partnership to develop ways to use stem cell lines in the safety assessment of new medicines). Stem Cells for Safer Medicines Ltd has awarded funding of over £500,000 to research projects, and has started to draw up plans to take the initiative to its second phase.

13.172 A review of the collection and use of umbilical cord blood collection for harvesting stem cells for transplant was carried out by the Department in 2008. Following a written ministerial statement to the House of Commons in January 2009, a report of the findings of the review was published.

### Human fertilisation

13.173 The Human Fertilisation and Embryology Bill successfully completed its passage through Parliament in November 2008, becoming the Human Fertilisation and Embryology Act 2008. This landmark legislation was the end product of an extensive review by the Department which included evidence-gathering, scrutiny and Parliamentary debate that addressed many profound ethical issues. The new Act updates and reforms the existing law on assisted reproduction and embryo research (the



Human Fertilisation and Embryology Act 1990). The Government decided that a review of the law was necessary in the light of factors such as developments in reproductive technologies since the original legislation was passed, and wider developments in society. In particular, it sought to ensure that the UK remains at the forefront of research that may lead to treatments for currently incurable conditions such as Parkinson's disease and Alzheimer's disease.

**13.174** The new law provides clarity as to the extent to which human–animal embryos, which scientists believe may be of great benefit in understanding and treating serious diseases, come within the framework of the 1990 Act. It also clarifies the scope for embryos to be selected to prevent children being born with inherited genetic diseases, and stresses the importance of supportive parenting. The law ensures that the UK has a regulatory scheme that allows scope for major benefits to be realised for both medical research and patients.

## Genetics

**13.175** The progress review of the 2003 Genetics White Paper was published in April 2008 (*Our inheritance, our future: Realising the potential of genetics in the NHS*, DH). While it was progressing, work continued on four major initiatives:

- the National Genetics Reference Laboratories;
- the NHS Genetics Education and Development Centre;
- pharmacogenetics; and
- the UK Genetic Testing Network to support the wider NHS.

**13.176** The House of Lords Science and Technology Committee has appointed a sub-committee, chaired by Lord Patel, to look at genomic medicine. The inquiry will provide an assessment of genome technologies and their actual and potential impact on clinical practice in the post-genome era.

**13.177** The NHS Genetics team has co-ordinated the memorandum of evidence on genomic medicine that was prepared by the Department of Health, DIUS and the Department for Business, Enterprise and Regulatory Reform, and ministers gave evidence in January 2009.

**13.178** The Gene Therapy Advisory Committee (GTAC) continued to cover the ethical review of novel clinical trials, approving 18 new trials. Ministers also extended GTAC's remit to cover the ethical oversight of certain types of stem cell, as well as clinical trials of gene therapy. This was to fulfil the Government's commitment to recommendation 8 of the UK Stem Cell Initiative.

**13.179** The Government agreed an extension to the *Concordat and Moratorium on Genetics and Insurance* (HM Government, 2005), and the Genetics and Insurance Committee continued to monitor the insurance industry's compliance.

**13.180** In 2008, the Human Genetics Commission (HGC) made progress in implementing the main recommendations of the independent review that reported in January 2008. It has also moved forward with a significant public engagement exercise focused on the forensic use of genetic information, and with work on genetic tests supplied directly to the public. This latter issue was the subject of an international consensus meeting hosted by the HGC in June 2008, leading to the establishment of a broad-based working group in 2009. The working group will develop a common framework of principles to protect and promote the interests of the public when accessing genetic tests directly.

## Organ donation

**13.181** In January 2008, the Organ Donation Taskforce published its recommendation to increase organ donor rates by 50 per cent by 2013. Implementation is now well under way, driven forward by the new National Clinical Director for Transplantation, and overseen by a Programme



Delivery Board chaired by Professor Sir Bruce Keogh, the NHS Medical Director.

13.182 The Organ Donation Taskforce also published its report, *The Potential Impact of an Opt out System for Organ Donation in the UK*, on 17 November 2008. The report was informed by a wide body of information and evidence, which included a systematic literature review, public deliberative events and personal interviews with leaders from 17 different faith groups. The report and supporting evidence can be found on the Department's website at: [www.dh.gov.uk](http://www.dh.gov.uk).

13.183 The Taskforce concluded that an opt out system for organ donation should not be introduced in the UK at the present time. It felt that, while it would have the potential to deliver benefits, it would also present significant challenges, and such a system might not be necessary in order to deliver the desired increase in organ donation rates.

13.184 The Government welcomed the report, and accepted the Taskforce's conclusions and recommendations, but did not rule out a future change in the law if sufficient progress is not achieved. A statement from the Secretary of State for Health can be found at: [www.dh.gov.uk](http://www.dh.gov.uk).

## Ethics

13.185 As part of the implementation programme for the Mental Capacity Act 2005, the Department introduced provisions to ensure a smooth transition from the previous arrangements to the new ones for people who had made an advance decision to refuse treatment. The Act also introduced provisions to support research projects involving people who lack capacity.

13.186 The Department has participated in a number of international forums on bioethics, including those of the Council of Europe and the United Nations Educational, Scientific and Cultural Organisation (UNESCO).



# 14 Research and Development

## Role

To improve the health and wealth of the nation through research.

### Key achievements in 2008-09 included:

Enhanced the role of research and development through the *NHS Constitution*.

Delivered significant benefits to industry-sponsored trials through the establishment of the National Institute for Health Research (NIHR) Clinical Research Networks.

Second cohort of 63 NIHR Senior Investigators announced in March 2009.

15 new NIHR Biomedical Research Units established in 2008 to drive innovation in the prevention, diagnosis and treatment of ill health.

Nine NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) became operational in October 2008.

Publication of the first cross-government research and surveillance plan that is focused on obesity, overweight, and their determinants in England.

## Summary

14.1 In this chapter you will find information on:

- strategy;
- research – a core NHS function;
- *Best Research for Best Health* – progress with implementation; and
- Office for Strategic Co-ordination of Health Research (OSCHR).

## Introduction

14.2 This chapter outlines progress made by the Department in implementing the Government's health research strategy, *Best Research for Best Health* and working with OSCHR partners to develop and realise a shared vision for UK health research.

## Strategy

14.3 The Government's aims are to:

- make the UK the best place in the world for health research, development and innovation;
- ensure that the NHS is equipped and able to make a key contribution; and
- realise the potential of the NHS to support research that improves national health and increases national wealth.

14.4 The Department's research and development (R&D) budget for the NHS for 2008-09 was £792 million, 3.5 per cent higher in real terms than in 2007-08. This pattern of increases in government funding for health research will continue across the 2007 Comprehensive Spending Review period. It will lead to a budget of £1.03 billion for the Department of Health and a total government investment in health research, including funding for the Medical Research Council (MRC), of more than £1.7 billion per annum by 2010-11.



**14.5** Furthermore, in 2008-09, £31 million of capital was allocated to the NHS to develop the research infrastructure in NIHR Biomedical Research Units and Clinical Research Facilities.

**14.6** The Department continues to make rapid and substantial progress with implementing *Best Research for Best Health* (DH, January 2006). The NIHR was established in April 2006 to provide the framework through which the research, research staff and infrastructure of the NHS in England can be positioned, managed and maintained as a virtual national research facility. Since then, an increasing amount of NHS R&D funding has been awarded through NIHR programmes (the distribution between the principal funding streams is shown in **Figure 14.1**). At the same time, transitional R&D funding has been allocated at reducing levels, as planned, to all previous recipients of NHS R&D support funding. The transition period ended in March 2009.

### Research – a core NHS function

**14.7** The new *NHS Constitution* places the promotion and conduct of research at the core of the NHS, to improve the current and future health

and care of the population. The *NHS Operating Framework for 2009-10* highlights the need for all providers of NHS care to increase their participation in research, and sets out the national ambition to double the number of patients taking part in clinical research within five years.

**14.8** To fulfil their new legal duty to promote innovation, SHAs will set out in an Annual Innovation Report the actions the SHA has taken to support the work of the NIHR Clinical Research Networks locally and to develop the collaborative capacity of the NHS to join in research studies and trials.

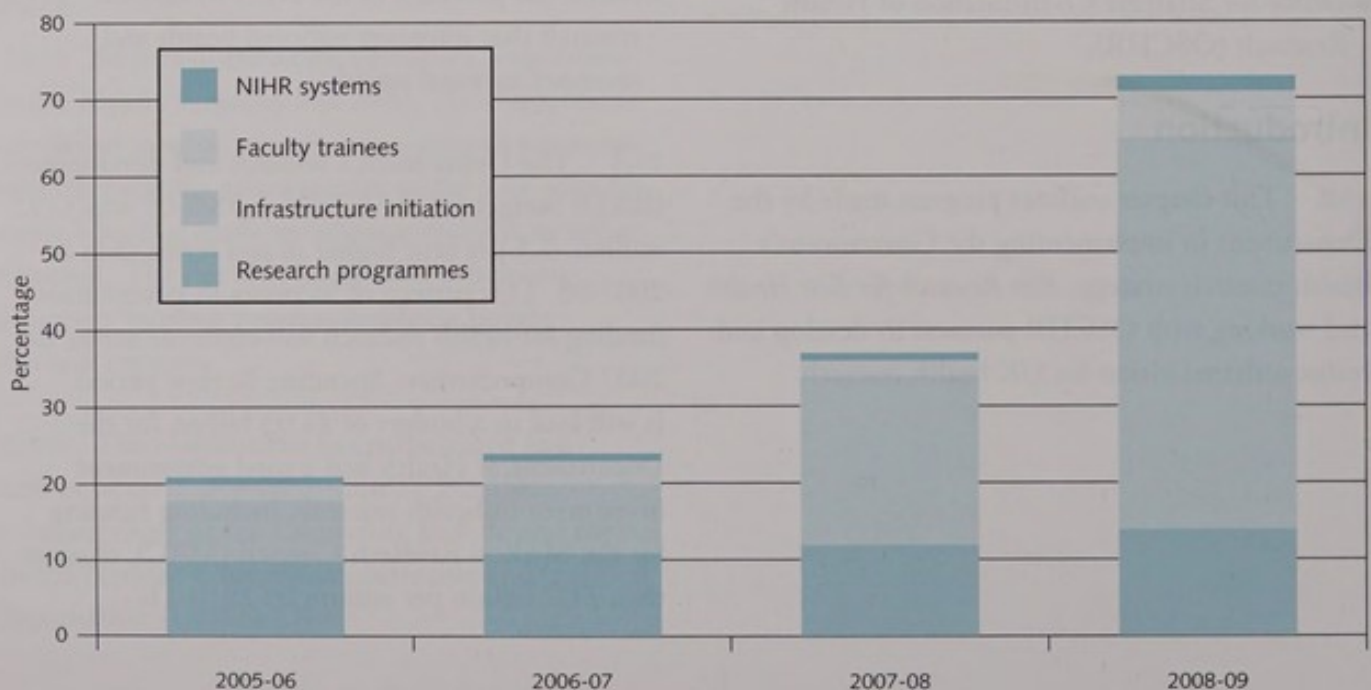
### Best Research for Best Health – progress with implementation

**14.9** A full account of progress will be published in summer 2009 in the NIHR annual report 2008-09.

### Research

**14.10** To ensure that the NIHR funds the highest quality research focused on improving health and care, the Department is continuing to expand

**Figure 14.1: Percentage of NHS research and development budget spent on NIHR programmes**





existing programmes and introduce new funding streams.

**14.11** The new NIHR Public Health Research Programme was announced in May 2008 and annual spending is planned to reach £10 million at full capacity. The programme will evaluate the benefits, costs and acceptability of public health interventions delivered outside the NHS. It will cover the range of public health interventions, from social marketing for the promotion of safer sex, to speed humps for the prevention of road traffic accidents.

**14.12** The NIHR Health Technology Assessment (HTA) Programme works in partnership with the National Institute for Health and Clinical Excellence (NICE) and other organisations. The budget will increase to more than £80 million at full capacity.

**14.13** The NIHR Service Delivery and Organisation (SDO) Programme commissions research to underpin improvements in the quality of patient care and the efficiency of NHS health services. The annual budget is planned to grow to £12.5 million at full capacity.

**14.14** The ultimate aim of the new NIHR Health Services Research Programme is to lead to an increase in service quality and patient safety. It will complement the remits of other NIHR programmes, including HTA and SDO, and have a budget of up to £5 million a year.

**14.15** Spending on NIHR Programme Grants for Applied Research will reach £75 million a year at full capacity. Each grant funds a series of interlinked projects on conditions that cause significant impact on the NHS.

**14.16** The NIHR Research for Patient Benefit Programme awards grants to promote health, prevent disease, overcome illness and improve

patients' everyday experience of the NHS. Funding is building to £25 million a year at full capacity.

**14.17** Launched in July 2008, the NIHR Invention for Innovation Programme brings together the work of several smaller programmes to help accelerate the development of new healthcare technologies and devices. The budget will grow to more than £13 million at full capacity.

**14.18** Following the successful launch of the NIHR School for Primary Care Research, the new NIHR School for Social Care Research began operation in February 2009. The School is based in the leading academic centres of social care research in England.

### Partnership programmes

**14.19** Under the auspices of OSCHR, the NIHR and MRC are working together to establish new initiatives to support the efficient translation of health research into health and economic benefits:

- The Efficacy and Mechanism Evaluation Programme was launched in April 2008.
- In September 2008, 18 NIHR Clinical Trials Units received three-year awards totalling £3.75 million a year.
- The jointly funded Methodology Research Programme awards grants for methods of research to underpin the whole spectrum of health research, from basic to applied.
- The Patient Research Cohorts initiative has been launched to create small, extensively defined groups of patients to help detect, treat or prevent disease – in areas of high unmet need or where there are bottlenecks in turning research into therapies.

### Systems

**14.20** The Department continues to promote a regulatory and governance environment that both facilitates high-quality research and protects the



rights, dignity and safety of those who agree to take part.

**14.21** Launched in 2008, the Integrated Research Application System enables researchers to enter information about their study in one place, rather than completing separate application forms for each type of approval by regulators and research ethics committees.

**14.22** From April 2009, the NIHR Coordinated System for gaining NHS Permission (CSP) became the standard process for all studies supported by the NIHR. The CSP is a managed process for seeking permission from all the NHS sites involved in a trial or other study, providing a 'one-stop shop' and shared information systems.

### **The National Institute for Health Research Faculty**

**14.23** The NIHR Faculty brings together the people funded by the Department to support applied, people-focused health and social care research. The goal is to attract, develop and keep the best research leaders, senior researchers and collaborators working in the NHS in England.

**14.24** The first cohort of 100 Senior Investigators – the most outstanding leaders of NIHR-funded research – was appointed from April 2008, and a second cohort of 63 Senior Investigators was announced in March 2009.

**14.25** NIHR Traineeships are awarded to support the academic training paths of all health and social care professionals. In line with the recommendations of the Cooksey review of UK health research funding, the budget for NIHR Trainees is planned to grow from £16 million in 2007-08 to £85 million at full capacity.

### **Health research infrastructure**

**14.26** The NIHR clinical research networks support a portfolio of clinical trials and studies throughout England, and promote patient and

public involvement in health research. They have significantly increased the number of participants taking part in clinical trials, improved the speed, quality and coordination of the trials, and strengthened NHS links with industry. The Department's investment in the networks has grown from £66 million in 2007-08 to £159 million in 2008-09 and is expected to be more than £285 million at full capacity.

**14.27** Total expenditure on the 12 NIHR Biomedical Research Centres grew to £108 million in 2008-09. In addition to the 12 NIHR Biomedical Research Units established in April 2008, a further three Units became operational in October 2008. The Centres and Units transform their scientific breakthroughs into life-saving treatments for patients.

**14.28** Funding for nine new CLAHRCs began in October 2008. The CLAHRCs undertake high-quality applied health research that is focused on the needs of patients and support the translation of research evidence into practice in the NHS.

**14.29** The NIHR Flexibility and Sustainability funding is a new research funding stream that started in April 2008. It is allocated to research-active NHS organisations to enable them to attract, develop and retain a cadre of high-quality research, clinical and support staff.

**14.30** The NIHR Research Design Service (RDS) is a major new initiative offering researchers advice and guidance on all aspects of research design and conduct. Investment will total around £50 million over five years. From October 2008, RDS became operational in eight out of ten SHA areas. In the remaining two areas, current R&D Support Units will continue until March 2010, and new RDS will commence from April 2010 following a selection process.



## Stakeholder involvement

14.31 The NIHR Advisory Board is chaired by Candy Morris, Chief Executive of South East Coast Strategic Health Authority. The Board provides advice and support on the strategic development of *Best Research for Best Health* and of the NIHR.

14.32 Chaired by the Department, the UK Clinical Research Collaboration brings together a wide range of partners, including research funders and industry, to facilitate and promote high-quality clinical research for the benefit of patients.

14.33 The Department funds the INVOLVE Programme to support and promote active involvement by patients and members of the public in health and social care research. The biannual INVOLVE conference on 11 to 12 November 2008 was attended by nearly 400 people.

14.34 In May 2008, a standard industry-costing template was introduced for trials intended for adoption by the NIHR Clinical Research Networks, to provide a clear rationale for calculating trial costs and to reduce the time required for site-by-site negotiations.

14.35 The first nationally approved model Clinical Investigation Agreement was launched in November 2008. It aims to speed up the contracting process for medical, technology, industry-funded trials in NHS hospitals, giving patients faster access to innovative treatments.

## Policy Research Programme

14.36 The Policy Research Programme, with an annual budget of £33 million, continues to provide the evidence base for policy development and evaluation of policy implementation in health and adult social care.

## Cross-government work

14.37 In December 2008, the Department published the first cross-government research and surveillance plan that is focused on obesity,

overweight, and their determinants in England. The Department also continues to work jointly with a number of government departments to address other key cross-cutting priorities for research evidence.

## Office for Strategic Co-ordination of Health Research

14.38 The *Office for Strategic Co-ordination of Health Research: Chairman's First Progress Report* was published in November 2008. OSCHR's mission is to facilitate more efficient translation of health research into health and economic benefits in the UK, through better co-ordination of health research and more coherent funding arrangements to support translation. In doing so, OSCHR supports NIHR, MRC and the other OSCHR partners.

14.39 In November 2008, the Prime Minister asked the Department of Health and the Department of Innovation, Universities and Skills for a new overarching set of national objectives to encourage the translation of major research breakthroughs into new NHS treatments and services within a decade. These 'National Ambitions' are being developed independently of government through NIHR and MRC under the auspices of OSCHR.



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Figure A.1: Department of Health CSR settlement 2007 – announced opening position

	2008-09	2009-10	£ million 2010-11
<b>NHS<sup>(1)</sup></b>			
NHS revenue	92,642	98,499	104,833
NHS capital	4,589	5,352	6,086
Depreciation	-800	-954	-1,113
<b>Total net NHS resource</b>	<b>96,431</b>	<b>102,897</b>	<b>109,806</b>
<b>Personal social services (PSS)</b>			
PSS revenue	1,237	1,293	1,395
PSS capital	121	121	121
Depreciation	-13	-13	-13
<b>Total net PSS resource</b>	<b>1,345</b>	<b>1,401</b>	<b>1,503</b>

Source: HM Treasury Pre-Budget Report 2007

Notes:

(1) Average real terms growth of 4 per cent.



Figure A.2: Track of departmental resources from CSR settlement 2007 to current position

	2008-09	2009-10	£ million 2010-11
<b>NHS revenue – near CSR settlement 2007</b>	<b>89,476</b>	<b>95,062</b>	<b>101,150</b>
Transfer to personal social services (PSS)	-167	-272	-250
Technical changes	-200	0	0
Transfers to/from other government departments (OGDs))	26	0	-8
Value for money savings (Budget 2009)	0	0	-2,300
Forecast underspend	-1,060	0	0
<b>Current position</b>	<b>88,075</b>	<b>94,791</b>	<b>98,592</b>
<b>NHS revenue – non CSR 2007 settlement</b>	<b>3,165</b>	<b>3,437</b>	<b>3,683</b>
PSS transfers/OGD transfers/technical	-3	-11	-3
Forecast underspend	-298	0	0
<b>Current position</b>	<b>2,865</b>	<b>3,426</b>	<b>3,680</b>
<b>NHS – total revenue CSR settlement 2007</b>	<b>92,642</b>	<b>98,499</b>	<b>104,833</b>
<b>Current position</b>	<b>90,940</b>	<b>98,217</b>	<b>102,272</b>
<b>PSS revenue – near CSR settlement 2007</b>	<b>1,223</b>	<b>1,279</b>	<b>1,381</b>
Transfers from NHS	167	272	250
Technical changes	0	0	0
Transfers to/from OGDs	-25	-29	-26
Forecast underspend	0	0	0
<b>Current position</b>	<b>1,365</b>	<b>1,522</b>	<b>1,605</b>
<b>PSS revenue – non CSR settlement 2007</b>	<b>14</b>	<b>14</b>	<b>14</b>
Transfer from NHS	3	10	3
Forecast underspend	0	0	0
<b>Current position</b>	<b>17</b>	<b>24</b>	<b>17</b>
<b>PSS – total revenue CSR settlement 2007</b>	<b>1,237</b>	<b>1,293</b>	<b>1,395</b>
<b>Current position</b>	<b>1,382</b>	<b>1,546</b>	<b>1,622</b>
<b>NHS capital CSR settlement 2007</b>	<b>4,589</b>	<b>5,352</b>	<b>6,086</b>
PSS transfers/OGD transfers/technical	171	-19	-27
Fiscal stimulus and technical adjustment (Pre-Budget Report 2008) <sup>(1)</sup>	0	100	-1,385
Forecast underspend	-350	0	0
<b>Current position</b>	<b>4,410</b>	<b>5,433</b>	<b>4,674</b>
<b>PSS capital CSR settlement 2007</b>	<b>121</b>	<b>121</b>	<b>121</b>
NHS transfers/OGD transfers/technical	29	19	27
Forecast underspend	0	0	0
<b>Current position</b>	<b>150</b>	<b>140</b>	<b>148</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) Technical adjustment to bring capital allocation in line with planned level of spend.



Figure A.3: Department of Health CSR settlement 2007 – current position

	2008-09	2009-10	£ million 2010-11
<b>NHS<sup>(1)</sup></b>			
NHS revenue	90,940	98,217	102,272
NHS capital	-4,410	5,433	4,674
Depreciation	-827	-988	-1,122
<b>Total net NHS resource</b>	<b>94,522</b>	<b>102,662</b>	<b>105,824</b>
<b>Personal social services (PSS)</b>			
PSS revenue	1,382	1,546	1,622
PSS capital	150	140	148
Depreciation	-16	-13	-15
<b>Total net PSS resource</b>	<b>1,516</b>	<b>1,673</b>	<b>1,755</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) Average real terms growth of 4.1 per cent.



