Departmental report : 1995/96 / Department of Health presented to Parliament by the Secretary of State for Health and the Chief Secretary to the Treasury.

OPCS
OFFICE OF POPULATION CENSUSES & SURVEYS

The Government's Expenditure Plans 1995-96 to 1997-98

DEPARTMENT OF HEALTH AND OFFICE OF POPULATION CENSUSES AND SURVEYS

DEPARTMENTAL REPORT

This is part of a series of departmental reports (Cm 2801 to 2820), accompanied by the Public Expenditure Statistical Supplement to the Financial Statement and Budget Report, 1995–96 (Cm 2821), which present the Government's expenditure plans for 1995–96 to 1997–98. The complete series is also available as a set at a discounted price.

The Governments' Expenditure Plans 1995-96 to 1997-98

DEPARTMENT OF HEALTH AND OFFICE OF POPULATION CENSUSES AND SURVEYS

DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health and the chief Secretary to the Treasury by Command of Her Majesty March 1995

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CONTENTS

The purpose of this report is to present to Parliament and to the public a clear and informative account of the expenditure and activities of the Department of Health and the Office of Population Censuses and Surveys. If you would like further information on anything contained in the report, or have any comments or suggestions on its content or presentation, please write to:

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I GENERAL

1 INTRODUCTION

1.1 This is the fifth annual report of the Department of Health and the Office of Population Censuses and Surveys (OPCS) providing financial information about the spending programmes of the Departments.

Department of Health

1.2 The Department of Health (covered in Part II) is responsible for health and personal social services in England.

1.3 The Health programme is funded mainly by central government. The Department sets overall policy on all health issues, including public health matters and the health consequences of environmental and food issues. It is also responsible for the provision of health services locally, a function which it discharges through the National Health Service Executive. The NHS Executive is responsible for the central management and guidance of the statutory regional and district health authorities, family health services authorities and certain special health authorities. It is also responsible for holding NHS trusts directly accountable to Ministers, in particular for the performance of their statutory financial duties. The Government proposes, subject to legislation, to make structural changes to the management of the NHS; these are outlined in Chapter 5.

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

Office of Population Censuses and Surveys

1.5 OPCS (covered in Part III) is a separate department, which reports to the Secretary of State for Health. It is responsible for securing the provision of an efficient and effective system for the registration of births, deaths and marriages, and for the provision of high quality demographic, social and medical information. The OPCS programme is funded largely by central government expenditure.

Cash Plans

1.6 **Table 1** summarises the cash plans for the Department of Health and OPCS; further details are given in **Annex A. Table 2** summarises local authority expenditure. Both these sets of figures are discussed in greater detail in the sections which follow.

1.7 Details of spending on health and personal social services programmes in Scotland, Wales and Northern Ireland are published in those departments' Departmental Reports. A breakdown of total Government expenditure on these programmes within the United Kingdom for current and past years is given in Table 1.2 of the Statistical Supplement to the Financial Statement and the Budget (Cm 2821). **Annex B** to this report summarises recent expenditure trends and future spending plans for the NHS in the United Kingdom.

Table 1 SUMMARY CASH PLANS - PRODUCED BY TREASURY

£ million

	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans	1996-97 plans	1997-98 plans
Department of Health									
Health services									
National Health Service hospital, community health, family health (cash limited) and related services [1] [2]	14,997	16,923	19,321	21,201	22,094	23,512	23,298	23,864	24,432
National Health Service trusts [3]			-24	223	303	588	648	615	516
National Health Service family health services (non-cash limited) [1]	4,228	4,690	5,219	5,613	5,622	5,620	7,024	7,363	7,718
Departmental administration	185	234	247	310	280	283	268	324	313
MCA Trading Fund [4]					5	2	1	1	1
Central health and miscellaneous services	444	482	593	626	648	701	732	770	800
General Practice Finance Corporation [5]									
Total health services	**19,855**	**22,328**	**25,356**	**27,973**	**28,953**	**30,706**	**31,971**	**32,937**	**33,779**
Other services									
Personal social services	18	24	31	40	43	45	43	42	42
Civil defence	2	1	1	1	2	3	3	3	3
General Practice Finance Corporation [5]									
Central government grants to local authorities	24	31	58	83	654	835	760	114	114
Credit approvals	67	84	106	126	132	140	144	137	137
Total Department of Health	**19,966**	**22,468**	**25,552**	**28,224**	**29,784**	**31,730**	**32,921**	**33,234**	**34,076**
Of which:									
Central government's own expenditure	*19,875*	*22,353*	*25,413*	*27,792*	*28,690*	*30,164*	*31,369*	*32,366*	*33,307*
Public corporations (excluding nationalised industries)			*-24*	*223*	*303*	*588*	*648*	*615*	*516*
Central government support to local authorities	*91*	*115*	*164*	*210*	*786*	*976*	*904*	*252*	*252*
Office of Population Censuses and Surveys	**34**	**53**	**101**	**40**	**32**	**36**	**36**	**38**	**38**
Total Department of Health and Office of Population Censuses and Surveys	**20,000**	**22,521**	**25,653**	**28,264**	**29,816**	**31,765**	**32,957**	**33,271**	**34,114**

(1) In 1991-92, 1992-93, 1993-94 and 1994-95 provision of £125, £295, £628 and £1,058 million respectively for drugs prescribed by GP fund holders is included in HCHS current expenditure. However, for other years all provision for FHS drug costs is included in FHS non-cash limited provision. This reflects the fact that there is no basis for adjusting previous years' figures because GP fundholders did not exist before 1 April 1991 and for future years decisions on the number of GP fund holders have not yet been taken.

(2) HCHS current expenditure includes that element of trust capital expenditure which they fund from their charges to health care purchasers (£231 million in 1991-92, £363 million in 1992-93, £696 million in 1993-94, £975 million in 1994-95 and provisional figures for 1995-96, 1996-97 and 1997-98).

(3) Figures for forward years are provisional estimates.

(4) Prior to 1993-94 MCA figures are included in departmental administration. MCA figures from 1993-94 reflect the reclassification of expenditure following the move to Trading Fund status.

(5) Cash amounts below £0.5 million are not shown.

Table 2 LOCAL AUTHORITY EXPENDITURE [1]

	1989-90 Outturn	1990-91 Outturn	1991-92 Outturn	1992-93 Outturn	1993-94 Estimated Outturn	1994-95 Estimated Outturn
Department of Health						
Net current spending						
Personal social services (2)(3)		4,213	4,622	4,974	5,726	6,594
Port Health	3,713 4	5				
Total net current spending	3,717	4,218	4,627	4,979	5,730	6,598
Net Capital spending						
Personal social services	157	147	133	132	127	165
Of which						
Gross spending	*224*	*174*	*166*	*169*	*183*	*201*
Capital receipts	*-67*	*-27*	*-34*	*-38*	*-57*	*-36*
Total local authority net expenditure	3,874	4,365	4,760	5,111	5,857	6,763

(1) Local authority expenditure did not form part of the control total until 1993-94, except for the element of central government support within it. This was described in the Statistical Supplement to the 1992 Autumn Statement (Cmd 2219). However, from 1993-94 local authorities' self financed expenditure forms part of the new control totals.

(2) From 1993-94 includes additional resources for community care reforms.

(3) Totals for 1992-93 and 1993-94 include capitalised current expenditure of £6.1m and £2.0m respectively.

II DEPARTMENT OF HEALTH

II DEPARTMENT OF HEALTH

2 AIMS, OBJECTIVES AND PRIORITIES

Aims

2.1 The Department of Health's overall aims are to improve the health and well-being of the people of England and to secure the provision of high quality health and social care for those who need it.

Goals

2.2 Its specific goals, under the direction of Ministers, are to develop appropriate policies, to determine and secure the necessary resources for its programmes, and to establish the right management and resource framework so that:

- the health of the nation can be protected, promoted and improved;
- high quality health care can be secured through the National Health Service;
- high quality social care can be secured through local authorities and other agencies;
- the United Kingdom can play an effective part in the work of the European Community and other international health and social services bodies;
- its programme expenditure has a clear purpose which is right for the 1990s, is used cost effectively and achieves value for money;

and to secure value for money from the resources provided to cover its own running costs.

The allocation of Ministerial responsibilities and the organisation of the Department of Health and of the NHS are shown at **Annexes C, D and E** of this report.

Priorities and Key Challenges

2.3 Each year, the Secretary of State identifies specific priorities and key challenges in support of these goals, in detail for the year ahead and in less detail for the following three years. Progress against all the 1994-95 priorities and priorities for 1994-95 to 1997-98 are set out at **Annex F**.

2.4 Major policy and service developments during 1993-94 and subsequently in pursuit of those priorities are described in detail in Chapter 4, and work to improve value for money in the Department itself in paragraphs 5.86 - 5.93 of Chapter 5. Summary reports on the work of the Department's executive agencies are at **Annex G**.

3 EXPENDITURE

THE HEALTH PROGRAMME

3.1 The health programme consists of:

- NHS Hospital and Community Health Services (HCHS), providing all hospital care and a wide range of community health services;
- NHS Family Health Services (FHS), providing general medical, dental, pharmaceutical and some ophthalmic services and covering the cost of medicines prescribed by general practitioners (GPs);
- Central Health and Miscellaneous Services (CHMS), providing services which can most effectively be administered centrally, for example welfare food and support to the voluntary sector;
- the administrative costs of the Department of Health.

Expenditure Plans

3.2 Spending on the NHS in 1995-96 reflects the priority being given to health. The Government plans to increase its spending on the NHS in England to £31,971 million in 1995-96, equivalent to £1,614 per household. This is an increase of 1 per cent in real terms over the original plan for 1994-95, and 0.8 per cent over forecast outturn. Current spending on the hospital and community health services will grow by 1.3 per cent in real terms.

3.3 Key elements of the Government's plans are:

- a significant improvement in the standards of service patients can expect to receive under the Patient's Charter, particularly from a new guarantee that from April 1995, nobody will have to wait more than 18 months for treatment; and a new national standard for outpatient waiting times, announced in January 1995. See paragraphs 4.30 and 4.32 for details;
- priority to improving mental health services and developing other services, including maternity care and services for cancer patients - see paragraphs 4.39, 4.36 and 4.35 for the Department's initiatives in these areas;
- the continued expansion of primary care - paragraph 4.53;
- further progress in improving primary care in London - paragraph 4.49;
- an improvement in overall HCHS efficiency of at least 3 per cent - equivalent to an extra £600 million for patient care. The NHS's record on efficiency gains is discussed in paragraphs 5.25 to 5.27;
- further streamlining of health authorities, saving approaching £60 million in 1995-96 rising to £150 million by 1997-98, as the NHS moves towards the new simplified management structure envisaged in the Health Authorities Bill now before Parliament. Progress on implementing the Government's proposals is described in paragraphs 5.2 to 5.8;
- a new management structure for the Department of Health itself, expected to save some £50 million by 1997-98, so that total savings from streamlining management in the health service and the Department will be around £200 million. The changes underway in the Department are outlined in paragraphs 5.79 to 5.82.

3.4 Full details of outturn and planned expenditure on the National Health Service both in total and for each of its subprogrammes are given in **Table 3**. This shows net expenditure (that is, spending financed by the Exchequer) as well as gross expenditure (that is, including the additional sums available to the health programme from receipts from sale of surplus land, income from private patients etc, and charges). Gross figures for the UK are given in **Annex B** to this report.

3.5 Table 3 reflects the areas in which funds are actually spent. By contrast, **Annex A** reflects the classification used for technical reasons when funds are voted by Parliament for the NHS. The main differences from Table 3 are that much spending on capital is now financed through trusts' external finance limits (EFLs) and an element of health authorities' payments to trusts for NHS services; and that spending by GP fundholders on drugs is included with HCHS, not FHS. Full details of the adjustments made to the Annex A figures to produce those used in Table 3 are given in the notes to the latter. All NHS figures quoted in the remainder of this Report relate to Table 3.

Table 3 NATIONAL HEALTH SERVICE, ENGLAND - BY AREA OF EXPENDITURE

£ million

	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans	1996-97 plans	1997-98 plans
Central government expenditure									
National Health Service Hospitals community health, family health (cash limited) and related services									
Current expenditure (1)									
gross	14,219	16,027	18,226	19,986	20,701	21,452	22,520	22,991	23,526
charges and receipts (2)	-413	-476	-523	-530	-477	-254	-358	-314	-314
Net	13,806	15,551	17,702	19,456	20,224	21,198	22,163	22,677	23,212
percentage change using GDP deflator		4.3	7.1	5.7	0.9	2.8	1.3	-0.2	0.1
Capital expenditure (3) (4)									
gross	1,423	1,551	1,639	1,785	1,759	2,009	2,003	2,022	1,956
charges and receipts (2)	-232	-178	-169	-113	-213	-165	-220	-220	-220
Net	1,191	1,372	1,470	1,672	1,546	1,844	1,783	1,802	1,736
percentage change using GDP deflator		6.7	0.8	9.4	-10.2	16.8	-6.3	-1.4	-5.8
Total									
gross	15,642	17,577	19,865	21,771	22,460	23,461	24,523	25,012	25,481
charges and recepts (2)	-645	-645	-693	-643	-690	-419	-578	-534	-534
Net	14,997	16,923	19,172	21,129	21,770	23,041	23,946	24,479	24,948
National Health Service family health services (non-cash limited) (5)									
current expenditure									
gross	4,811	5,304	6,005	6,577	6,934	7,394	7,816	8,191	8,570
charges and receipts	-583	-614	-661	-669	-684	-715	-792	-829	-852
net	4,228	4,690	5,344	5,908	6,250	6,678	7,024	7,363	7,718
percentage change using GDP deflator		2.7	7.2	6.3	2.6	4.8	1.9	2.3	2.5
Departmental administration									
current expenditure									
gross	192	233	260	298	285	293	281	337	326
charges and receipts	-16	-20	-36	-31	-21	-20	-21	-21	-21
net	176	213	224	267	264	273	260	316	305
capital expenditure									
gross	9	21	23	43	16	11	8	8	8
charges and receipts	0	0	0	0	0	0	0	0	0
net	9	21	23	43	16	11	8	8	8
Total									
gross	201	254	284	341	301	304	289	345	334
charges and receipts	-16	-20	-36	-31	-21	-20	-21	-21	-21
net	185	234	247	310	280	283	268	324	313
MCA Trading Fund (6)									
current expenditure									
gross					5	0	0	0	0
charges and receipts					0	0	0	0	0
net					5	0	0	0	0
capital expenditure									
gross					0	2	1	1	1
charges and receipts					0	0	0	0	0
net					0	2	1	1	1
Total									
gross					5	2	1	1	1
charges and receipts					0	0	0	0	0
net					5	2	1	1	1
Central health and miscellaneous services									
current expenditure									
gross	472	506	629	664	688	758	781	821	843
charges and receipts	-50	-56	-67	-75	-71	-83	-79	-82	-84
net	422	450	562	589	617	674	702	740	769
capital expenditure									
gross	22	32	31	40	32	29	31	31	31
charges and receipts	0	0	0	-3	-1	-2	0	0	0
net	22	32	31	37	31	27	31	31	31

Total									
gross	494	538	660	704	720	787	812	852	884
charges and receipts	-50	-56	-67	-77	-72	-85	-79	-82	-84
net	444	482	593	626	648	702	732	770	800
Total National Health Service current expenditure (1)									
gross	19,694	22,069	25,120	27,525	28,612	29,896	31,399	32,340	33,274
charges and receipts (2)	-1,061	-1,167	-1,288	-1,305	-1,252	-1,074	-1,250	-1,245	-1,271
net	18,633	20,902	23,832	26,220	27,360	28,823	30,149	31,095	32,004
capital expenditure									
gross	1,454	1,604	1,693	1,868	1,807	2,050	2,042	2,061	1,995
charges and receipts (2)	-232	-178	-169	-115	-213	-167	-220	-220	-220
net	1,222	1,426	1,524	1,753	1,594	1,883	1,822	1,841	1,775
Total									
gross	21,148	23,673	26,813	29,393	30,419	31,946	33,441	34,402	35,269
charges and receipts (2)	-1,293	-1,345	-1,457	-1,420	-1,466	-1,240	-1,470	-1465	-1491
net	19,855	22,328	25,356	27,973	28,953	30,706	31,971	32,937	33,779
percentage change using GDP deflator		4.1	6.9	6.1	0.4	4.0	0.8	0.5	0.3

(1) Funding for that element of trusts' capital expenditure which they fund from their charges to health care purchasers (£231m in 1991-92, £363m in 1992-93, £696m for 1993-94, an estimated £975m for 1994-95 and provisional figures in 1995-96, 1996-97 and 1997-98), included within HCHS capital here, is included within HCHS current in Table 1 and Annex A.

(2) From 1991-92, includes trust receipts / charges (For current, £37m in 1991-92, £82m in 1992-93, £153m in 1993-94, and an estimated £228m for 1994-95; For capital, £3m in 1991-92, £6m in 1992-93, £37m in 1993-94, and an estimated £15m for 1994-95). Figures for all receipts and charges for future years are provisional estimates.

(3) Provision for capital spending within GMS cash-limited expenditure (£44m in 1991-92, £23m in 1992-93 and £21m in 1993-94), included in HCHS capital here, is included in HCHS current in Table 1 and Annex A.

(4) HCHS capital includes all NHS trust capital expenditure, ie that funded from charges to care purchasers (see Note 1) and that financed from their EFLs (£-24m in 1991-92, £223m in 1992-93, £304m in 1993-94, an estimated £607m for 1994-95 and provisional figures in 1995-96, 1996-97 and 1997-98).

(5) Expenditure on drugs prescribed by GP fundholders (£125m in 1991-92, £295m in 1992-93, £628m in 1993-94 and £1,058m in 1994-95), included here in FHS non-cash limited current, is included in HCHS Current in Table 1 and Annex A for those years. Since decisions on the number of GP fundholders in future years have not yet been taken, all FHS drug costs from 1995-96 onwards are included in the non-cash limited provision.

(6) Prior to 1993-94, MCA figures are included in departmental administration. MCA figures from 1993-94 reflect the reclassification of expenditure following the move to trading fund status.

3.6 **Table 4** compares net expenditure on the NHS in 1994-95 and the planned expenditure for 1995-96 with the figures published in last year's Departmental Report (Cm 2512). As every year, the Government reviewed its existing plans in the Public Expenditure Survey. It decided to retain the plans for the NHS for 1995-96 and 1996-97: because inflation prospects have improved this represents twice the real growth over 1994-95 plans previously envisaged for the NHS in 1995-96 (owing to various small transfers between programmes of funding for particular services the figures in Table 3 differ slightly from those in Cm 2512). Details of changes are shown in the table.

3.7 In 1994 the Public Expenditure Survey was again informed by the work of the fundamental review of health expenditure, announced by the Chief Secretary to the Treasury on 8 February 1993. The review's main contribution will be to increasing the efficiency and effectiveness of NHS spending on patients. HCHS efficiency is expected to improve by at least 3% in 1995-96, compared with the 1994-95 target of 2¼%. In addition, scope has been identified for achieving this through differential targets negotiated with purchasers. This will make it possible to take better account of local progress and opportunities, setting realistic but challenging targets in each case. Some authorities should be able to achieve significantly more than the average.

Table 4 COMPARISON OF EXPENDITURE PLANS FOR 1994-95 AND 1995-96 WITH THOSE IN LAST YEAR'S DEPARTMENTAL REPORT (CM 2512) TABLE 4.

	1994-95		Table	1995-96		Table
£m	Cm 2512	Difference	3	Cm 2512	Difference	3
HCHS current	21,191	+7	21,198	21,962	+201	22,163
HCHS capital	1,840	+4	1,844	1,981	-198	1,783
FHS current	6,648	+30	6,678	7,013	+11	7,024
CHMS	706	-4	702	738	-6	732
Departmental administration[1]	284	+1	285	283	-14	269
NHS total	30,669	+38	30,707	31,977	-6	31,971

(1) For consistency, Dept Admin current includes MCA, NHS estates and cost of collection

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

1994-95

FHS current: £30m
£-10m Transfer to cash-limited London Initiative Zone funds to promote primary care improvements.
£40m Addition from the Reserve to meet increased forecast demand.

1995-96

HCHS current: £201m
£205m Change agreed in 1994 Public Expenditure Survey

HCHS capital: £-198m
£-198m Change agreed in 1994 Public Expenditure Survey

FHS current: £11m
£11m Change agreed in 1994 Public Expenditure Survey

Departmental Administration: £-15m
£-18m Change agreed in 1994 Public Expenditure Survey

Sources of Finance

3.8 The NHS is financed mainly through general taxation and an element of National Insurance contributions. In 1994-95 it is estimated that 96.8 per cent of gross NHS spending in England will be met from these two sources: 83.4 per cent from the Consolidated Fund, that is, from general taxation, and 13.4 per cent from the NHS element of National Insurance contributions. Decisions taken in the annual public spending round relate to the total amount of NHS spending to be financed through public expenditure. Changes in the sums raised by the NHS element of National Insurance contributions (for example, because of an increase in earnings) therefore do not in themselves provide more or fewer resources for the NHS in total, but merely change the balance of funding between the taxpayer and the contributor. The remainder of NHS expenditure comes from charges and other receipts, including land sales and the proceeds of income generation schemes (see **Figure 1**). **Table 5** shows how sources of finance have changed over time.

FIGURE 1 - NHS SURCES OF FINANCE IN 1993-94

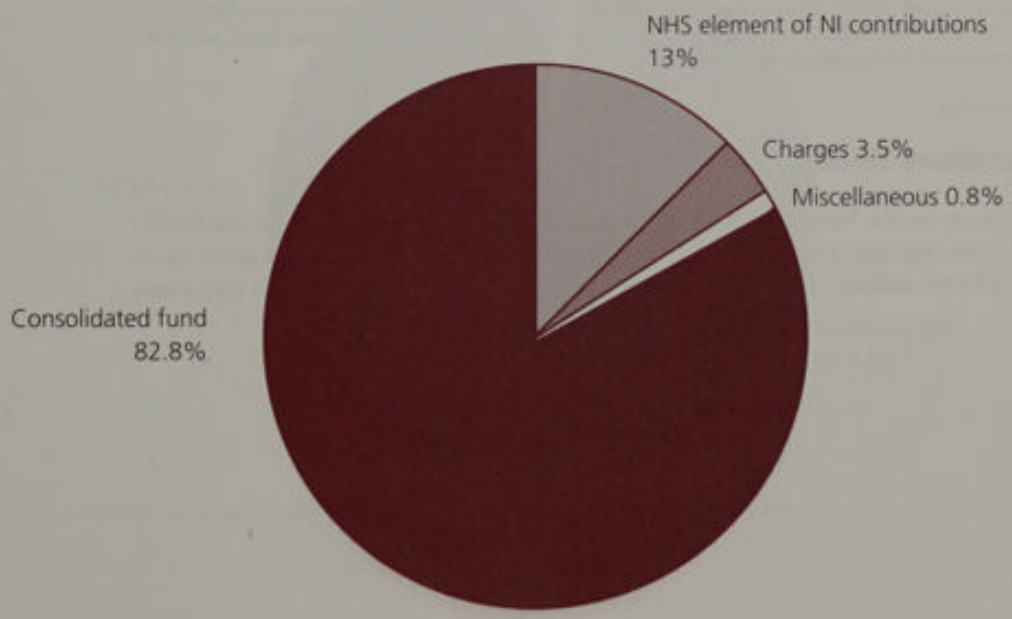


TABLE 5 NHS SOURCES OF FINANCE [1]

Financial year	Total public	of which: Consolidated fund expenditure	of which: NHS contributions	Total from other	of which: Charges (2)	of which: Miscellaneous (3)
	%	%	%	%	%	%
1986-87	95.8	83.7	12.1	4.2	3.1	1.1
1987-88	95.7	82.2	13.5	4.3	2.9	1.4
1988-89	95.2	80.1	15.1	4.8	3.1	1.7
1989-90	94.1	77.5	16.6	5.9	4.5	1.4
1990-91	94.4	78.7	15.7	5.7	4.5	1.2
1991-92	94.9	80.9	14.0	5.1	4.1	1.0
1992-93	95.7	82.5	13.2	4.3	3.7	0.6
1993-94	95.8	82.8	13.0	4.3	3.5	0.8
1994-95 estimate	96.8	83.4	13.4	3.9	3.0	0.9
1995-96 estimate	95.6	n/a	n/a	4.4	n/a	n/a
1996-97 estimate	95.8	n/a	n/a	4.2	n/a	n/a
1997-98 estimate	95.8	n/a	n/a	4.2	n/a	n/a

(1) Figures for 1994-95 to 1997-98 are based upon the gross and net data provided in Table 3.

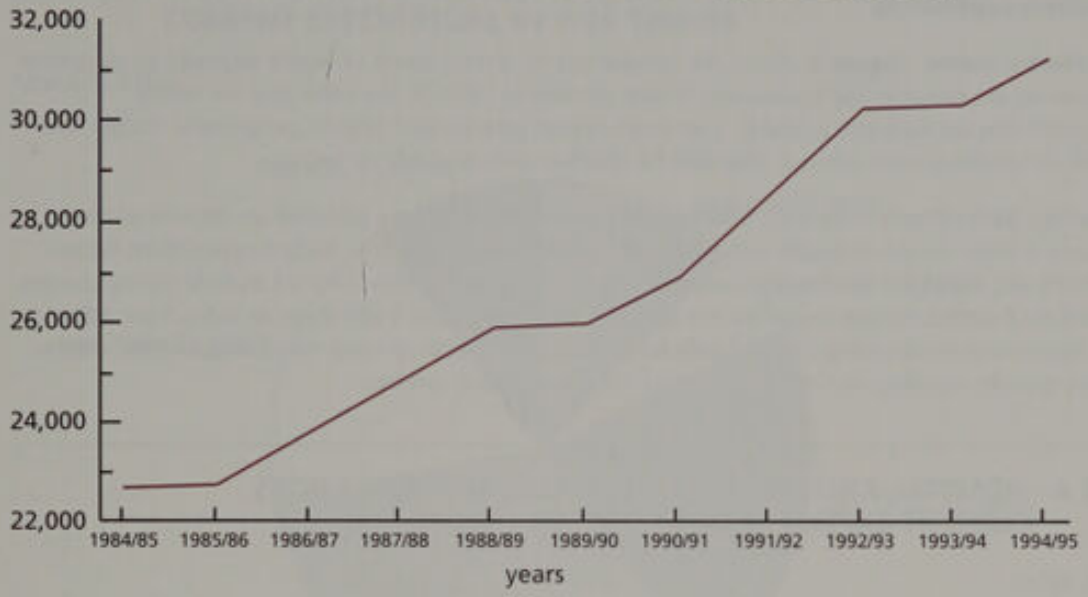
(2) The increase in the proportion contributed by charges from 1989-90 is mainly attributable to increased income from private patient charges. This in turn is the result of provisions in the Health and Medicines Act 1988 which allow health authorities to set their own charges for private patients at commercial rates.

(3) Mainly HA capital receipts.

Recent Expenditure Trends

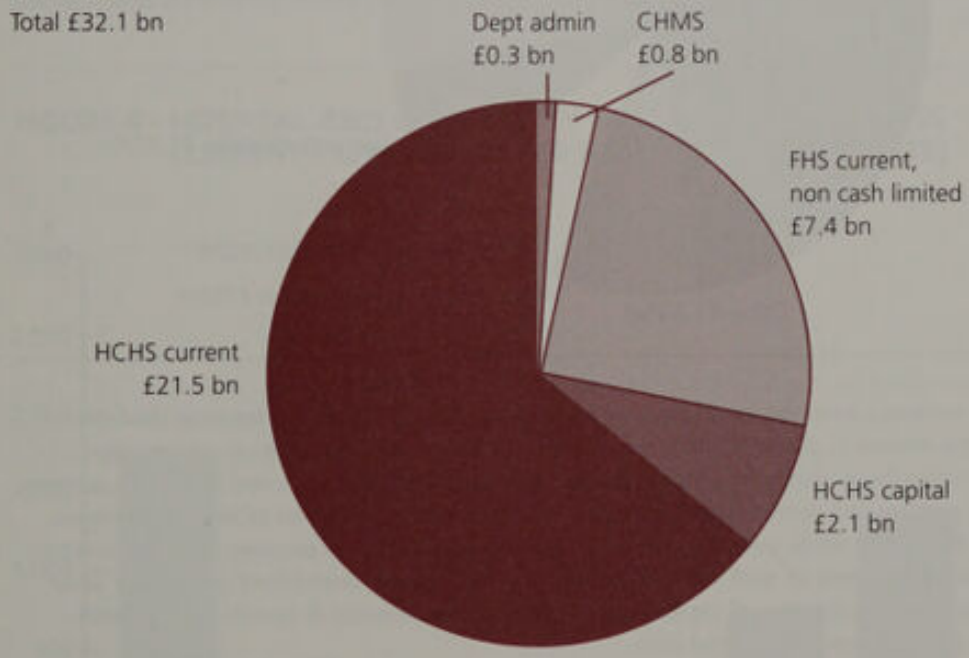
3.9 Net expenditure on the NHS in 1994-95 is forecast to be £30,706 million, an increase of 39.7 per cent in real terms (measured by the GDP deflator) since 1984-85. The equivalent gross figure is forecast to be £31,946 million. **Figure 2** shows how NHS expenditure has grown in real terms.

FIGURE 2 - GROWTH IN NHS GROSS EXPENDITURE (1993-94 PRICES)



3.10 The largest part of NHS spending is on the Health and Community Health Services: forecast at £21,452 million on current and £2,009 million on capital in 1994-95. Within the HCHS total, £793 million is forecast for FHS cash limited spending including infrastructure support for GP fundholders. The non cash limited Family Health Services account for £7.4 billion. The remainder will be spent on the Central Health and Miscellaneous Services and Departmental Administration. (See Figure 3).

FIGURE 3 - NHS GROSS EXPENDITURE 1994-95 (ESTIMATE)



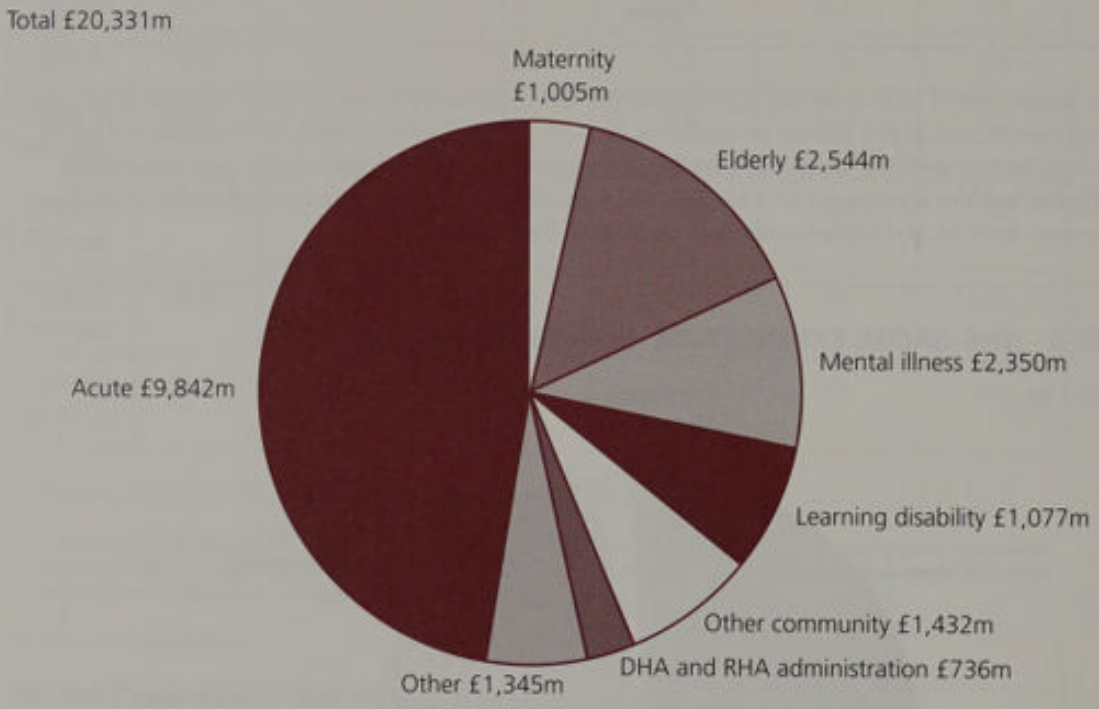
Expenditure Breakdown

HCHS Current Expenditure

3.11 **By Service Sector** **Figure 4** shows the breakdown by service sector of health authority gross current expenditure on the Hospital and Community Health Services in 1992-93, the latest year for which disaggregated data are currently available. Last year's Report gave revised 1990-91 programme budget data since 1991-92 estimates were delayed. The 1991-92 data are now available on request.

3.12 Since the NHS reforms in 1991-92, hospital and community units have included an element of their capital costs in their charges to health authorities and fundholders.Programme budget expenditure figures from 1991-92 are, therefore, not directly comparable with earlier years, which do not include capital charges. The inclusion of capital charges mean that the figures underlying Figure 4 and those in Table 3 are different. Figure 4 figures include spending by GP fundholders on acute hospital services amounting to £386 million, but do not include spending on GMS cash limited and other related services.

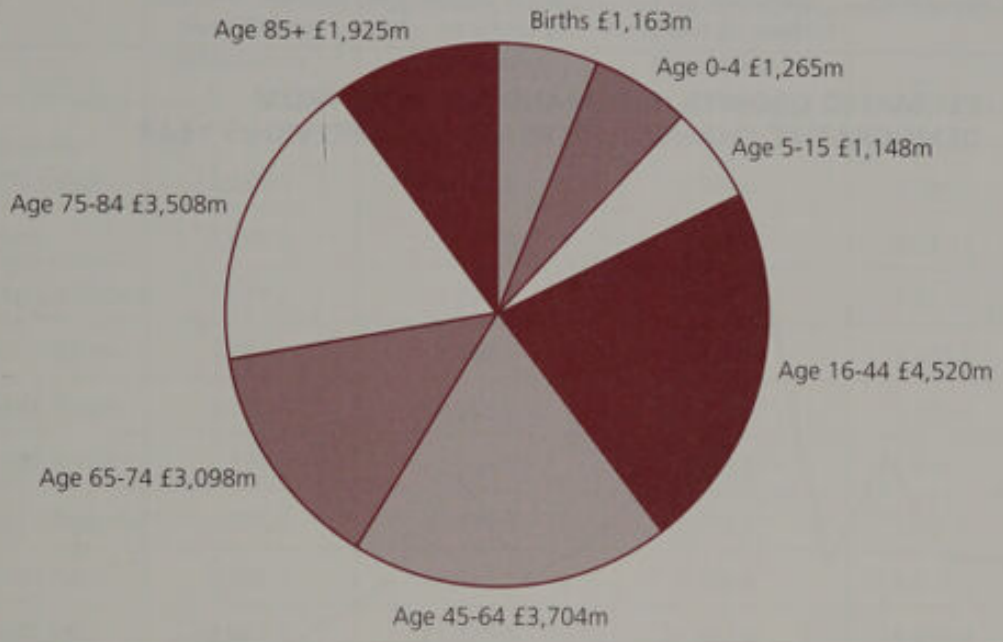
FIGURE 4 - HOSPITAL AND COMMUNITY HEALTH SERVICES GROSS CURRENT EXPENDITURE BY SECTOR 1992-93



3.13 Acute hospital services accounted for 48 per cent of the total. Mental illness and learning disability services accounted for around 17 per cent, just over an eighth of which was spending on community services. Services specifically or mainly for elderly people - that is, geriatric inpatient and outpatient services, day care, chiropody services and district nursing services - accounted for 13 per cent of total expenditure. However, **Figure 5** shows that while people aged 65 and over make up only 16 per cent of the population, they account for some 42 per cent of total HCHS spending. This is because around forty per cent of acute expenditure and significant proportions of expenditure on services for mentally ill people and on other community services are for those aged 65 and over.

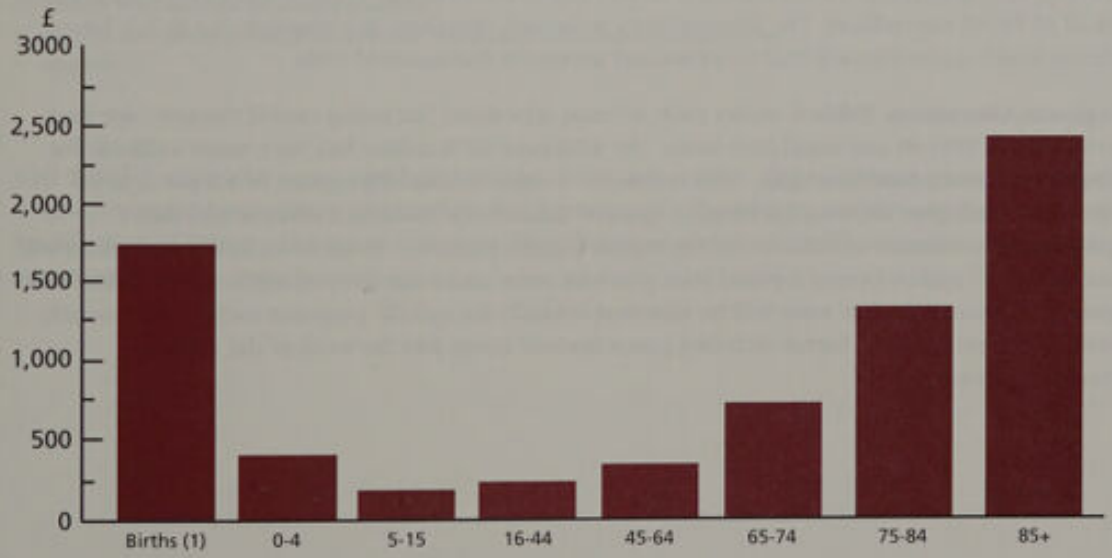
FIGURE 5 - HOSPITAL AND COMMUNITY HEALTH SERVICES GROSS CURRENT EXPENDITURE BY AGE 1992-93

Total £20,331m



3.14 **By Age Group** **Figure 6** shows the estimated expenditure on the HCHS for each age group, expressed as a cost per head of population. Expenditure per head rises with age after childhood, reflecting the greater use of health services by elderly people.