Figure A.4: Department of Health public spending (core table 1)

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan	£ million
<b>Consumption of resources</b>									
NHS	61,865	66,873	74,168	78,468	86,382	90,940	98,217	102,272	
Personal social services	1,617	2,110	2,070	1,817	1,876	1,382	1,546	1,622	
NHS pensions <sup>(1)(2)</sup>	6,194	6,396	9,281	10,226	10,174	13,387	12,527	13,434	
NHS (AME)	60	30	74	139	465	364	652	577	
Credit guarantee finance (AME) <sup>(3)</sup>	40	24	54	84	84	182	355	127	
<b>Total Department of Health resource budget</b>	<b>69,776</b>	<b>75,434</b>	<b>85,647</b>	<b>90,734</b>	<b>98,982</b>	<b>106,256</b>	<b>113,297</b>	<b>118,033</b>	
<i>Of which:</i>									
Department of Health Departmental Expenditure Limit (DEL)	63,481	68,983	76,238	80,285	88,258	92,322	99,763	103,894	
<i>of which:</i>									
Near cash	61,030	68,591	74,295	77,290	83,475	89,439	96,312	100,197	
Non-cash	2,451	391	1,943	2,995	4,783	2,882	3,451	3,697	
<b>Capital spending</b>									
NHS <sup>(4)</sup>	2,602	2,624	2,151	3,069	3,597	4,410	5,433	4,674	
Personal social services	84	83	92	124	215	150	140	148	
NHS (AME)	0	229	292	0	0	0	0	0	
Credit guarantee finance (AME) <sup>(5)</sup>	0	0	357	89	37	14	0	0	
<b>Total Department of Health capital budget</b>	<b>2,686</b>	<b>2,937</b>	<b>2,893</b>	<b>3,282</b>	<b>3,849</b>	<b>4,574</b>	<b>5,573</b>	<b>4,822</b>	
<i>Of which:</i>									
Department of Health Departmental Expenditure Limit (DEL)	2,686	2,707	2,244	3,193	3,812	4,560	5,573	4,822	
<b>Total public spending in Department of Health<sup>(5)</sup></b>									
	<b>72,061</b>	<b>77,860</b>	<b>87,909</b>	<b>92,794</b>	<b>101,549</b>	<b>109,427</b>	<b>116,869</b>	<b>121,010</b>	
<i>Of which:</i>									
NHS (6) (7)	64,173	69,051	75,822	80,561	89,261	94,522	102,662	105,824	
Personal social services <sup>(8)</sup>	1,693	2,182	2,153	1,927	2,076	1,516	1,673	1,755	
NHS pensions	6,194	6,396	9,281	10,226	10,174	13,387	12,527	13,434	
NHS (AME) <sup>(9)</sup>	0	228	292	0	9	0	0	0	
Credit guarantee finance (AME) <sup>(3)(10)</sup>	0	3	362	80	28	2	7	-3	
<b>Spending by local authorities on functions relevant to the Department</b>									
<b>Current</b>	<b>14,705</b>	<b>16,059</b>	<b>17,243</b>	<b>17,874</b>	<b>18,505</b>	<b>19,310</b>	<b>0</b>	<b>0</b>	
<i>Of which:</i>									
Funded by grants from the Department of Health	1,816	2,148	2,141	1,772	1,795	1,207	0	0	
<b>Capital</b>	<b>164</b>	<b>209</b>	<b>300</b>	<b>278</b>	<b>306</b>	<b>312</b>	<b>0</b>	<b>0</b>	
<i>Of which:</i>									
Financed by grants from the Department of Health	132	140	122	181	159	221	0	0	

Source: HM Treasury public expenditure database (COINS)

Notes:

- (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 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 HM Treasury. This line also includes some funding for PCT impairments.
- (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 £301/458/507/990/733/843/1,001/1,138 million (this excludes impairments funded in AME which is outside the DEL).
- (6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £293/446/497/975/718/827/988/1,122 million (this excludes impairments funded in AME which is outside the DEL).
- (7) For a more detailed breakdown of NHS expenditure in England see figures A.5 (core table 2), A.6 and A.7 (core table 3).
- (8) Personal social services public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £8/12/10/14/16/16/13/15 million.
- (9) Total NHS (AME) is calculated as the total of the resource budget plus the capital budget, less impairments of £60/32/74/139/456/364/652/577 million.
- (10) Total credit guarantee finance is calculated as the total of the resource budget plus the capital budget, less impairments of £40/21/50/93/93/195/348/130 million.
- (11) Figures are presented net of receipts £-4,173/-5,008/-6,379/-5,584/-4,746/-4,946/-4,489/-4,624 million.
- (12) Figures may not sum due to rounding.

Figure A.5: Department of Health resource budget (core table 2)

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan	£ million
<b>Consumption of resources by activity</b>									
National Health Service (NHS)	61,865	66,873	74,168	78,468	86,382	90,940	98,217	102,272	
<i>Of which:</i>									
Hospital and community health services <sup>(3)</sup>	58,412	63,373	70,757	76,011	83,760	88,478	95,395	99,289	
<i>of which:</i>									
Health authorities unified budget and central allocations and grants to local authorities	58,412	63,373	70,757	76,011	83,760	88,478	95,395	99,289	
Family health services	2,141	2,129	2,131	1,021	1,022	1,108	1,182	1,263	
<i>of which:</i>									
General dental services <sup>(1)</sup>	1,283	1,246	1,038	19	0	0	0	0	
General ophthalmic services	322	341	358	381	400	443	468	571	
Pharmaceutical services	962	966	1,162	1,033	1,054	1,110	1,145	1,137	
Prescription charges income	-426	-422	-427	-412	-432	-445	-431	-445	
Central health and miscellaneous services	993	1,062	979	1,157	1,324	1,083	1,369	1,453	
<i>of which:</i>									
Welfare foods DEL	138	119	104	110	97	114	117	120	
EEA medical costs	390	429	517	598	759	441	655	818	
Other central health and miscellaneous services	465	514	359	449	468	528	597	515	
Departmental administration including agencies	320	309	300	278	276	271	272	267	
Personal social services (PSS)	1,617	2,110	2,070	1,817	1,876	1,382	1,546	1,622	
<i>Of which:</i>									
Personal social services	192	240	191	239	267	308	318	315	
Local authority personal social services grants	1,425	1,871	1,880	1,578	1,609	1,074	1,228	1,307	
<i>of which:</i>									
Training Support Programme	57	55	0	0	0	0	0	0	
Specific grants: AIDS/HIV	16	17	17	16	16	20	22	26	
Specific grants: Mentally Ill	133	131	133	132	148	0	0	0	
Carers Grant	100	125	185	185	185	0	0	0	
Performance Fund	96	0	0	0	0	0	0	0	
Deferred Payments Grant	23	0	0	0	0	0	0	0	
Care Direct	2	0	0	0	0	0	0	0	
Preserved Rights Grant	500	435	340	298	275	0	0	0	
Residential Allowance Grant	182	406	217	0	0	0	0	0	
National Training Strategy	25	29	92	108	108	0	0	0	
Delayed Discharge	51	100	100	100	100	0	0	0	
Access and Systems Capacity Grant	170	484	643	546	546	0	0	0	
Human Resources Development Strategy	10	24	63	50	50	0	0	0	
Assistive Technology	0	0	0	30	50	0	0	0	
Prevention Service	0	0	0	20	39	0	0	0	
Individual Budget Pilots	0	0	0	3	3	0	0	0	
Area Based Grant	0	0	0	0	0	943	968	979	
Learning Disabilities: closure of campuses	0	0	0	0	0	14	31	51	
Transforming Personalisation, Prevention and Well-being	0	0	0	0	0	82	192	237	
Grants for children	60	65	91	90	89	0	0	0	
Stroke Strategy	0	0	0	0	0	15	15	15	
NHS – superannuations – England and Wales	6,194	6,396	9,281	10,226	10,174	13,387	12,527	13,434	
NHS (AME)	60	30	74	139	465	364	652	577	
Credit guarantee finance <sup>(2)</sup>	40	24	54	84	84	182	355	127	
<b>Total Department of Health resource budget</b>	<b>69,776</b>	<b>75,434</b>	<b>85,647</b>	<b>90,734</b>	<b>98,982</b>	<b>106,256</b>	<b>113,297</b>	<b>118,033</b>	

Source: HM Treasury public expenditure database (COINS)

Notes:

(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 GDS 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 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 HM Treasury.

(3) Further disaggregation of HCHS component of expenditure is given in figure A.6.

(4) Figures are presented net of receipts £-3,622/-4,474/-5,171/-4,417/-4,239/-4,652/-4,343/-4,594 million.

(5) Figures may not sum due to rounding.



Figure A.6: Disaggregation of hospital and community health services (HCHS) expenditure, 2003-04 to 2007-08

	£ million					
	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn
<b>PCT allocations</b>						
Announced allocations SR 2002	41,468	45,027	49,328	53,925		
Growth (%)		9.2%	9.6%	9.3%		
Budgets/funding transferred/managed by PCTs during SR 2002		4,015	8,114	4,967		
Announced allocations SR 2004				58,892	64,310	70,355
Growth (%)					9.2%	9.4%
Budgets/funding transferred/managed by PCTs during SR 2004				3,383	1,292	2,010
<b>PCT revenue resource limit</b>		<b>49,042</b>	<b>57,442</b>	<b>62,275</b>	<b>65,602</b>	<b>72,365</b>
<b>Strategic health authority (SHA) funding</b>						
SHA running costs		122	137	145	145	102
Budgets/funding transferred/managed by SHAs		3,721	3,923	4,220	4,796	5,867
<b>SHA revenue resource limit</b>		<b>3,843</b>	<b>4,060</b>	<b>4,366</b>	<b>4,942</b>	<b>5,969</b>
<b>Market forces factor</b>				303	2,202	2,479
<b>Surplus/deficit in PCTs and SHAs</b>		<b>210</b>	<b>100</b>	<b>34</b>	<b>592</b>	<b>1,295</b>
<b>Centrally managed HCHS</b>						
Central budgets, special health authority funding and technical adjustments		5,737	1,971	3,848	3,858	4,242
<b>Total HCHS expenditure</b>		<b>58,412</b>	<b>63,373</b>	<b>70,757</b>	<b>76,011</b>	<b>83,760</b>

Source: PCT and SHA consolidated accounts; HM Treasury COINS database; and Department of Health allocations records

Notes:

(1) The table illustrates the transfer of funds and functions from central to locally managed within PCT and SHA revenue resource limits.

(2) HCHS funding outside PCT and SHA resource limits in 2007-08 includes: payments direct to trusts and NHS foundation trusts of the market forces factor adjustments to payments under tariff, these funds clawed back from PCT allocations and paid direct to trusts; and funding of special health authorities, research and development and the National Programme for IT.

(3) Key transfers into revenue resource limits include: from 2003-04, additional funds to cover commitments on free nursing care; from 2004-05, additional funds to cover pensions indexation, funding for Quality and Outcomes Framework; from 2005-06, funding for prison healthcare; from 2006-07, funding for dentistry; and from 2007-08, national specialist commissioning (funds hosted by SHA), student bursaries.

(4) Details of PCT expenditure against its revenue resource limit is given in figure A.15.

(5) Details of SHA expenditure against its revenue resource limit is given in figure A.16.

Figure A.7: Department of Health capital budget (core table 3)

	£ million							
	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan
<b>National Health Service (NHS)</b>	<b>2,602</b>	<b>2,624</b>	<b>2,151</b>	<b>3,069</b>	<b>3,597</b>	<b>4,410</b>	<b>5,433</b>	<b>4,674</b>
<i>Of which:</i>								
Hospital and community health services(1)	2,566	2,592	2,111	3,033	3,554	4,327	5,360	4,632
<i>of which:</i>								
Health authorities unified budget and central allocations and grants to local authorities	2,566	2,592	2,111	3,033	3,554	4,327	5,360	4,632
Central health and miscellaneous services	13	16	22	20	22	61	51	20
Departmental administration including agencies	23	16	19	17	21	21	22	23
Personal social services (PSS)	84	83	92	124	215	150	140	148
<i>Of which:</i>								
Personal social services (including Credit Approvals)	59	58	67	77	149	31	19	26
Local authority PSS grants	25	25	25	47	66	119	120	121
<i>of which:</i>								
AIDS/HIV capital grants	0	0	0	2	3	3	3	3
Improving Information Management	25	25	25	25	25	0	0	0
Learning Disabilities	0	0	0	0	0	11	11	11
Transforming Personalisation, Prevention and Well-being	0	0	0	0	0	15	16	17
Mental Health Capital Grant	0	0	0	0	0	23	23	23
Social Care Capital Grant	0	0	0	0	0	28	28	28
Extra Care Housing Grant	0	0	0	20	38	40	40	40
NHS (AME)	0	229	292	0	0	0	0	0
Credit guarantee finance (AME) <sup>(2)</sup>	0	0	357	89	37	14	0	0
<b>Total Department of Health capital budget</b>	<b>2,686</b>	<b>2,937</b>	<b>2,893</b>	<b>3,282</b>	<b>3,849</b>	<b>4,574</b>	<b>5,573</b>	<b>4,822</b>

Source: HM Treasury public expenditure database (COINS)

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 HM Treasury.

(3) Figures are presented net of receipts £-551/-533/-1,208/-1,167/-507/-294/-146/-30 million.

(4) Figures may not sum due to rounding.



Figure A.8: Comparison of 2008-09 outturn with 2008-09 planned expenditure in departmental report 2008

	Departmental report 2008 plan	Departmental report 2009 estimated outturn	£ million Difference
2008-09			
NHS revenue	92,475	90,940	-1,535
<i>Of which:</i>			
Departmental administration	219	222	3
NHS capital	4,567	4,410	-157
<i>Of which:</i>			
Departmental administration	21	22	1
PSS current	1,384	1,382	-2
PSS capital	143	150	7
<b>Total</b>	<b>97,725</b>	<b>96,038</b>	<b>-1,687</b>

Source: Financial Planning and Allocations Division, DH

Notes:

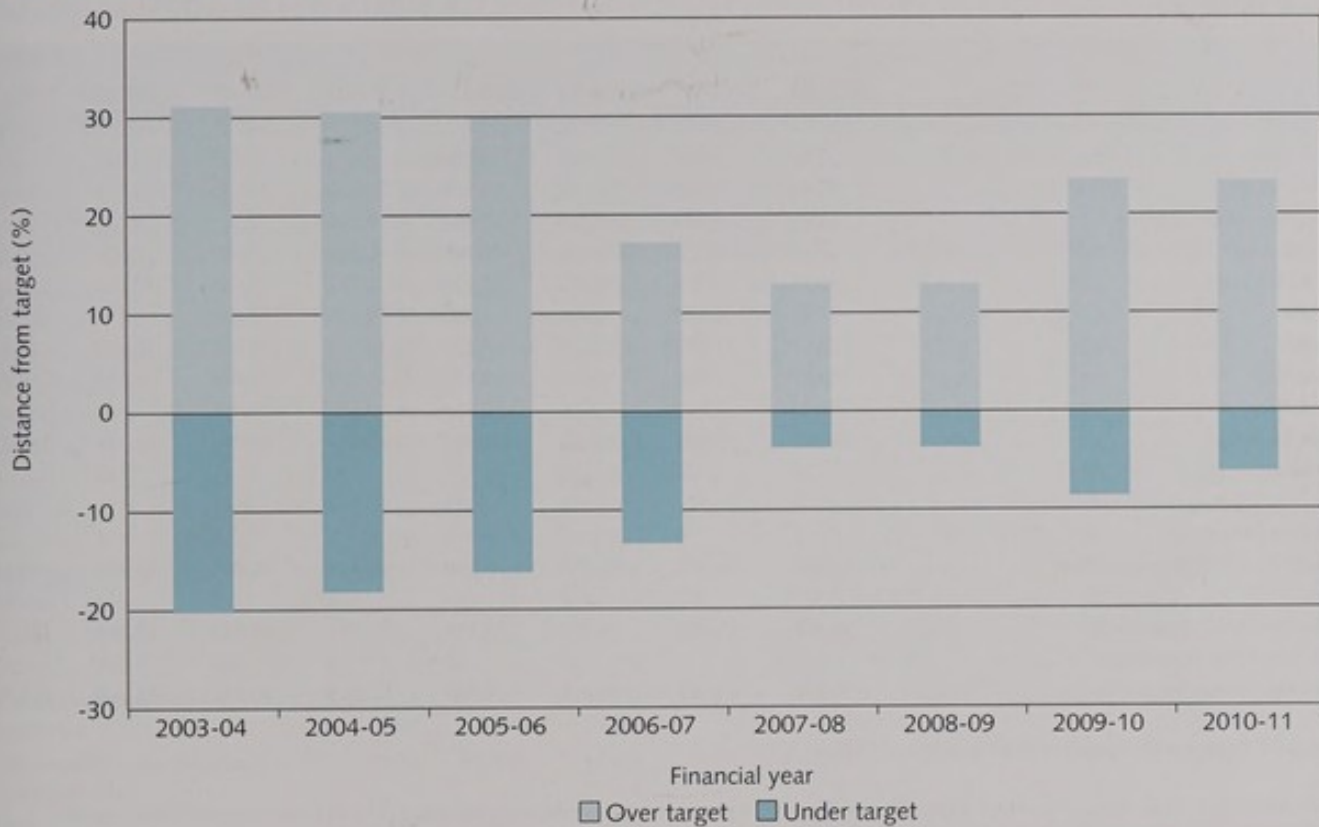
(1) Totals may not sum due to rounding.

Figure A.9: Main areas of change to the headline spending plans presented in last year's Departmental report

2008-09	Difference	Reason	£ million
NHS revenue	-1,535	Forecast underspend	-1,358
		Transfer to capital	-200
		OGD transfers	26
		Technical changes	-3
NHS capital	-157	Forecast underspend	-350
		Transfer from revenue	200
		Transfer to PSS	-7

Source: Financial Planning and Allocations Division, DH

Figure A.10: Range of PCT DFTs between 2003-04 and 2010-11



Source: PCT revenue resource limit exposition book

Figure A.11: Total capital employed by the Department of Health (core table 4)

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan	£ million
Within the Departmental account <sup>(1)(2)</sup>	11,597	14,333	14,551	14,948	15,394	15,894	16,132	16,576	
Investment outside accounting boundary <sup>(3)(4)(5)(6)</sup>	27,468	32,692	33,596	35,502	38,671	39,928	40,527	41,641	
<b>Total capital employed</b>	<b>39,065</b>	<b>47,026</b>	<b>48,147</b>	<b>50,450</b>	<b>54,065</b>	<b>55,822</b>	<b>56,659</b>	<b>58,217</b>	

Source: Department of Health

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) Includes the NHS Litigation Authority which moved inside the accounting boundary in 2000-01.
- (4) Includes 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.12: Department of Health identifiable expenditure on services, by country and region (core table 7)

	£ million							
	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 plan	2009-10 plan	2010-11 plan
North East	3,181	3,580	3,907	4,138	4,472	4,999	5,266	5,581
North West	8,737	9,523	10,342	10,918	11,923	13,181	13,878	14,697
Yorkshire and the Humber	5,909	6,647	7,306	7,602	8,209	9,319	9,610	10,194
East Midlands	4,411	4,972	5,453	5,799	6,426	7,047	7,528	8,009
West Midlands	5,970	6,707	7,272	7,923	8,582	9,345	10,010	10,608
Eastern	5,701	6,433	6,909	7,350	7,828	8,836	9,554	10,156
London	10,169	11,467	12,128	12,213	13,723	15,060	15,654	16,540
South East	8,607	9,635	10,146	11,018	11,829	12,846	14,139	14,964
South West	5,383	6,087	6,686	6,923	7,620	8,357	8,948	9,493
<b>Total England</b>	<b>58,068</b>	<b>65,050</b>	<b>70,149</b>	<b>73,884</b>	<b>80,610</b>	<b>88,990</b>	<b>94,587</b>	<b>100,240</b>
Scotland	26	28	30	34	39	45	46	48
Wales	-159	-174	-194	-193	-169	-144	-158	-168
Northern Ireland	4	4	4	4	5	6	6	6
<b>Total UK identifiable expenditure</b>	<b>57,939</b>	<b>64,907</b>	<b>69,990</b>	<b>73,730</b>	<b>80,485</b>	<b>88,897</b>	<b>94,482</b>	<b>100,126</b>
Outside UK	379	561	473	669	908	786	913	996
<b>Total identifiable expenditure</b>	<b>58,318</b>	<b>65,469</b>	<b>70,463</b>	<b>74,398</b>	<b>81,393</b>	<b>89,682</b>	<b>95,394</b>	<b>101,122</b>
Non-identifiable expenditure	0	0	0	0	0	709	1,074	453
<b>Total expenditure on services</b>	<b>58,318</b>	<b>65,469</b>	<b>70,463</b>	<b>74,398</b>	<b>81,393</b>	<b>90,392</b>	<b>96,468</b>	<b>101,575</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

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 are estimates.

Figure A.13: Department of Health identifiable expenditure on services, by country and region, per head (core table 8)

	£ per head							
	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 plan	2009-10 plan	2010-11 plan
North East	1,252	1,408	1,533	1,619	1,744	1,946	2,044	2,159
North West	1,285	1,396	1,512	1,593	1,737	1,907	1,999	2,106
Yorkshire and the Humber	1,175	1,313	1,431	1,478	1,586	1,781	1,820	1,913
East Midlands	1,037	1,159	1,260	1,329	1,461	1,583	1,674	1,762
West Midlands	1,124	1,259	1,359	1,476	1,595	1,725	1,838	1,937
Eastern	1,041	1,167	1,242	1,311	1,383	1,546	1,655	1,742
London	1,381	1,552	1,627	1,626	1,816	1,976	2,037	2,134
South East	1,064	1,186	1,240	1,338	1,424	1,538	1,679	1,764
South West	1,076	1,207	1,314	1,351	1,472	1,602	1,699	1,785
<b>Total England</b>	<b>1,164</b>	<b>1,298</b>	<b>1,390</b>	<b>1,455</b>	<b>1,578</b>	<b>1,728</b>	<b>1,823</b>	<b>1,917</b>
Scotland	5	5	6	7	8	9	9	9
Wales	-54	-59	-66	-65	-57	-48	-52	-56
Northern Ireland	2	2	3	2	3	3	3	3
<b>Total UK identifiable expenditure</b>	<b>973</b>	<b>1,085</b>	<b>1,162</b>	<b>1,217</b>	<b>1,320</b>	<b>1,448</b>	<b>1,527</b>	<b>1,607</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

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 are estimates.

Figure A.14: Department of Health identifiable expenditure on services by function, by country and region, 2007-08 (core table 9)

	£ million							Grand total
	Health			Social protection				
	Central and other health services	Medical services	Total health	Incapacity, disability and injury benefits	Old age	Survivors	Total social protection	
North East	47	4,523	4,571	19	-130	12	-99	4,472
North West	125	12,067	12,192	50	-353	33	-270	11,923
Yorkshire and the Humber	87	8,312	8,399	35	-248	23	-190	8,209
East Midlands	67	6,507	6,574	27	-192	18	-147	6,426
West Midlands	89	8,673	8,762	36	-238	22	-180	8,582
Eastern	82	7,947	8,029	33	-258	24	-201	7,828
London	142	13,813	13,955	57	-320	30	-233	13,723
South East	122	12,051	12,174	49	-435	41	-345	11,829
South West	80	7,774	7,854	32	-293	28	-234	7,620
<b>Total England</b>	<b>841</b>	<b>81,669</b>	<b>82,509</b>	<b>337</b>	<b>-2,467</b>	<b>232</b>	<b>-1,899</b>	<b>80,610</b>
Scotland	0	0	0	0	37	2	39	39
Wales	0	0	0	0	-186	17	-169	-169
Northern Ireland	0	0	0	0	5	0	5	5
<b>UK identifiable expenditure</b>	<b>841</b>	<b>81,669</b>	<b>82,509</b>	<b>337</b>	<b>-2,612</b>	<b>251</b>	<b>-2,025</b>	<b>80,485</b>
Outside UK	762	0	762	0	139	8	147	908
<b>Total identifiable expenditure</b>	<b>1,602</b>	<b>81,669</b>	<b>83,271</b>	<b>337</b>	<b>-2,473</b>	<b>259</b>	<b>-1,878</b>	<b>81,393</b>
Not identifiable	0	0	0	0	0	0	0	0
<b>Total</b>	<b>1,602</b>	<b>81,669</b>	<b>83,271</b>	<b>337</b>	<b>-2,473</b>	<b>259</b>	<b>-1,878</b>	<b>81,393</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(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.

Figure A.15: Primary care trust expenditure

	£ million	
	2006-07	2007-08
Revenue resource limit	65,602	72,365
(Under)/over spend against revenue resource limit	370	-391
Adjustment for non-discretionary expenditure	1,056	1,026
<b>Net operating costs</b>	<b>67,027</b>	<b>73,000</b>
Other income	2,872	2,880
<b>Gross operating costs</b>	<b>69,899</b>	<b>75,880</b>
<i>Of which:</i>		
Secondary care	36,583	39,950
Primary drugs	7,590	7,663
Primary new general medical services	6,938	7,067
Contractor-led general and personal dental services	2,131	2,312
Pharmaceutical services	1,141	1,175
General ophthalmic services	381	405
Purchase of healthcare from non-NHS bodies	4,685	5,717
Other	10,449	11,591
<b>Total</b>	<b>69,899</b>	<b>75,880</b>

Source: Audited PCT consolidated accounts 2007-08



Figure A.16: Strategic health authority expenditure

	£ million	
	2006-07	2007-08
Revenue resource limit	4,942	5,969
(Under)/over spend against revenue resource limit	-962	-903
Net operating costs	3,980	5,066
Other income	147	60
Gross operating costs	4,127	5,125
<i>Of which:</i>		
Training	3,381	4,129
Staff costs	229	150
NHS Direct funding	123	138
Other	393	709
<b>Total</b>	<b>4,127</b>	<b>5,125</b>

Source: Audited SHA consolidated accounts 2007-08

Figure A.17: Expected cost of implementing the new GMS contract

Financial year	£ billion
	Cost
2003-04	5.8
2004-05	6.9
2005-06	7.7
2006-07	7.8
2007-08 <sup>(1)</sup>	7.8

Source: Primary Care Division, DH

Notes:

(1) Estimated cost subject to validation and agreement with GPC.

(2) No forecast figures are currently available for 2008-09.

(3) Figures are not consistent with those reported in figure A.15 as they include dispensing doctor drugs expenditure.

Figure A.18: Family health services – general ophthalmic services, 2003-04 to 2007-08, England

	£ million				
	2003-04 resource	2004-05 resource	2005-06 resource	2006-07 resource	2007-08 resource
General ophthalmic services	322	340	359	381	405

Source: PCT accounts

Figure A.19: Family health services – primary dental care services, 2003-04 to 2007-08, England

	2003-04 resource	2004-05 resource	2005-06 resource	2006-07 resource	2007-08 resource
GDS <sup>(1)</sup>	1,767	1,671	1,448	N/a	N/a
PDS (discretionary) <sup>(2)</sup>	48	280	757	N/a	N/a
<b>Total primary dental care<sup>(3)</sup></b>	<b>1,815</b>	<b>1,951</b>	<b>2,205</b>	<b>2,212</b>	<b>2,386</b>

Source: Dental Practice Board and PCT accounts data

Notes:

- (1) General dental services (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 converted from GDS to PDS terms of service. PDS expenditure figures were 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 the Dental Practice Board. All PDS expenditure figures are gross of patient charge income, and exclude any related capital investment by NHS trusts.
- (3) Under the new service framework introduced from 1 April 2006 for local commissioning of primary dental care services, PCTs may commission general dental or specialist personal dental services according to local needs but only report aggregate primary dental care expenditure in central financial returns.
- (4) Expenditure in 2005-06 was enhanced by an accounting adjustment to correct an historic under-estimate of GDS creditor payments outstanding at the year end.

Figure A.20: Family health services – community pharmacy contractual framework expenditure, 2005-06 to 2007-08, England

	2005-06 resource	2006-07 resource	2007-08 resource
Community Pharmacy Contractual Framework <sup>(1)</sup>	1,175	1,247	1,306

Source: Prescription Pricing Division of the NHS Business Services Authority, England.

Notes:

- (1) Introduced in April 2005.
- (2) The above represent expenditures against the funding made available through the central global sum and money released in PCT budgets by lower generic medicine prices. In addition to these two funding sources, pharmacies also have access to funding of around £500 million from the margin retained on medicine purchases.

Figure A.21: Primary care gross drugs bill, 1996-97 to 2007-08, England

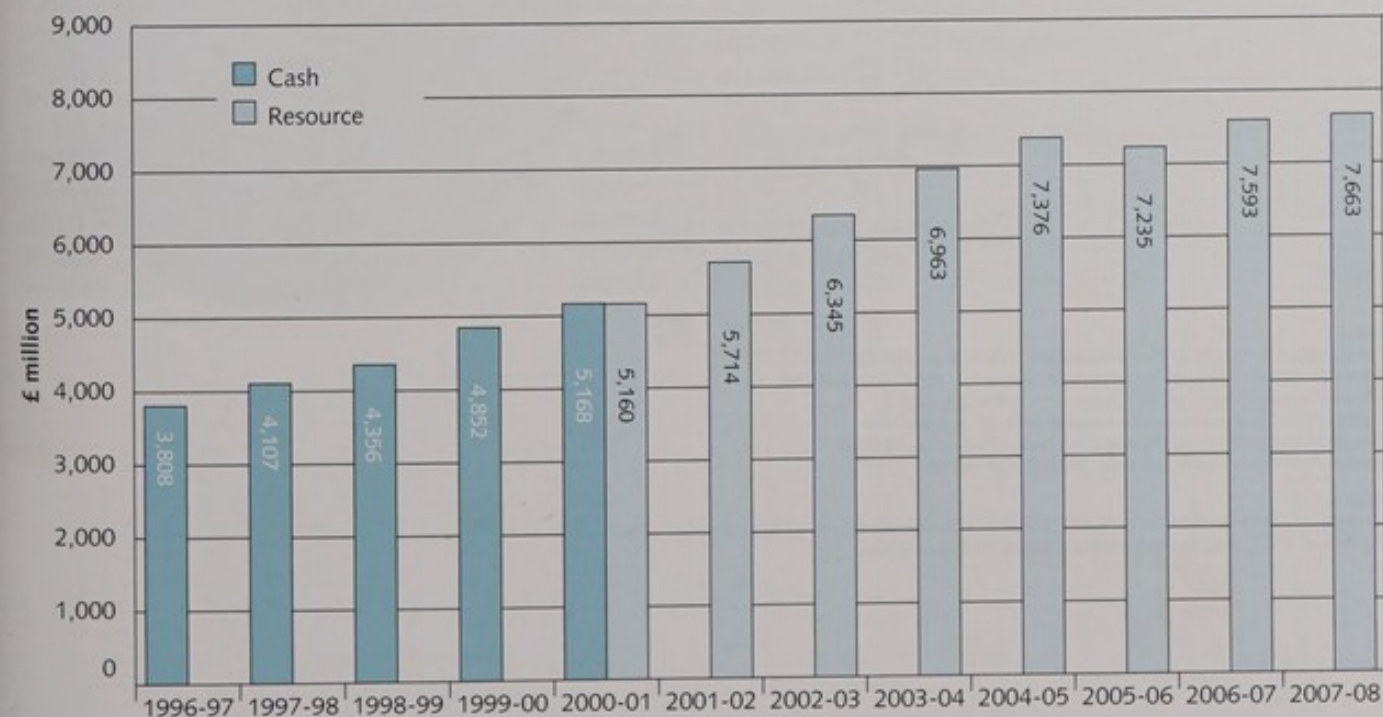




Figure A.22: Secondary care gross drugs bill, 1996-97 to 2007-08, England

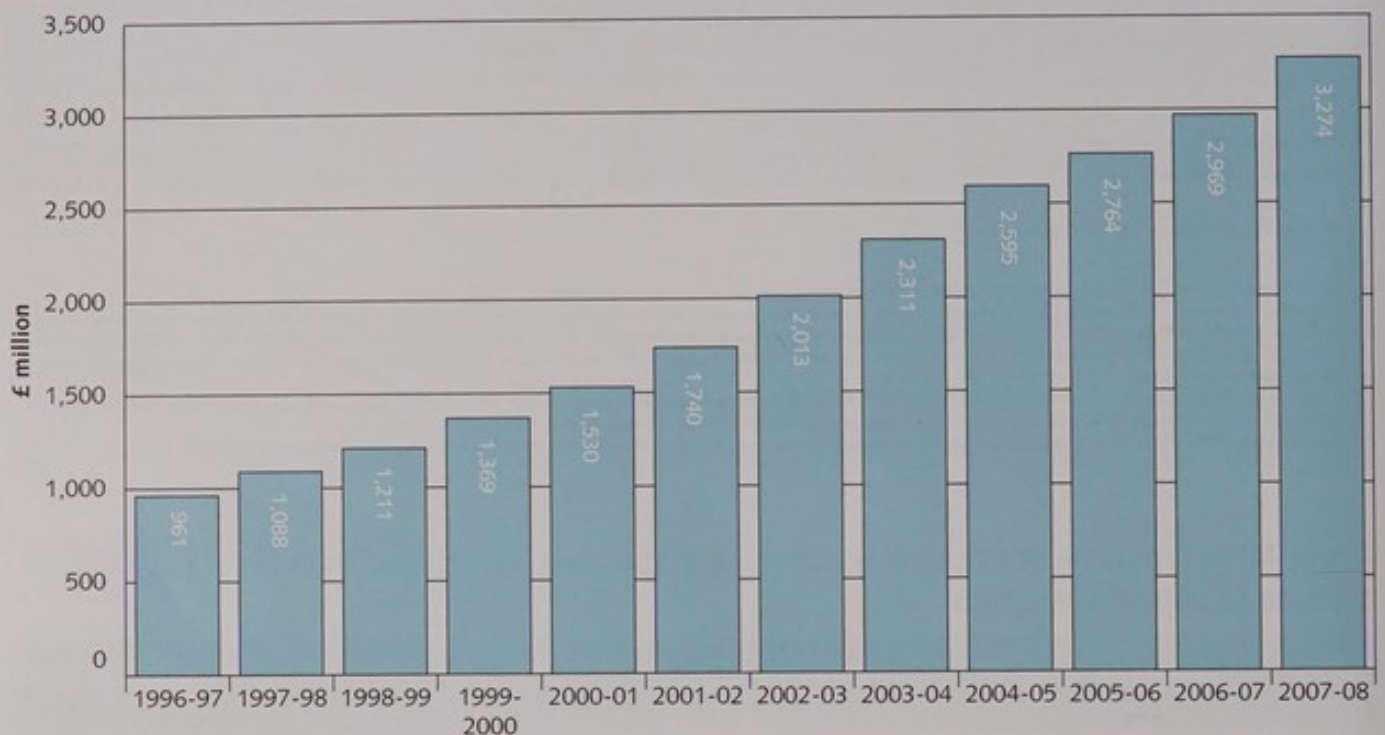


Figure A.23: Expenditure by NHS bodies on the purchase of healthcare from non-NHS bodies

£ thousands				
Year	Health authorities/strategic health authorities	Primary care trusts	NHS trusts	Total expenditure
1997-98	985,746	N/a	122,436	1,108,182
1998-99	1,108,471	N/a	121,954	1,230,425
1999-2000	1,166,412	N/a	134,784	1,301,196
2000-01	1,328,208	33,774	187,190	1,549,172
2001-02	1,136,793	409,936	246,238	1,792,967
2002-03	27,234	1,873,925	338,172	2,239,331
2003-04	3,329	2,903,763	408,801	3,315,893
2004-05	0	3,353,036	312,988	3,666,024
2005-06	0	4,096,300	319,231	4,415,531
2006-07	0	4,685,111	297,440	4,982,551
2007-08	0	5,717,489	295,079	6,012,568

Sources:

Annual Financial Returns of Health Authorities, 1997-98 to 2001-02  
 Annual Financial Returns of Strategic Health Authorities, 2002-03 to 2007-08  
 Annual Financial Returns of NHS Trusts, 1997-98 to 2005-06  
 Audited NHS Trust summarisation schedules 2006-07 and 2007-08  
 Annual Financial Returns of Primary Care Trusts, 2000-01 to 2005-06  
 Audited PCT summarisation schedules 2006-07 and 2007-08

Notes:

(1) 2004-05, 2005-06, 2006-07 and 2007-08 NHS trusts data do not include NHS foundation trusts.  
 (2) 2006-07 PCT spend has been restated following further validation.

Figure A.24: Expenditure by local authorities on Personal Social Services

	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn
<b>£ million</b>									
<b>Current expenditure<sup>(1)</sup></b>									
gross <sup>(2)</sup>	12,050	12,850	13,600	15,200	16,840	12,830	13,727	14,314	14,696
charges <sup>(2)</sup>	2,000	2,150	2,230	2,310	2,080	1,955	2,009	2,068	2,126
net <sup>(3)</sup>									
cash	10,050	10,700	11,370	12,890	14,190	10,873	11,718	12,246	12,570
real terms <sup>(4)</sup>	12,232	12,855	13,362	14,675	15,707	11,717	12,374	12,587	12,570
<b>Capital expenditure<sup>(2)</sup></b>									
gross	134	156	158	199	260	285	387	364	411
income	51	63	70	75	74	75	84	85	100
net	83	93	88	124	186	210	303	279	311

Source: Social Care Finance, DH (PSS EX1, RO, RA LAs returns and Capital Outturn)

Notes:

(1) Figures up to and including 2003-04 include adults and children's services. Figures from 2004-05 relate to adults personal social services only, due to the transfer of responsibilities for children's social services from the Department of Health. Adults are all those aged 18 and over.

(2) Gross current expenditure, income from charges and capital figures are not available for 2008-09.

(3) Net expenditure figures exclude the Supporting People Grant, which began in April 2003.

(4) At 2007-08 prices using the GDP deflator (as at 23 April 2009).

(5) Total expenditure on Supporting People was £570 million. This is not reported in the gross current expenditure on adults.

Figure A.25: Local authority adult personal social services gross expenditure by client group, 2007-08 (excluding Supporting People)

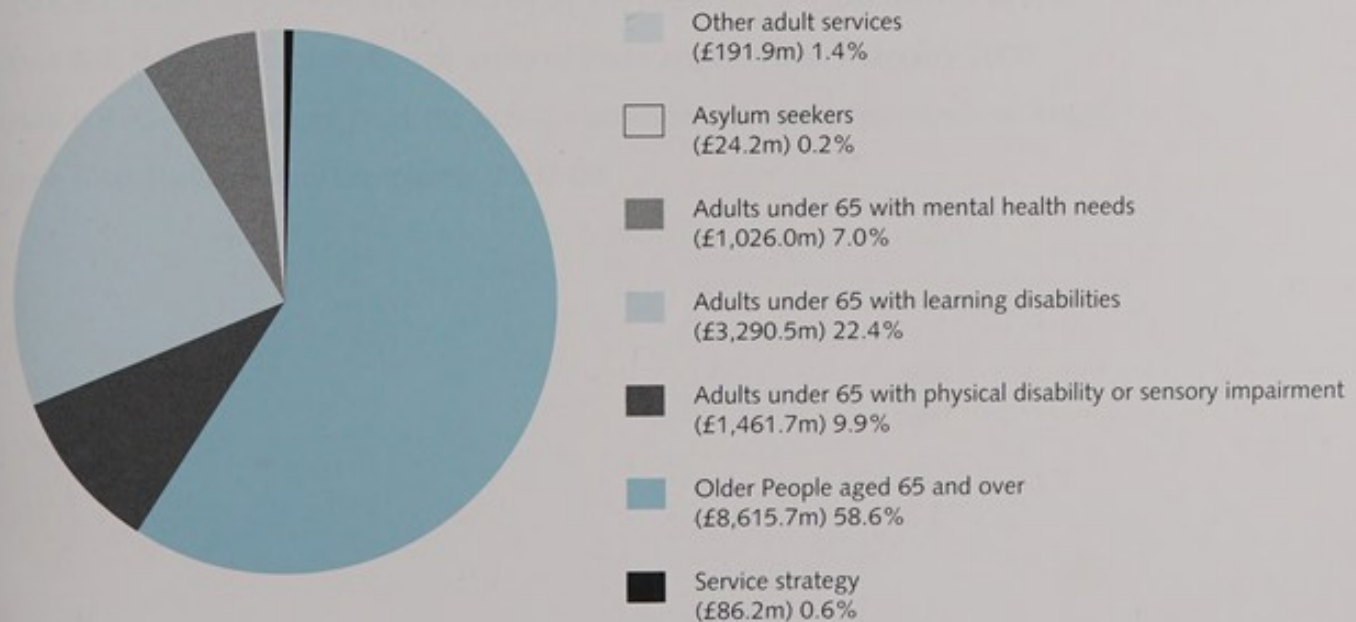
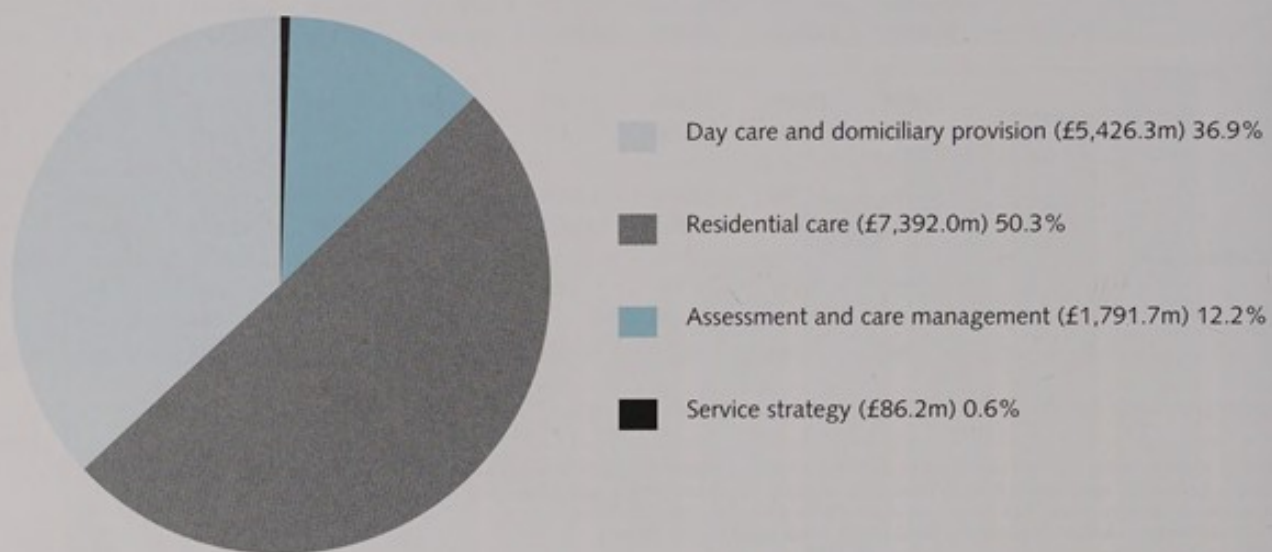




Figure A.26: Local authority adult personal social services gross expenditure by type of service, 2007-08 (excluding Supporting People)



## B Departmental Data Tables

Figure B.1: Salaries of Senior Civil Service staff in post in the Department of Health at 1 April 2008

Figure B.2: Recruitment into the Department of Health in 2008 – by gender, ethnicity and disability

Figure B.3: Department of Health administration costs (core table 5)

Figure B.4: Department of Health staff numbers (core table 6)

Figure B.5: Expenditure on professional services, 2008-09

Figure B.6: Department of Health accident statistics for 2008

Figure B.7: Public appointments sponsored by the Department – members in post at 1 January 2009

Figure B.8: Public appointments – diversity of those appointed at 1 January 2009

Figure B.9: Correspondence from the public – achievement against performance targets

Figure B.10: Parliamentary complaints, 2007-08



**Figure B.1: Salaries of Senior Civil Service staff in post in the Department of Health at 1 April 2008**

Payband (per annum)	Number of staff
£55,000–£59,999	3
£60,000–£64,999	25
£65,000–£69,999	30
£70,000–£74,999	37
£75,000–£79,999	45
£80,000–£84,999	18
£85,000–£89,999	24
£90,000–£94,999	15
£95,000–£99,999	11
£100,000–£104,999	10
£105,000–£109,999	6
£110,000–£114,999	5
£115,000–£119,999	6
£120,000–£124,999	3
£125,000–£129,999	8
£130,000–£134,999	7
£135,000–£139,999	5
£140,000–£144,999	3
£145,000–£149,999	1
Over £150,000	17
<b>Total</b>	<b>279</b>

Source: Payroll system, DH

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.

**Figure B.2: Recruitment into the Department of Health in 2008 – by gender, ethnicity and disability**

	By gender:		By ethnicity:			By disability:			Total
	Male	Female	White	BME <sup>(1)</sup>	Unknown	Not disabled	Disabled	Unknown	
<b>Permanent staff joining in 2008 who were still employed by the Department on 31 March 2009</b>									
Senior Civil Service	12	6	6	0	12	7	0	11	18
Fast Stream	7	13	19	0	1	14	5	1	20
Posts at former UG6 and below	75	116	149	27	15	169	11	11	191
<b>Total</b>	<b>94</b>	<b>135</b>	<b>174</b>	<b>27</b>	<b>28</b>	<b>190</b>	<b>16</b>	<b>23</b>	<b>229</b>
<b>Permanent staff joining in 2008 who were no longer employed by the Department on 31 March 2009</b>									
<b>Total</b>	<b>12</b>	<b>10</b>	<b>10</b>	<b>8</b>	<b>4</b>	<b>19</b>	<b>0</b>	<b>3</b>	<b>22</b>
<b>All permanent staff joining in 2008</b>									
Senior Civil Service	12	6	6	0	12	7	0	11	18
Fast Stream	7	13	19	0	1	14	5	1	20
Posts at former UG6 and below	87	126	159	35	19	188	11	14	213
<b>Total</b>	<b>106</b>	<b>145</b>	<b>184</b>	<b>35</b>	<b>32</b>	<b>209</b>	<b>16</b>	<b>26</b>	<b>251</b>

Source: Business Management System (BMS), DH

Notes:

(1) Black and minority ethnic.

Figure B.3: Department of Health administration costs (core table 5)

	£ million							
	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan <sup>(1)</sup>	2010-11 plan <sup>(1)</sup>
<b>Administration expenditure</b>								
Paybill	140	113	114	118	117	117	N/a	N/a
Other	156	163	140	116	114	109	N/a	N/a
<b>Total administration expenditure</b>	<b>296</b>	<b>277</b>	<b>254</b>	<b>234</b>	<b>231</b>	<b>225</b>	<b>218</b>	<b>212</b>
Administration income	-11	-9	-9	-5	-5	-4	-4	-4
<b>Total administration budget</b>	<b>285</b>	<b>268</b>	<b>246</b>	<b>229</b>	<b>226</b>	<b>221</b>	<b>214</b>	<b>209</b>
<b>Analysis by activity</b>								
Central Department	285	268	246	229	226	221	214	209
Other	0	0	0	0	0	0	0	0
<b>Total administration budget</b>	<b>285</b>	<b>268</b>	<b>246</b>	<b>229</b>	<b>226</b>	<b>221</b>	<b>214</b>	<b>209</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) A breakdown between paybill and other for years 2009-10 to 2010-11 is not available.

(2) Figures may not sum due to rounding.

Figure B.4: Department of Health staff numbers (core table 6)

	Financial year average								
	2003-04 actual	2004-05 actual	2005-06 actual	2006-07 actual	2007-08 actual	2008-09 plan	2008-09 estimated outturn	2009-10 plan	2010-11 plan
<b>Department of Health (gross control area)<sup>(1)(2)</sup></b>									
Core Department of Health (full-time equivalents)	2,964	2,050	2,245	2,250	2,178	2,221	2,222	2,245	2,245
Other	0	0	0	0	0	0	0	0	0
Designated to transfer from the Department (full-time equivalents)	0	139	119	65	50	24	34	0	0
<b>Agencies</b>									
NHS Pensions Agency (full-time equivalents) <sup>(3)</sup>	258	0	0	0	0	0	0	0	0
Medicines and Healthcare products Regulatory Agency (full-time equivalents) <sup>(4)</sup>	747	781	819	831	875	959	923	977	995
NHS Purchasing and Supply Agency (PASA) (full time equivalents) <sup>(5)</sup>	318	332	350	321	283	290	289	314	314
NHS Estates <sup>(6)</sup>	375	314	0	0	0	0	0	0	0
<b>Total Department of Health</b>	<b>4,662</b>	<b>3,616</b>	<b>3,533</b>	<b>3,467</b>	<b>3,386</b>	<b>3,494</b>	<b>3,468</b>	<b>3,536</b>	<b>3,554</b>

Source: Department of Health (core) – Business Management System (BMS); executive agencies – HR systems.

Notes:

(1) 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 ministers and special advisers. From 2008-09 they do not include Connecting for Health civil servants.

(2) The Department announced a major change programme in March 2003, under which it committed to reduce 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 2007, the Department's full-time equivalent staffing was 2,189 (excluding ministers and special advisers), representing a reduction of 1,456 from March 2003. This consisted of 637 transfers and 819 posts removed.