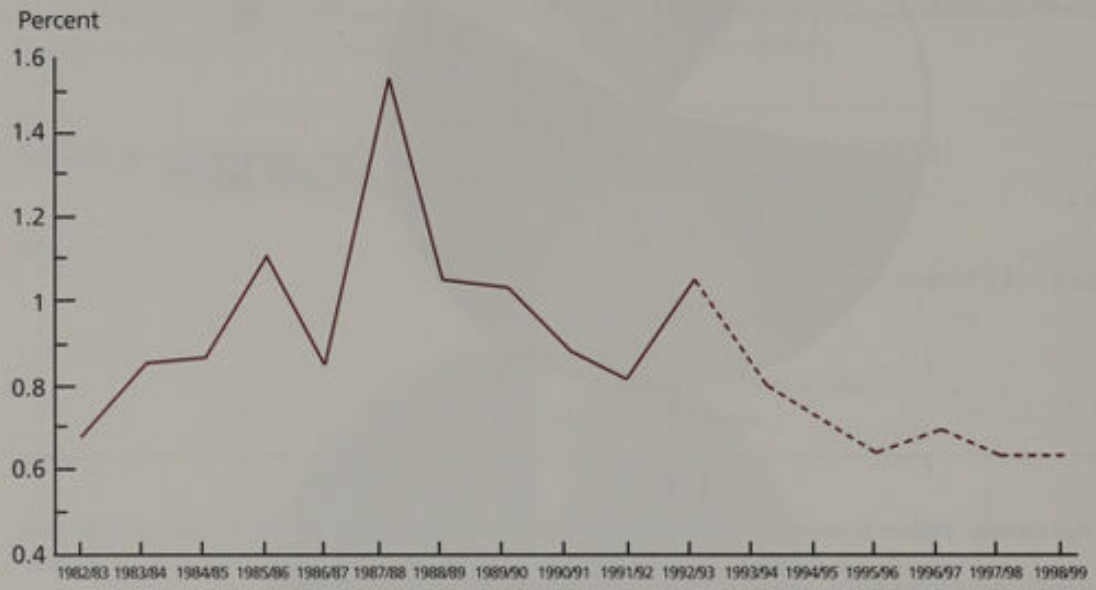
FIGURE 6 - HOSPITAL AND COMMUNITY HEALTH SERVICES GROSS CURRENT EXPENDITURE PER HEAD 1992-93 (ESTIMATE)



(1) This figure is for all births, including stillbirths

3.15 The increasing number of elderly people in the community therefore represents a continuing cost pressure on the HCHS. As **Figure 7** shows, the annual increase was particularly high in the second half of the 1980s, and again in 1992-93. These results are based on the new methodology for estimating growth in demand related to the age of the population mentioned in last year's Report. Whilst previously the results were calculated on the basis of ten-year age bands for people aged 65 and over, the new method uses single-year age bands from age 65. This gives a more accurate representation of the cost pressures on the HCHS associated with demographic change and removes the artificial fluctuation.

FIGURE 7 - ESTIMATED GROWTH IN DEMAND FOR HCHS FROM DEMOGRAPHIC CHANGES: INCREASE OVER PREVIOUS YEAR



3.16 Total expenditure on the community health services accounted for £2,915 million in 1992-93, 14.3 per cent of the total. This proportion has risen over the decade, reflecting changes in patterns of care. In 1982-83, only 9 per cent of HCHS expenditure was on the community health services.

3.17 The cost of regional health authorities and district health authorities in 1992-93 was £736 million, 3.6 per cent of all HCHS expenditure. The Government's proposals, described in paragraphs 5.2 to 5.8, for streamlining health authorities will lead to substantial savings in management costs.

3.18 **Regional Allocations Table 6** shows main revenue allocations (including capital charges - see para 3.22) to regions in 1995-96 and initial cash limits. An additional £970 million has been made available for hospital and community health services. This represents a cash increase for regions of 4.4 per cent or 0.85% growth overall after allowing for inflation (general inflation for traditional revenue and the appropriate specific measure of inflation for the capital charges element). In addition, health authorities will have available £237 million carried forward from previous years under the Government's end year flexibility arrangements. As usual, further sums will be allocated centrally for specific purposes such as the research and development programme, further reducing junior doctors' hours and the work of the London Implementation Group.

Table 6 REVENUE ALLOCATIONS TO REGIONAL HEALTH AUTHORITIES

Figures in £ million

Region	1994-95 Adjusted baseline for 1995-96 allocations [1]	1995-96 Allocations if based fully on weighted capitation [2]	1995-96 Actual allocation for spend on resident population [3]	1995-96 Initial cash limits [4]
Northern & Yorkshire	3,050.4	3,150.2	3,184.6	3,186.7
Trent	2,089.6	2,191.4	2,181.5	2,221.1
Anglia & Oxford	2,091.5	2,236.5	2,183.5	2,213.2
North Thames	3,402.1	3,499.1	3,551.8	3,784.1
South Thames	3,190.4	3,383.9	3,330.8	3,433.5
South & West	2,829.1	2,946.1	2,953.5	2,980.2
West Midlands	2,335.8	2,399.6	2,438.5	2,417.8
North West	3,064.7	2,217.1	3,199.6	3,255.2
ENGLAND	**22,053.6**	**23,023.9**	**23,023.9**	**23,491.8**
Sums not yet allocated, including central budgets				1,046.4
Total net current cash limits				24,538.2
Current spending to be financed by receipts (subhead AZ(1),(3) (part) and (4))				35.4
Total gross current provision (subhead A1)				24,573.6

(1) 1994/5 allocation for resident population including in-year adjustments & transfers.
(2) The weighted capitation formula has been modified in the light of a review of weighted capitation.
(3) 1995/96 basic allocation for resident population.
(4) 1995/96 basic allocation plus General Medical Services cash limited expenditure and other adjustments.

3.19 **Table 7** shows the main capital planning totals for each region. Capital planning totals are based on shares of weighted population projected for five years hence. The NHS Executive's regional offices advise the Secretary of State on the balance of expenditure between trusts and health authorities. Most capital expenditure is now made by trusts.

Table 7 REGIONAL MAIN CAPITAL PLANNING TOTALS 1995-96

Region	Capital Planning Total [1]
	£000's
Northern & Yorkshire	214,806
Trent	150,370
Anglia & Oxford	149,131
North Thames	204,037
South Thames	203,558
South & West	199,022
West Midlands	162,545
North West	215,513
ENGLAND	1,498,982

(1) Most of this capital expenditure is financed through trusts' income from purchasers and so is also included in the figures in Table 6.

3.20 Allocations were made to fourteen Regional Health Authorities in 1994/5. When a number of these regions merged in April 1994 (see para 5.7) their allocations were added together. As part of this reconfiguration two district health authorities moved from one region to another and amounts were transferred from Northern & Yorkshire to North West and North Thames to Anglia & Oxford in respect of this.

HCHS Capital Expenditure

3.21 Gross HCHS capital spending was £1759 million in 1993-94 - an increase in real terms over 1983-84 of 32.6 per cent. During this period over 750 major building schemes, each costing over £1 million, were completed. The NHS reforms, including the introduction of capital charges, led to a thorough reappraisal of major capital schemes (especially new build) and this contributed to the fall in real terms expenditure in 1993-94, shown in Table 3. Forward expenditure plans take account of this process of reappraisal. However, net capital plans remain at historically high levels, and will be boosted by land sale receipts forecast to rise to over £200 million per annum. Investment under the Private Finance Initiative will be additional to this. Health authorities' and NHS trusts' forward capital programmes include a further 85 major building schemes (each costing over £1 million) due for completion in 1994-5. An additional 238 schemes are planned to start on site, costing over £2 billion in the next three years. The number of capital schemes completed in 1992-93 and 1993-4 and those planned for completion in 1994-95 are shown in **Table 8. Annex I** gives details of long term capital projects costing over £15 million.

Table 8 HCHS CAPITAL SCHEMES COMPLETED OR PLANNED FOR COMPLETION

Scheme [1]	1992-93	1993-94	1994-95 planned [2]
£25m+	3	2	1
£10m-£25m	12	5	8
£1m-£10m	62	93	76
Total	77	100	85

(1) Construction costs only. Fees and equipment are excluded.
(2) Some schemes planned for completion in 1994-95 may slip into 1995-96.

3.22 **The Trust Financial Regime and Capital Charges** Trusts earn all their income through contracts to provide healthcare for DHAs, GP Fundholders and the private sector. As well as their normal costs, trusts plan to recover in prices a 6% return on their average net relevant assets and depreciation (capital charges). The requirement on an individual trust to borrow or repay debt and build up investment is set by the external financing limit (EFL) issued to each trust by the NHS Executive. The EFL represents the difference between a trust's internally generated resources, its retained surplus and depreciation and its approved capital spend. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the initial resources are more then the capital spend then the money is used to meet any due repayments of the debt principal with any excess being invested.

3.23 The capital charging system, which has now been operating for four years, means capital is no longer a free good. This has led to a new emphasis on the efficient management of the existing capital stock and the more effective deployment of new capital. Capital charging encourages the disposal of underused assets and has led to a preference for refurbishment rather than new build. In 1995-96 capital charges have been integrated into RHA revenue allocations (previously they were separately identified). This will serve to focus contracting decisions more on the totality of resources available, encouraging health service managers to consider the cost of capital alongside other resources, and discourage the concept that capital charges are in some way different from general revenue. It also supports the aim of ensuring that the costs of provision can be evaluated on a broadly comparable basis between NHS and private providers (including PFI options) and between capital intensive and labour intensive approaches.

3.24. **The Private Finance Initiative** (PFI) was announced in the 1992 Autumn Statement. For the NHS, a stronger partnership with the private sector offers the opportunity to draw on additional resources of skill and expertise, access to new sources of capital, and opportunities to transfer risk, share overheads and benefit from economies of scale. The aim is to exploit these benefits to secure best value for the taxpayer through the more cost effective development of newer, more modern facilities. Since the launch of the PFI, 36 schemes with a capital value of over £1m have been approved in the NHS. The total value of these schemes is nearly £100m.

3.25. The NHS Executive has taken the following steps to support the health service in reaping maximum benefit from the PFI:

- it has established a Private Finance Unit whose role is to make the NHS and the private sector much better informed about the Private Finance Initiative and the opportunities it offers, and to promote the PFI so that PFI possibilities are explored for every capital scheme. To achieve this the Unit has issued clear guidance about the procedures and how to make a business case using appropriate investment appraisal techniques; provided advice direct to NHS and private sector enquirers on particular projects; organised training sessions for NHS Trust finance directors and others, set up a network of private finance specialists in regional offices; and issued a guidance booklet "Public Service, Private Finance" which has been reprinted as the "Private Finance Guide" within the "Capital Investment Manual".

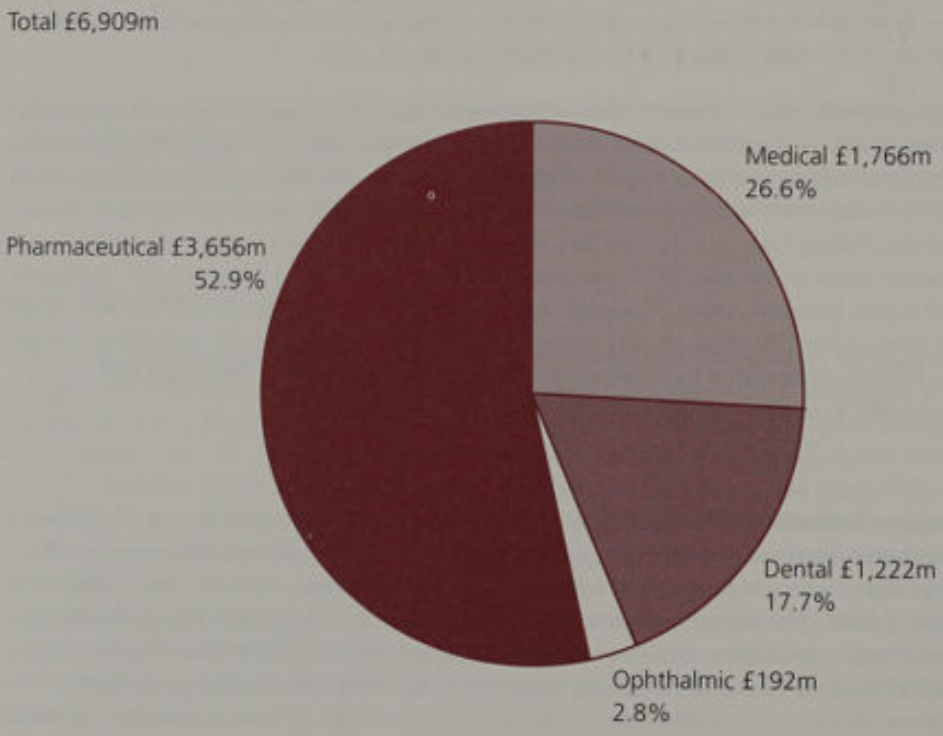
- In June 1994, the NHS Executive issued a new Capital Investment Manual, including a guide to preparing business cases. This spells out the strategic planning that must precede the making of a case for public funds for a capital project, making it clear that options for use of private finance must always be considered.

- it engaged Newchurch and Company to set up and operate a PFI Database and Enquiry point. The Database provides market intelligence on existing and newly developing private finance experience within the NHS. Drawing on material from NHS trusts, health authorities and private companies, Newchurch has assembled information on what is needed and is available, and is able to offer a full enquiry service. The aim is to help all concerned identify good quality opportunities. The number of enquiries to the Database is rising fast, reflecting the high level of interest in the NHS and the private sector. The Database lists around 500 projects which may be suitable for private finance (for the whole of the UK) whose total value could be as much as £1.5 billion, if they all came to fruition.

FHS Expenditure

3.26 Gross expenditure on all elements of the non cash limited FHS (including spending by GP fundholders on drugs) amounted to £6.9 billion in 1993-94, of which 9.2 per cent was met from prescription and dental charges paid by patients. **Figure 8** shows how gross expenditure is distributed among the constituent services.

FIGURE 8 - NON CASH LIMITED FHS GROSS EXPENDITURE 1993-94



Note: Excludes some items of miscellaneous expenditure and therefore figures do not sum to totals in table 3.

3.27 In the ten year period between 1983-84 and 1993-94, gross expenditure on the non cash limited Family Health Services increased by 35 per cent in real terms. The main changes in spending over this period were:

General Medical Services (GMS) : an increase of 76 per cent in real terms. The number of General Medical Practitioners (GMPs) has increased by 13 per cent and gross expenditure per GP has increased by 55 per cent in real terms (see table 22). Since the introduction of the new GMP contract in 1990-91 expenditure on certain directly reimbursed expenses - computing and staff reimbursements and some premises costs together with GP fundholders' management allowances (PFMA) and computing costs - has been cash limited. By 1993-94 cash limited reimbursements represented 28 per cent of total GMS expenditure and had grown by 35 per cent in real terms since 1990-91 (or by 28 per cent excluding PFMA). This is shown in **Table 9**. This compares with a 9 per cent real increase in non cash limited expenditure since 1990-91.

Table 9 FAMILY HEALTH SERVICES GMS CASH LIMITED EXPENDITURE

GMS CASH LIMITED EXPENDITURE £million

	1990-91	1991-92	1992-93 (1)	1993-94	1994-95 allocation
Staff	345	418	482	514	
Premises Improvements	96	126	134	116	} 697
Computers	17	34	40	36	
PFMA	6	14	29	49	66
TOTAL	464	592	685	715	763
Total Cash at 1993-94 prices	528	634	706	715	748
Real terms increase over previous year (%)		20.0	11.4	1.1	3.6

(1) From 1992-93 allocations/ expenditure for practice staff, premises improvements and computers were accounted for as one amount. Consequently, the expenditure split for these items from 1992-93 onwards, is estimated.

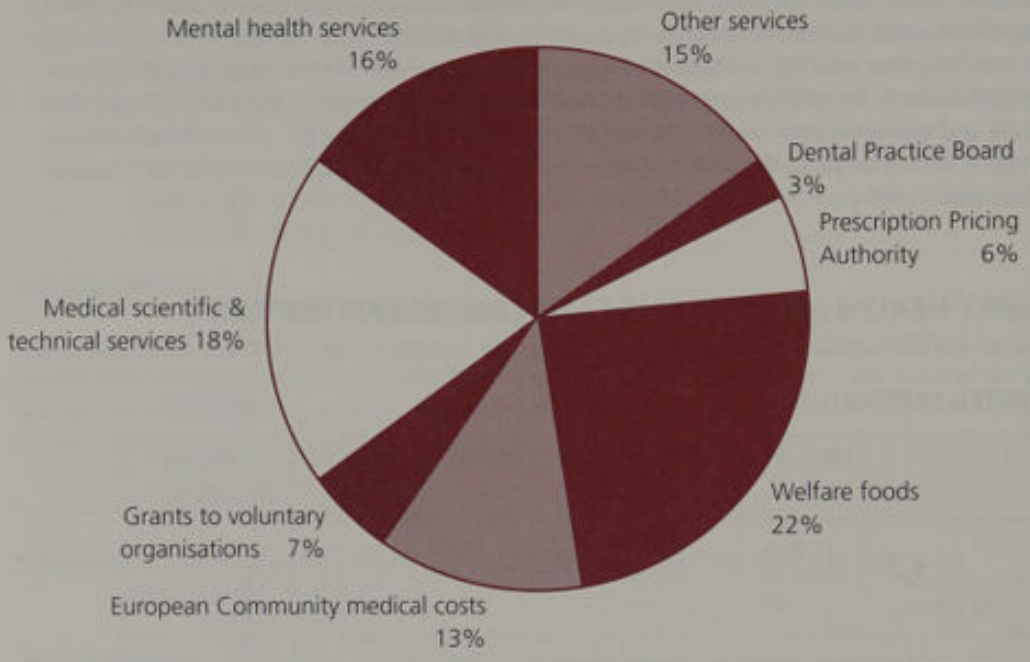
Pharmaceutical Services (PhS): an increase of 51 per cent in real terms. The PhS consists of the "drugs bill" and the cost of dispensing prescriptions. The drugs bill, the largest component of the pharmaceutical services, amounted to £2.95 billion in 1993-94. In real terms, it has grown by almost 55 per cent over the period. In 1993-94 more than 455 million prescriptions were dispensed, 35 per cent more than in 1983-84. The cost of dispensing prescriptions (fees paid to pharmacists, dispensing doctors and appliance contractors) was £681m which represents an increase of 34 per cent in real terms over 1983-84. The proportion of gross costs met from prescription charges (including receipts from the sales of prescription prepayment certificates) has fallen from 7.7 per cent to 7.3 per cent and the Government's net expenditure has risen by nearly 52 per cent in real terms.The costs per prescription dispensed are set out in Table 21.

General Dental Services: an increase of 24 per cent in real terms. The proportion of gross costs met from patient charges has increased from 27 per cent to 30 per cent. The Government's net expenditure has increased by 18 per cent in real terms.