(3) The NHS Pensions Agency became a special health authority (part of the NHS) in April 2004.

(4) The Medicines Control Agency and the Medical Devices Agency merged with effect from 1 April 2003 to become the Medicines and Healthcare products Regulatory Agency (MHRA).

(5) The Procurement Policy and Advisory Unit and the Centre for Evidence-based Purchasing joined PASA from the core Department from 2004-05 following an organisational review. During 2006-07, some PASA activities and associated staffing were outsourced to DHL/NHS Supply Chain.

(6) 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.

(7) Future planned staff numbers are subject to change.



Figure B.5: Expenditure on professional services, 2008-09

Organisation	£ million Spend
Department of Health professional services expenditure (including consultancy, temporary agency staff and interim personnel)	262.0
Executive agency professional services expenditure (including consultancy, temporary agency staff and interim personnel)	9.0
<b>Total</b>	<b>271.0</b>

Source: NHS Purchasing and Supply Agency

Notes:

(1) Expenditure is reported against the Office of Government Commerce definition of professional services.

(2) NHS consultancy spend is not included in the above table.

(3) Figures exclude NHS Connecting for Health.

(4) The expenditure figures are from 1 April 2008 to 31 March 2009. The figures are estimated from month 11 actual year to date general ledger data due to actual spend not being available for the whole year.

Figure B.6: Department of Health accident statistics for 2008

	Number
Total reported accidents	48
Of which:	
Resulting in absence	0
Total reported near misses <sup>(1)</sup>	13

Source: Health and Safety Unit, DH

Notes:

(1) A near miss is 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.

Figure B.7: Public appointments sponsored by the Department – members in post at 1 January 2009

Type of body	Chairs	Members	Total
Strategic health authorities	10	49	59
NHS trusts	124	664	788
Primary care trusts	146	911	1,057
Special health authorities	11	170	181
Advisory non-departmental public bodies	29	431	460
Executive non-departmental public bodies	10	111	121
Other bodies	1	20	21
<b>Total</b>	<b>331</b>	<b>2,356</b>	<b>2,687</b>

Source: The Appointments Commission

Figure B.8: Public appointments – diversity of those appointed at 1 January 2009

Total number of appointments	2,687
Percentage of non-executive board members (including chairs) who are women	35.4
Percentage of non-executive board members (including chairs) from black and minority ethnic communities	11.9
Percentage of non-executive board members (including chairs) who are disabled	4.4

Source: The Appointments Commission

Figure B.9: Correspondence from the public – achievement against performance targets

Type of correspondence						Percentage
	2003	2004	2005	2006	2007	2008
Private office case <sup>(1)</sup>	54.0	80.9	90.1	88.9	92.0	95.4
Treat official case <sup>(2)</sup>	67.2	88.0	97.3	92.3	99.0	97.3
Departmental e-mail <sup>(3)</sup>	87.1	95.4	96.6	95.8	99.0	98.4
Calls <sup>(4)</sup>	N/a	42.0	76.1	88.1	84.0	87.0

Source:

Correspondence: From 2004, all private office, treat official and Departmental e-mail cases from Department of Health (DH) Correspondence Database. Figures include all cases with a 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) Callisan System. Figures include all calls taken during the period. Data are not available before 2004.

Notes:

(1) Letters signed by ministers.

(2) Letters signed by officials on behalf of ministers.

(3) E-mails received through the Department's website.

(4) Telephone calls received in the call centre.

Figure B.10: Parliamentary complaints, 2007-08

Area	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
Department of Health	0	0	2	0	2	50%	0%	50%	0
Commission for Social Care Inspection	1	0	1	0	2	0%	100%	0%	0
General Social Care Council	1	0	0	0	1	0%	0%	100%	0
Healthcare Commission	0	0	1	0	1	0%	0%	100%	0

Source: Parliamentary and Health Service Ombudsman Annual Report 2007-08





## C Public Service Agreement and Departmental Strategic Objective Indicators (CSR 2007) Analysis

The Government articulated its highest priorities and outcomes for the CSR 2007 period (from 2008-09 to 2010-11) through the introduction of 30 cross-government Public Service Agreements (PSAs) and a set of Departmental Strategic Objectives (DSOs), published in December 2008.

The Department leads on two PSAs:

- PSA Delivery Agreement 18 – Promote better health and well-being for all; and
- PSA Delivery Agreement 19 – Ensure better care for all.

These are also the Department's DSO1 and DSO2 respectively. DSO3 is:

- To provide better value for all.

The Department has a set of 44 DSO indicators – to which PSAs are a subset – underpinning its wider departmental business such as the Department's contribution to the delivery of other government departments' PSAs.

Following publication of initial progress in the Department's *Autumn Performance Report 2008*, this report provides some further reporting of progress on the CSR 2007 commitments.

The data systems underpinning PSA and DSO indicators are subject to validation by the National Audit Office (NAO). It has published its reports on the two PSAs that the Department leads ([www.nao.gov.uk](http://www.nao.gov.uk)) and the ratings on the data systems for each indicator (refer to **figure C.1**) are captured here. The NAO has not rated the data systems for the DSO indicators. The data systems for indicators that the Department lead on that contributes to the delivery of PSAs led by other government departments have not yet been reported on by the NAO, and are not included in this report. The Department accepts that there are some areas where data collection needs to improve, and work is in place to ensure that this is happening.

Figure C.1: National Audit Office ratings on data systems

Rating	Definition
Green (fit for purpose)	The data system is fit for the purpose of measuring and reporting performance against the indicator.
Green (disclosure)	The data system is appropriate for the indicator and the Department has fully explained the implications of limitations that cannot be cost-effectively controlled.
Amber (systems)	Broadly appropriate, but needs strengthening to ensure that remaining risks are adequately controlled.
Amber (disclosure)	Broadly appropriate, but includes limitations that cannot be cost-effectively controlled; the Department should explain the implications of these.
Red (systems)	The data system does not permit reliable measurement and reporting of performance against the indicator.
Red (not established)	The Department has not yet put in place a system to measure performance against the indicator.



## PSA Delivery Agreement 18: Promote better health and well-being for all

### Summary assessment

PSA 18 sets out the Government's commitment to deliver the best possible health and well-being outcomes for everyone, helping people to live healthier lives, empowering them to stay independent for longer and tackling inequalities.

Five key indicators have been chosen to monitor progress against this PSA. Overall, PSA 18 is making some progress with improvement in 2 out of the 5 indicators.

#### Indicator 18.1

Vital Sign Tier 2 and Local Government National Indicator 120.

All age all cause mortality (AAACM) rate. This is a proxy measure for life expectancy – **improvement**.

This is linked to the SR 2004 commitment: By 2010, increase average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women. (The current estimate is that this is equivalent to AAACM in England decreasing to 649 deaths per 100,000 for men and 467 deaths per 100,000 for women by 2009 to 2011. Precise numbers will change as the age distribution of deaths changes; the current estimate is based on 2005 to 2007 age distribution of deaths.)

#### Progress

The 1995 to 1997 baseline figure for AAACM rates was 931.1 deaths per 100,000 population (males), 606.4 deaths per 100,000 population (females). In the period 2005 to 2007, AAACM rates have fallen to 710.1 deaths per 100,000 population (males) (24 per cent below the baseline rate), 500.2 deaths per 100,000 population (females) (18 per cent below the baseline rate). The 2005 to 2007 figures also show that life expectancy at birth in England continued to increase for both males (77.5 years) and females (81.7 years).

For more information, visit the publications and statistics section of the Department's website at: [www.dh.gov.uk](http://www.dh.gov.uk)

#### Data quality

Green (fit for purpose)

## Indicator 18.2

Vital Sign Tier 2 and Local Government National Indicator 120.

Gap in the AAACM rate between spearhead group and England average. This is a proxy measure for life expectancy – **no improvement**.

This is linked to the SR 2004 commitment: Reduce health inequalities by 10 per cent by 2010 as measured by life expectancy at birth. (The current estimate is that this is equivalent to the AAACM gap decreasing to 98 deaths per 100,000 for men and 58 deaths per 100,000 for women by 2009 to 2011. Precise numbers will change as the age distribution of deaths and England life expectancy change; the current estimate is based on 2005 to 2007 age distribution of deaths and current England life expectancy trend.)

### Progress

The 1995 to 1997 baseline figure for the gap in AAACM rates was 142.3 deaths per 100,000 population (males), 75.5 deaths per 100,000 population (females). The 2005 to 2007 gap in AAACM rates show 124.1 deaths per 100,000 population (males), 76.1 deaths per 100,000 population (females).

Life expectancy has improved significantly for both spearhead areas and England on average, but the gaps have not narrowed compared with the baseline. The baseline figure is a three-year average for the period 1995 to 1997, when the spearhead group life expectancy was 72.7 years for males and 78.3 years for females, and the relative gap in life expectancy between England and the spearhead group was 2.57 per cent for males and 1.77 per cent for females. In the period 2005 to 2007, spearhead group life expectancy has risen to 75.6 years for males and 80.2 years for females; however, the relative gap in life expectancy was 4 per cent wider than the baseline gap for males (compared with 2 per cent wider in 2004 to 2006), and was 11 per cent wider than the baseline gap for females (the same as in 2004 to 2006).

For more information, visit the publications and statistics section of the Department's website.

### Data quality

Green (fit for purpose)



### Indicator 18.3

Vital Sign Tier 2 and Local Government National Indicator 123.

Smoking prevalence is linked to the SR 2004 commitment to reduce adult smoking rates by 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less – **improvement**.

#### Progress

The rate of stop smoking service clients who successfully quit smoking at the four-week follow-up per 100,000 population is currently used as a proxy measure for this indicator. The 2004-05 to 2006-07 baseline figure for the average annual rate was 782 quitters per 100,000 population. The rate for quarters 1 to 3 of 2008-09 was 497 quitters. This shows that the services are currently on track to exceed the baseline in 2008-09.

In 2007 the percentage of the overall population aged 16 or over who smoked was 21 per cent, and in the routine and manual occupations was 26 per cent.

For more information on stop smoking services visit the website of the NHS Information Centre ([www.ic.nhs.uk](http://www.ic.nhs.uk)), and for smoking prevalence figures visit the UK National Statistics website ([www.statistics.gov.uk](http://www.statistics.gov.uk))

#### Data quality

Green (disclosure)

### Indicator 18.4

Vital Sign Tier 3 and Local Government National Indicator 136.

Number of adults (aged 18 or over) per 100,000 population supported to live independently at home either directly through social care or via organisations that receive social services grants – **not yet assessed**.

#### Progress

This is a new indicator. First-time data are available for 2007-08, in which year 3,143 people per 100,000 population were helped to live independently at home (refer to **figure C.2**).

For more information, visit the website of the Information Centre.

#### Data quality

Amber (systems)

Figure C.2: Number of adults per 100,000 helped to live at home

Period	Number of adults aged 18+ per 100,000 population helped to live at home
2001-02	2,475
2002-03	2,531
2003-04	2,564
Definition restated	
2004-05	2,512
2005-06	2,560
2006-07	2,572
Definition restated	
2007-08	3,143

Source: Copyright © 2009 Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Notes:

(1) Clients helped to live at home include Referrals, Assessments and Packages of Care (RAP) data from 2000-01 to 2006-07 and include RAP and Government Finance Statistics (GFS) data from 2007-08.

(2) The figure for 2007-08 includes GFS data but there is some double counting between RAP and GFS data where a person receives services arranged by their council following an assessment and services from a grant-funded voluntary organisation. This is estimated at around 20 per cent of the GFS data. There is also double counting within the GFS data where a person receives services from more than one grant-funded scheme or organisation, but it is difficult to estimate how large this is due to data sharing issues.

## Indicator 18.5

### Vital Sign Tier 3

Improving access to psychological therapies (IAPT) through the proportion of people with depression and/or anxiety disorders who are offered psychological therapies – **not yet assessed**.

### Progress

This is a new indicator and IAPT services have been rolled out across 35 PCTs in year 1 (2008-09) of the IAPT Programme. In year 2 (2009-10), IAPT services will be rolled out across a further 81 sites, bringing the total to 116 PCTs by April 2010. A baseline will be established from quarter 4 key performance indicator data returns in May 2009.

For more information, visit [www.iapt.nhs.uk](http://www.iapt.nhs.uk)

### Data quality

Amber (disclosure)



## PSA Delivery Agreement 19: Ensure better care for all

### Summary assessment

PSA 19 sets out the Government's commitment to ensure that people have high-quality, safe and accessible care that is sensitive to their individual health and adult social care needs, and their particular lifestyles and aspirations. Eight key indicators have been chosen to monitor progress against this PSA.

Overall, PSA 19 is making strong progress with improvement in 6 out of the 8 indicators.

### Indicator 19.1

Vital Sign Tier 2 and Local Government National Indicator 127.

Self-reported experience of patients and users – **improvement**.

### Progress

The baseline is drawn from the 2007-08 survey programme, and results for 2008-09 will be drawn from the accident and emergency services survey, adult in-patient survey, ambulance services (category C) survey, and mental health in-patient survey. Baseline results for 2007-08 were published on the Department's website in November 2008 and the next update will be published in June 2009.

For more information, visit the publications and statistics section of the Department's website.

### Data quality

Green (disclosure)

## Indicators 19.2 (admitted) and 19.3 (non-admitted)

Vital Sign Tier 1.

This is linked to the SR 2004 commitment: To ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment (for clinically appropriate patients who choose to start their treatment within 18 weeks). The minimum operational standards that the NHS is expected to deliver against are 90 per cent for admitted patients and 95 per cent for non-admitted patients – **improvement**.

### Progress

From 1 January 2009, 90 per cent of patients who require admission to hospital and 95 per cent of patients who do not require admission to hospital can expect to start their consultant-led treatment within a maximum of 18 weeks from referral, unless it is clinically appropriate to do so or they choose to wait longer. As set out in *The Operating Framework 2009-10*, delivering treatment within a maximum of 18 weeks continues to be a priority for the NHS. Every PCT and trust needs to achieve this standard across all services and specialties, monitoring waits over of 18 weeks so that patients do not wait for reasons other than choice or clinical exception.

The baseline figure for admitted patients was 48 per cent in March 2007, and for non-admitted patients it was 75.5 per cent in August 2007. In February 2009, the NHS delivered the operational standards for 18 weeks for the seventh month since August 2008. Some 92.7 per cent of admitted patients and 97.3 per cent of non-admitted patients began treatment within 18 weeks of referral. The median time waited for admitted patients was 8.7 weeks, and for non-admitted patients it was 3.7 weeks (refer to **figure C.3**.)

Reducing waiting times for diagnostic tests has been pivotal in delivering treatment within a maximum of 18 weeks from referral. Stage of treatment waiting time data for the 15 key diagnostics tests show that the number of waits over 6 weeks at the end of February was 3,500 – which is 0.8 per cent of the total number of waits. This compares with 276,800 in February 2007. Patients can expect to wait around 2 weeks for one of the 15 key diagnostic tests, compared with 6.1 weeks in April 2006 when data were first published (refer to **figure C.4**.)

For more information, visit the publications and statistics section of the Department's website.

### Data quality

Green (disclosure)



Figure C.3: Percentage of patients waiting less than 18 weeks

Month	Percentage within 18 weeks:	
	admitted <sup>(1)</sup>	non-admitted
March 2007	48%	
April 2007	51%	
May 2007	53%	
June 2007	54%	
July 2007	54%	
August 2007	56%	76%
September 2007	57%	76%
October 2007	60%	77%
November 2007	63%	77%
December 2007	69%	79%
January 2008	69%	82%
February 2008	75%	86%
March 2008	87%	93%
April 2008	87%	93%
May 2008	89%	94%
June 2008	89%	94%
July 2008	90%	95%
August 2008	90%	95%
September 2008	90%	96%
October 2008	91%	96%
November 2008	91%	96%
December 2008	93%	97%
January 2009	93%	97%
February 2009	93%	97%

Source: NHS Finance, Performance and Operations, DH

Notes:

(1) Admitted figures unadjusted (to account for clock pauses) up to February 2008, adjusted for March 2008 onwards.

Figure C.4: Diagnostic over 6 week waiters (patient numbers)

Month	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	September 2007	October 2007	November 2007	December 2007
15 monthly tests	350,822	276,824	243,190	249,481	224,972	211,004	186,154	174,066	140,052	114,296	89,905	86,185
All other diagnostic tests (quarterly census)	186,580	186,580	101,489	101,489	101,489	87,630	87,630	87,630	69,160	69,160	69,160	44,400
Month	January 2008	February 2008	March 2008	April 2008	May 2008	June 2008	July 2008	August 2008	September 2008	October 2008	November 2008	December 2008
15 monthly tests	67,473	33,121	12,904	12,021	11,751	10,083	11,088	10,494	6,616	6,115	4,839	5,703
All other diagnostic tests (quarterly census)	44,400	44,400	12,600	12,600	12,600	7,069	7,069	7,069	7,457	7,457	7,457	6,279
Month	January 2009	February 2009										
15 monthly tests	5,686	3,470										
All other diagnostic tests (quarterly census)	6,279	6,279										

Source: NHS Finance, Performance and Operations, DH

## Indicator 19.4

### Vital Sign Tier 2 and Local Government Indicator 126

The percentage of women who have seen a midwife or maternity healthcare professional for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy – **not yet assessed**.

### Progress

This is a new indicator in 2008-09. The proxy, unvalidated data for quarter 3 2008-09 shows that nationally around 78 per cent of women in England are seen by the 12th completed week of pregnancy, although wide variation exists between SHAs. The first full assessment of performance improvement will be made in quarter 2 2009-10, when quarter 4 2008-09 12-week assessment data are compared with quarter 2 2009-10 birth data and performance in quarter 3 and quarter 4 2008-09 can be compared.

### Data quality

Amber (disclosure).

Figure C.5: Access for women to maternity services

Strategic health authority	% of maternities assessed by 12th completed week of pregnancy (quarter 3, 2008-09)
North East	85.2%
North West	75.1%
Yorkshire and the Humber	76.5%
East Midlands	89.0%
West Midlands	83.3%
East of England	75.3%
London	66.4%
South East Coast	85.7%
South Central	87.8%
South West	84.4%
England	78.5%

Source: PCT Vital Signs monitoring returns

Notes:

(1) The definitions for the numerator and denominator for quarter 1 and quarter 3 were revised for quarter 3 based on the variation in PCT returns due to varying interpretations of the original definitions.

(2) Quarter 3, 2008-09 shows significant improvement in number of data returns by PCTs.



### Indicator 19.5

Vital Sign Tier 3 and Local Government National Indicator 124

Percentage of people with a long-term condition (LTC) supported to be independent and in control of their condition(s) – **not yet assessed**.

#### Progress

Change in the number of emergency bed days is used as a proxy measure for this indicator during 2008-09. In 2007-08, there were 28.2 million emergency bed days and 74 per cent of people with an LTC reported feeling either fully (45 per cent) or partially (29 per cent) supported to manage their condition. Updated results for the proportion of people with LTCs feeling supported will be published by February 2010.

#### Data quality

Green (disclosure)

### Indicator 19.6

Vital Sign Tier 1.

Patient-reported experience of access to GP services, as measured by an average of five indicators in the GP Patient Survey (GPPS) covering telephone access, 48-hour access, advanced booking, seeing a specific GP and opening hours – **improvement**.

#### Progress

The GPPS showed that overall satisfaction aggregated from the five indicators was 84 per cent in 2006-07 and 85 per cent in 2007-08 (refer to **figure C.6**).

The 2008-09 GPPS will cover a broader range of questions covering overall patient experience of GP practice, and a new baseline will be established using new survey questions in the 2008-09 survey prior to publishing the latest data in July 2009.

For more information, visit the publications and statistics section of the Department's website.

#### Data quality

Green (disclosure)

Figure C.6: GP Patient Survey results

Area	Score
Reported that they were satisfied with their ability to get through to their doctor's surgery on the telephone	87.0%
Reported that they were able to get a quick appointment within 48 hours with a GP	87.0%
Reported that they were able to book ahead for an appointment with a doctor	77.0%
Reported that they were able to see a specific GP when they wanted to do so	88.0%
Reported that they were satisfied with the current opening hours in their practice	82.0%

Source: GP Patient Survey, 2007-08

### Indicator 19.7

Vital Sign Tier 1.

Healthcare-associated infection (HCAI) figures – MRSA – **improvement.**

#### Progress

Baseline figures for 2003-04 show that there were 7,700 cases. For quarter 2 in 2008-09 there were 725 MRSA cases reported and by quarter 3, 676 MRSA cases had been reported. These data bring the total of MRSA cases for quarter 1 to quarter 3 in 2008-09 to 2,239. Data for quarter 4 in 2008-09 will not be published until June 2009; however, indications are that MRSA cases continue to fall.

For more information, visit the Health Protection Agency website ([www.hpa.org.uk](http://www.hpa.org.uk)).

#### Data quality

Green (fit for purpose)

### Indicator 19.8

Vital Sign Tier 1.

Healthcare-associated infection (HCAI) figures – *Clostridium difficile* – **improvement.**

#### Progress

Baseline figures show that in 2007-08 there were 55,499 *C. difficile* cases. For quarter 2 in 2008-09 there were 8,948 cases (all cases for age 2 and over) reported, and by quarter 3, 7,906 cases had been reported. These data bring the total of *C. difficile* cases for quarter 1 to quarter 3 in 2008-09 to 27,737. Data for quarter 4 in 2008-09 will not be published until June 2009; however, indications are that *C. difficile* cases continue to fall.

For more information, visit the Health Protection Agency website.

#### Data quality

Green (fit for purpose)



### **Jointly shared indicator DWP 17.5**

Local Government National Indicator 139.

The extent to which people over 65 receive the support they need to live independently at home – **not yet assessed**.

#### **Progress**

This is a new perception-based measure. Data is now taken from the ONS Omnibus Survey that provides monthly monitoring data. The rationale for using the ONS Omnibus rather than the Natcen Omnibus (as originally intended) or Place Survey, is based on frequency of data. The Department's will continue to jointly work with CLG and DWP to ensure data quality. A baseline will be set using the ONS data in June 2009.

## **DSO 1: Promote better health and well-being for all (including the Department's contribution to OGD PSAs)**

### **Summary assessment**

The Department's DSO 1 aims to deliver the best possible health and well-being outcomes for everyone. PSA Delivery Agreement 18 is closely linked with this DSO, as the five PSA indicators are also DSO indicators. Progress against this DSO is measured by 19 of the Department's full set of 44 indicators, as set out in the Department Strategic Framework published in July 2008. Where DSO indicators contribute to the delivery of cross-government PSAs led by other government departments, this is shown in the heading of the indicator.

Overall, DSO 1 is making some progress with some indicators while others require more work which the Department is putting in place – improvement in 7 out of 19 indicators:

### **Indicator DSO 1.3**

Vital Sign Tier 2.

Reduce mortality rates from suicide and injury of undetermined intent mortality rate by at least 20 per cent by 2010.

#### **Progress**

This is an SR 2004 commitment. The baseline figure is a three-year average rate for the period 1995 to 1997, which showed 9.2 deaths per 100,000 population. In the period 2005 to 2007, the figure was 7.9 per 100,000 population (a decrease of 13.9 per cent).

For more information, visit the publications and statistics section of the Department's website.

### Indicator DSO 1.4 and DCSF PSA 12.4

Vital Sign Tier 2 and Local Government National Indicators 50 and 51.

Emotional health and well-being, and child and adolescent mental health services (CAMHS) are the two sub-measures monitoring progress against this indicator – **not yet assessed** (emotional health and well-being) and **improvement** (CAMHS)

#### Progress

Emotional health and well-being: The baseline for this sub-measure was established at December 2008 as 63.3 per cent of school-aged children reporting good emotional health. New data will be collected through the DCSF Tell Us surveys due in autumn 2009 and autumn 2010.

CAMHS: The baseline for this sub-measure was established at December 2008 as 15 per cent for PCTs and 20 per cent (provisionally) for local authorities on reporting maximum scores on their CAMHS self-assessments. There are four sub-measures in the CAMHS self-assessment which require PCTs to declare if they provide (1) a full range of CAMHS, (2) access for 16- to 17-year-olds, (3) 24-hour cover, and (4) a full range of universal services by local authority/PCT (note: this measure was introduced in April 2008). In quarter 3 2008-09, the number of PCTs in England fully compliant with the four sub-measures were as follows: (1) 68, (2) 88, (3) 97, and (4) 42. This showed that 22 per cent of PCTs were compliant with all measures.

### Indicator DSO 1.6

Vital Sign Tier 2 and Local Government National Indicator 121.

Reduce mortality rates by 2010 from heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a 40 per cent reduction in the inequalities gap between the fifth of areas with worst health and deprivation indicators (the spearhead group) and the population as a whole.

#### Progress

This is an SR 2004 commitment and is measured in three-year averages. The baseline figures for the period 1995 to 1997 showed that the England rate was 141.3 deaths per 100,000 population and the inequalities gap was 36.7 deaths per 100,000 population. For the period 2005 to 2007, the England rate was 79.1 deaths per 100,000 population (a decrease of 44.0 per cent) and the inequalities gap was 23.5 deaths per 100,000 population (a decrease of 35.9 per cent).

For more information, visit the publications and statistics section of the Department's website.



### **Indicator DSO 1.7**

Vital Sign Tier 2 and Local Government National Indicator 122.

Reduce mortality rates from cancer by 2010 by at least 20 per cent in people under 75, with a reduction in the inequalities gap of at least 6 per cent between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

#### **Progress**

This is an SR 2004 commitment and is measured in three-year averages. The baseline figures for the period 1995 to 1997 showed that the England rate was 141.2 deaths per 100,000 population and the inequalities gap was 20.7 deaths per 100,000 population. For the period 2005 to 2007, the England rate was 115.5 deaths per 100,000 population (a decrease of 18.2 per cent) and the inequalities gap was 18.0 deaths per 100,000 population (a decrease of 13.2 per cent).

For more information, visit the publications and statistics section of the Department's website.

### **Indicator DSO 1.8**

NHS Operating Framework national priority, 2008-09 to 2010-11.

Preparedness against pandemic influenza is measured by the requirement for all NHS organisations to have robust plans in place to respond to a flu pandemic by December 2008.

#### **Progress**

NHS organisations are reviewing the pandemic influenza plans put in place by December 2008 via a self-assessment, with results due in spring 2009. Procurement of antivirals had commenced and the stockpile should be increased to provide treatment to half of the population, in the event of an influenza pandemic. Procurement of the antibiotic stockpile is scheduled to commence during 2009 and a National Pandemic Flu Line Service will be established to operate during a pandemic with the first release due to take place by summer 2009.

### **Indicator DSO 1.9 and DWP PSA 17.3**

Vital Sign Tier 3 and Local Government National Indicator 137.

Healthy life expectancy (HLE) at age 65. This is a composite measure of actual life expectancy mortality data and the self-reported health question in the General Household Survey (which the Office for National Statistics will run as the Integrated Household Survey in the future) – **not yet assessed**.

#### **Progress**

The HLE indicator is measured over a three-year average. The latest data (reflecting the period 2004 to 2006) put healthy life expectancy at 12.9 years for men and 14.7 years for women and reflects a trend of sustained improvement over the last 20 years. This means that approximately 75 per cent of life after 65 is spent in good or fairly good health. The baseline data for this indicator (2005 to 2007) are expected in February 2010.

For more information, visit the UK National Statistics website ([www.statistics.gov.uk](http://www.statistics.gov.uk)).

### **Indicator DSO 1.11**

Vital Sign Tier 3 and Local Government National Indicator 125.

Proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation who are at home or in extra care housing or an adult placement scheme three months after the date of their discharge from hospital.

#### **Progress**

This is a new indicator and work is under way to finalise the data collection so that the baseline will be available in autumn 2009.

### **Indicator DSO 1.1**

Vital Sign Tier 3 and Local Government National Indicator 119.

Self-reported measure of people's overall health.

#### **Progress**

This is a new self-reported measure in the Department for Communities and Local Government's Places Survey; the baseline will be established in spring 2009 when the new data is published.



### Indicator DSO 1.13 and DCSF PSA 12.3

Vital Sign Tier 2 and Local Government National Indicator 55.

Levels of childhood obesity: To hold the rate of obesity among children under 11 to a maximum of 18.1 per cent by 2011, with the aim of reducing the proportion of overweight and obese children to 2000 levels by 2020. This indicator supersedes the SR 2004 commitment – **not yet assessed**.

#### Progress

In 2008, the HSE showed that the estimated prevalence of obesity among 2- to 10-year-olds has increased very slightly to 15.4 per cent in 2007, from 15.2 per cent in 2006. This change on its own is not considered statistically significant and, taken with the fall from 16.8 per cent in 2005, suggests that, as the HSE reports from its own data, “there are indications that the trend in obesity prevalence may have begun to flatten out over the last two to three years” (NHS Information Centre). Confirmation of this change will require at least one more year’s data. HSE 2008 will report around the end of 2009 and early 2010.

For more information, visit the website of the NHS Information Centre.

### Indicator DSO 1.14 and HO PSA 25.2

Vital Sign Tier 3 and Local Government National Indicator 39.

Rate of hospital admissions per 100,000 for alcohol-related harm – **improvement**.

#### Progress

The baseline rate for 2006-07 is, 1,384 admissions per 100,000 with a baseline rate of increase, based on data for 2002-03 to 2006-07, of 119 admissions per 100,000 per annum. The figures for 2002-03 to 2006-07, of 119 admissions per 100,000 per annum. The figures for 2002-03 to 2006-07 have been revised since publication of the *Autumn Performance Report 2008* to bring the indicator in line with published research on alcohol attributable conditions and with standard practice regarding the production of hospital episode statistics.

The rate for 2007-08 is 1,473 admissions per 100,000 – an increase of 89 admissions per 100,000 from 2006-07, showing an improvement on the baseline rate of increase.

For more information, visit the website of North West Public Health at [www.nwph.net](http://www.nwph.net)

### Indicator DSO 1.15 and HO PSA 25.1

Vital Sign Tier 2 and Local Government National indicator 40.

Percentage change in the numbers of drug users recorded as being in effective treatment – **improvement**.

#### Progress

The baseline figure in 2007-08 recorded 156,387 drug users in effective treatment. For the period July 2007 to July 2008 158,595 persons were recorded as being in effective treatment, a 1.4 per cent increase on the baseline.

### Indicator DSO 1.16 and DCSF PSA 12.1

Vital Sign Tier 2 and Local Government National Indicator 53.

Prevalence of breastfeeding at 6 to 8 weeks – **not yet assessed**.

#### Progress

Initiation of breastfeeding is used a proxy measure and shows a steady increase from 66.2 per cent in 2005-06 to 69.9 per cent in 2007-08. The Department has been collecting 6-8 week breastfeeding centrally for three quarters in 2008-09. During the first year of collection, the emphasis is on getting PCT systems up-and-running and getting data coverage up to a high level. At quarter 3 2008-09, the data show that among PCTs breastfeeding prevalence ranged from 78 per cent to 13 per cent.

The Department published a report on 6–8 week breastfeeding by PCT each quarter. For more information, visit [www.dh.gov.uk/infantfeeding](http://www.dh.gov.uk/infantfeeding)



### Indicator DSO 1.17 and DCSF PSA 13.3

Vital Sign Tier 3 and Local Government National Indicator 70.

Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people aged 0 to 17 years (per 10,000 population) – **improvement**.

#### Progress

The baseline figure for 2006-07 was 123.1 admissions per 10,000 and the latest 2007-08 data show 121.5 admissions per 10,000 population aged 0-17, in England a decrease of 1.3 per cent in the admission rate. Refer to **figure C.7**.

Figure C.7: Emergency hospital admissions resulting from deliberate and unintentional injury

Year	Admissions per 10,000	% change in admission rate
2003-04	116.1	
2004-05	116.2	0.11%
2005-06	120.6	3.80%
2006-07	123.1	2.07%
2007-08	121.5	-1.30%

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Notes:

(1) Age 0-17 years per 10,000 population aged 0-17, excluding patients not resident in England and patients of unknown residence

### Indicator DSO 1.18 and DCSF PSA 14.4

Vital Sign Tier 2 and Local Government National Indicator 112.

Reduce the under-18 conception rate by 50 per cent by 2010 – **no improvement**.

#### Progress

The baseline figure for 1998 showed there were 46.6 conceptions per 1,000 females aged 15 to 17-years-old. In 2007, there were 41.7 conceptions per 1,000 females aged 15 to 17 years old showing that England's rate fell overall by 10.7 per cent between 1998 and 2007. Within the overall reduction in conceptions, there has been a steeper decline of 23.3 per cent of conceptions leading to births. However, the latest annual data shows a reversal in trend as the 2007 under-18 conception rate was 2.6 per cent higher than the 2006 rate. The 2008 abortion data shows a 4.5 per cent reduction in the abortion rate for under-18s. As the increase in 2007 was as a result of all conceptions leading to abortion, the reduction in abortion rate may suggest that the rate of conceptions is returning to a downward trend. Nonetheless, meeting the 2010 target remains a significant challenge, but work is underway to support PCTs to successfully reduce teenage pregnancy rates.

### **Indicator DSO 1.19**

Vital Sign Tier 2 and Local Government National Indicator 113.

Prevalence of chlamydia in under-25-year-olds is measured by a proxy of the percentage of the population aged 15 to 24 accepting a test/screen for chlamydia.

#### **Progress**

The baseline figure screened in 2007-08 was 4.9 per cent of the target population. Work is under way with PCTs to increase the numbers screened in order to establish the prevalence baseline.

### **Indicator DSO 1.20 and CO PSA 16.4**

Vital Sign Tier 3 and Local Government National Indicator 145.

Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation – **not yet assessed**.

#### **Progress**

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. The Department has identified resources in 2009-10 for the regional level to help deliver accommodation outcomes for the learning disability client group.

### **Indicator DSO 1.21 and CO PSA 16.7**

Vital Sign Tier 3 and Local Government National Indicator 150.

Proportion of adults in contact with secondary mental health services in employment – **not yet assessed**.

#### **Progress**

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. Work is under way on an employment strategy for the mental health client group, developed by cross-government teams including input from the Social Exclusion Taskforce at the Cabinet Office and DWP, among others. The employment strategy will be completed by summer 2009. In addition, the Department has identified resources in 2009-10 for the regional level to help deliver employment outcomes for the mental health client group.



### **Indicator DSO 1.22 and CO PSA 16.3**

Vital Sign Tier 3 and Local Government National Indicator 149.

Proportion of adults in contact with secondary mental health services in settled accommodation – **not yet assessed**.

#### **Progress**

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. The Department has identified resources in 2009-10 for the regional level to help deliver accommodation outcomes for the mental health client group.

### **Indicator DSO 1.23 and CO PSA 16.8**

Vital Sign Tier 3 and Local Government National Indicator 146.

Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment – **not yet assessed**.

#### **Progress**

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. Work is under way on an employment strategy for the learning disability client group, developed by cross-government teams including input from the Social Exclusion Taskforce at the Cabinet Office and DWP, among others. The employment strategy will be completed by summer 2009. In addition, the Department has identified resources in 2009-10 for the regional level to help deliver employment outcomes for the learning disability client group.

## **DSO 2: Ensure better care for all (including the Department's contribution to OGD PSAs)**

### **Summary assessment**

The Department's DSO 2 aims to deliver high-quality, safe and accessible care for everyone. PSA Delivery Agreement 19 is closely linked with this DSO, where the eight PSA indicators are also DSO indicators. Progress against this DSO is measured by 8 of the Department's full set of 44 indicators, as set out in the Department's *Strategic Framework* published in July 2008. Where DSO indicators contribute to the delivery of cross-government PSAs led by other government departments, this is shown in the heading of the indicator.

Overall, DSO 2 is making some progress with some indicators while others require more work which the Department is putting in place – improvement in 6 out of 8 indicators.

#### **Indicator DSO 2.26**

Vital Sign Tier 3 and Local Government National Indicator 131.

Number of delayed transfers of care from all NHS hospitals, both acute and non-acute, per 100,000 population (aged 18 and over).

#### **Progress**

The baseline figure in 2006-07 showed 14.9 per 100,000 population, and in 2007-08, this decreased to 13.8 per 100,000 population.

#### **Indicator DSO 2.31**

Vital Sign Tier 3 and Local Government National Indicator 132.

Timeliness of social care assessment is measured through the percentage of new clients (aged 18 and over) where the time from first contact to completion of assessment is less than or equal to four weeks.

#### **Progress**

The baseline figure in 2006-07 was 76 per cent, and data for 2007-08 show an increase to 79.5 per cent.

For more information, visit the website of the NHS Information Centre.

#### **Indicator DSO 2.32**

Vital Sign Tier 3 and Local Government National Indicator 133.

Timeliness of social care packages is measured through the percentage of new clients (aged 18 and over) where the time from completion of assessment to provision of all services in the care packages is less than or equal to four weeks.

#### **Progress**

The baseline figure in 2006-07 was 89.3 per cent, and in 2007-08, this increased to 90.9 per cent.

For more information, visit the website of the NHS Information Centre.



### **Indicator DSO 2.33**

Vital Sign Tier 3 and Local Government National Indicator 129.

Proportion of all deaths that occur at home.

#### **Progress**

The baseline figure in 2005 was 18.4 per cent and in 2007 it was 19.5 per cent, showing a steady rise of people choosing to die at home.

### **Indicator DSO 2.34**

Vital Sign Tier 3 and Local Government National Indicator 130.

Percentage of adults (aged 18 or over), older people and carers receiving social care through a direct payment (and/or an individual budget) in the year to 31 March.

#### **Progress**

The baseline figure in 2006-07 showed that 4.5 per cent of clients received social care through a direct payment or individual budget; this figure rose to 5.6 per cent in 2007-08.

For more information, visit the website of the NHS Information Centre.

### **Indicator DSO 2.37**

Vital Sign Tier 3 and Local Government National Indicator 135.

Proportion of carers receiving a 'carer's break' or a specific service for carers, or advice and information in their role as carers as a percentage of clients receiving community-based services.

#### **Progress**

The baseline figure in 2006-07 showed that 20.7 per cent of carers received a carer's break, a specific service or advice and information; this figure rose to 21.9 per cent in 2007-08.

### **Indicator DSO 2.38**

Vital Sign Tier 3 and Local Government National Indicator 128.

Patient and user-reported measure of respect and dignity in their treatment.

#### **Progress**

The baseline figure in 2002 showed that, when asked if they were always treated with respect and dignity, of 92,961 respondents, 79 per cent said 'Yes, always', 18 per cent said 'Yes, sometimes', and 3 per cent said 'No'. In 2007, of 74,873 surveyed, the figures showed 78 per cent, 19 per cent and 3 per cent respectively. The next data from the 2008 National Patients Survey will be published in May 2009.

For more information, visit the Care Quality Commission website at: [www.cqc.org.uk](http://www.cqc.org.uk)

### Indicator DSO 2.39 and DCSF PSA 12.5

Vital Sign Tier 3 and Local Government National Indicator 54.

Parents' experience of services for disabled children and the 'core offer' – **not yet assessed**.

#### Progress

This is a new indicator. The first data for England and from those local authorities who chose this indicator as a Local Area Agreement target will be published in May 2009, with further data published in September 2009 to establish the baseline.

## DSO 3: To provide better value for all

### Summary assessment

The Department's DSO 3 aims to deliver affordable, efficient and sustainable services by contributing to the wider economy and nation through providing better value for everyone. Progress against this DSO is measured by 5 of the Department's full set of 44 indicators, as set out in the Department's *Strategic Framework* published in July 2008.

Overall, DSO 3 is making some progress with some indicators while others are new and require more work, which the Department is putting in place – improvement in 3 out of 5 indicators.

### Indicator DSO 3.40

Vital Sign Tier 3 and Local Government National Indicator 134.

Reduce emergency bed days per head of weighted population by 5 per cent by 2008.

#### Progress

In 2007-08, there were 28.2 million emergency bed days (refer to **figure C.8**). This indicator is linked to the long-term conditions indicator (see PSA Delivery Agreement 19, indicator 19.5).

Figure C.8: Emergency bed days

Period	Number of emergency bed days	% change from baseline
2003-04	32,479,221	
2004-05	31,902,650	-1.8%
2005-06	30,699,595	-5.5%
2006-07	29,254,686	-9.9%
2007-08	28,193,185	-13.2%

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### **Indicator DSO 3.41**

Vital Sign Tier 1.

Financial balance (PCT).

#### **Progress**

As reported in the PCT audited financial monitoring and accounts forms in 2007-08, the NHS ended the 2007-08 year with a net surplus in PCT accounts of £391 million. At the end of 3 quarter of 2008-09, PCTs are forecasting an overall surplus of £421 million. There is only one PCT forecasting a gross operating deficit. This totals £7.5 million compared with the last quarter where there were three PCTs with a combined deficit of £27 million, and to the first quarter where no PCTs were forecasting a gross operating deficit. The Department is working through SHAs to ensure that the PCT forecasting an operating deficit develops a recovery plan to return to financial balance while maintaining and improving services to patients.

The unaudited draft annual accounts information for 2008-09 will be published during June 2009 in *The Quarter* on the Department's website.

### **Indicator DSO 3.42**

Vital Sign Tier 3.

Prescribing indicator.

#### **Progress**

A set of three better care and better value indicators has been in development in order to provide a composite measure of this new indicator; these focus on low-cost prescribing of drugs for lipid modification, low-cost proton pump inhibitor prescribing, and low-cost prescribing of drugs affecting the rennin-angiotensin system. This set was published in January 2008 and data for quarter 1 of 2008-09 indicate that, if all PCTs moved to the level of performance achieved by the top quartile of trusts, £114 million would be saved over a year.

For more information, visit: [www.productivity.nhs.uk](http://www.productivity.nhs.uk)

### Indicator DSO 3.43

Vital Sign Tier 2.

Public confidence in local NHS.

#### Progress

This is a new indicator and has been in development under three broad headings in order to provide a composite measure covering an indication that the organisation: organises services with a focus on the individual; arranges services with a focus on dignity and respect for the patient; and makes use of patient and public feedback and learns from experience. The Department is currently working with NHS performance leads to agree this set with the aim to begin data collection in 2009-10.

The baseline position as at April 2009 is shown in **figure C.9**.

Figure C.9: Public confidence in local NHS

Area	Score
Focus on the individual	67.8
Dignity and respect	83.3
Improving as an organisation	41.1
Overall score	64.2

Source: Various including the adult in-patient survey, the A&E patient survey, the NHS staff survey and NHS written complaints data

Notes:

(1) Scores out of 100.

### Indicator DSO 3.44

Vital Sign Tier 3.

NHS Estates energy/carbon efficiency is measured in two targets: to reduce the overall level of primary energy consumption by 15 per cent or 0.15 MtC (million tonnes carbon) from March 2000 to March 2010; and to achieve a level of 35–55 GJ/100 m<sup>3</sup> (gigajoules per 100 m<sup>3</sup>) energy performance for all new capital developments and major redevelopments/refurbishments, and 55–65 GJ/100 m<sup>3</sup> for existing facilities.

#### Progress

The baseline is the 1999-2000 Estates Related Information Collection (ERIC). Initial analysis for 2007-09 shows that energy performance has improved by 6.5 per cent since 2000 and total energy consumption has increased by 9 per cent as the size of the NHS has increased by 18 per cent; and that 55 per cent of NHS buildings meet the target for new capital development, with an additional 17 per cent meeting the existing facilities target.

The Department continues to report on the following legacy targets from previous Spending Reviews.



## SR 2004

Targets 1, 3, 4, 5 and 7 have been subsumed into CSR 2007. Targets 6 and 8 have been achieved and final reporting took place in the 2008 Departmental Report.

### Target 2

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

### Progress

Infant mortality – **slippage**.

The baseline figure is a three-year average for the period 1997 to 1999; the infant mortality rate among the routine and manual group was 13 per cent higher than in the total population. In the period 2005 to 2007, the infant mortality rate among the routine and manual group was 16 per cent higher than in the total population, a wider gap than at the baseline. However, the gap has narrowed in recent years – the rate among the routine and manual group was 19 per cent higher than in the total population in the period 2002 to 2004, 18 per cent higher in the period 2003 to 2005, and 17 per cent higher in the period 2004 to 2006.

For more information, visit the publications and statistics section of the Department's website.

Life expectancy: See under PSA Delivery Agreement 18 Indicator 18.2: Gap in the AAACM measure.

## SR 2002

Information on the one remaining target is provided below.

### Target 11

Reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth – **slippage**.

### Progress

Infant mortality: See under SR 2004 measure.

Life expectancy – **slippage**.

Note that the life expectancy target was revised as part of SR 2004 – the SR 2004 target relates to the spearhead group of local authorities, while the SR 2002 target relates to the fifth of local authorities with the lowest life expectancy. The baseline figure is a three-year average for the period 1997 to 1999; the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 2.67 per cent for males and 1.92 per cent for females. In the period 2005 to 2007, the relative gap in life expectancy was 2 per cent wider than the baseline gap for males (compared with 1 per cent wider in 2004 to 2006), and was 12 per cent wider than the baseline gap for females (compared with 11 per cent wider in 2004 to 2006).

## CSR1998

The majority of SR 1998 targets were subsumed within the SR 2002 targets and details were given in previous performance reports. Information on the remaining targets 3 and 4 are provided below.

### Target 3

Reduction in the rate of hospital admissions for serious accidental injury by at least 10 per cent by 2010 – **slippage**.

### Progress

The baseline figure for the financial year 1995-96 was 315.9 admissions per 100,000 population. In 2006-07, this had risen by 3.1 per cent to 325.8 admissions per 100,000 population, showing an increase in the number of accidents such as falls among people aged over 65.

### Target 4

Reduction in the death rate from accidents by at least 20 per cent by 2010 – **slippage**.

### Progress

The baseline figure is a three-year average for the period 1995 to 1997 and showed 15.8 deaths per 100,000 population. In the period 2005 to 2007, the figure was the same as at the baseline.

For more information, visit the publications and statistics section of the Department's website.



The following table shows the results of the survey conducted in 2023. The data is presented in a clear and concise manner, allowing for easy comparison and analysis of the findings.

Category	Item 1	Item 2	Item 3	Item 4
Group A	15	20	10	5
Group B	10	15	20	10
Group C	5	10	15	20
Group D	20	10	5	15
Group E	10	5	15	10
Group F	15	20	10	5
Group G	5	10	15	20
Group H	20	10	5	15
Group I	10	5	15	10
Group J	15	20	10	5
Group K	5	10	15	20
Group L	20	10	5	15
Group M	10	5	15	10
Group N	15	20	10	5
Group O	5	10	15	20
Group P	20	10	5	15
Group Q	10	5	15	10
Group R	15	20	10	5
Group S	5	10	15	20
Group T	20	10	5	15
Group U	10	5	15	10
Group V	15	20	10	5
Group W	5	10	15	20
Group X	20	10	5	15
Group Y	10	5	15	10
Group Z	15	20	10	5

## D Executive Agencies of the Department of Health and Other Bodies

### Executive agencies

#### Medicines and Healthcare products

##### Regulatory Agency (MHRA)

The MHRA helps to safeguard public health through the regulation of medicines and medical devices. It does this by ensuring that they meet the required 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 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 for taking enforcement action in order to safeguard public health. The agency provides advice and support to the Department's 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](http://www.mhra.gov.uk)

##### NHS Purchasing and Supply Agency (NHS PASA)

NHS PASA was established in April 2000. It 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.