General Ophthalmic Services: a decrease of 30 per cent in real terms. This reflects the fact that, from 1 April 1989, eligibility for free NHS sight tests has been available only to certain groups, namely all children, students aged under 19 in full time education and adults entitled to full help from the NHS Low Income Scheme or with special medical needs.

FIGURE 9 - CENTRAL HEALTH AND MISCELLANEOUS SERVICES GROSS EXPENDITURE 1994-95 (ESTIMATE)

Total £6,909m



CHMS Expenditure

3.28 **Figure 9** shows the breakdown of estimated gross expenditure on the Central Health and Miscellaneous Services in 1994-95. **The welfare food programme** provides entitlement to free liquid and dried milk and vitamins for families with children under five and expectant mothers in receipt of Income Support, and to subsidised dried milk for families with children under one in receipt of Family Credit. The programme also provides one third of a pint free milk daily to children under five in non-residential day care. Expenditure on **EC medical costs** is for treatment given to UK nationals by other member states: this continues to grow as a result of increases both in the number of people treated and in the treatment costs of member states. The other major elements of the CHMS are **mental health services**, of which 96 per cent is accounted for by the Special Hospital Services Authority; and **medical, scientific and technical services**, of which some 94 per cent of expenditure is for the National Radiological Protection Board, the National Biological Standards Board and the Public Health Laboratories Board. Further information on non departmental public bodies (including the Dental Practice Board and the Prescription Pricing Authority) and services funded through CHMS is at **Annex H**.

THE PERSONAL SOCIAL SERVICES PROGRAMME

3.29 Local authorities provide or arrange Personal Social Services (PSS) for the most vulnerable members of the community. These services include help for elderly people, people with physical and/or sensory disabilities, people with learning disabilities, mentally ill people and people who misuse alcohol or drugs. They also include services for disabled children who cannot be cared for by their own parents and many other children who are in need of protection, supervision and help. From 1 April 1993, local authorities have also taken over responsibility, from the Department of Social Security, for the financing of placements in independent residential care and nursing homes.

Expenditure Plans

Revenue Spending

3.30 **PSS Standard Spending** (the Government's view of the amount of expenditure which it would be appropriate for local authorities to incur) has been set at £6,965.9 million for 1995-96, an increase of 8.8 per cent, or 5.4 per cent in real terms, over the 1994-95 figure of £6,403.2 million. This includes £1,838 million for local authorities' new community care responsibilities, compared to £1,274.5 million in 1994-95.

3.31 **Community Care** For the initial years of the new community care arrangements, the Government has established a Special Transitional Grant (STG), which is a ringfenced grant which can only be spent on community care services. The STG consists of new resources each year, with the previous year's STG being distributed through the Revenue Support Grant. The Government has decided that the grant will be phased out in 1996-97.

3.32 The STG for 1995-96 will be £647.6 million and will consist of a transfer of funds from the Department of Social Security (£517.7m), additional monies provided to encourage further the development of home and respite care services (£30 million) and the monies allocated to local authorities as a result of changes to the Independent Living Fund (£99.9 million). The remaining resources for the community care reforms, totalling £1190.4 million, will be distributed through the Revenue Support Grant in 1995-96.

3.33 **Specific Grants** In 1995-96 total PSS specific grants will be £103.9 million, an increase of £13.4 million over 1994-95. Total expenditure supported will be £147.1 million. Local authorities make a minimum 30 per cent contribution as a condition of receiving a grant and as evidence of their commitment to developing the service. The levels of the individual grants for 1995-96 are as follows:

	£m
Services for mentally ill people	47.3
Training Support Programme	34.6
Services for people with HIV/AIDS	13.4
Guardian ad litem and reporting officer service	6.2
Services for alcohol and drug misusers	2.5

Capital Spending

3.34 Government support for personal social services comes also through capital grants, which finance expenditure on specific projects, and credit approvals (permissions to borrow for capital expenditure). Credit approvals can be either basic credit approvals which may be used for any local authority service, or supplementary credit approvals, which are earmarked for particular projects or services.

3.35 For 1995-96, basic credit approvals for personal social services will be £117.3 million. In addition, there will be £26.7 million of supplementary credit approvals, and a £20.9 million capital grant available to finance spending on the programme for secure accommodation for children. £11.4 million of supplementary credit approvals will be available to finance spending for mentally ill people, £12.2 million to help authorities develop IT systems for community care services, and £3.1 million for services for people with AIDS/HIV.

3.36 Local authorities are also able to finance capital expenditure from their own resources, that is, receipts generated from the sale of capital assets and contributions from revenue. Capital receipts do not have to be spent on the service from which they are generated. Local authorities therefore have flexibility to spend the receipts on any service according to local priorities, including personal social services. In 1995-96, Annual Capital Guidelines of £124.3 million were distributed to local authorities for personal social services. Annual Capital Guidelines are Basic Credit Approvals plus receipts taken into account (RTIAs), ie a proportion of receipts which it is estimated will be spent on personal social services.

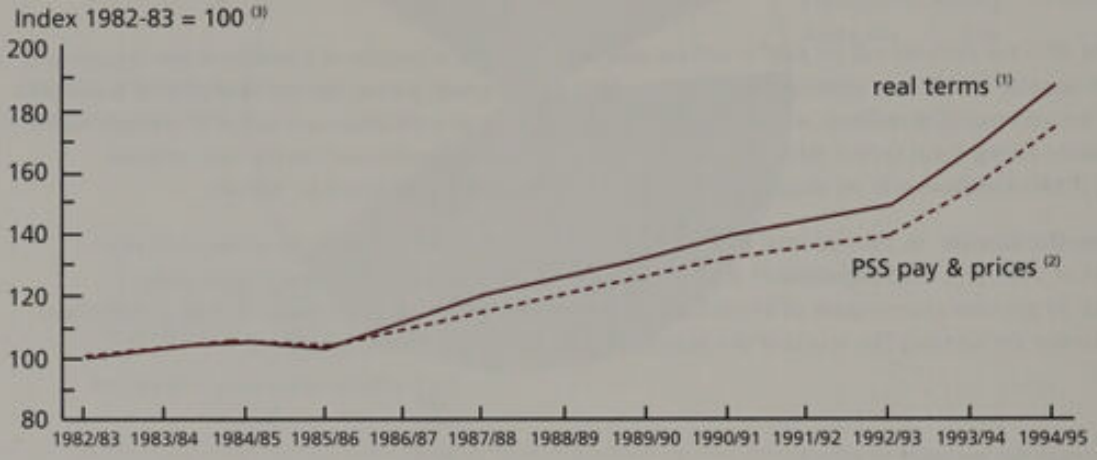
3.37 PSS gross capital expenditure has risen from £100 million in 1984-85 to an estimated £201million in 1994-95, an increase of 22.39 per cent in real terms.

Recent Expenditure Trends

3.38 **Table 10** shows total local authority current and capital expenditure on PSS. Local authority net expenditure increased by 47 per cent in real terms between 1982-83 (when it was £1,967 million) and 1992-93 (when it was £4,968 million). On 1 April 1993 local authorities took over responsibility, from the

Department of Social Security, for the financing of placements in independent residential care and nursing homes. In 1993-94, local authorities received an additional £565 million in recognition of these new responsibilities which was paid via the STG which is described in paragraph 3.31. In 1994-95 total additional resources available for these new responsibilities increased to £1,274 million. These additional resources are reflected in the 1993-94 and 1994-95 planned outturn figures shown in the table. They are also illustrated in **Figure 10** by the sharp increase in the rate of growth of expenditure since 1992-93. By 1994-95 local authority expenditure was some 86 per cent higher in real terms than in 1982-83.

FIGURE 10 - GROWTH IN REAL TERMS IN LOCAL AUTHORITY NET CURRENT EXPENDITURE ON PERSONAL SOCIAL SERVICES



(1) Revalued to average 1993-94 prices using Gross Domestic Product deflator

(2) Revalued to average 1993-94 prices using PSS Pay & Prices deflator

(3) Indices derived from figures shown in Table 10

Table 10 EXPENDITURE ON LOCAL AUTHORITY PERSONAL SOCIAL SERVICES

£ million

	1982-83 outturn	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 estimated outturn	1994-95 budget
Current expenditure							
gross	2,304	4,196	4,698	5,128	5,470	(1)	(1)
charges	337	483	486	506	502	(1)	(1)
net [2]							
cash	1,967	3,713	4,213	4,622	4,968	5,724	6,594
real terms [3]	3,544	4,659	4,894	5,052	5,222	5,838	6,594
PSS pay & prices [4]	3,818	4,813	5,017	5,144	5,274	5,873	6,594
Capital expenditure							
gross	85	224	174	166	169	183	201
income	11	67	27	34	38	56	36
net	74	157	147	133	132	127	165
Total local authority expenditure							
gross	2,389	4,419	4,872	5,294	5,639	(1)	(1)
charges/income	348	550	513	540	540	(1)	(1)
net	2,041	3,870	4,359	4,754	5,100	5,851	6759

(1) Net figures only available for 1993-94 and 1994-95.

(2) Excluding capitalised current expenditure, mainly redundancy payments, for 1992-93 and 1993-94 - which are included in table 2.

(3) Cash figures revalued to average 94-95 prices using Gross Domestic Product deflator.

(4) Cash figures revalued to average 94-95 prices using PSS Pay and Prices deflator.(An index which is specific to LA social services costs).

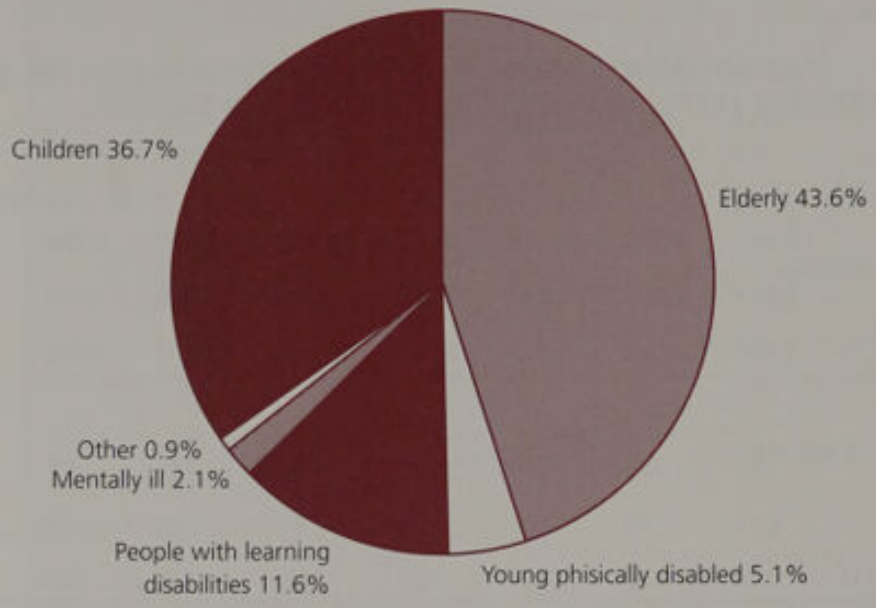
(5) The above figures are inclusive of grants from central government

Expenditure Breakdown

3.39 **Figure 11** shows the breakdown of social services net current expenditure between the main client groups. Between 1986-87 and 1992-93 the proportion of PSS spending on children and the elderly has declined and the proportion of expenditure on people in all other client groups has increased. Over this period there was a growing tendency for elderly people, who might otherwise have received social services from a local authority, to become resident in independent homes where they were often funded through the social security system. Also there has been a move away from the more expensive residential services for children. **Figure 12** shows that total expenditure rose in real terms for all client groups between 1986-87 and 1992-93. It also shows that non residential expenditure rose at a faster rate than residential expenditure.

FIGURE 11 - LOCAL AUTHORITY NET CURRENT EXPENDITURE ON PERSONAL SOCIAL SERVICES BY CLIENT GROUP

1986-87 Total £2,644m



1992-93 Total £4,968m

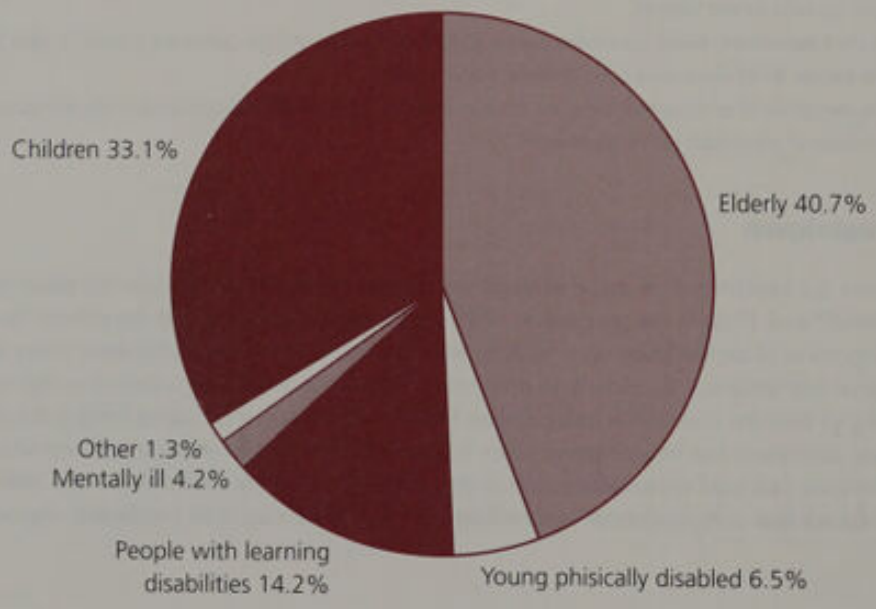
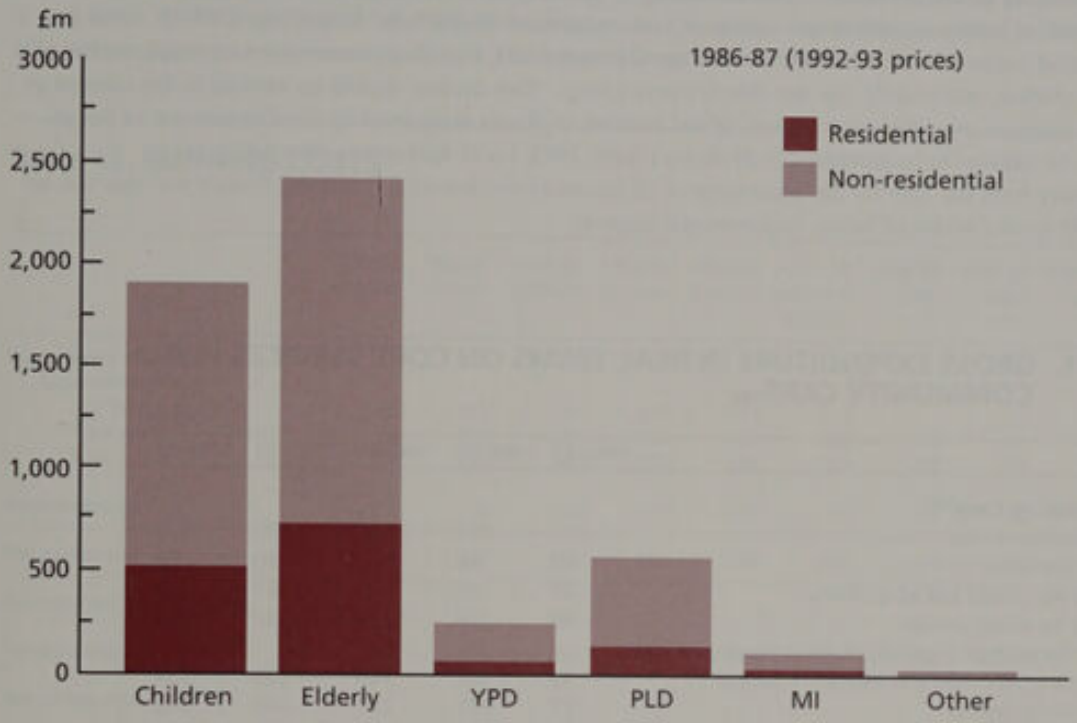
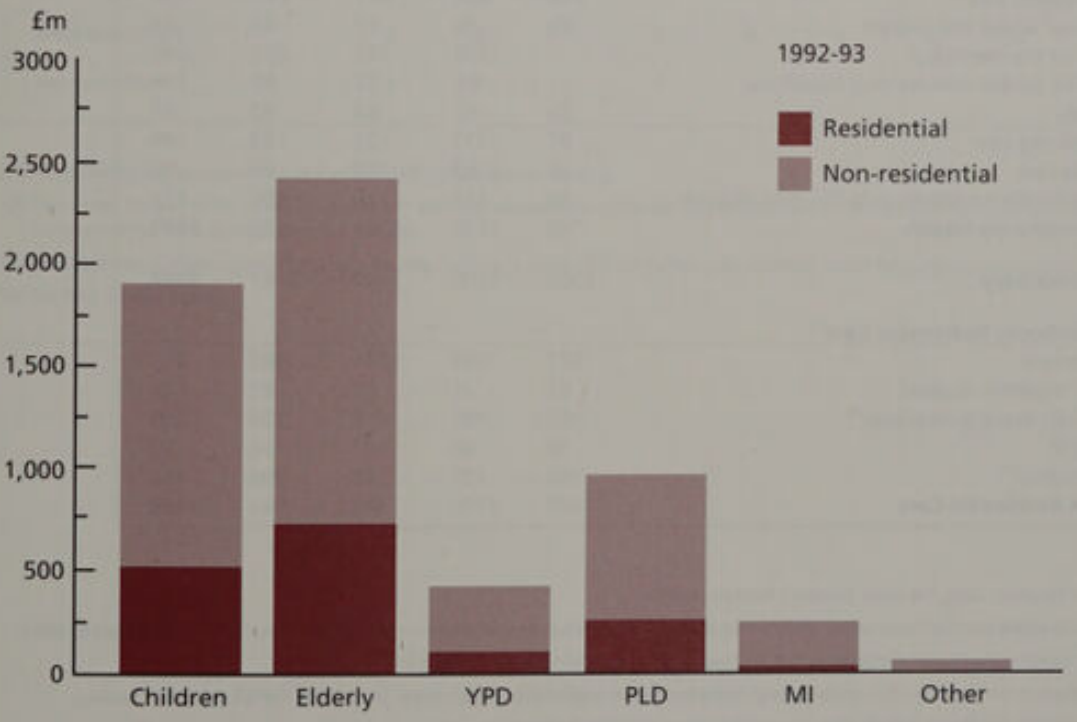


FIGURE 12 - LOCAL AUTHORITY NET CURRENT EXPENDITURE ON PERSONAL SOCIAL SERVICES BY CLIENT GROUP AND TYPE OF CARE





COMMUNITY CARE EXPENDITURE

3.40 **Table 11** shows how expenditure has grown in real terms between 1986-87 and 1992-93 (the latest year for which detailed figures are available) on services broadly classified as local authority domiciliary care, community health services, and residential care. There has been a substantial and steady increase in expenditure on local authority domiciliary care and community health from 1986/87 to 1992-93. Over the whole period expenditure on residential care has also increased, though in recent years expenditure has started to decline, particularly for the elderly client group. This decline should be viewed in the context of the rapid increase, over the same period, of the number of clients supported by the Department of Social Security. As referred to in paragraph 3.29 from 1 April 1993, Local Authorities have taken over responsibility from the DSS for the placement of all clients in residential and nursing homes and this will be reflected in similar tables of future Departmental Reports.

Table 11. GROSS EXPENDITURE IN REAL TERMS ON CORE SERVICES FOR COMMUNITY CARE(1)(2)

£ million

	1986-87	1989-90	1990-91	1991-92	1992-93
LA Domiciliary Care(3)(4)					
Home care/Home help	512	647	650	669	678
Meals in the home	66	66	67	70	68
Disability equipment and adaptations	47	54	56	53	54
Day Care for elderly people	88	128	134	132	136
Day care for younger physically disabled people, people with learning difficulties and mentally ill people	92	102	109	123	134
Adult Training Centres	177	221	227	242	243
Other domiciliary care	115	149	176	203	228
Social work (5)	247	271	281	371	398
Administration (7)	265	322	328	314	379
Total LA Domiciliary Care	1609	1961	2029	2177	**2318**
Community Health					
General patient care	428	624	621	785	726
Professional advice and support	35	36	37	44	43
Services for the mentally ill	-	175	193	205	240
Services for people with learning disabilities	-	65	72	99	139
Chiropody	50	62	64	90	87
Psychiatric day care	97	113	122	163	189
Other day care	72	53	58	76	80
Health authority contributions to PSS joint finance	98	112	114	106	115
Total Community Health	780	1239	1281	1570	**1619**
Total Domiciliary	2389	3200	3310	3747	**3937**
Local Authority Residential Care(4)					
Elderly people	977	1037	1016	985	913
Younger physically disabled	67	71	69	81	107
People with learning disabilities(6)	152	192	215	234	255
Mentally ill	30	40	42	36	35
Administration(7)	165	191	205	206	188
Total LA Residential Care	1391	1532	1548	1542	**1498**

(1) At 1992-93 prices using the Gross Domestic Product deflator.

(2) Additional expenditure on community care not shown in the table includes expenditure on some Social Security benefits, details of which may be found in the Departmental Report of the Department of Social Security (CM 2813).

(3) Expenditure on services for which social services departments are responsible, except those provided in staffed residential homes.

(4) Local authority PSS figures include their own contributions to jointly financed schemes.

(5) It is assumed that expenditure on social work is for people in non-residential settings.

(6) Including children.

(7) Also included here are occupational therapy, unspecified training and research and development.

DEPARTMENTAL ADMINISTRATION

3.41 **Table 12** gives information about the running costs of the Department of Health. **Table 13** gives information about staffing levels. The figures reflect a three year settlement which commits the Department to reducing its staffing costs by 21 per cent and its other administrative costs by 20 per cent in real terms by the beginning of the 1997-98 financial year. The tables also reflect the move by the NHS Estates Agency to a net running costs control regime from 1 April 1995.

Table 12 RUNNING COSTS

£ million

	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans	1996-97 plans	1997-98 plans
Department of Health									
Gross running costs: [1]									
Civil Service paybill [2]	85	103	114	127	117	115			
Other	89	113	126	150	137	148			
Total	175	216	240	277	254	262	249	305	294
Related receipts	-10	-13	-22	-19	-15	-14	-15	-15	-15
Net expenditure	165	203	218	258	239	248	235	291	279
Running costs by control area:									
Gross control	160	198	222	256	245	253	240	297	285
Net control areas:									
Medicines Control Agency [3]									
Gross expenditure	7	9	12	13					
Net expenditure	5	5		7					
NHS Estates Agency [4]									
Gross expenditure	8	8	7	7	9	9	9	9	9
Net expenditure	1	1	-1	-1	1	1			

(1) The gross figures are net of any VAT refunds on contracted out services.

(2) This covers the pay costs, including employers' earnings related national insurance contributions, of civil servants in running costs (as given in the table on departmental staffing).

(3) The Medicines Control Agency became a Trading Fund on 1 April 1993 and previously operated under net running costs control.

(4) The NHS Estates Agency

Table 13 STAFF NUMBERS

Staff - years

		1989-90 actual	1990-91 actual	1991-92 actual	1992-93 actual	1993-94 actual outturn	1994-95 estimated	1995-96 plans	1996-97 plans	1997-98 plans
Department of Health	CS FTEs	3,947	4,171	4,257	4,390	4,381	4,148	3,757	4,585	4,577
(Gross Control Area)	Overtime	64	82	96	92	49	38	43	43	43
Casuals	Casuals	132	252	204	209	175	229	229	219	199
	Total	4,143	4,505	4,557	4,691	4,605	4,415	4,029	4,847	4,819
NHS Estates Agency [1]	CS FTEs	(1)	(1)	127	135	105	105	117	141	141
(Net Control Area)	Overtime	(1)	(1)	0	0	1	1	1	1	1
	Casuals	(1)	(1)	2	3	0	2	1	1	1
	Total	(1)	(1)	129	138	106	108	119	143	143
Medicines Control Agency [2]	CS FTEs	256	290	306	318	345	404	420	393	379
Total Department of Health		4,399	4,795	4,992	5,147	5,056	4,927	4,568	5,383	5,341

(1) The NHS Estates Agency will be subject to net running costs control from 1 April 1995. Figures for the years 1989-90 and 1990-91 are included within Department of Health (Gross Control Area).

(2) The Medicines Control Agency became a trading fund on 1 April 1993.

3.42 **Departmental Spending on Publicity and Advertising**. The Department runs a number of publicity campaigns directly and funds others run by the Health Education Authority (part of the Central Health and Miscellaneous Services). Spending in 1994-95 is planned to be £58 million. The main components of this are given in **Table 14**. The balance of £19 million includes other Health Education Authority campaigns (including their cancer campaign) and Departmental core expenditure,which includes over 45 separate campaign budgets, many of which amount to only a few thousand pounds each.

Table 14 DEPARTMENTAL SPENDING ON PUBLICITY AND ADVERTISING 1994-95

	£ million
Campaigns run by the Department	
Drug and Solvent misuse	5.0
Health Service and Professions Recruitment	2.9
Health of the Nation	1.8
AIDS Helpline	1.7
Help with NHS Costs	1.1
Overseas Travel	1.0
Blood Donor Recruitment	1.0
Keep Warm Keep Well	0.5
Campaigns run by the Health Education Authority	
Anti Smoking Campaigns	7.7
AIDS	7.4
"Look After Your Heart"	3.8
Immunisation	1.8
Alcohol Misuse	1.1
Family and Child Health	0.8
Contraception	0.6

4 MAJOR POLICY AND SERVICE DEVELOPMENTS

4.1 The Secretary of State set her priorities for the Department for 1994-95 in March 1994, as outlined in Chapter 2. This Chapter describes the main developments and new initiatives in these areas of work since the last Departmental Report was published. Overall progress against each of the Secretary of State's Priorities and Key Challenges, including other developments, is summarised at **Annex F.**

Improving Health

4.2 The Government's strategy for improving health in England was set out in the 1992 White Paper "The Health of The Nation" and the broad programme of action to implement it is described below. In addition the Department continues to react to other specific actual or potential health risks that arise, including in 1994 drug misuse, plague and measles. The Department's R&D strategy has the dual challenge of maximising the benefits for health of science and technology and of applying research rigour to the problems confronting the NHS, public health and the social services. The transfer of good research evidence into changed and improved health service practice is a key goal for the Department and the NHS, reflected in the Secretary of State's Priorities and Planning Guidance for 1995-96.

"The Health of the Nation"

4.3 The Health of the Nation strategy is now well into full implementation. The targets set in the five key areas - coronary heart disease and stroke; cancers; mental illness; HIV/AIDS and sexual health and accidents - were intended to be challenging but achievable. In most areas there has been steady progress towards those targets but, in a few cases, movement is out of step with the timetable. The 1995 target for gonorrhoea has already been reached. However, the targets for teenage smoking, for obesity and for suicide look particularly challenging.

4.4 Implementation of the strategy across government as a whole is overseen by a special Cabinet Committee. Within the Department, work is led by the Wider Health Working Group, chaired by Baroness Cumberlege, which advises on the wider public health dimensions of the health strategy; the CMO's Working Group, which oversees the monitoring of the health strategy and reviews the more general public health and epidemiological issues concerned with its development; and the Chief Executive's Working Group, which advises on implementation in the NHS.

4.5 **Wider health issues** A key theme of "Health of the Nation" is that responsibilities for achieving the strategy's objectives and targets go wider than the NHS. Reflecting this, a broad based approach is being taken to developing and supporting "Health of the Nation" in areas such as:

- nutrition: "Eat Well" was published in March 1994, followed up by the well-publicised "plate" of healthy foods;
- physical activity, where proposals are being developed aimed at encouraging more people to be more active more often;
- encouraging health promotion in the workplace.

An important task for 1995 is coordinating the approach to publicising the wide range of activity which underpins "Health of the Nation" so as to raise awareness of the strategy in the world at large.

4.6 The Health Alliances Award Scheme was launched in July 1994 to encourage the formation of effective health promoting partnerships, with or without the involvement of the NHS. The initial response to the scheme was very positive. Over 25,000 entrance forms were requested. Entries will be judged at regional level for regional awards, and regional winners will come forward for the national level of the competition. The first national award ceremony will take place in April 1995. This has been arranged as a partnership between the Department and SmithKline Beecham, paving the way for the introduction of full business partnership arrangements for future years of the award.

4.7 **Public health issues** A new subgroup of the CMO's Working Group has been asked to make recommendations about effective interventions for the NHS and the Department of Health in relation to variations in health in the five Health of the Nation key areas and advise on areas where more research is needed, and is due to report to the CMO's Working Group in spring 1995. A second new subgroup will advise on the current state of knowledge about asthma and how far the condition measures up to the criteria for key area status.

4.8 **The NHS's role** Improving health through the Health of the Nation strategy is a key objective for the NHS. This was reflected in the NHS Executive's Priorities and Planning Guidance for 1994-95 and also in the 1995-96 guidance. The NHS is required to achieve significant local improvements in the key areas specified by the Health of the Nation, and in particular where performance is not at an acceptable level. The Executive has agreed local targets with the RHAs representing their contribution towards the national targets, but which also reflect additional local health priorities. The NHS Executive published a booklet "Information To Support Health of the Nation" in April 1994. The booklet explains the current position on the sources and limitations of available information to enable tracking of progress of implementation. The NHS Executive is also seeking to establish central information requirements for managing and monitoring Health of the Nation implementation by the NHS.

4.9 The NHS Executive established a National Reference Group to address the White Paper commitment to examine how best the concept of health promoting hospitals can be developed and taken forward. It examined work already under way at a number of hospitals in England. The Executive published guidance on health promoting hospitals in September 1994. This makes clear the role of hospitals in health improvement and the development of health alliances.

4.10 The role of primary care is crucial to the success of "Health of the Nation". An introductory booklet for the primary health care team was issued in September 1994 to spread good practice.

Health Outcomes

4.11 Adequate systems for the measurement of health outcomes - the assessment of the health benefits of particular health care or other interventions - are an important yardstick for measuring achievement against objectives. Following the publication for consultation in 1993 of an initial set of Population Health Outcome Indicators, the Department has supported various projects, including coordinating an outcomes research and development programme, to facilitate better health outcomes assessment. During 1994-95, the initial range of indicators, based on currently available data - covering, for example, maternal and child health, general health and mental health -are being piloted by HAs to test their validity and usefulness as an aid to purchasing health care.

4.12 As a separate exercise, the Department's Central Health Outcomes Unit is working to determine the data needed to support an 'ideal' set of indicators for a number of key health topics. The Unit has developed a Population Health Outcome Model to provide a framework for mapping the principal factors that can affect health outcomes at various stages and help to highlight areas where outcome indicators are needed.

4.13 The 1992 Health Survey for England report was published in March 1994 and the 1993 report is due in early 1995. The 1993 Survey was the first to have an enlarged sample of approximately 17,000 adults and the corresponding report will include regional as well as national data. Fieldwork for the 1994 Survey has been completed. The 1995 Survey will shift its focus away from cardiovascular disease (although certain assessments, for example of blood pressure and obesity, will continue). Instead it will include the new topic areas of asthma and related conditions; disability; and accidents. The contract for the NHS Survey Advice Centre was awarded to OPCS. The centre will provide assistance to those at local level who wish to mount surveys of their catchment population. It will help to promote appropriate methodologies and also comparability of methods from one area to another.

Drug Misuse

4.14 In October 1994 the Government launched its proposals for a strategy to tackle drug misuse over three years from April 1995 as a Green Paper entitled 'Tackling Drugs Together'. The three year strategy is driven by the statement of purpose:

- To take action by vigorous law enforcement and a new emphasis on education and prevention to:
- increase the safety of communities from drug-related crime
- reduce the acceptability and availability of drugs to young people; and
- reduce the health risks and other damage caused by drug misuse."

4.15 The Department of Health has a key role in implementing the strategy nationally. Major new steps are:

- setting up a national drugs and solvent misuse helpline. This will provide advice and support to anyone concerned about either their own or someone else's drug misuse, including solvent misuse. The helpline is expected to be up and running in April 1995 and will be evaluated after one year.

- taking the lead across government departments in coordinating a new publicity strategy, to involve private and commercial interests as well as other government departments, national and local voluntary organisations and statutory bodies. This will include ways of supporting those in contact with young people with accurate information and relevant skills; and

- a review of the effectiveness of existing services, to report to Ministers in January 1996. This will provide the most comprehensive and important review of the treatment of drug misuse ever undertaken in England. It will include results from Departmentally funded pilot studies to test what level of support and care is best suited to those receiving oral methadone as part of their treatment for opiate addiction. The review findings will feed into the Government's overall strategy and inform future work by the Department to reduce the health risks and other damage caused by drug misuse.

4.16 At local level, the strategy proposes over 100 new drug action teams to tackle drug misuse, to be set up by the chief executives of district health authorities. Chief executives will be asked to report to central Government on the arrangements for the Teams by 30 September 1995. Teams will consist of senior representatives of health, education, local authorities, police, probation and prison services. Their role will be to ensure that action to tackle drug misuse is taken locally and that progress is monitored and evaluated. Action will be in line with the Statement of Purpose and planned in the light of local needs. The chair of the team - selected by Team Members - will be required to report on the results of local action to the Chair of the Ministerial Sub-Committee of the Cabinet on Drug Misuse. Development funds will be made available over the next three years to provide support for the teams.

Plague

4.17 Epidemics of pneumonic and bubonic plague in India in September 1994 caused media and public alarm. Ministers set up a Plague Task Force, chaired by the Chief Medical Officer, bringing together external health experts, port health representatives, general practitioners and representatives from the Asian community together with representatives from the government departments most involved including the Home Office, Department of Trade and Industry and the Foreign and Commonwealth Office. Its remit was to advise the Chief Medical Officers on the public health implications of the epidemic in India. A portfolio of guidance was issued to the field within a week of setting up the Task Force.

Measles/ Rubella

4.18 A nationwide school based immunisation campaign was launched in November 1994 to prevent a measles epidemic predicted for early 1995, otherwise expected to cause up to an estimated 200,000 cases and 50 deaths in England and Wales. The campaign covered school children up to 16, who were identified as the group at highest risk. A combined measles and rubella vaccine was used in the campaign because of the public health benefit of immunising boys as well as girls against rubella, which would bring forward the elimination of rubella in this country by some five years. The campaign was carried out through the school health service and involved close co-operation between the Department, the health service, school services, GPs, the Public Health Laboratory Service and the Health Education Authority, which handled the publicity and information for the campaign, and professional organisations. The total cost was estimated at some £20 million. Early indications are that over 90% coverage will have been achieved by most districts. The campaign is the first of its kind in the United Kingdom and will generate lessons for any future campaigns.

Research And Development

4.19 The Department's R&D strategy has the dual challenge of maximising the benefits for health of science and technology and of applying research rigour to the problems confronting the NHS, public health and social services. As a core function of the NHS and an integral part of the Department's responsibilities including personal social services, R&D furnishes the information necessary for the development and execution of policy and provides the basis for prioritising problems and identifying solutions across a wide range of activities which contribute to the greater quality and cost effectiveness of the NHS.

4.20 The NHS R&D programme and the Department's centrally commissioned research programme (CCP) have adopted a coherent approach to health and social need and reflect priorities expressed in "The Health of the Nation". A new strategic approach has been developed for the CCP, an overview of which is provided in the CCP publication "The Centrally Commissioned Research Programme". A series of strategic initiatives will be defined in important policy areas which will form a framework within which individual priority studies can be commissioned. The Central Research and Development Committee continues its work identifying NHS priorities for health technology assessment and carrying out individual priority setting reviews for NHS R&D in fields such as cancer, mother and child health, and primary dental care. In the light of this, new centrally funded NHS research programmes have been established in physical and complex disabilities, the primary and secondary care interface, health technology assessment and cancer.

4.21 The report of the NHS R&D Task Force, "Supporting Research and Development in the NHS", was published in September 1994. The broad thrust of the report was welcomed by Ministers. Its recommendations are designed to improve the targeting of funds for NHS R&D through better arrangements for identifying and agreeing R&D priorities; introduce more explicit and transparent funding for R&D and service support through the creation of a single funding stream for NHS R&D; and improve the management of R&D resources and accountability for their use. "R&D in the New NHS", published in November 1994, describes how R&D is to be organised within the new management arrangements for the NHS.

Clinical Effectiveness

4.22 Improving health is the core purpose of the NHS. This means that improving the effectiveness of clinical services, through the transfer of good research evidence about what works and what does not, must be a constant aim and is a key goal for the Department. In December 1993, the then NHSME wrote to purchasers and providers, drawing their attention to information already available on clinical effectiveness, an initiative to integrate professional guidelines more effectively into the delivery of health care, and the development of the health technology assessment programme. Purchasers and providers, with the support of clinicians involved, were encouraged to begin more systematically to incorporate such initiatives into the contracting process. The Priorities and Planning Guidance for 1995-96 built on this initiative, identifying as a priority the need to invest an increasing proportion of resources in interventions which are known to be effective and where outcomes can be systematically monitored, while reducing investment in interventions shown to be less effective. Specific requirements for 1995-96 include increased use of clinical outcome specifications and audit criteria in contracts betwen purchasers and providers.

4.23 To support these developments, in September 1994, the NHS Executive wrote again to commissioners and providers, listing further sources of clinical effectiveness information, announcing the availablitity of a pilot version of a register of Cost Effectiveness Studies and commending a small number of high quality guidance documents, covering the management of cancer pain, ovarian cancer, lung cancer and back pain, and the control of hospital acquired infection. The Executive has taken into account local initiatives on improving clinical effectiveness such as the work undertaken by the then Oxford RHA, "Getting Research into Practice" and has sought feedback from the NHS through a series of national workshops.