For further information, visit the website at: [www.pasa.nhs.uk](http://www.pasa.nhs.uk)



## **Other bodies (including executive non-departmental public bodies and special health authorities)**

### **Executive non-departmental public bodies**

Alcohol Education and Research Council (AERC)  
[www.aerc.org.uk](http://www.aerc.org.uk)

Appointments Commission (AC)  
[www.appointments.org.uk](http://www.appointments.org.uk)

Care Quality Commission (CQC)  
[www.cqc.org.uk](http://www.cqc.org.uk)

Commission for Social Care Inspection (CSCI)  
(closed on 1 April 2009 when the Care Quality Commission took over the work)  
[www.csci.org.uk](http://www.csci.org.uk)

Council for Healthcare Regulatory Excellence (CHRE)  
[www.chre.org.uk](http://www.chre.org.uk)

General Social Care Council (GSCC)  
[www.gsc.org.uk](http://www.gsc.org.uk)

Healthcare Commission (HC) (closed on 1 April 2009 when the Care Quality Commission took over the work)  
[www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

Health Protection Agency (HPA)  
[www.hpa.org.uk](http://www.hpa.org.uk)

Human Fertilisation and Embryology Authority (HFEA)  
[www.hfea.gov.uk](http://www.hfea.gov.uk)

Human Tissue Authority (HTA)  
[www.hta.gov.uk](http://www.hta.gov.uk)

Independent Regulator of NHS Foundation Trusts (Monitor)  
[www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

National Institute for Biological Standards and Control (NIBSC) (became part of the Health Protection Agency on 1 April 2009)  
[www.nibsc.ac.uk](http://www.nibsc.ac.uk)

Postgraduate Medical Education and Training Board (PMETB)  
[www.pmetb.org.uk](http://www.pmetb.org.uk)

### **Special health authorities**

Information Centre for Health and Social Care (HSCIC)  
[www.ic.nhs.uk](http://www.ic.nhs.uk)

Mental Health Act Commission (MHAC)  
(closed on 1 April 2009 when the Care Quality Commission took over the work)  
[www.mhac.org.uk](http://www.mhac.org.uk)

National Institute for Health and Clinical Excellence (NICE)  
[www.nice.org.uk](http://www.nice.org.uk)

National Patient Safety Agency (NPSA)  
[www.npsa.nhs.uk](http://www.npsa.nhs.uk)

National Treatment Agency for Substance Misuse (NTA)  
[www.nta-nhs.org.uk](http://www.nta-nhs.org.uk)

NHS Blood and Transplant (NHS BT)  
[www.nhsbt.nhs.uk](http://www.nhsbt.nhs.uk)

NHS Business Services Authority (NHS BSA)  
[www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk)

NHS Institute for Innovation and Improvement (NHSi)  
[www.institute.nhs.uk](http://www.institute.nhs.uk)

NHS Litigation Authority (NHS LA)  
[www.nhsla.com](http://www.nhsla.com)

NHS Professionals (NHS P)  
[www.nhsprofessionals.nhs.uk](http://www.nhsprofessionals.nhs.uk)

For a full listing of public bodies that exist to support the Department's business, please go to:  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_092395](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092395)

The following advisory non-departmental public bodies were established during 2008 and do not currently appear in the above publication:

Medical Education England  
[www.mmc.nhs.uk](http://www.mmc.nhs.uk)

National Information Governance Board (NIGB)  
(please note the Patient Information Advisory Group (PIAG) was abolished and their responsibilities transferred to NIGB)  
[www.nigb.nhs.uk](http://www.nigb.nhs.uk)





## E Public Accounts Committee Recommendations

The Department's *Autumn Performance Report 2008* (DH, December 2008) set out the recommendations made by the Committee of Public Accounts (PAC) since April 2008. This can be viewed at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091854](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091854)

Since the Autumn Performance Report, the Department has responded to two PAC reports: *NHS Pay Modernisation: New Contracts for General Practice Services in England* (The Stationery Office, 2008); and *The National Programme for IT in the NHS: Progress since 2006* (The Stationery Office, 2008).

### NHS Pay Modernisation: New Contracts for General Practice Services in England

**Recommendation (i):** Incomplete data on the cost of services provided by GPs led the Department to underestimate expenditure in the first three years of the contract. Where practicable, major changes should be piloted before they are implemented so that costs can be determined with greater accuracy.

**Progress:** The Department has already introduced more robust systems for costing and evaluating proposals for contract changes. These comprise internal scrutiny and review by the Department's Revenue Investment Branch on all planned investments with costs over £40 million per annum. In addition, as part of the Department's

proposals for introducing an independent process for reviewing Quality and Outcomes Framework (QOF) indicators led by NICE, the Department is proposing that new QOF indicators should be piloted. This is one of the proposals made in a consultation document on the new process, *Developing the Quality and Outcomes Framework: Proposals for a new, independent process* (DH) published on 30 October 2008.

**Recommendation (ii):** The Office for National Statistics' (ONS) method for estimating productivity in primary care was not accepted by the Department as sufficiently robust. An agreed method for measuring productivity in primary care should be developed, which has the support of the NHS, the Department, the Treasury and the ONS. More specifically, the Department needs to set a clear strategy and timetable for PCTs to report to SHAs on how their GP practices have improved productivity.

**Progress:** The Department has commissioned a three-year research project from the Centre for Health Economics (CHE) to take forward work on measuring NHS productivity. As part of this work, CHE has just published a report on NHS output growth which presents separately, outputs in primary medical care. In April 2009, a similar report on inputs was published and from these two reports it should be possible to produce much better estimates of GP productivity. In addition, the Department continues to work closely with the ONS to improve its measures of output and



productivity. ONS is currently developing an alternative approach to measuring GP input to the NHS based on the volumes of service delivered by practices to PCTs under the various contractual arrangements for primary medical services. This would enable calculation of NHS productivity treating GP practices as a contracted-out service but could also facilitate estimation of GP practice productivity.

**Recommendation (iii):** Many PCTs have failed to negotiate with their GPs for the provision of enhanced services to meet specific local needs, and have not spent to the minimum level set by the Department for enhanced services. PCTs should use the standards developed as part of the Department's World Class Commissioning Programme to benchmark their commissioning performance and identify priority areas requiring improvement.

**Progress:** The world class commissioning assurance system was launched on 4 June 2008. It is a national system to hold commissioners to account, reward performance and ensure that health outcomes are improving.

The World Class Commissioning Programme has set out 11 competences – the skills, knowledge, behaviour and processes of world class commissioning organisations. These include knowledge management and data analysis skills, investment prioritisation and strategic planning skills, and the ability to commission collaboratively with clinicians, patients and the public, local authorities and other community partners. PCTs' development and performance are assessed against these competences as part of the assurance system. The system also reviews PCT governance, including financial management, strategy and board function. The third strand of commissioning assurance assesses how PCTs achieve improvement against local health outcomes, an approach which reflects the fact that world class commissioning is driven by health outcomes and focused on local priorities. In addition, because the assurance system has a

strong focus on improvement, PCTs will receive a commentary on the organisation's 'potential for improvement', which will review the PCT's status, current direction of travel and its development needs, focusing on organisational health issues. The system will provide a common basis for agreeing development by PCTs as they move towards world class performance.

**Recommendation (iv):** The Minimum Practice Income Guarantee (MPIG) has stood in the way of the needs-based funding formula reducing historic inequality of service provision. The Department should consider replacing MPIG with a redesigned global sum allocation in order to move more money into areas of greatest need.

**Progress:** The Department agrees that MPIG, which was introduced as part of the new contract to protect GP practices' historic income for essential core services, has outlived its purpose and should be phased out. Through NHS Employers, the Department has been discussing this with the British Medical Association (BMA) and on 14 October 2008 announced changes to the contract for 2009-10, which will take the first step towards abolishing MPIG, depending on the Doctors' and Dentists' Review Body (DDRB) recommendation for GPs for 2009-10 and the Government's response. The Government has now accepted, in full, the Doctor's and Dentists' Pay Review Body (DDRB) recommendation for GPs for 2009-10, that gross contract payments will be increased by 2.29 per cent to allow for an average increase in GMS practitioners net income of 1.5 per cent, after allowing for movement in their expenses.

DDRB recommendations for GPs for 2009-10 will now be applied differentially, which will now see every GMS practice receive a national minimum uplift of 0.70 per cent to their global sum equivalent. Consequently, 91 per cent of practices currently reliant on MPIG correction factor payments in 2008-09 at a cost of £285 million will, in 2009-10, be reduced to 68 per cent



at a cost of £131 million. NHS Employers and the BMA have agreed the principle that there should be a comparable process in future years to continue the phasing out of MPIG.

The formula approach (or a comparable process) is likely to make significant progress in phasing out MPIG over a five-year period (subject to the annual recommendations of the DDRB).

The contract changes agreed for 2009-10 also include moving towards a full prevalence adjustment for QOF payments by April 2010. This means that by April 2010 practices will receive the same weighting per patient with a relevant disease no matter what their practice list size. At the moment, the prevalence weighting is damped down by the QOF payment formula in order to protect practices with low prevalence such as university practices. This will be a major step forward in ensuring that QOF payments are fairly related to the relative prevalence of long-term conditions within a practice population. This will see more money going to deprived areas and create better incentives for identifying patients with conditions that need treatment.

More immediately, the Department has already initiated a programme of investment and procurement to deliver 112 new GP practices in the areas that need them most. This will begin to deliver new additional services and capacity to patients in the 50 most poorly served PCTs (in primary care) in the country during 2009-10, with additional investment increasing to £120 million by 2010-11.

**Recommendation (v):** Access to general practice services has not improved significantly since the new contract was introduced, although the Department is taking action to address this. PCTs need to commission services that are more clearly linked to local needs, underpinned by a performance management framework that enables them to monitor how well GP practices meet this and

other requirements. They must also tackle poor performance as necessary.

**Progress:** The organisational competences for world class commissioning set out the knowledge, skills, behaviours and characteristics that underpin effective commissioning. They set out how world class commissioners will be fully engaged with local people and communities, aware of their needs and addressing them in the most effective ways. The Department is also developing a range of practical support to help PCTs manage contracts with GP practices and tackle poor performance, drawing on examples of good practice in PCTs. Earlier this year the Department also consulted on proposals to bring all GP services within the scope of the new Care Quality Commission in order to assure standards of safety and quality.

Since April 2008 there have been significant improvements in access to GP services, with 72.5 per cent of them now offering extended opening hours to their patients (as of February 2009). The 2008 GP Patient Survey (carried out from January to March 2008), showed that 87 per cent of patients are able to get GP appointments within 48 hours when they want to, up from 86 per cent the previous year, and that 87 per cent of patients are satisfied with telephone access and 88 per cent with the ability to see the GP of their choice. There was relatively lower performance on advance booking, with 77 per cent of patients reporting that they were able to book appointments more than two days in advance when they wanted to. This is an area where a number of PCTs need to work with GP practices to secure further improvements.

The Department has secured additional investment to provide a new GP-led health centre in each PCT. The new health centres will be open from 8am to 8pm, 7 days a week, 365 days a year, offering both bookable appointments and walk-in services for any member of the public; patients may also choose to register at a health centre if more convenient than their existing practice. PCTs have been asked to



work with the local NHS and patients to ensure that the services provided reflect local needs. The new centres already will provide over 2.5 million extra GP appointments a year. The first centre opened in Bradford on 28 November 2008; evidence from centres already open suggest that they are being well used and are popular, especially at times when GPs are closed, eg Saturdays.

**Recommendation (vi):** The QOF links GPs' pay to the quality of patient care they deliver but requires further enhancement, with less emphasis on indicators that are easy to measure and more on improvements in population health. The Department should:

- develop the QOF so that it is better aligned to national health priorities;
- give more weight to achieving health outcomes, rather than to clinical practices which are easy to measure; and
- allow PCTs some discretion to agree the content of the framework to reflect local priorities.

**Progress:** The contract changes agreed for 2009-10 include the reallocation of 72 QOF points, worth around £80 million, to reward GP practices for delivering a range of new interventions for their patients across seven clinical areas – cardiovascular disease, contraception, depression, chronic kidney disease, diabetes, chronic lung disease and heart failure.

*Lord Darzi's High Quality Care For All: Final Report* (DH, 2008) NHS Next Stage Review acknowledged that the number of organisational or process indicators in the QOF should be reduced and resources focused instead on new or enhanced indicators to promote health and greater clinical quality. The report also gave a commitment to introduce a new, independent process to provide advice on QOF indicators.

The Department published a consultation document on 30 October 2008 to seek views from

professional groups, patient groups and other stakeholders on how the new process should work. The Government's response to the consultation was published on 19 March 2009.

The Department has asked NICE to oversee an independent, transparent and objective process for prioritising, developing and reviewing QOF clinical and health improvement indicators for England from 1 April 2009 as part of their role in providing guidance for the NHS based on evidence of clinical effectiveness and cost effectiveness.

The main elements of the new process are:

- collating information to inform the prioritisation of potential new indicators, including setting up a facility on the NICE website for interested parties to submit ideas for priority topics;
- carrying out a prioritisation process to decide on areas for indicator development and advising on candidates for new indicators in these areas based on evidence of clinical and cost effectiveness;
- ensuring that the existing clinical and health improvement indicators are regularly reviewed;
- setting up a Primary Care QOF Indicator Advisory Committee, consisting of a range of experts and representatives from the primary care field, to consider the relative priority of potential new clinical and health improvement topics;
- appointing a contractor to develop and pilot potential new indicators and review existing indicators, applying a methodology for assessing cost-effectiveness;
- carrying out a consultation on the developed indicators during the piloting phase;
- validating the final proposals for new and reviewed indicators through the Primary Care QOF Advisory Committee and publishing its conclusions via the NICE website; and
- giving advice on:
  - time limits for new indicators after which they should be reviewed;



- the potential lower and upper thresholds for new indicators based on information about baseline uptake and expected increased uptake;
- information based on the assessment of cost-effectiveness evidence to inform the financial value of indicators; and
- guidance on the application of existing indicators in the light of the latest evidence.

At national level, NHS Employers (on behalf of the Department) would then (as now) negotiate with the BMA on which indicators should be applied nationally (or, with the agreement of the devolved administrations, across the UK as a whole) and what the value of those indicators should be.

**Recommendation (vii):** While GP partners' pay has increased by an average of 58 per cent since March 2003, practice staff have tended just to get inflation pay rises and some practice nurses do not even have appropriate contracts of employment. PCTs need to require practices, as part of their GMS contracts, to have appropriate contracts of employment in place for all staff, and advise practices on appropriate pay rates. PCTs should also, as part of the contract, require GP partners to provide annual feedback on how they have used NHS funding to improve practice productivity.

**Progress:** The contractual and statutory requirements that GMS practices need to observe are set out in the standard GMS contract and in the National Health Service (General Medical Services Contracts) Regulations 2004 (SI 2004/291). In particular, this requires a GMS contractor to comply with all relevant legislation and have regard to all relevant guidance issued by the PCT, the relevant SHA or the Secretary of State for Health. Employment Equality legislation would be considered to be 'relevant legislation' for this purpose. Contractors are rewarded as part of the QOF for having a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absences.

*Delivering Investment in General Practice: Implementing the new GMS Contract* (DH, December 2003) stated that salaried staff should be supported through the introduction of Agenda for Change (AfC) principles in general practice. The guidance made clear that, while AfC was not mandatory, GMS contractors were expected to implement its principles and to work with their PCTs on this.

While practices may approach their PCT for advice on appropriate rates of pay for practice staff, it is ultimately a matter for each practice, as independent employers, to determine themselves.

PCTs have a range of potential options where a contractual term is breached. In serious cases, such as a breach that puts the safety of patients at serious risk, the contract can be terminated immediately. For less serious breaches there is a mechanism for issuing breach and remedial notices; multiple minor breaches under these procedures can also lead to termination on notice. There are also alternatives to termination such as financial penalties, where termination is disproportionate to the contractor's failures.

The GMS and PMS contracts provide that each contractor shall submit an annual return to their PCT. The content of the annual report is not centrally directed, but each PCT must require the same categories of information from each of its contractors. Consequently, PCTs can already seek information about practice productivity from each of their contractors.

On productivity improvements, the Committee has already noted (PAC conclusion (II)) that there is no agreed robust methodology for measuring productivity. As mentioned above, the Department will work with others to agree such a methodology. Until that work is concluded, the Department will keep the final part of this recommendation under review.



## The National Programme for IT in the NHS: Progress since 2006

**Recommendation (i):** Recent progress in deploying the new care records systems has been very disappointing, with just six deployments in total during the first five months of 2008–09. The completion date of 2014–15, four years later than originally planned, was forecast before the termination of Fujitsu's contract and must now be in doubt. The arrangements for the South have still not been resolved. The Department and the NHS are working with suppliers and should update the deployment timetables. Given the level of interest in the programme, the Department should publish an annual report of progress against the timetables and revised forecasts. The report should include updates on actions to resolve the major technical problems with care records systems that are causing serious operational difficulties for trusts.

**Progress:** The Department accepts this recommendation. While many of the programme's systems have been delivered successfully, it is regrettable that progress has been slower than anticipated with the NHS Care Record Service at a local trust level. Some progress is being made and the Department continues to work closely with suppliers to ensure that software is fit for purpose before deployment. This approach ensures that quality takes priority over target dates before go-live, and that trusts are fully involved in the testing and sign-off of products.

The Department agrees the need to revise and publish new deployment timetables. However, precise go-live dates will always depend on quality and readiness criteria being met before deployment in healthcare settings.

The Department will consider the recommendation to publish an annual report of progress against the timetables and revised forecasts. This may, from 2009-10, take the form of a single document combining the Annual Report and

the Annual Benefits Statement (see this section, recommendation (viii)).

**Recommendation (ii):** By the end of 2008 the Lorenzo care records software had still not gone live throughout a single acute trust. Given the continuing delays and history of missed deadlines, there must be grounds for serious concern as to whether or not Lorenzo can be deployed in a reasonable timescale and in a form that brings demonstrable benefits to users and patients. Even so, pushing ahead with the implementation of Lorenzo before trusts or the system are ready would only serve to damage the programme. Future plans for deployment across the North, Midlands and East should therefore only follow successful deployment and testing in the three early adopter trusts. This will mean that lessons can be learned before any decision is taken to begin a general roll-out.

**Progress:** The Department accepts this recommendation, which reflects the current approach. The plan is for Lorenzo to be deployed and tested successfully in the three early adopter sites and for lessons to be learned before any decision is made on national implementation. Although not deployed fully throughout an acute trust by the end of 2008, the Lorenzo software was being used for clinical processes in the South Birmingham PCT and University Hospitals Morecambe Bay early adopter sites as part of the process to deliver software to bring benefits for patients, clinicians and administrators. The Department is already taking the approach in the recommendation to ensure that the implementation of Lorenzo occurs only when trusts and the IT system are both ready.

**Recommendation (iii):** The planned approach to deploy elements of the clinical functionality of Lorenzo (Release 1) ahead of the patient administration system (Release 2) is untested, and therefore poses a higher risk than previous deployments under the programme. The



Department and the NHS should undertake a thorough assessment of whether or not this approach to deployment will work in practice. No trust other than the three early adopters should be invited to take the first release of Lorenzo until it is certain that Release 1 and Release 2 will work effectively together.

**Progress:** The Department's approach with the three Release 1 early adopter sites has been to ensure that the Release 1 software and the existing Patient Administration System are thoroughly tried and tested together. Release 2 contains both clinical and Patient Administration System functionality and will be a replacement system for Release 1. This will be a significant upgrade and will be tested and managed carefully.

A different approach to upgrading will be taken for Lorenzo from Release 2 onwards. Release 2 offers the capability to introduce functionality to a trust progressively. This is a tried and tested approach used regularly in the introduction of large-scale Enterprise Resource Planning systems in the private sector. The introduction of this approach will be carefully tested and reviewed with the early adopter sites prior to national roll-out.

Any specific issues for resolution will be identified as the Lorenzo releases are progressed and any new challenges are encountered. No trusts will be expected to take a Lorenzo Release until the functionality has been demonstrated to work in practice.

**Recommendation (iv):** Of the four original Local Service Providers, two have left the programme and two remain, both carrying large commitments. CSC is responsible for deploying care records systems to the whole of the North, Midlands and East after taking over Accenture's contracts. As well as deploying systems in London, BT is responsible for the N3 broadband network and the Spine. In the light of the experience of Accenture's and Fujitsu's departures from the programme, it is vitally

important that the Department assesses BT's and CSC's capacity and capability to continue to meet their substantial commitments. The assessment should consider the impact on the strength of the Department's position of having only two suppliers responsible for the programme's major components.

**Progress:** The Department accepts this recommendation. The Department recognises the need to review suppliers' performance regularly for any signs of financial difficulties and has continually assessed the capability and capacity of its suppliers to deliver the programme as part of its arrangements for supplier management. The contracts provide the Department with the right to undertake audits, including financial audits, and these have been carried out as appropriate. The contracts also permit action to be taken if a supplier's credit rating reduces. Since 2004, NHS Connecting for Health has engaged independent analysts specifically to monitor suppliers in order to identify emerging financial issues.

The programme's contracts have proved robust, and protect the taxpayer through the principle of payment only on delivery. There are still two system suppliers for the NHS Care Records Service (iSOFT and Cerner) and two system integrators (CSC and BT). As a contingency, framework contracts were awarded to a range of companies last year in order to increase the number of potential suppliers to the programme, thereby reducing the risk from supplier failure. Framework contracts were awarded to selected suppliers who can now compete for business if the need arises. These framework contracts are complementary to the existing suite of programme contracts and provide contingency. The procurement exercise demonstrated a high level of interest among suppliers in developing IT for the NHS.

**Recommendation (v):** The termination of Fujitsu's contract has caused uncertainty among trusts in the South and new deployments have stopped. One option being considered for new



deployments is for trusts to have a choice of either Lorenzo provided through CSC or the Millennium system provided through BT. However, there are, considerable problems with existing deployments of Millennium and serious concerns about the prospects for future deployments of Lorenzo. Before the new arrangements for the South are finalised, the Department should assess whether it would be wise for trusts in the South to adopt these systems. Should either of the Local Service Providers take on additional commitments relating to the South, the Department should take particular care to assess the implications of the extra workload on the quality of services to trusts in the Local Service Providers' existing areas of responsibility.

**Progress:** The Department accepts this recommendation. Assessments of capability and capacity are key features in determining the future arrangements for the provisions of services in the South, following the termination of the contract with Fujitsu. Both BT and CSC will have to demonstrate their capacity and capability to deliver across the wider area, and be subject to independent evaluation. However, the Department has not yet contracted with either of these suppliers and other options are not yet closed.

No decisions have been made on the placing of the contracts for the South beyond protecting the position of those sites that had previously deployed systems from Fujitsu.

**Recommendation (vi):** The programme is not providing value for money at present because there have been few successful deployments of the Millennium system and none of Lorenzo in any acute trust. Trusts cannot be expected to take on the burden of deploying care records systems that do not work effectively. Unless the position on care records system deployments improves appreciably in the very near future (ie within the next six months), the Department should assess the financial case for allowing trusts to put forward applications for

central funding for alternative systems compatible with the objectives of the programme.

**Progress:** The Department agrees with some of the principles behind this recommendation, in particular that trusts should not be expected to deploy care records systems that do not work effectively. However, it does not accept that the programme is not providing value for money at present. Many elements of the programme have been delivered and are working successfully, and the principle of payment on delivery has provided protection for the taxpayer for items that are late.

The Department remains confident in the potential of both Cerner's Millennium and iSOFT's Lorenzo systems to work effectively once development and testing have been completed. Trusts will not be expected to take the systems until they work effectively, and they will be involved fully in the sign-off processes that lead to the implementation going live. Lorenzo will be tested fully in the early adopter sites before national implementation begins. In London, an improvement programme for Millennium has been completed successfully in the Royal Free Hospital, resulting in the approval by the NHS of a resumption of deployments to acute trusts across London.

Although the Department does not agree the six-month timetable, it does agree that the position on the deployment of care records systems needs to improve appreciably over the coming months, and it also agrees the principle of checkpoints as part of firm contract management. In response to recommendation (i) in this section, the Department has agreed to publish an annual report on progress. As the first of these will not be available until after the end of the 2009-10 financial year, the Department proposes to provide the Committee with a note on progress of the deployment of the NHS Care Records Service by the end of 2009.

**Recommendation (vii):** Despite the Department's previous recommendation, the estimate of



£3.6 billion for the programme's local costs remains unreliable. The Department intends to collect some better data as part of the process of producing the next benefits statement for the programme. In the light of that exercise, the Department should publish a revised, more accurate estimate for local costs and, thereby, for the cost of the programme as a whole.

**Progress:** The Department accepts the need for an accurate estimate of local costs. In line with the devolved governance structure of the programme, local costs are managed by a hierarchy of local boards. Previous approaches to collate the information in an effective manner have proved unsuccessful. The Department will consult on how best to meet the Committee's recommendations in reporting local costs and benefits without introducing an overly complex procedure into the NHS (see recommendation (viii) in this section).

**Recommendation (viii):** The Department hopes that the programme will deliver benefits in the form of both financial savings and improvements in patient care and safety. In March 2008, the Department published the first benefits statement for the programme, for 2006-07, predicting total benefits over ten years of over £1 billion. There is, however, a lot of work to do within the NHS to realise and measure the benefits. Convincing NHS staff of the benefits will be key to securing their support for the programme, and the credibility of the figures in the benefits statement would be considerably enhanced if they were audited. The Department considers future benefits statements should be subject to audit by the Comptroller and Auditor General. The Department should also review achievements under the programme so that lessons can be identified and shared where products and services are working well.

**Progress:** The Department accepts this recommendation. The first Annual Statement of Costs and Benefits (for 2006-07) prompted questions about the local costs element of the

expenditure and the ability to measure benefits satisfactorily. It is acknowledged that progress in resolving these matters has been difficult, and a fresh approach will be developed for 2009-10 alongside the Annual Report – see this section, recommendation (i) to determine how best to establish a reliable base for capturing the benefits of the national programme.

**Recommendation (ix):** Little clinical functionality has been deployed to date, with the result that the expectations of clinical staff have not been met. Deploying systems that offer good clinical functionality and clear benefits is essential if the support of NHS staff is to be secured. For all care records systems offered under the programme, the Department and the NHS should set out clearly to NHS staff which elements of clinical functionality are included in existing releases of the software, which ones will be incorporated in the next planned releases and by what date, and which will be delivered over a longer timescale.

**Progress:** The Department accepts this recommendation. It is true that there is potential for greater clinical functionality to be deployed. For both Lorenzo and Millennium, full functionality is planned to be delivered over four releases. Some systems are already providing considerable clinical advantages – for example the Picture Archiving and Communications System (PACS), which make X-rays and other images readily available to clinicians and the RiO system which has brought clinical benefits to mental health and community health trusts.

The *Health Informatics Review* Report (DH, July 2008) acknowledged the 'clinical five' elements to be provided in order to deliver value to clinicians and patients:

- the Patient Administration System (PAS), with integration with other systems and sophisticated reporting;



- Order Communications and Diagnostics Reporting (including all pathology and radiology tests and tests ordered in primary care);
- letters with coding (discharge summaries, clinic and accident and emergency letters);
- scheduling (for beds, tests, theatres etc.); and
- e-prescribing (including 'To Take Out' medicines).

The Department agrees the need to ensure that staff are aware of the content and timing of forthcoming releases. Clinicians are engaged in all aspects of the programme. The Department will consider how best to ensure that clinicians and other NHS staff are aware of the content of the new systems and when they will be delivered.

**Recommendation (x):** The Department has taken action to engage clinicians and other NHS staff but there remains some way to go in securing their support for the programme. In order to assess and demonstrate the impact of its efforts to secure support for the programme, the Department should repeat its surveys of NHS staff at regular intervals (at least every year) and publish the results.

**Progress:** The Department accepts this recommendation. The Department recognises the importance of the engagement of clinicians and other NHS staff, and welcomes the Committee's acknowledgement of the work already undertaken. The Department did not conduct a survey of NHS staff in 2008 because it was conducting a review of health informatics on which it consulted widely, involving over 1,400 stakeholders including patients, the public, clinicians, and other front-line health and social care professionals from every NHS region in England. The Department intends to keep under review its work to engage clinicians and other NHS staff, and has already established a Clinical Leaders' Network, aiming to involve at least 60 senior practising clinicians within each SHA.

**Recommendation (xi):** Patients and doctors have understandable concerns about data security. However extensive the Care Record Guarantee and other security provisions being put in place are, ultimately data security and confidentiality rely on the actions of individual members of NHS staff in handling care records and other patient data. To help provide assurance, the Department and the NHS should set out clearly the disciplinary sanctions that will apply in the event that staff breach security procedures, and they should report on their enforcement of them.

**Progress:** The Department has already directed that NHS trusts should publish details of disciplinary outcomes in relation to confidentiality breaches and data losses in their annual reports. However, the Department does not accept that it would be appropriate or practicable to change the disciplinary sanctions that should be applied at a local level or to generalise on which sanctions should be applied as each case must be looked at fairly with all facts and any extenuating circumstances considered. Guidance has been issued by NHS Employers to clarify expectations that staff who breach security procedures should be disciplined appropriately.

As with other employers, NHS bodies must comply with the statutory dismissal and disciplinary procedures set out in the Employment Act 2002 and should adhere to the Advisory, Conciliation and Arbitration Service's (ACAS) *Code of Practice on Disciplinary and Grievance Procedures* (ACAS, May 2009). The law on unfair dismissal requires employers to act reasonably when dealing with disciplinary issues, and the ACAS Code states that the core principles of reasonable behaviour include making sure that disciplinary action is not taken until the facts of the case have been established and that the action taken is reasonable in the circumstances.

All NHS trusts have documented disciplinary procedures in line with these legal and best practice requirements. The code outlines appropriate



sanctions including written warnings, final written warnings and dismissal.

**Recommendation (xii):** The Department does not have a full picture of data security across the NHS as trusts and SHAs are required to report only the most serious incidents to the Department. The Department's view is that it is not practical for it to collect details of all security breaches, but at present it can offer little reassurance about the nature and extent of lower-level breaches that may be taking place. Given the importance of data security to the success and reputation of the programme, the Department should consider how greater assurance might be provided through regular reporting. The Department should also report annually on the level of 'serious untoward incidents', on any penalties that have been imposed on suppliers for security breaches, and on the steps being taken to keep patient data secure.

**Progress:** The Department recognises the concerns expressed in this recommendation. The Department takes all security incidents seriously and will consider the recommendation further, including the implications of publishing annually a report of serious untoward incidents. In respect of data loss, a serious untoward incident is regarded as any event that involves the actual or potential loss of personal information that could lead to a significant impact on individuals. In the context of the assurance that the Committee has recommended, it will be important to ensure that these reports distinguish between security incidents relating to systems, and applications provided by the national programme and other systems; as one of the purposes of the programme is to provide a greater degree of security of data over and above that which exists currently in paper and local IT systems.

While the Department only receives reports of significant security incidents, details of lower-level breaches are reported to the SHAs and published in NHS trusts' annual reports. The Department accepts that SHAs must take all reasonable steps

to provide greater assurance on data security and will direct them to publish, each quarter, details of data losses in their areas, including details of any disciplinary action taken.

**Recommendation (xiii):** Confidentiality agreements that the Department made with CSC in respect of two reviews of the delivery arrangements for Lorenzo are unacceptable because they obstruct Parliamentary scrutiny of the Department's expenditure. The Department made open-ended confidentiality agreements in respect of these reviews, with the result that information will not be disclosed even after commercial confidentiality has lapsed with the passage of time. We believe that this is improper and that the Department should desist from entering into agreements of this kind.

**Progress:** The Department accepts this recommendation. The Department will aim to avoid this situation as far as possible. In this particular instance, the Department judged that the circumstances were unusual and that there were good grounds for accepting confidentiality agreements, without which it would have been impossible to complete the reviews.

The Department wished to engage independent analysts to review the work on Lorenzo, but had no contractual power to impose this measure on subcontractors of CSC. The parties agreed to the reviews provided that a binding confidentiality clause was included. This enabled an independent and objective assessment to be obtained leading to changes managed through a programme of improvements, which would otherwise not have been possible.

Since the *Autumn Performance Report 2008* was published, the Department, has been able to update progress against a number of recommendations.

## Prescribing Costs in Primary Care

**Recommendation (i):** The NHS could save more than £200 million a year, without affecting patient



care, by GPs prescribing lower-cost but equally effective medicines. Many drugs are available in both branded and generic versions, and the latter is usually much cheaper than the brand-name drug, for which the manufacturers have to recover research and development costs.

**Progress:** The National Audit Office has updated its original calculations, and has estimated that £396 million was saved in 2008 through more cost-effective prescribing practices.

**Recommendation (ii):** The proportion of prescriptions written by chemical name rather than by brand name, known as generic prescribing, rose from 51 per cent in April 1994 to 83 per cent in September 2006. However, only 59 per cent of prescription items were actually dispensed as generics in 2005, mainly because not all drugs prescribed were available in generic form. For some common conditions doctors have a choice of clinically equally effective drugs, some of which are available in generic form while others are only available as branded medicines. Where it is clinically appropriate, GPs should prescribe those available in generic form.

**Progress:** The NHS Institute for Innovation and Improvement's Better Care Better Value (BCBV) indicator on statins is already in operation and will continue. Two new BCBV indicators will be introduced shortly:

- proton pump inhibitors; and
- anti-hypertensive drugs.

**Recommendation (iii):** The proportion of lower-cost prescriptions for some common conditions varies greatly between PCTs, for example between 28 per cent and 86 per cent for statins. SHAs should work with the National Prescribing Centre to spread best practice in prescribing and to help those PCTs that have difficulty implementing switching programmes to learn from PCTs that have successfully done so.

**Progress:** The Department understands that there is considerable progress on this recommendation by PCTs and they are taking action in many areas to reflect their local circumstances. The BCBV indicators have generated a lot of publicity – PCTs are now taking action on their own account, backed up by the National Prescribing Centre.

**Recommendation (iv):** Comparing GP practices and PCTs on indicators of efficient prescribing is an effective way of influencing prescribing behaviour. The Department, in conjunction with the NHS Institute for Innovation and Improvement, should develop more BCBV prescribing indicators to measure the proportion of generics dispensed and the level of potential savings where more cost-effective prescribing would generate significant savings, such as for renin-angiotensins used to treat high blood pressure. SHAs should use these indicators to hold PCTs to account for prescribing costs.

**Progress:** See this section, progress for recommendation (ii).

**Recommendation (vii):** Hospital consultants' prescribing choices are bound by agreed 'formularies' of cost-effective drugs, but GPs are generally not subject to formularies. Although prescribing decisions must be sensitive to the needs of the individual patient, evidence on the cost and clinical effectiveness of treatments for a particular disease should apply consistently across the country. The Department should encourage PCTs to pilot joint primary/secondary care formularies. SHAs should work with the National Prescribing Centre to promote agreement and consistency of formularies across primary and secondary care, and across PCTs.

**Progress:** The National Prescribing Centre has undertaken some work, as part of the *NHS Constitution* activity, to provide advice to PCTs about local decisions on funding for drugs for which NICE guidance is not available.



The National Prescribing Centre's *supporting rational local decision-making about medicines (and treatments)*, a handbook of good practice guidance, was published in February 2009.

The Department believes that this will lead to more collaboration by PCTs on prescribing decisions, facilitated by SHAs.

**Recommendation (viii):** Some 88 per cent of prescription items are dispensed free of charge, and the remainder for a standard charge not directly linked to actual cost. The Department should do more to make patients aware of the costs of drugs, and hence the importance of not wasting them, for example by displaying on dispensed drugs information such as the cost of the specific items dispensed or an indication of the typical cost of items to the NHS.

**Progress:** The Department has commissioned a joint research team from the York Health Economics Consortium of the University of York, and the School of Pharmacy, University of London, to undertake research into the scale, causes and costs of waste medicines. The research teams have begun the preliminary work in undertaking the research and are due to report in mid-2009.

**Recommendation (ix):** Unused and wasted drugs cost the NHS at least £100 million a year. The Department does not have robust or up-to-date information on the cost of drugs wastage or a good understanding of the varied and complex reasons why patients do not always use their drugs. It should commission research to establish the extent to which medicines are not used, and establish the reasons why patients do not take their drugs.

**Progress:** See this section, recommendation (x).

**Recommendation (x):** Generic versions of drugs can vary considerably in appearance, colour and packaging. This variation can be confusing for patients, particularly elderly patients on several

medications, and can increase the risk of patients taking their drugs wrongly, or not at all. The Department should explore with the industry the scope to achieve greater consistency of appearance, labelling and/or packaging of the more common drugs supplied to the NHS.

**Progress:** No further update to the Department's response in the PAC Treasury Minute of March 2008.

## Caring for Vulnerable Babies: The Reorganisation of Neonatal Services in England

**Recommendation (i):** PAC recommendation (2). The reorganisation of neonatal services into clinical networks has had limited impact in reducing geographic variations in mortality rates. Prematurity and illness in newborn babies are associated with a complex range of factors, including social deprivation, ethnicity and maternal age. PCTs need to improve their understanding of the changing demographics of their local population and model the impact on demand for neonatal services to target intervention and prevention strategies on key high-risk groups.

**Progress:** The Department accepts the Committee's conclusion that the reorganisation of neonatal services into clinical networks has had limited impact to date in reducing geographic variations in mortality rates. It is important that PCTs improve their understanding of the changing demographics of their local population and model the impact on demand for neonatal services. This should be undertaken as part of the local strategic needs assessment and capacity planning process.

The Department's framework document, *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* (DH, April 2007), sets out the strategy for modernised maternity services, placing safety, quality and improving standards of care at the heart of its vision. It promotes the provision of



co-ordinated maternity and neonatal care delivered through networks. This will ensure that all women and their babies have equitable access to the whole range of specialist services where necessary.

*Maternity Matters* recognises that for the best health outcomes, it is important that women access maternity care at an early stage. The Department has developed a maternity indicator to increase the proportion of women who access maternity services by 12 completed weeks of pregnancy for a health and social care assessment of needs, risk and choices. This will enable women from high-risk groups to be identified at an early stage and an individualised care plan developed.

The Department also published the *Implementation Plan for Reducing Health Inequalities in Infant Mortality* (DH, December 2007). This plan featured key interventions to help reduce the infant mortality rate between disadvantaged groups and the whole of the population, and provided examples of good practice to help narrow the infant mortality gap – one of the aims of the 2010 national health inequalities target. In line with the commitment made in *Health Inequalities: Progress and Next Steps* (DH, June 2008), the Department has established a health inequalities infant mortality national support team to help deliver the recommendations of the plan.

**Recommendation (ii):** PAC recommendation (4). There are currently no formal arrangements for performance-managing neonatal networks. In return for continued funding of networks, SHAs should agree a set of performance measures and review networks' performance against these objectives. SHAs should also require the two areas without a formal managed network to establish them as a priority.

**Progress:** The Department accepts the Committee's recommendation that, in return for continued funding of networks, SHAs should agree a set of performance measures and review networks'

performance against these objectives. In order to assist in this local process, the taskforce will develop a suite of quality standards by autumn 2009, which can be used locally to create indicators covering quality, efficiency and capability, and which will allow trusts and commissioners to agree and review achievement against these indicators.

The Department is working with the NHS to ensure that both the Northern region and Essex are covered by formal managed networks. The Northern network is currently working to formalise its board, appoint a network manager, lead clinician and lead nurse, while in Essex a review has been established to assess the options for the future network arrangements. Its recommendations have gone out to public consultation from March 2009, with implementation in the 2009-10 commissioning cycle.

## Improving Services and Support for People with Dementia

**Recommendation (i):** There are over 560,000 people in the UK with dementia, costing the economy some £14 billion a year, yet dementia has not been an NHS priority. In response to a report by the Comptroller and Auditor General, the Department is now developing a National Dementia Strategy. The strategy should have a clear timetable for implementation and should include criteria for evaluation and reporting progress and addressing areas of under-performance such as poor diagnosis or availability of interventions recommended by NICE. It will also require an effective communications strategy to engage patient groups, health and social care professionals, the Royal Colleges, health and social care inspectorates, and the voluntary sector, all of whom are essential to improving care for people with dementia.

**Progress:** The Government's *National Dementia Strategy* was published on 3 February 2009. This followed wide consultation both before and during a formal consultation exercise in 2008.



Stakeholder events were held throughout the country, with representation from NHS and social care professionals, people with dementia and their carers, and many others. In preparing the final strategy, account was also taken of over 600 written responses to the draft strategy consultation document.

The published strategy contains 17 objectives, focusing on:

- raising awareness and understanding of dementia;
- early diagnosis and support;
- living well with dementia; and
- delivering the strategy.

Some £150 million is being made available for implementation of the strategy in the first two years, as part of PCTs' overall general allocations. These are increasing by 5.5 per cent in each of 2009-10 and 2010-11 – a total increase of £8.6 billion over the two years. This growth in allocations is new money going into the NHS and the £150 million is the Department's national estimate of the proportion of this required to implement the strategy.

Alongside the strategy, the Department has published an implementation plan based on a five-year programme of change. This is available at the Department's dementia website at: [www.dh.gov.uk/dementia](http://www.dh.gov.uk/dementia). The plan identifies the support that will be offered to PCTs, local authorities, care homes and others in implementing the strategy. It sets out the arrangements for local and national support for implementation of the strategy, and the Department's intention to work with a wide range of key stakeholders in delivering the changes required. The Department has established an Implementation Working Group to help deliver the strategy. The Working Group will co-ordinate the support programme that will be delivered regionally. It will also oversee the evaluation of demonstrator sites and other piloting

work, and the production of materials to support implementation.

Governance arrangements for the strategy will also include an Implementation Programme Board, responsible for strategic direction, and an Implementation Reference Group to ensure that key stakeholders play a central part in the process. Membership and terms of reference for all these groups will be published on the Department's dementia website. A communications plan for the implementation of the strategy will also be finalised shortly.

**Recommendation (ii):** Unlike cancer and coronary heart disease, there is no single individual with responsibility for improving dementia services. Without clear leadership there is a risk that dementia care will continue to lack priority. The Department should appoint a Senior Responsible Officer to drive through the dementia strategy, learning from the model used for cancer services.

**Progress:** David Behan, Director general for Social Care, Local Government and Care Partnerships, is the Senior Responsible Officer in the Department for the development of the National Dementia Strategy.

The Department is still considering whether there is a compelling case for a National Clinical Director as part of the strategy.

**Recommendation (iii):** Between one-half and two-thirds of people with dementia never receive a formal diagnosis. Diagnosis should always be made, regardless of whether or not interventions are available. The rate of diagnosis could be significantly improved by GP practices receiving greater support from mental health services; by the Royal College of Psychiatrists and the Royal College of General Practitioners developing a dementia care pathway including guidance on the importance of early diagnosis; and by the Institute of Innovation



and Improvement promulgating good diagnostic practice.

**Progress:** The Department agreed with the conclusions reached by the Committee on the need for the diagnosis of dementia to be made in all cases and the importance of that diagnosis being made as early as possible. The second objective in the strategy identifies the need for good-quality early diagnosis and intervention for all, with all people with dementia having access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support as needed following diagnosis.

**Recommendation (iv):** There is poor awareness among the public and some professionals of dementia and what can be done to help people with the disease. The Department should commission a dementia awareness campaign in order to increase understanding of the symptoms of dementia, emphasising that there are interventions and treatments which can slow the progress of the disease and help people with dementia and their carers lead independent lives for longer.

**Progress:** Objective 1 of the strategy identifies the need for public and professional awareness of dementia to be improved, and the stigma associated with it addressed. Individuals need to be informed of the benefits of timely diagnosis and care, the prevention of dementia should be promoted, and social exclusion and discrimination reduced. Individuals also need to be encouraged to seek appropriate help and support.

The Department has already commissioned the *Worried About Your Memory?* public awareness campaign being undertaken by the Alzheimer's Society. This was launched in May 2008. The Society sent a supply of leaflets to all GPs in England, to be made available to patients in surgeries. Copies were also made available in

pharmacies, libraries, community centres and other appropriate venues. The leaflet encourages people who are worried about their memory or someone else's memory to talk to their GP, call the Alzheimer's Society helpline, go to the Alzheimer's Society website, or request more detailed information in an information booklet. The leaflet and booklet are available in a range of languages and accessible versions.

The materials are intended to raise public awareness about dementia; to encourage people to seek help when appropriate; to enable the diagnosis of dementia earlier; and to signpost people to appropriate local help and support. Follow-up evaluation will survey GPs, people who requested information, helpline call volumes and booklet request volumes. Further awareness-raising will be undertaken by the Department as part of the strategy's implementation as part of the work on objective 1, with support given locally for awareness-raising by PCTs and local authorities.

**Recommendation (v):** People with dementia require support from multiple health and social care professionals but this is often difficult to manage. On diagnosis, people with dementia and their carers should be given a single health or social care professional contact point in order to improve the co-ordination of care between the various services and professionals. The contact point could be a social worker or a community psychiatric nurse, for example.

**Progress:** The Committee rightly acknowledged the difficulty in managing the course of this complex illness over the passage of time given the number of different health and social care professionals that may need to be involved as needs develop and change. The Department agreed that an identified single point of contact would be desirable for people with dementia and their carers, in order to co-ordinate care over time. This was covered in the consultation document issued in June 2008, and will be addressed explicitly in the final strategy.



As a result, objective 4 of the strategy identified the need for the appointment of 'dementia advisers' in order to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers. The role of dementia adviser would not be that of intensive case management. Rather, they will provide a single identifiable point of contact for people with dementia and their carers, with knowledge of access to the whole range of local services available. Their role will therefore be to identify what the problem might be, and then to signpost and facilitate engagement with the specialist services that can best provide the person with dementia and their carer with the help, care and support they need, simply and quickly. As this is a new role, there will be a need first for the development and generation of demonstrator projects, and for the piloting and evaluation of models of service prior to decisions on implementation.

**Recommendation (vi):** Between one-half and two-thirds of carer's do not receive the carers assessment to which they are entitled. Carers often struggle to cope with caring for a relative with dementia at home, particularly if the person with dementia has challenging behaviour, leading to costly admission to a care home or hospital. The Department should emphasise to local health organisations and their social care partners that they need to develop an action plan, which gives priority to assessing and meeting the needs of carers. The Department should develop a commissioning toolkit to help demonstrate the cost and benefits of the different options for providing support, including respite and domiciliary care.

**Progress:** Objective 7 of the strategy addresses the need for the provisions of the Carer's Strategy to be available for people with dementia, and emphasises the right of carers to have an assessment of their needs.

The Department accepts that not enough carers receive the carer's assessment to which they are

entitled. The Carers Strategy, *Carers at the Heart of 21st-Century Families and Communities* (DH, June 2008), recognises the increasingly important role that carers play in our society and acknowledges that all carers, including carers of those diagnosed with dementia, need more help and support than has been available in the past. The Carers Strategy contains a number of commitments including information and advice, new break provision and a recognition that family carers should be involved in decisions about treatment and support.

The Department knows that carers need accessible and reliable information that enables them to access services and support for themselves and the person they care for. This may especially be the case for people caring for someone with a mental health problem who may feel particularly isolated and in need of help and advice. The Department recognise that, although caring for someone with mental health problems can be intermittent, it may be very intensive and stressful when the need arises.

The Department has therefore established Carers Direct, an information service for carers. The service provides advice and support for anyone looking after someone else – everything from benefits to local help – via a website, a single national freephone number, e-mail and post. One of the aims of the service is to ensure that carers are aware of their rights, including the right to an assessment. The website, hosted by NHS Choices, went live on 26 January 2009. The Carers Direct helpline is under development and went live in April 2009 and will reach full capacity by July 2009.

The Department's vision is that carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.

The key to achieving greater integration of services is the use of more effective holistic assessment, which enables the person cared for and their carer



to identify their needs, what matters to them and how their own outcomes will best be met.

It will also be important that carers (who have a specific right to an assessment) have their own individual assessment, to ensure that specific needs around their own health and well-being are identified. This approach will enable individuals and their carers to design care and support which better meets their individual needs and draws in contributions from a range of people, organisations, family and friends.

Such assessment will be supported by the development of a Common Assessment Framework for Adults, in order to share relevant information between agencies and encourage close working between councils, the NHS and other statutory agencies as well as the third sector.

The Department is supporting a consortium, made up of stakeholder bodies (The Princess Royal Trust for Carers; Crossroads Caring for Carers; Carers UK; the National Black Carers and Care Workers Network; the Association of Directors of Adult Social Services; the Local Government Association; NHS Confederation; the Social Care Institute for Excellence; and the Improvement and Development Agency for local government), to gather good practice on commissioning for local health organisations and their social care partners.