4.24 This is a long term endeavour and the Department is working widely with the professions, and the NHS on the long term strategy needed to achieve improved clinical effectiveness. The Clinical Outcomes Group (COG), chaired by the Chief Medical and Nursing Officers, has been recognised as the professional steering mechanism for this work, and has established sub-groups on Clinical Guidelines and Guidelines for Purchasers. The COG also oversee the strategic development of clinical audit, which seeks to improve the quality and outcome of patient care through clinicians examining their procedures and comparing them with best practice.

4.25 A national survey, undertaken for the Department by CASPE Research and published in September 1994 has confirmed that audit has been established as part of clinical practice and healthcare provision, creating a good foundation for the future development of audit and for quality improvement. 'The Evolution of Clinical Audit' provided advice for all healthcare professionals on the practical steps required to support the evolution of clinical audit and to inform general managers of this development. The key messages of the document are that clinical audit should be developed by ensuring that it is focussed on the patient, undertaken by multi-professional healthcare teams and within a culture of constant evaluation of clinical effectiveness focussing on patient outcomes. It was accompanied by guidance drafted by the Clinical Outcomes Group on the funding of audit through the contracting process.

SECURING QUALITY HEALTH CARE

Better Services

4.26 The Department has a range of initiatives to improve services provided to patients, both across the board (the Patient's Charter) and in certain key areas, such as cancer services and the provision of services in London.

The Patient's Charter

4.27 The Patient's Charter sets out the rights of patients and the standards of service they can expect to receive from the National Health Service. A new and expanded Patient's Charter was issued in January 1995, replacing the original Charter which had come into force on 1 April 1992. The new Charter carries forward the development of new and improved standards announced by the Secretary of State during 1994. It contains new standards on waiting times (see para 4.30), on the keeping of appointment times by nurses, health visitors and midwives working in the community, mixed sex wards, improving patient choice of hospital food, and measures for the personal protection and safety of patients. Health authorities are required to report annually to the public on the performance of their services against Patient's Charter standards. The second set of reports were produced in 1994 by all health authorities.

4.28 **Primary Care Charters** The Primary Care Charter Initiative was launched in April 1993. All Family Health Services Authorities have produced local charters which include statements of the standards of service patients can expect to receive from the authorities. The Department of Health will continue to support the implementation of the Primary Care initiative, especially the development of GP Practice Charters to meet the Prime Minister's target for 60 per cent of GP practices to have Practice Charters by 31 March 1995.

4.29 **Performance Tables** The first set of performance tables were published in June 1994 and included information on how hospitals and ambulance services were performing on a number of key Patient's Charter national standards. The second set of tables will be published in June 1995. They will update the information published in the 1994 tables, showing year-on-year performance, along with information on first outpatient appointments and the percentage of GP practices with a practice charter within individual FHSAs. The Department is also working closely with the medical profession to find suitable clinical indicators to include in future sets of performance tables.

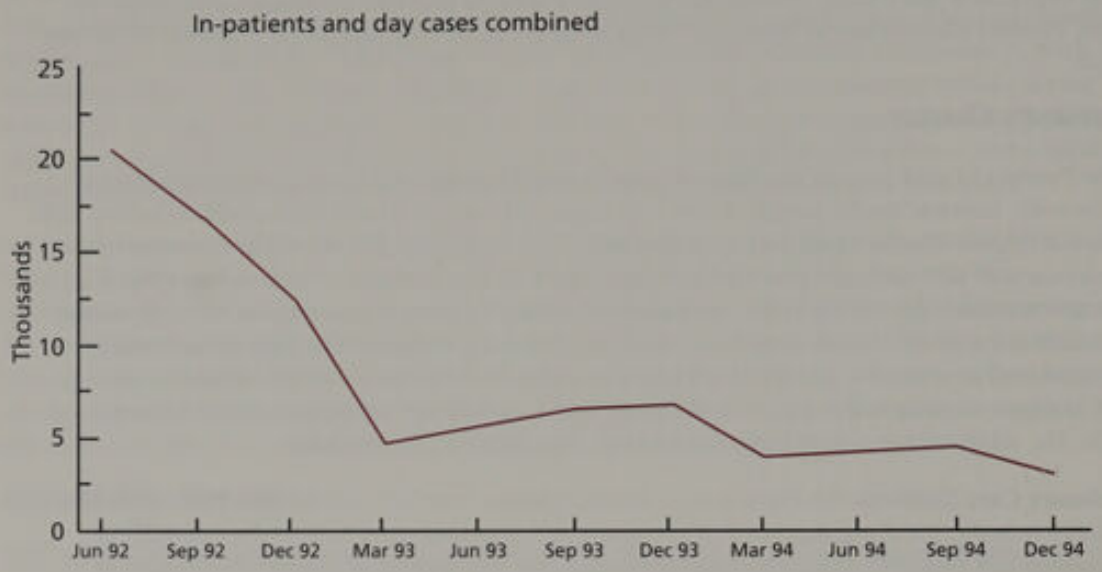
Waiting times

4.30 From 1 April 1995 the guaranteed maximum waiting time from a decision to admit to receiving in-patient or day-case treatment will be reduced to a maximum of 18 months for all patients, from the present guarantee of two years for all procedures and 18 months for hip and knee replacement and cataract surgery. In addition patients listed for admission for coronary revascularisation will, from 1 April 1995, benefit from a new standard of admission within 12 months, expected to become a guarantee in due course.

4.31 Most patients are treated much more quickly than the maximum waits outlined in the Patient's Charter, with nearly 50 per cent of those who have to wait at all being admitted within five weeks. Progress continues on reducing longer waiting times for all patients and the last two years have seen a fall of over 80 per cent in the numbers waiting over 18 months for treatment (see **Figure 13**). In the same period the numbers waiting over twelve months were reduced by nearly 24 per cent. This continues the trend of the last few years which has seen the average waiting time for all patients fall from over nine months to less than five. From April 1995, the Patients Charter will guarantee that no-one waits more than 18 months for in-patients treatment.

4.32 Also from 1 April 1995 a national standard will be introduced for the first time ever for outpatient waiting times: a maximum wait of 26 weeks for first outpatient appointment. Within this standard nine out of ten patients should be seen for their first appointment within 13 weeks or less.

FIGURE 13 - NUMBER WAITING OVER 18 MONTHS: JUNE 1992-DECEMBER 1994



4.33 **NHS Complaints** During 1993 an independent committee, under the chairmanship of Professor Wilson, was appointed to review NHS complaints procedures. Its report was published for consultation on 11 May 1994. The report recommended a single complaints procedure for the whole of the NHS - hospitals, community services, and primary care - with the emphasis on the speedy resolution of complaints locally. Over 600 responses were received to the consultation. The Government intends to take action to improve the NHS complaints procedure and Ministers are expected to announce their conclusions shortly.

Cancer Services

4.34 Cancer places a major burden of disease on the community. One in three people will contract the disease and one in four will die from it. The potential for reducing deaths from cancer by prevention and screening was identified in the Health of the Nation White Paper and has been the subject of considerable service commitment.

4.35 Against a background of concern that in the United Kingdom there are apparent variations in recorded outcomes of treatment, the Chief Medical Officers for England and Wales established an Expert Advisory Group on Cancer to advise on the treatment and care of patients with cancer and on the organisation of cancer services. The Group published their consultative report, "A Policy Framework for Commissioning Cancer Services" in May 1994, and recommendations are to be put to Ministers in 1995.

The NHS Executive Priorities and Planning Guidance for 1995-96 requires health authorities to ensure the best quality of care for cancer patients when commissioning health services, and cites this report.

Changing Childbirth

4.36 Following consultation, the Government accepted the recommendations of "Changing Childbirth" in January 1994. This, the report of an Expert Maternity Group, proposed a shift to "woman-centred" maternity care, where women are asked what they want and levels of satisfaction are tested with good clinical outcomes being maintained.

4.37 The NHS Executive has asked purchasers to draw up plans for implementing "Changing Childbirth" within five years. £250,000 has also been made available to establish a small full-time Implementation Team, based in Anglia and Oxford RHA, to identify, support and disseminate good practice in the purchasing and provision of maternity services. An Advisory Group has also been established, chaired jointly by the NHS Executive's Chief Nursing Officer and Director of Health Care, to advise the NHS Executive on implementation, particularly on education and training. Membership is drawn from professional and statutory bodies, consumer organisations, NHS management and the Department of Health.

4.38 £368,000 has been provided to fund fourteen Changing Childbirth development projects in 1994-95. The projects address a wide range of issues, such as continuity of carer, information for consumers and the role of GPs. A new Patient's Charter leaflet on maternity services explains how existing Charter rights and standards apply to maternity services, and also contains some new standards specific to maternity care. The NHS Executive has also opened discussions with representatives of GPs on the implications for their role of implementing "Changing Childbirth".

Mental Health Services

4.39 The Government's policy is to provide mental health services locally so far as possible. The cornerstone of community care for mentally ill people is the Care Programme Approach (CPA). Each patient in contact with the specialist services should receive an assessment and a care plan, be appointed a key worker to keep in touch with him or her, and be given regular reviews. Implementation of the CPA is being monitored closely by the NHS Executive.

4.40 The role of local authorities is crucial in ensuring that mentally ill people can live safely in the community. **Table 15** shows how local authority personal social services for mentally ill people have been developed over recent years. For example, local authority residential places for this client group increased by 61 per cent between 1983-84 and 1993-94. For 1995-96, an extra £10 million is being committed to the Mental Illness Specific Grant, bringing it to £47.3 million, supporting expenditure by local authorities of some £66 million. This should further improve services and secure closer local and health authority collaboration. This money is ring-fenced for the provision of services for mentally ill people and does not take account of the other resources committed by local authorities for this client group.

4.41 The high priority the Government places on improving mental health services has been demonstrated by the inclusion of mental illness as one of the five key areas in the "Health of the Nation" strategy. There are three mental illness targets: to improve the health and social functioning of mentally ill people; to reduce the general suicide rate by 15 per cent by the year 2000; and to reduce the suicide rate in severely mentally ill people by 33 per cent by the year 2000. The Department is accordingly undertaking a broad programme of work aimed at improving mental health services in all settings - primary care, community services, acute care and personal social services. Improving interagency working and monitoring mental health outcomes more effectively are also key parts of the Department's strategy.

4.42 At present data are not available to allow the first and third of the targets to be precisely measured. However, the Department has commissioned work on a simple standardized schedule which clinicians can use to measure the health and social functioning of their patients on a regular basis. This will be ready for widespread use from April 1996 and will enable the Department both to monitor and set targets for improving the health and social functioning of mentally ill people. Work is also in hand to measure progress towards the third target, that of reducing suicides by severely mentally ill people.

4.43 Under the aegis of "Health of the Nation" the Department is taking forward a number of measures to improve the management of mental illness in primary care, for example supporting the work of a senior GP fellow in mental health and researching different models of delivering mental health care in primary care. There is also a programme to reduce suicides, focusing on education, improving the audit of suicides and tackling access to the means of suicide. The Department has also held discussions with the Department of the Environment on mental health and housing, and meets regularly with the Department of Employment, the Health and Safety Executive and other bodies to discuss issues surrounding mental health in the workplace.

Table 15 HEALTH AND PERSONAL SOCIAL SERVICES FOR MENTALLY ILL PEOPLE 1983-84 AND 1989-90 TO 1993-94

	1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	% change 1983-84 to 1993-94
Local authority residential places [1]	4,200	7,600	7,700	7,600	7,200	6,800	61
Voluntary and private residential places	2,600	12,100	13,200	14,700	16,100	17,100	568
Day centre places specifically for mentally ill people [2]	na	na	na	na	39,800	45,300	na
NHS daycare places [3]	16,300	22,700	22,700	22,800	23,000	na	na

(1) Figures include places in homes for elderly mentally infirm people from 1989-90 onwards.

(2) Figures relate to places during a sample week in September/October. Comparable figures are not available for earlier years as the system of data collection for day centre activity was changed in 1992. Figures exclude places for elderly mentally infirm people.

(3) Figures on a calendar year basis.

4.44 Most patients receive a high standard of care in the community. However, there have been a few high profile cases where patients have fallen out of contact with services, with tragic results. The Secretary of State's Ten Point Plan was launched in 1993 to strengthen community care for the most vulnerable patients. As part of that Plan the Department has published a revised Code of Practice for the Mental Health Act 1983, issued Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community (HSG(94)27/LASSL(94)4), which makes clear that no patient should be discharged unless it is safe to do so, and introduced supervision registers for those patients who are judged to be at significant risk of suicide, severe self-neglect or of committing serious harm to others. The ten Point Plan includes a proposed new power of supervised discharge, which will require that patients detained under the Mental Health Act who meet specified criteria abide by the terms of their care plan when they are discharged from hospital. A Bill to make the necessary amendment to the Mental Health Act is being introduced in the current Parliamentary session. In addition to the Ten Point Plan, the Department will publish a Guide to Arrangements for Inter-agency working for the Care and Protection of Severely Mentally Ill People early in 1995. This Guide is designed to help local agencies work more effectively to care for severely mentally ill people and was produced as a response to the issues identified in the Report of the Inquiry into the Care and Treatment of Christopher Clunis.

4.45 Mentally disordered patients who are too difficult or dangerous to be managed in local psychiatric services, but not dangerous enough to justify their admission to one of the three special hospitals, are cared for in medium secure psychiatric provision. The Department has made available £45 million of centrally funded capital over the period 1991-95 to increase the total of medium secure places nationwide to more than 1,150 places and £4.4 million of revenue funding in 1994-95 to support the additional medium secure places.

4.46 The Department gives financial support to a variety of organisations to help improve the mental heath of the nation. For 1994-95, 58 grants amounting to some £2.4 million were awarded to 44 organisations under the Section 64 scheme to support the activities of the voluntary sector. The Department, in conjunction with the Mental Health Task Force, has pledged over £300,000 together with logistical support to support the Sainsbury Initiative. This provides £3 million in grants, available to statutory and voluntary agencies to develop models of good practice in community care for people with serious mental illness.

Child And Adolescent Mental Health Services

4.47 Provision for children and adolescents with psychological problems is among the main components of a proper locally-based mental health service. A recent research report on service provision, commissioned by the Department, highlights uneven service provision across the country and poorly developed matching of need and service, an absence of specific strategies amongst many purchasers, and strains on the inter-agency nature of these services as, for example, social services and education authorities redeploy staff resources in response to new statutory imperatives.

4.48 Action by the Department to raise the profile of these services includes publication of an information leaflet, a leaflet for GPs sponsored by the department, the commissioning of a purchasing handbook and a needs assessment study, and the commissioning of a Thematic Review by the NHS Health Advisory Service to consider "what is a good service".

London

4.49 Central to the future provision of health in London is the need for a more patient-focused NHS, concentrating on high quality primary care services supported by appropriate acute services. "Making London Better", published in February 1993, set out the strategic direction for action to improve health services in London . The London Initiative Zone, established through "Making London Better" is the focus for new investment and new approaches in primary care services in London. A further £85 million has been made available for the LIZ in 1994-95, including £10 million specifically for schemes and initiatives in the London Initiative Zone (LIZ) aimed at improving services and facilities for people with a mental illness. LIZ strategic plans will develop over a five year period with a rolling development programme across a wide range of services in the community; over 900 projects are planned or underway. In addition, £7.5 million has been made available over three years for voluntary sector schemes aimed at reducing inappropriate hospitalisation or enabling early discharge.

4.50 "Making London Better" also emphasised the need to encourage the recruitment of good quality GPs and to sustain those already practising in the LIZ area. A package of new measures is being developed to address these problems; the first of these was announced in October 1994 by the Minister for Health : a programme of Educational Initiatives which will be delivered through an expanded educational infrastructure in the LIZ area.

4.51 North and South Thames RHAs have made proposals for the reconfiguration of the acute hospital service in London, in the light of their discussions with purchasers, providers and academic interests, subject to normal statutory consultation procedures. Consultations on proposals to reconfigure services in South East London (including Guy's and St Thomas' NHS Trust) and services in east London (Royal Hospitals Trust and Homerton hospital) will be completed in early 1995.

4.52 Following the Tomlinson recommendations for merger, good progress continues to be made with medical school mergers: Charing Cross and Westminster Medical School have agreed to merge with the Imperial College of Science, Technology and Medicine; the National Heart and Lung Institute (associated with the Brompton Hospital) have signed terms of agreement with Imperial; and North Thames Region have established a "West London Forum" to bring education and service parties together with the aim of advancing change in a coordinated way.

Better Primary Care

4.53 The family health services remain the first point of contact with the NHS for most people. For example, there are about 250 million consultation a year with family doctors. Those who visit their family doctor, dentist or community pharmacist know that they will receive high quality treatment and, where necessary, professional advice. Increasingly this includes advice on how to stay healthy and prevent illness by adopting healthy lifestyles. The Government's long standing policy has been to build up and extend these services, to ensure that the highest standards of care are available to patients everywhere.

General Medical Services

4.54 GPs are increasingly important in ensuring that the NHS develops in the way that best meets the needs of patients: of all the professionals and managers in the NHS, family doctors have most frequent contact with their patients, both in surgery and in patients' own homes. The expansion of the GP fundholding scheme and proposals for a stronger partnership between health authorities and all GPs (fundholders and non-fundholders) are outlined at paragraph 5.16. Paragraphs 5.32 to 5.39 describe how GMS funds were spent in 1993-94 in maintaining high standards. Specific initiatives to improve and stregthen services during 1994 are outlined below.

4.55 **Services outside normal hours** The Department of Health has, over the last 18 months, been addressing GPs' concerns about the pressures faced by family doctors providing services outside normal surgery hours. Following consultation with the profession, changes have been made to the GPs' terms of service to give full clinical responsibility to the attending doctor and to permit family doctors to ask patients to attend primary care centres outside normal surgery hours. The Department has funded a poster campaign in GP surgeries to remind patients that they will get the most from their family doctor services if they use them wisely and written to FHSAs to clarify a GP's right to take time off work following heavy on-call duty.

Discussions are continuing with the profession on the structure of the feescale aimed at reducing further the burden of out of hours care on individual GPs and by increasing the scope for GPs to decide how best to deliver services for their patients, including greater opportunity for them to organise care above the practice level.

4.56 **Violence against GPs** In line with the recommendations of a joint Working Group with the profession, established in response to GPs' concerns about their personal safety, GPs' Terms of Service have been changed to allow for the immediate removal of a patient from a GP's list where the patient has assaulted the GP, or has behaved in such a way that the GP has fears for his or her safety and has made a complaint to the police.

4.57 **GP/FHSA Links** Electronic links between GPs and FHSAs are being developed under the GP/FHSA Links project which aims to replace a paper based system with electronic data interchange. The Project has set out to achieve through a Registration module, for GPs to use for notifying FHSAs of new patient registrations, followed by an Items of Service Module, which is to help with the handling of GP claims for payment for particular services. By November 1994, electronic links with practices had been achieved for the purposes of Registration with 89 FHSAs. The main benefits will be: speedier claims processing; faster transfer of patient medical records (in days not weeks, in line with Patients Charter standards); reduced clerical effort at practices and FHSAs; the elimination of the risk of losing paperwork in transit; and easier identification of audit trails.