Significantly, the *NHS Operating Framework*, which sets out the specific business and financial arrangement for the NHS in any given year, in 2008-09 makes specific reference for the first time to supporting carers.

There are similar references in guidance on practice-based commissioning and in the guidance covering joint strategic needs assessments. The aim of these various measures is to ensure that the new local performance framework recognises the importance the Government attaches to supporting carers. Improvements in the identification of cases

of dementia resulting from the strategy will also mean that carers can be identified and appropriate assessments completed.

**Recommendation (vii):** Some 62 per cent of care home residents are currently estimated to have dementia, but less than 28 per cent of care home places are registered to provide specialist dementia care. Few care home staff have specialist-nursing qualifications or have been trained in dementia care. There is high turnover of staff and high vacancy levels, and some staff do not have English as a first language. Poor standards of care have resulted in instances of inappropriate medicines management and complaints that people are not afforded sufficient dignity and respect. The Commission for Social Care Inspection should assess staff qualifications and training as part of its review of the quality of care for people with dementia, and local mental health services should use the findings when allocating resources to community psychiatric teams so that they can provide adequate out reach services to support care homes.

**Progress:** The issue of registration of care homes providing for people with dementia is not straightforward. Guidance issued by the Commission for Social Care Inspection makes clear that not all services that provide support for people who have a diagnosis of dementia must be registered as providing dementia care. Nor does this mean that a care home that is not so registered is unable to support a person with a diagnosis.

Most people with dementia are supported by general services in their own home, or in a non-specialist care home, and this is entirely appropriate. Specialist mental health services should be targeted at those people who have more complex needs and who require a higher level of expertise in their management and treatment. However, the Department needs to be confident that the services offered by all care homes fully meet the needs of all those residents with dementia.

Objective 11 of the strategy identifies the need for improved quality of care for people with dementia in care homes, by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services for community mental health teams, and through inspection regimes. Objective 13 also addresses the need for all health and social care staff, including staff in care homes, to have the necessary skills to provide the best quality of care for people with dementia, to be achieved by effective basic training and continuous professional and vocational development in dementia. Both these objectives will be priorities for the Department's Implementation Working Group and regional support network (as set out in the implementation plan) in implementing the strategy, engaging with and providing support for appropriate stakeholders, including third sector provider organisations, the Care Quality Commission, Skills for Care and others.

**Recommendation (viii):** Hospital care for people with dementia is often not well managed, increasing the risk of longer stays, admission to a care home and deterioration in the patient's health. Hospital staff generally focus on the physical reason for admission and can fail to identify or deal with dementia as a disease, resulting in longer stays and poorer outcomes than for people who are psychiatrically well. In order to improve the cost effectiveness of acute care, families of people with dementia should hold a copy of the person's care record so that paramedics will be able to make an informed decision about whether the person needs to be taken into hospital or can be treated at home. For older patients admitted and known or suspected to have cognitive impairment, hospitals should routinely undertake a mental health assessment.

**Progress:** The strategy addresses the need for better leadership on and knowledge of dementia care in general hospitals. Objective 8s set out the need for a senior clinician to be identified in general hospitals to provide leadership on improving the

quality of dementia care; to be responsible for the development of an explicit care pathway for the management of care; and to commission specialist liaison older people's mental health teams to work in general hospitals. Objective 3 of the strategy sets out the need for good-quality information to be given to family and carers throughout the course of the illness. This should include advice on the progression of the illness, and the care and medication required for people with dementia.





## F Spending on Publicity and Advertising and Income from Sponsorship, 2008-09

### 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 F.1: Departmental spending on publicity, advertising and sponsorship, 2008-09

Campaign title	£ million Amount
Tobacco control	25.5
Change4Life	8.6
Alcohol (Department of Health contribution to cross-government initiative)	5.9
Stroke	4.3
Sexual health (including the Department of Health's contribution to cross-government initiative)	3.0
Human papillomavirus (HPV) vaccination	3.0
Social care recruitment	2.5
NHS Choices	2.0
Respiratory and hand hygiene	1.7
Flu immunisation	1.6
Hepatitis C	1.4
Antibiotics	1.3
Frank (Department of Health contribution to cross-government initiative)	0.6
Patient choice	0.6
Other	0.6
<b>Total</b>	<b>62.6</b>

Source: Communications Directorate, DH

Notes:

(1) These figures represent projected totals for advertising-led campaigns delivered in the course of 2008-09. They should not be considered the total for all communications expenditure in the course of the year, which would incorporate a wider range of activity (eg stakeholder events).

Figure F.2: Sponsorship paid by the Department of Health to other organisations, 2008-09

Recipient	£	
	Amount sponsored	Support donated
None	0	None

Source: Communications Directorate, DH



Figure F.3: Sponsorship received by the Department of Health from other organisations, 2008-09

Campaign	Sponsor/Partner	Value (£s)	Reach	Support received
Tobacco control	Northern Foods	972	11,000 employees	Poster space in staff areas, space in staff newsletter and staff intranet.
Tobacco control	Tragus restaurants	N/a	5,000 employees	Poster space in staff areas across 270 sites.
Tobacco control	ARAMARK	1,872	13,000 employees	Poster space in staff areas and distribution of resource items.
Tobacco control	Uniq Prepared Foods	72	5,000 employees	Poster space and distribution of resource items.
Tobacco control	Arla Foods	N/a	5,000 employees	Poster space in all sites.
Tobacco control	First Group	N/a	38,000 employees	Poster space across all sites, article in staff newsletter.
Tobacco control	Premier Foods	3,708	22,000 employees	Poster space across all sites, quit kits distributed, articles on intranet and in staff newsletter, link up with NHS local stop smoking services.
Tobacco control	ASDA	100,800	175,000 employees	Poster space in staff areas of all stores, space in newsletters, intranet and link up with NHS local stop smoking services.
Tobacco control	Anchor Trust	54	10,000 employees	Activity with Bradford Local Stop Smoking Service.
Tobacco control	Rentokil Pest Control	691	1,000 employees	Distribution of Smoke-free materials.
Tobacco control	United Biscuits	1,008	7,000 employees	Distribution of Smoke-free materials.
Tobacco control	Lafarge Cement	54	1,500 employees	Work with NHS local stop smoking services.
Tobacco control	Pickfords	36	1,300 employees	Poster space and distribution of Smoke-free materials.
Tobacco control	Netto	N/a	3,000 employees	Poster space and Smoke-free collateral items distributed across all sites.
Tobacco control	Iceland	N/a	32,200 employees	Poster space in staff areas.
Tobacco control	Stagecoach	14,400	25,000 employees	Poster space in staff areas and Smoke-free items distributed.
Tobacco control	Robert McBride	162	2,000 employees	Distribution of Smoke-free materials.
Tobacco control	Greggs	864	22,000 employees	Distribution of Smoke-free materials.
Tobacco control	Tesco	5,320	240 pharmacy stores	Materials distributed in pharmacies.
Tobacco control	Morrisons	27,501	94 pharmacy stores	Materials distributed in pharmacies, in-store campaign planned for March 2009.
Tobacco control	Superdrug	22,712	260 pharmacy stores	Materials distributed in pharmacies, in-store point of sale in January 2009.
Tobacco control	ASDA	5,275	150 pharmacy stores	Materials distributed in pharmacies, in store campaign planned for March 2009.
Sexual health	Club 18-30	166,424	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	Escapades	124,337	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	Freestyle	123,497	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	2wentys	103,021	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	Morrisons	4,455	N/a	A3 in-store poster in 99 stores, visited by an average of 5.5 million customers a week.
Sexual health	Cosy Camper/Mates	52,170	N/a	30,000 festival kits distributed for free.
Sexual health	Company Time (now Yellow Hammer Bars)	97,366	N/a	Collateral sampling, and messaging on toilet roll holders, standees, cue cards and plasma screens. SMS and e-mail messaging sent out to database, and dedicated page on club website.
Sexual health	The Body Shop	32,420	N/a	In-store point of sale, 300,000 leaflets distributed, and branded condom cases inserted in the Student Guide which sold 8,000 copies.
Keep warm, keep well	Lidl	N/a	400 stores	Posters, leaflets and thermometers distributed to 400 stores in England.
Keep warm, keep well	The Co-operative	35,937	N/a	In-store DJ and till screen advertising.
Change4Life	ASDA	N/a	N/a	E-media, point of sale, staff and customer magazine activity.
Change4Life	Tesco	N/a	N/a	E-media, point of sale and customer magazine activity.
Change4Life	The Co-operative	N/a	N/a	Point of sale and in-store radio activity.
Change4Life	Convenience stores	N/a	N/a	Point of sale activity.
Change4Life	Wright Foundation	N/a	N/a	Point of sale activity.
Change4Life	Kellogg's	N/a	N/a	Direct mail, e-media, point of sale and staff activity.
Change4Life	Fitness Industry Association	N/a	N/a	Direct mail, e-media and staff activity.
Change4Life	PepsiCo	N/a	N/a	E-media activity.
Change4Life	Fit For Sport	N/a	N/a	E-media activity.

Source: Communications Directorate, DH

Notes:

(1) When attributing an advertising equivalent value on activity, the Central Office of Information only put values on activity that could be purchased. The opportunities within the employer campaigns are 'money can't buy' and therefore cannot be valued. Instead, 'reach' information has been included. Media partnerships are not included in the above. At the time of publication it was too early to report further figures for Change4Life.

## G Glossary

### **A&E (Accident & Emergency)**

The emergency department of and hospital that deals with people who need emergency treatment because of sudden illness or injury. Sometimes called the casualty department.

### **Acute services**

Medical and surgical interventions usually provided in hospital. Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

### **Annually Managed Expenditure (AME)**

Totally Managed Expenditure (TME) is divided into Annually Managed Expenditure (AME) and Departmental Expenditure Limits (DEL). AME is public expenditure for which multi-year spending limits are not seen as appropriate, and which is instead subject to annual review.

### **Arm's length bodies (ALBs)**

Government-funded organisations which work closely with local services, and other ALBs. In the Department they regulate the system, improve standards, protect public welfare and support local services. The Department has 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, and 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, primary care trusts and NHS trusts.

### **Central health and miscellaneous services**

These are a wide range of activities funded from the Department spending programmes whose only common feature is that they receive funding direct from the Department, and not via primary care trusts. Some of these services are managed directly by departmental staff; others are run by executive non-departmental public bodies, or other separate executive organisations.

### **Commissioning for Quality and Innovation (CQUIN)**

The key aim of the CQUIN framework is to support a shift towards the vision set out in *High Quality Care for All* of an NHS where quality is the organising principle. The framework helps to make quality part of the commissioner/provider discussion everywhere.

### **Community care**

Care, particularly for elderly people, people with learning or physical disabilities or a mental illness, which is provided outside a hospital setting, ie in the community.

### **Corporate governance**

The 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)**

Totally Managed Expenditure (TME) is divided into Annually Managed Expenditure (AME) and Departmental Expenditure Limits (DELs). The DEL is made up of departmental budgets for which there are multi-year spending limits. Almost all the Department budget, including allocations to the NHS, is within the DEL.

## **Departmental Strategic Objectives (DSOs)**

The core purpose of the Department – what it is here for – is enshrined in the Departmental Strategic Objectives so that its individual and team objectives and its departmental targets can all connect directly to them.

## **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.

## **Derogation**

The partial revocation of a law.

## **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 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 receipts. Funding is subject to local resource limits and forms part of primary care trusts' revenue 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 (EEA)**

The European Union countries plus Norway, Iceland and Liechtenstein.

## **Executive agencies**

A discrete unit set up to undertake an executive function of government. The Department has two executive agencies; the Medicines and Healthcare products Regulatory Agency and the NHS Purchasing and Supply Agency.

## **Family health services (FHS)**

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, most of whom are independent contractors.

## **General dental services (GDS)**

The GDS scheme offers patients personal dental care via general dental practitioners (GDPs), most of whom work as independent contractors from high street and local surgeries. Since April 2006, PCTs have been responsible for the local commissioning of GDS and other primary dental care services. Formerly GDPs claimed item of service fees for each individual treatment provided, but remuneration is now based on PCTs agreeing with each dental practice an annual contract sum for a specified level of dental services. 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, or 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. While 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.

### **General ophthalmic services (GOS)**

The GOS scheme offers priority groups of patients free NHS sight tests and, where necessary, optical vouchers to help with the purchase of glasses. NHS sight tests are mainly available to children, people aged 60 or over, adults on low incomes, or people suffering from, or who are predisposed to, eye disease. Entitlement to NHS optical vouchers is mainly restricted to 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 services are administered by PCTs, terms of service are set nationally and funding is provided from a national demand-led, or non-discretionary, budget.

### **Gershon Programme**

An independent efficiency review of Whitehall departments looking at common core functions.

### **Green Paper**

Green Papers are consultation documents produced by the Government. Often when a government department is considering introducing a new law or other major policy change, it will put together a discussion document called a Green Paper. The aim of this document is to allow people both inside and outside Parliament to debate the subject and give feedback on the proposals.

### **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 of GDP deflators 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 (HRGs)**

Groupings of similar clinical procedures that require approximately similar levels of resource input. They provide a way of categorising the treatment of patients in order to monitor and evaluate the use of resources.

### **Health Improvement Programmes**

An action programme to improve health and healthcare locally and led by the PCT. It will involve NHS trusts and other primary care professionals, working in partnership with the local authority and engaging other local interests.

### **Hospital and community health services (HCHS)**

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by primary care trusts and provided by NHS trusts or NHS foundation trusts. HCHS provision is discretionary and also includes funding for those elements of family health services spending that are discretionary (GMS discretionary expenditure). It also covers related activities such as research and development, and education and training purchased centrally from central budgets.

### **Independent sector treatment centre (ISTC)**

Private sector treatment centres that offer pre-booked day and short-stay surgery, and diagnostic procedures.

### **In-patient**

A person admitted on to a hospital ward for treatment.

### **MRSA**

MRSA (sometimes referred to as the superbug) stands for methicillin-resistant *Staphylococcus aureus*. It is a bacterium from the *S. aureus* family.

### **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.



### **National Service Framework (NSF)**

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 that 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.

### **NHS foundation trusts**

NHS hospitals that are run as independent, public benefit corporations, which are both controlled and run locally.

### **NHS LIFT**

NHS LIFT stands for NHS Local Improvement Finance Trust. A local LIFT will build and refurbish primary care premises which it will then own. It will rent accommodation to GPs on a lease basis (as well as other parties such as chemists, opticians dentists).

### **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.

### **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 that may require cash payments but in the longer term (e.g. provisions).

### **Non-discretionary**

Expenditure that is not subject to a cash limit, mainly applying to certain 'demand-led' family health services, such as the general ophthalmic services, dispensing remuneration for pharmacists and income from prescription charges.

### **Outpatient**

A person treated in a hospital but not admitted on to a ward.

### **Outturn**

The actual year end position in cash terms.

### **Overage**

Overage (also called 'clawback') is a term to describe a sum of money in addition to the original sale price which a seller of land may be entitled to receive following completion if and when the buyer complies with agreed conditions.

### **Payment by results**

A transparent rules-based system that sets fixed prices (a tariff) for clinical procedures and activity in the NHS, enabling all trusts to be paid the same for equivalent work.

### **Performance indicator**

Measures of achievement in particular areas used to assess the performance of an organisation.

### **Personal dental services (PDS)**

PDS schemes initially started as pilots where dentists offered patients personal dental care equivalent to that provided within the general dental services (GDS) scheme, but within a more flexible framework of local commissioning arrangements and alternative payment systems to item of service fees. From April 2006 most former PDS pilots switched to the new GDS contract terms. PDS agreements are now generally reserved for the commissioning of specialist care within the community, for example from practices offering orthodontic services only. 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 a system of locally agreed contracts between practices and PCTs for delivering primary medical services and is seen as a local alternative to GMS. This means that primary care service provision is responsive to the local needs of the population. As a result, PMS has been successful in reaching deprived and under-doctored areas. Many PMS pilots focus on the care of vulnerable groups, including 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 care and support services for people who may require them as a result of old age, mental or other ill health, substance misuse, physical or learning disability, and children being 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)

NHS 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 which are the remuneration paid to contractors (community pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for dispensing NHS prescriptions. Net PhS expenditure is the gross expenditure less income from prescription charges.

Funding for the total drugs bill is subject to local resource limits and forms part of primary care trusts' (PCTs') hospital and community health services discretionary allocations. However, funding for dispensing costs is currently provided from the national demand-led or non-discretionary budget, and is not subject to local resource limits and is not included in a PCT's discretionary allocation.

## Primary care

The initial contact for many people when they develop a health problem is a member of the primary care team. The term covers family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners. NHS Direct and NHS walk-in centres are also primary care services.

## Primary care trust (PCT)

Primary care trusts are responsible for identifying the healthcare needs of their relevant population from within their available resources, 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.

## Private finance initiative (PFI)

An initiative aimed at securing private sector money and management expertise for the provision of services which have traditionally been undertaken by the public sector. It was introduced as a means by which private funds can be used to supplement public investment in capital projects such as hospitals. The aim is to transfer risks of cost overruns, design faults, servicing and maintaining over the lifetime of the contract onto the private sector.

## Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, eg 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 (PAC)

The PAC is a Committee of the House of Commons that examines the regularity and propriety of government expenditure and how it is accounted for. It also examines the economy, efficiency and effectiveness of public expenditure.

## Public Service Agreement (PSA)

PSAs accompany the Spending Review and set out output targets agreed with HM Treasury detailing the exact outcomes departments have committed to 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

Reference costs are the average cost to the NHS of providing a defined service in a given financial year. Reference cost data allow NHS trusts to compare their costs with the NHS average and therefore benchmark their relative efficiency.

## Revenue

Revenue is expenditure other than capital, for example staff salaries and drug budgets. It is also known as current expenditure.

## Secondary care

Specialised medical services and commonplace hospital care, including outpatient and in-patient services. Access is often via referral from primary care services.



## **SNOMED**

Systematised Nomenclature of Medicine. It is a common computerised language that will be used by all computers in the NHS to facilitate communications between healthcare professionals in clear and unambiguous terms.

## **Social Services**

These are local authority departments that provide direct services in the community to clients.

## **Special health authority**

Independent health authorities that provide a service to the public and/or the NHS. They generally provide a service to the whole population of England and not just to a particular local community. Examples include NHS Direct and the National Patient Safety Agency.

## **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**

HM Treasury-led review of public funding across all government departments, leading to the publication of Public Service Agreements and the budgets departments will receive to fulfil those agreements.

## **Strategic health authority (SHA)**

The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans, and that primary care trusts are performing well. There are ten in England, largely coterminous with Government Offices of the Regions.

## **Supply Estimate**

The term is loosely used for the Main Estimates, a request by the Department to Parliament for funds required in the coming financial year. There are also Supplementary Estimates. Supply Estimates are 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 has three Votes which form Class II. Vote 1 covers the Department 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.

## **Telecare**

The use of information and communications technology systems to provide diagnosis, advice, treatment and monitoring to patients remotely. It is being used in both primary and secondary care settings.

## **Third sector**

Non-governmental organisations that are run on a not-for-profit basis and are not part of the public sector. They are motivated primarily by a desire to further social, environmental or cultural objectives rather than to make a profit for their own sake, and any surpluses they make are reinvested to further these objectives. This includes the voluntary and community sector as well as co-operatives and social enterprises, trade unions, not-for-profit trade associations etc.

## **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 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.

## **TUPE – Transfer of Undertakings (Protection of Employment) Regulations**

This is an important part of UK labour law, protecting employees whose business is being transferred to another employer.

## **Voluntary and community sector (VCS)**

Groups set up for public or community benefit such as registered charities, and non-charitable non-profit organisations and associations.

## **Vote**

See 'Supply Estimate'.

## **Walk-in centre**

Centres staffed by nurses that offer patients fast and convenient access to treatment and information without an appointment.

### **Weighted capitation formula**

This determines PCTs' target share of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare needs. It is a formula that uses PCT populations, which are then weighted for (i) the cost of care by age group; (ii) relative need over and above that accounted for by age; and (iii) unavoidable geographical variations in the cost of providing services (the market forces factor).

### **White Paper**

A document produced by the Government setting out details of future policy on a particular subject. A White Paper will often be the basis for a Bill to be put before Parliament. The White Paper allows the Government an opportunity to gather feedback before it formally presents the policies as a Bill.





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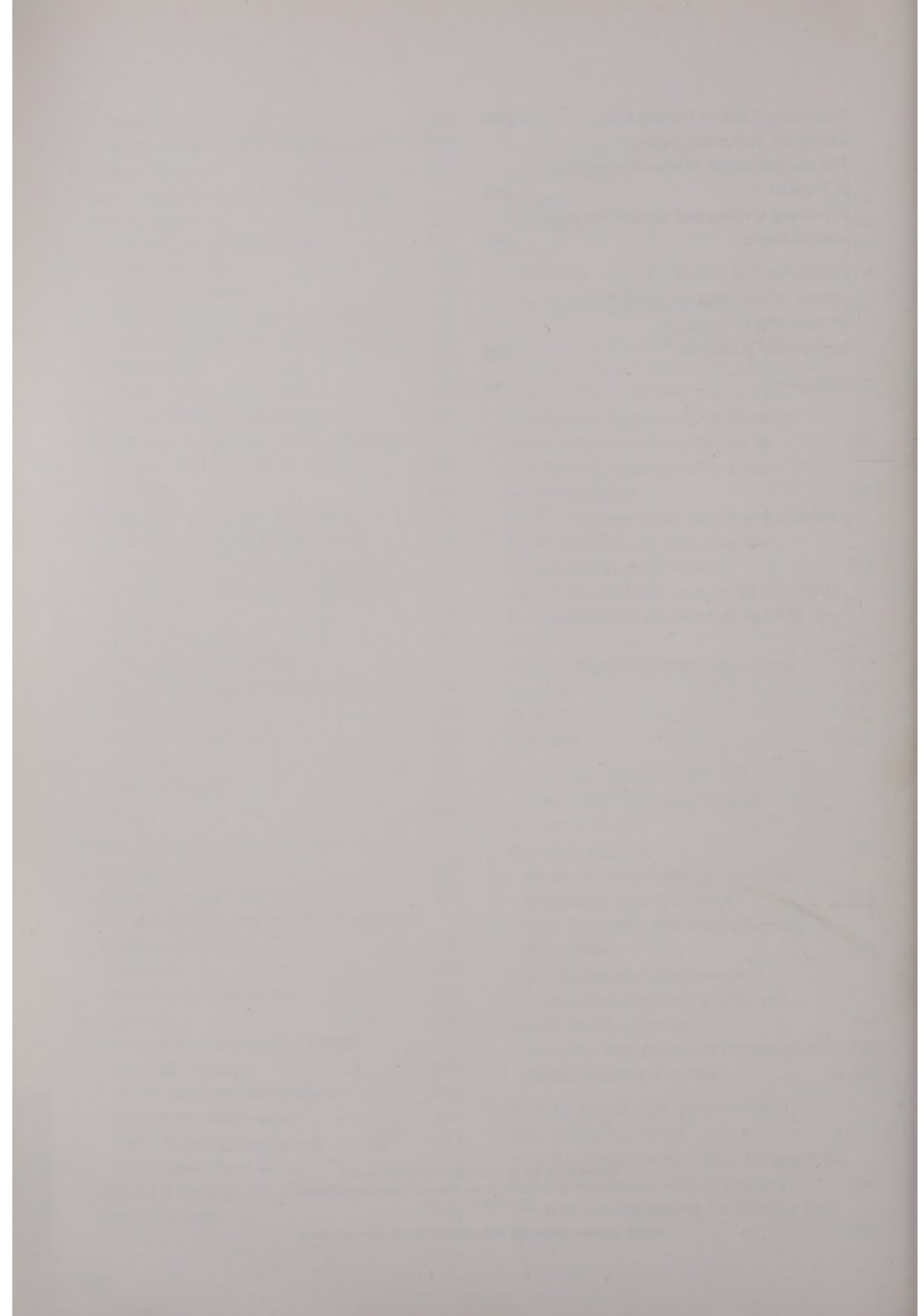




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