Dental Services

4.58 **"Improving NHS Dentistry"**, published on 14 July 1994, set out the Government's proposals for reform of the dental remuneration system. The proposals are intended to implement the Government's commitment to an effective NHS dental service accessible to all. The Government's objective in proposing reform is to create a system of remuneration which provides value for money and a proper framework of financial control; is fair to dentists, patients and the taxpayer; is as simple as possible; and contributes positively to the development of the NHS dental service and oral health generally. The proposals draw heavily on the recommendations of the Health Select Committee and Sir Kenneth Bloomfield, who undertook a fundamental review of the system.

4.59 For the long term, the Green Paper proposes that NHS dental care could be provided through a system of local purchasing by health authorities. This system, which would represent a radical change for primary care, would be piloted by volunteer health authorities and evaluated carefully before decisions were taken on whether it should be extended nationwide. Two further options are proposed for improving the system while these long term reforms are being developed. A sessional fee system would reward dentists for the time spent with NHS patients, rather than the number of treatments performed. Another option would be to modify the current fee-per-item system of remuneration.

4.60 The publication of the Green Paper was followed by a period of formal consultation which invited views from the dental profession, NHS management and others involved with the service. That consultation ended on 1 November 1994. The Government is now considering the results of consultation and disussions on the way forward will be announced shortly.

4.61 **Oral Health Strategy** An Oral Health Strategy for England was published alongside the Green Paper. It reviews the present state of oral health in England and highlights problem areas. The Strategy suggests in broad terms how these might be tackled and sets objectives for future improvement. Surveys carried out at 10 year intervals by the OPCS have shown continued improvement in oral health. **Figures 14** and **15** from the 1993 Child Dental Health Survey show substantial increases in the number of children who are caries free. There still remain, however, regional and inter-regional variations to be tackled. The strategy has been promoted through a series of roadshows held in each of the eight regions with the aim of setting a climate of discussion and action at local level, for example by greater emphasis on oral health promotion or canvassing support for local fluoridation schemes.

Community Pharmacy

4.62 The Department remains fully committed to developing the professional role of community pharmacists where it can be shown that it is cost-effective to do so. Paragraph 5.49 summarises the changes that have already been made to the fee structure to reflect this wider role. In addition, the Department has funded a number of initiatives aimed at raising standards within pharmacies and making fuller use of pharmacists' skills. These include the development of a comprehensive programme of continuing education and training and a number of pharmacy audit initiatives to facilitate community pharmacists' participation in

FIGURE 14 - PERCENTAGE OF CHILDREN WITH CARIES FREE PERMANENT TEETH 1973, 1983 AND 1993

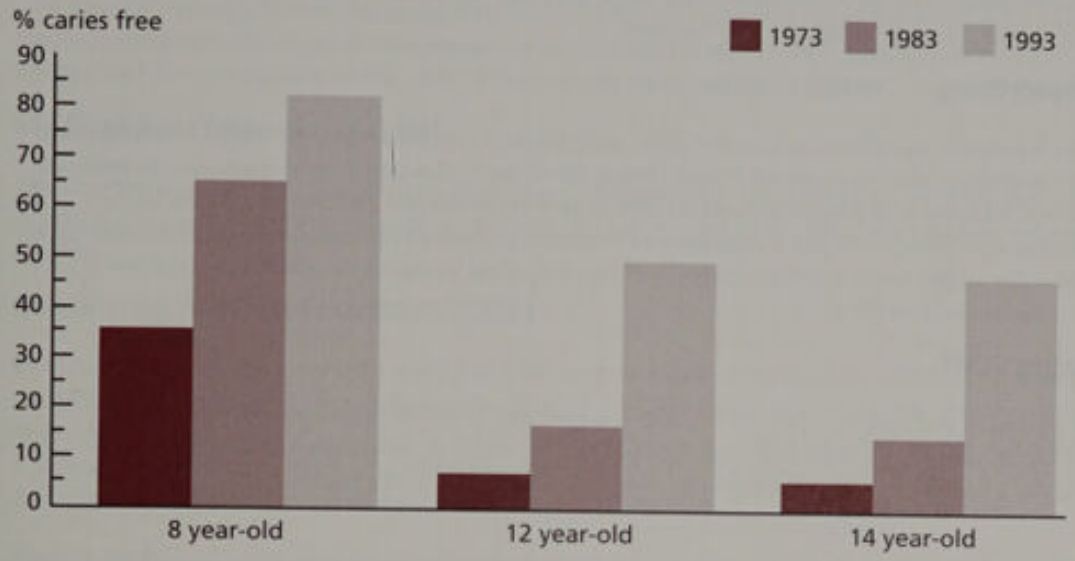
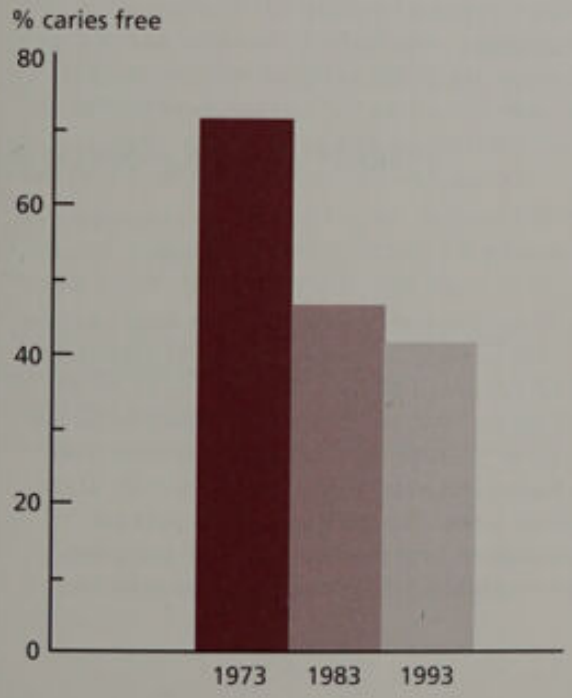


FIGURE 15 - DENTAL CARIES EXPERIENCE OF DECIDUOUS TEETH OF 5 YEAR-OLD CHILDREN



Source: OCPS and Br Dent J 1994; 176:209-214

clinical audit. Since 1992-93 some £7 million has been made available to encourage participation by pharmacists in local needle exchange schemes and in the safe disposal of unwanted medicines. At the local level, a large number of FHSAs have involved pharmacists in a wide range of service developments. These include participation in health promotion campaigns and closer co-operation with family doctors in the management of the drugs bill. The Department has set aside £1 million for 1995-96 to encourage further involvement by pharmacists in better prescribing. More generally, it intends to build on FHSAs' initiatives through the development of local pharmacy budgets.

Nurse Prescribing

4.63 Under legislation introduced in October 1994, appropriately qualified nurses in eight GP fundholding demonstration sites are able to prescribe from a limited list of medicines and wound management products. The aim of this initiative is to ensure patients receive more convenient and better targeted care in the community and have their necessary medicines and dressings prescribed through health professionals whom they see on a day to day basis. A full evaluation will be carried out to assess the effectiveness of the measures as the projects develop.

Developing Staff

4.64 The education and training of the NHS's staff is a vital part of improving treatment and care for patients. Work on developing skills and working practices continues to move forward at every level, recognising the important contribution made by everyone who works in the health service.

BETTER PROFESSIONAL EDUCATION AND TRAINING

Working Group on Specialist Medical Training

In December 1993 Ministers announced acceptance of the report of the working group on specialist medical training (The "Calman Report"). Implementation of the report will result in shorter, more intensive and better structured training programmes for doctors; the reduction from three to two training grades; the introduction of the certificate of completion of specialist training (CCST) to define the end-point of training; and a significant increase in the amount of service provided to NHS patients by consultants rather than those still in training. During the year, a working group has been considering the educational principles of the new unified training grade (or specialist registrar grade): their report will be issued for consultation; the medical Royal Colleges have been developing curricula and training programmes for the new grade and a broad consensus has been reached on the principles of a numbering system for higher specialist trainees, training programmes and posts. Working groups have also been considering the implications of the Calman Report for general practice, academic and research medicine and overseas doctors: the reports of these groups will be issued for consultation. The necessary Order of Council needed to implement the Report and introduce the CCST into UK law will be enacted during 1995.

The New Deal

Health authorities and trusts have made further important progress in implementing the **New Deal** for junior doctors which aims to reduce significantly the hours of duty of hospital doctors and dentists in training. In 1990, there were more than 13,300 junior doctors in England contracted for over 83 hours a week. By 30 September 1994 this figure had reduced to only 4. The priority for 1994 was to reduce hard-pressed on-call posts to a maximum average of 72 hours a week. In the year to 31 March 1994 the number of these posts reduced by 34%. In the following six months there was a further reduction of over 40%. Since 1991, £117 million has been made available to help reduce junior doctors' hours. This has been used to fund the creation of 850 new consultant and staff grade posts and to support local projects to improve living and working conditions. Health authorities and trusts have also established 845 new medical posts from their own resources.

Part-time Consultants Scheme

The Part-time Consultants Scheme is intended to help promote part-time working as a sensible, businesslike option for employers. It should encourage employing bodies to experiment increasingly with flexible working patterns, including part-time posts, that ensure both staff satisfaction and high quality health care for patients. The first phase was announced in April 1993 with 61 posts established. A second phase was announced in April 1994 and posts are now being established.

Locum Doctors

Following concerns over a small number of locum doctors, a Locums Working Group examined ways to improve quality control of locums working in the NHS. Its Report has been published for consultation. The Group reviewed procedures currently used in appointing locum doctors, measures used to monitor their performance, factors affecting the demand for and supply of locums and the pressures these can exert upon quality control procedures. Its recommendations covered both possible short term measures (eg a Code of Practice and the introduction of fair and open reporting) and longer term options.

Medical Act (Amendment) Bill

The Government intends to introduce a Medical Act (Amendment) Bill in order to introduce new procedures to enable the General Medical Council to deal with doctors whose professional performance is found to be deficient.

Continuing Medical Education (CME)

The Chief Medical Officer started a review of CME to draw together the thinking of the Royal Colleges and others into a coherent and affordable national strategy for CME which will ensure that the commitment to high quality patient services is underpinned by a robust system of continuing medical and dental education. Following a workshop attended by invited experts from the Royal Colleges and the NHS, a consultation document was launched at a national conference on 13 June 1994.

Project 2000 The Project 2000 reform of student nurse training was completed in 1994 within five years of its announcement, supported by a contribution of over £400m by the Government. All colleges in England are now approved and funded to provide the new style Project 2000 programme. In future, nurses and midwives will have to meet new standards for education and practice after registration. Proposals put forward by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and accepted by Ministers, will mean regular updating for all nurses and midwives wishing to remain in the professional register, and standards for post-registration education provide a new framework for specialist training.

Strategic Framework for Nursing, Midwifery and Health Visiting The twelve targets set by "A Vision for the Future: the contribution of nurses and midwives to health and health care", launched in April 1993, to help trusts establish a strategic framework for high quality, cost-effective nursing, midwifery and health visiting, were monitored and progress assessed after twelve months. "Testing the Vision", published in April 1994, suggests significant developments in quality in nursing and midwifery, and a forward programme for the initiative has been agreed as a result of a consultation exercise with members of the professions and the NHS Executive.

Professions Allied to Medicine

The Department funds education for the professions allied to medicine (PAMS), which is increasingly being delivered in Higher Education premises. This has encouraged professional teachers to raise their educational standards by undertaking higher degrees.

It has also proved to be a valuable mechanism for evaluating the framework of the various core curricula. These are now becoming more focused on meeting the needs of the future Health Service and strengthening qualitative aspects of clinical practice.

SECURING QUALITY SOCIAL CARE

Community Care

4.65 Government policy on community care aims to ensure that vulnerable people affected by the problems which attend ageing, mental illness, physical, sensory or learning disability or drug and alcohol misuse receive the care they need in homely surroundings. The policy is underpinned by the White Paper "Caring for People" (1989) and the NHS and Community Care Act (1990). The Department of Health has lead responsibility for community care in England. Other Departments, particularly Environment and Social Security, also have an interest. At local level, local authorities have lead responsibility and work closely with health and housing authorities to assess needs and arrange services. Independent sector providers, users and their carers are actively involved in this process.

4.66 Monitoring of the new arrangements has shown that individuals' needs are being properly assessed before key decisions are made about their social care and a growing number of individuals are receiving more flexible and innovative packages of care that really meet their needs. The findings of a further eight special studies undertaken by the NHS Executive and the Social Services Inspectorate were published during the year. These showed that LAs were generally continuing to make good progress. The second Audit Commission report on community care "Taking Stock", published in December 1994, confirmed this.

4.67 In 1994, for the first time, local authorities were required to report on their own performance, in a number of key community care areas, in consultation with representatives of all agencies and stakeholders. A national monitoring report is expected to be published by March 1995.

4.68 **Community Care Charters** Following consultation the Secretary of State launched the charter framework for local community care charters on 4 November 1994. Local authorities should have local charters in place by April 1996. These charters will give local people more information about the services and standards they can expect under the community care reforms. Health authorities will be expected to play their full part in the development of these local charters. Community care charters are the first charters to involve several statutory agencies. Local social services, health and housing authorities can use the Charter Framework to draw up local charters. Local authorities are in the lead. They are being encouraged to have their local charters in place by April 1996.

4.69 **Citizen's Charter and Social Services Inspection** The Department issued guidance to local authorities on the extension of Citizen's Charter principles in social services inspection. To help underpin the independence of inspection and to bring fresh perspectives to the task, local authorities were instructed to include lay assessors in inspections and to strengthen the influence of lay people on inspection unit advisory panels. Other measures include requiring chief executives to produce annual assessments of the independence and effectiveness of inspection units, and a requirement for the follow up of inspection reports on local authority services. The importance of publishing reports and making them accessible was emphasised

4.70 **Improving the Regulation of Residential Care and Nursing Homes** As part of the Department's contribution to the Government's review of regulations affecting business, draft guidance was issued for comment in August 1994, on ways of improving the regulatory system for residential care and nursing homes while continuing to protect resident's interests. It is intended that final guidance will be issued by Spring 1995.

Services for Individual Client Groups

Services for Children

4.71 As part of the Department's continuing commitment to monitoring the provision of children's services, the Secretary of State submits to Parliament each year a report in respect of local authority functions relating to children under the Children Act 1989. The third in the series of reports will be presented in early 1995. It will provide an overview of the progress made in the third year of the Act in operation and will concentrate on key issues and major developments. It is still too early to make a firm judgement on the overall impact of the Act, but the last two reports confirm the impression that it is working smoothly.

4.72 The findings from over fourteen projects in the current DH child protection programme will be widely disseminated and will form the basis for setting the programme for the future. In October 1994, a joint working party comprising representatives of the medical profession and the Department, issued new guidelines for doctors on medical responsibilities in child protection, emphasising the importance of medical input.

4.73 The Department has been developing, in partnership with the Dartington Research Unit, a framework and set of materials to help local authorities take appropriate action at the right time for children in their care. This programme is being launched in April 1995.

4.74 The Department launched a new initiative in March 1994 to test the concept of Childcare Circles, informal support or self-help networks or groups of parents - particularly young lone mothers - who cooperate in reconciling work and family responsibilities. Barnado's, NCH Action for Children and Save the Children Fund have been awarded grants totalling £300,000 to set up and run four projects in different local authority areas - three in urban or inner city areas and one in a rural area. The results of the initiative will be written up and disseminated during 1995.

4.75 1994 was the United Nations International Year of the Family (IYF). During the year the Prime Minister asked the Secretary of State for Health to take the lead in responding to questions and presenting issues about Government policies affecting the family. The Secretary of State was actively involved in IYF events and in meeting organisations providing help and support to families.

Services for Elderly People

4.76 The Department's policy is to promote services for older people aimed at facilitating independent living in the community. This is reflected in the increasing support provided by community nursing and rehabilitation services and falling lengths of hospital stay (see **Table 16**). These improvements have been mirrored by the growth of local authority provision in domiciliary services predominantly used by older people, which is also illustrated in Table 16. Total expenditure on health services for elderly people has increased in real terms by 41 per cent between 1978-79 and 1990-91, and expenditure on social services has increased by 37 per cent between 1978-79 and 1991-92.

4.77 In reviewing policies for the NHS, the Department has placed increasing emphasis on the need for sensitive hospital discharge practices and high quality community and rehabilitation services. Particular importance has been given to the need for individual assessment and the early detection of problems. The 1995-96 Priorities and Planning Guidance for the NHS has identified services for elderly people, including arrangements for continuing care, as a specific area for review.

4.78 The Department has continued to promote work on sickness and disability prevention in older people in line with the national strategy for health, "The Health of the Nation". This has included an extensively revised edition of "Health and Well Being: A Guide for Older People" and continuing research on Healthy Active Life Expectancy. The Department has also supported the development of peer health mentoring and other volunteering projects and the production of advice to GPs on health promotion for older patients. The Department published an evaluation report on the 1993 European Year of Older People and Solidarity between Generations at the end of 1994.

Table 16 HEALTH AND PERSONAL SOCIAL SERVICES FOR ELDERLY PEOPLE 1983-84 AND 1989-90 TO 1993-94

	1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	% change 1983-84 to 1993-94
Geriatric Hospital Inpatients (thousands)	320 (4)	447	468	508	527	554	73
Average Length of Inpatient Stay (days)	58.0	35.9	32.7	27.0	23.5	–	-59
Hospital Outpatient Attendances	302	390	427	433	452	459	52
Number of District Nurses (WTE) (3)	18,640	19,090	19,800	19,150	19,010	19,100	7.5
Local authority residential places (1)	115,913	105,400	97,900	86,700	77,000	69,000	-41
Voluntary and private residential places	89,373	180,400	192,000	199,600	205,500	210,000	107
Day centre places specifically for elderly people (2)	na	na	na	na	139,100	147,600	na
Meals served (million)	49.5	46.3	45.9	45.8	45.1	na	na

(1) Figures include places inhomes for elderly, elderly mentally infirm and elderly with disabilities and adults with physical and/or sensory disabilities.

(2) Figures relate to places during a sample week in September/October. Comparable figures are not available for earlier years as the system of data collection for day centre activity was changed in 1992. Figures cover places for people aged 65 and over.

(3) Figures quoted include all nurses involved in district nursing. All figures are rounded to the nearest ten whole time equivalents and percentages are calculated on rounded figures.

(4) Figures estimated from data on discharge and deaths.

Services for people with learning disabilities

4.79 The Government's policy is to assist the development of community based services for people with learning disabilities, and, in particular, services for those who are also behaviourally disturbed or mentally ill. **Table 17** illustrates the continuing major shift from inpatient care in large institutions towards more appropriate community based services for people with learning disabilities, which has been a policy aim for over twenty years. Numbers of hospital beds have declined, whereas the overall number of local authority and independent sector places has risen significantly, supported by an increase in the numbers of community nurses.

The main steps being taken are shown in the box.

SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

Since publication of the **Mansell Report** in 1993 the Advisory Group on Behavioural Disturbance and Mental Health Services Developments for People with Learning Disabilities has met regularly. It has produced a paper on the need for multi-disciplinary specialist mental health services for people with learning disabilities and is being funded by the Department to run a series of national workshops on key purchasing issues.

A **National Implementation Network** has been set up by the Tizard Centre, and funded by the Department, to assist commissioners, planners and purchasers of health and social services authorities to develop better services locally in the light of the recommendations of the Mansell Report. The Network now includes contacts in almost all the health and local authorities in England. Activities include a series of Regional Workshops for purchasers and regular Network Newsletters.

The Department has commissioned the **National Development Team** to produce a handbook of guidance on replacing long stay hospitals for people with learning disabilities with appropriate community services based on individual need. Work is continuing on this and the handbook will be published in 1995.

In July 1994, the Chief Nusing Officer announced a major initiative financed by the Department, to identify and describe the range of **learning disability nursing skills.** The project is due to be completed by 31 March 1995.

To follow up publication of guidance on the **prevention and treatment of sexual abuse** of people with learning disabilities in residential settings ("It Could Never Happen Here"), an Inter-Agency Study Day was held in March 1994 followed by three workshops funded by the Social Services Inspectorate on prevention and treatment of sexual abuse. The Department has also contributed over £180,000 towards a number of projects and organisations dealing with the prevention and treatment of abuse of people with learning disabilities.

In 1994-95 grants totalling £1.6 million were made through **Section 64 and the Shared Training scheme** in support of projects related to people with learning disabilities.

Table 17 HEALTH AND PERSONAL SOCIAL SERVICES FOR PEOPLE WITH LEARNING DISABILITIES 1983-84 AND 1989-90 TO 1993-94

	1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	% change 1983-84 to 1993-94
Local authority residential places	14,300	16,900	16,700	16,300	15,500	14,300	0
Voluntary and private residential places	6,300	16,300	18,900	21,200	24,100	25,500	305
Day centre places specifically for people with learning disabilities (1)	na	na	na	na	236,200	259,200	na

(1) Figures relate to places during a sample week in September/October. Comparable figures are not available for earlier years as the system of data collection for day centre activity was changed in 1992.

Services for people with a physical or sensory disability

4.80 In consultation with other Government Departments, the Department has worked towards ensuring that the UK plays a full and active part in the EU's disability programme, HELIOS II (1993-1996), through the selection of UK participants, the hosting of a UK HELIOS II National Information Day, and by liaising with the European Commission and UK disability organisations. In order to improve the provision of information to disabled people, their carers and service providers, the Department set up and funded the National Disability Information Project. The project, which helped establish and develop a number of federations of local information providers, ended on 30 September 1994, and its outcomes are being evaluated. Following the publication of a report in April 1994 on direct referral by GPs to audiology clinics, the NHS has been asked to consider whether its implementation would improve hearing aid services and shorten waiting times. Local authority awareness of the training needs of staff working in the field of visual impairment has been raised by the establishment of a special sub-programme within the Social Services Training Support Programme.

Adoption

4.81 **Reform of Adoption Law** The White Paper 'Adoption: The Future' published in November 1993 set out the Government's proposals for amending the adoption law in England and Wales. Two further consultation paper papers on specific issues were published in 1994 and the responses taken into account in preparing revised proposals. The necessary legislation will be introduced as soon after the forthcoming session as parliamentary time permits. Some changes to adoption law which do not require legislation will be introduced earlier.

4.82 **Hague Convention on Intercountry Adoption** The United Kingdom signed the Hague Convention, which aims to protect children involved in intercountry adoption, on 12 January 1994 and intends to ratify as soon as the necessary legislation is in place. A meeting of a special commission of the Hague Conference on Intercountry Adoption took place in the Hague in October 1994 to consider issues of implementation and the application of the Convention to refugees.

INTERNATIONAL COOPERATION AND HEALTH

4.83 During 1994 the European Commission published four proposals to follow up its Communication on the Framework for Action in the Field of Public Health, covering cancer, health promotion, drug dependence, and AIDS and other communicable diseases. On 2 June the Health Council adopted a resolution setting out its priorities and aims in this area, which reflected UK interests such as full consultation between the Commission and Member States and the need for an overview of EC public health activity.

4.84 Coherence between EC health policy and other EC activities has been a particular UK goal, and the Department has made progress in ensuring that the content of the medical research programme, BIOMED, adopted on 1 December, complemented Community public health work. In other Councils, the Government has secured amendments to the Young Workers' Directive to safeguard the current UK position, and negotiated improvements to the handling of health data in the Data Protection Directive in areas covering the Department's interests.

4.85 The UK continues to make an effective contribution to the work of the World Health Organization (WHO) and other international bodies. The UK obtained one of six places leading work on the reform of the WHO now under way. Reform of WHO has become important as the Organization has been facing critical challenges arising from global political, economic, social and health changes. The major objectives for WHO reform are better prioritisation of its programmes; an improved system of programme budgeting; better co-ordination of the work of its headquarters in Geneva and its six regional offices; and better co-ordination with other UN and inter-governmental bodies and non-governmental organisations.

4.86 Work to promote the development of the export of health sector goods and services continues. In addition, the Department has been developing an inward investment campaign in conjunction with the pharmaceutical industry, the DTI and the Invest in Britain Bureau. This builds on the success of the UK in winning the decision of the European Agency for the Evaluation of Medicinal Products (EMEA) in London, and capitalises on the strengths the UK has to offer as a location for the global pharmaceutical industry.

5 PERFORMANCE AND USE OF RESOURCES

5.1 The previous chapter of this report described a range of initiatives to improve the quality and effectiveness of services, and their efficiency (for example, Health of the Nation, R&D, the Patient's Charter, community care). This chapter discusses the performance of, and use of resources within, each of the Department's programmes as a whole:

- reforms to the management and organisation of the NHS;
- trends in activity levels and overall efficiency in each sector of the health service (HCHS, FHS and CHMS);
- selected regional comparisons of health status, service performance and use of resources;
- the use of staff within the NHS;
- other NHS initiatives for maximising efficiency and value for money;
- efficiency measures within the Personal Social Services; and
- the programme of action to improve value for money within the Department itself.

THE HEALTH PROGRAMME

The New NHS

5.2 **"Managing the New NHS"** The Secretary of State's announcement on "Managing the New NHS" in October 1993 set the direction for the central management of the NHS. The changes she announced, which form the final stage of the NHS reforms introduced in 1991, are intended to improve services to patients by devolving decision making to local level, streamlining central management and encouraging integrated purchasing across the boundaries of primary and secondary care.

5.3 The changes to the structure of the NHS are:

- abolition of Regional Health Authorities (RHAs) and creation of a single structure for central management, the NHS Executive, comprising a headquarters and eight regional offices;
- merger of District Health Authorities (DHAs) and Family Health Services Authorities (FHSAs) to form new health authorities.

A Bill to abolish RHAs and enable DHAs and FHSAs to merge is currently before Parliament.

5.4 To inform decisions about where responsibility for functions should lie in the new NHS, a detailed analysis of functions was carried out by twelve Functions Groups, with membership drawn from different disciplines and from all parts of the NHS: primary care, Trusts, DHAs, FHSAs, RHAs and the Department of Health. Each group examined a particular functional area, and produced a report for the NHS Executive Board setting out their recommendations for the future organisation of functions in the NHS.

5.5 "Functions and Responsibilities in the New NHS", published on 28 July, set out a framework for the future organisation of the NHS, based on the work of the Functions Groups. It identified functions to be carried out at local level - by NHS trusts, GPs and other primary care providers, and health authorities - and the more strategic functions which will be the responsibility of the NHS Executive either at headquarters or in regional offices. These will include setting strategies in key areas of management including resources, research and development and market development and regulation - the role of the Executive in the operation of the internal market was set out in detailed guidance issued to the NHS last December (see paragraph 5.8).

5.6 The framework set out in "Functions and Responsibilities" was shaped by the twin objectives of maximising the responsiveness of services to local people and achieving best value for money for patients and the public from the resources spent on the NHS. By 1997-98, total annual savings from streamlining health authorities at regional and district level are expected to approach £150m, with a further £50m expected from savings in Department of Health running costs following this and a parallel review (see paragraphs 5.79 to 5.82).

5.7 The NHS Executive regional offices were established on 1 April 1994 and from the same date the number of RHAs was reduced to eight, sharing common boundaries with the regional offices. Each of the transitional RHA/regional offices has a joint management structure headed by a Regional Director. The Regional Directors are members of the NHS Executive Board. On the same date the NHS Policy Board was restructured and now includes eight regional non-executive members who also act as Regional Chairmen of the transitional RHAs. Prior to their proposed abolition, RHAs will continue to discharge their statutory functions. Regional offices will carry out both performance management of purchasers and monitoring of NHS Trusts.

5.8 "The Operation of the Internal Market: Local Freedoms, National Responsibilities", published in December 1994 as HSG(94)55, aims to set out clearly the way in which the internal market should develop in the future in the light of this reorganisation to protect the interests of patients and taxpayers. The guidance covers the actions to be taken by those in the NHS, regional offices and NHS Executive Headquarters regarding mergers and joint ventures between providers, mergers and boundary changes between purchasers, managing change when trusts are in difficulty, and action to prevent collusive behaviour while allowing collaboration to promote the interest of patients.

Purchasing

5.9 The Government took a significant step towards a primary care led NHS, where decisions about purchasing and provision of health care are taken as close to patients as possible, with the Secretary of State's announcement in October 1994 of proposals for the further development of the GP fundholding scheme. These involve:

a continued expansion of the options for GP fundholding (which remains voluntary). See paragraph 5.16 ;

a continuing and important role for DHAs and FHSAs and for the new health authorities which (subject to Parliament's consent) will replace them; and

a stronger partnership between health authorities and all GPs (fundholders and non-fundholders).

5.10 The implications of these proposals for the role of health authorities need to be seen in the context of the organisational changes which flow from "Managing the New NHS". The proposed new HAs will be responsible for implementing national health policy. They will have overall responsibility for assessing the health care needs of the local population and for developing integrated services for meeting those needs across primary and secondary care boundaries. Managing the New NHS envisages a key role for the new health authorities in developing primary care and forging constructive partnerships with GPs. As GP fundholding develops, HAs need to shift the balance of their activity more towards strategic, monitoring and support roles. In many parts of the NHS, experience is already being gained as to how these roles can best be performed. Already, better coordination across the boundaries of primary and secondary care has been achieved through joint working between DHAs and FHSAs; all DHAs and FHSAs are working together and over half have joint management arrangements. The number of DHAs has reduced from 189 in 1990 to 110 by October 1994.

5.11 The Department has continued its work to develop efficient and effective purchasing. £2 million was made available centrally in 1994-95 to support the development of purchasing, most of which will be apportioned to HAs to support them in the lead up to the creation (subject to Parliament) of the new HAs. The NHS Executive has supported developments locally through policy guidance, funding for local initiatives and dissemination of good practice through publications and conferences.

5.12 The third national review of contracting took place in the Summer of 1994. Its main findings indicated a substantial move away from "simple" block contracts to "sophisticated" block contracts with floors and ceilings and a greater use of of case-mix, leading to more patient focused contracts. Guidance resulting from the review was issued to the Service in November 1994. Involving Local People and Clinicians in Purchasing was introduced by the then Minister for Health at the beginning of 1994 to restate the need for HAs to involve both public and clinicians in their purchasing decisions. A leaflet giving examples of good practice was launched by the Minister at a major purchasing conference in April 1994.

NHS Trusts

5.13 There are now 419 operational trusts - about 96 per cent of all provider units. They are providing stronger management for the NHS with the aim of ensuring that the extra resources committed to the health service are put towards improved patient care. The arrangements for funding trusts are set out at paragraph 3.22. Trusts' have three core financial duties:-

- to generate the required return (currently six percent) on relevant net assets;
- to break even on an income and expenditure basis taking one year with another;
- to meet, or come within agreed limits of flexibility, the external financing limit set by the NHS Executive.

In 1993-94, the latest year for which trusts have published accounts, the vast majority (90 per cent) of the 292 operational trusts achieved their financial duties. The remainder in the main missed their targets by non material amounts or for technical accounting reasons.

GP Fundholding

5.14 The objective of GP fundholding is to enable GPs to improve services for their patients by taking direct responsibility for purchasing services which best meet their needs. Over four years, the number of practices participating has grown to over 2,000, including over 8,500 GPs covering 35 per cent of the population. More practices are planning to join the fifth wave from April 1995 by which time over 40 per cent of the population are expected to be cared for by a fundholding GP.

5.15 In the first two years of the scheme fundholders have achieved savings of close to 4 per cent of budgets set. Resources freed up are used for the benefit of patients, for example to purchase additional hospital services to reduce waiting lists; for equipment to allow patients to be treated in the surgery so shortening hospital waiting times for all patients and improving the quality of care received; improving practice facilities so that more in-house clinics can be provided.

5.16 In 1995, there will be a major expansion in the range of options for GPs wishing to enter fundholding:

- a new community fundholding option for smaller practices of 3,000 or more patients;
- an expanded standard fundholding scheme to include virtually all elective surgery and outpatients (with a few very high cost exceptions eg heart transplants), also to include specialist nursing services (eg diabetic and stoma care) with a lowered list size eligibility from 7,000 to 5,000 patients;
- up to 50 total purchasing pilot projects where GPs will purchase all hospital and community health services for their patients.

The changes to the fundholding scheme represent a significant step towards a primary care led NHS where decisions are taken as close to patients as possible, ensuring the most efficient and effective use of resources. This will enable many more GPs to become directly involved in purchasing. Fundholding will remain voluntary. However, it has yielded valuable innovations and the aim in expanding the scheme is to bring benefits available from these to more patients. There is a strong interest from GPs in the expanded range of options now available. At the same time, the Government's intention is to include GPs in purchasing whether they are fundholders or not. All GPs (including fundholders) are expected to work with DHAs to inform decisions about strategy and priorities.

Table 18

	1991-92	1992-93	1993-94	1994-95
Percentage of population covered	7	13	25	35

5.17 There are currently 8,670 GP fundholders in 2,040 practices, managing 1,673 funds, covering 35% of the population. **Table 18** shows the proportion of the population covered since the introduction of fundholding.

Codes of Conduct and Accountability

5.18 In April 1994, the Secretary of State issued new Codes of Conduct and Accountability to the chairmen of all NHS boards. The Codes reaffirm the public service values of openness, probity and accountability. Drawing on existing good practice, they impose new requirements for each board, including the need to establish separate committees for audit and board members' remuneration and terms of service, for health authorities to publish annual reports, for all boards to maintain a publicly available register of members' private interests, and publication of directorships and other interests in the annual reports. Both Codes are mandatory on all NHS boards and compliance is a condition of appointment for board members.

5.19 The Code of Accountability clarifies board functions, defining the roles of chairmen, non executive directors and the board as a whole. The statutory accountabilities within the NHS, between the NHS and the NHS Executive, and the Secretary of State's accountability to Parliament are set out. Each board is responsible for its organisation's performance, stewardship of financial and other resources, and for communicating with the public. The Code of Conduct gives firm guidance about disclosure of private interests, expenditure on hospitality and tendering procedures, emphasising that the highest standards of conduct are required at all times.

Open Government: Openness in the NHS

5.20 The White Paper 'Open Government', published in 1993, aimed to make Government more open and accountable. The Department of Health, including the NHS Executive and the regional offices, has been covered by the central government Code of Practice from April 1994. The NHS is required to have a code of practice in place for 1995. Accordingly, the Corporate Governance Task Force was invited by the Secretary of State to continue in order to develop a code of practice on openness for the health service. A draft was the subject of consultation between September and November 1994.

Financial Probity

5.21 A special initiative to strengthen the skills of internal auditors and improve internal control in the NHS, under the leadership of Sir Stuart Burgess, Chairman of Anglia and Oxford Regional Health Authority, is currently considering a wide range of measures aimed at improving internal control in the service. These measures will help boards, managers, auditors, and the new audit committees to highlight and eliminate potential areas of financial risk of all kinds.

5.22 During 1994 the Department has issued a number of publications which support financial control and stewardship, including the Codes of Conduct and Accountability, model Standing Financial Instructions, the "Role of the Director Of Finance", and a Guide to Improving Internal Control in the NHS. The Internal Audit Development Initiative will be taken further during 1995, with a new NHS Internal Audit Manual (revising the mandatory audit standards and providing good practice guidance for auditors); a guide for boards on the provision of effective internal audit, a study of the possibilities of benchmarking as a means of identifying specific areas of best practice so as to improve the standard of NHS audit teams in general, an extensive national training programme for auditors, pump priming of local audit development initiatives which can be shared nationally, and further guidance on the role of audit committees.

Hospital and Community Health Services

Table 19 HEALTH SERVICE ACTIVITY

	1983	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94 (Thousands)	Annual average % change 1983 to 1993-94	% change 1992-93 to 1993-94
Ordinary Admissions (1)									
General and Acute (2)	5,113	5,572	5,677	5,685	5,913	5,987	6,125	1.8	2.3
Geriatric	320	412	447	468	508	527	554	5.5	5.1
Maternity (3)	849	951	968	990	1,010	1,015	1,056	2.1	4.0
All Specialties	6,692	7,335	7,477	7,524	7,755	7,828	7,984	1.7	2.0
Day Cases									
General and Acute	787	1,005	1,152	1,251	1,535	1,785	2,080	9.9	16.5
All Specialties	813	1,016	1,163	1,261	1,547	1,808	2,106	9.7	16.5
All Finished Consultant Episode (1)									
General and Acute (2)	5,900	6,577	6,829	6,936	7,448	7,772	8,205	3.3	5.6
All Specialties	7,506	8,352	8,639	8,785	9,302	9,635	10,090	2.9	4.7
New Outpatients									
(Referral attendances)									
New Outpatients (4)	8,311	8,389	8,519	8,502	8,942	9,342	9,685	1.5	3.7
General and Acute	7,400	7,543	7,621	7,593	8,036	8,488	8,832	1.7	4.0
Geriatric	48	58	60	72	70	77	83	5.4	8.7
Maternity (3)	716	650	689	695	684	612	600	-1.7	-1.9
Mental Illness	192	192	207	211	218	238	248	2.5	4.1
Learning Disabilities	3	3	3	3	3	4	5	6.9	34.7
New A & E (First attendances)	9,950	10,984	11,207	11,204	11,035	10,993	11,365	1.3	3.4
Ward Attenders (4)	na	853	900	981	1,008	1,029	985	–	-4.2
Occupied bed days (5)								1983 to 1992-93	1991-92 to 1992-93
Mental Illness	25,500	20,990	20,800	19,300	17,100	15,400	–	-5.3	-9.9
Learning Disabilities	14,900	10,100	9,100	8,600	7,600	6,500	–	-8.6	-14.5
Average Length of Episode (Ordinary Admissions) Days (1)									
General and Acute	11.1	8.8	8.3	8.0	7.4	7.0	–	-4.9	-5.5
Geriatrics	58.0	38.5	35.9	32.1	26.4	23.5	–	-9.6	-11.0

(1) The figures for 1983 are estimates of Finished Consultant Episodes based on 1983 Discharges and Deaths adjusted using 1988-89 data where information was collected using both methods.
(2) Excluding well babies.
(3) Obstetrics and GP Maternity.
(4) From April 1992 patients seen by medical staff on a ward are recorded as outpatients rather than ward attenders.
(5) Figures from 1988-89 onwards are estimated based on data obtained directly from Regions.

5.23 **Table 19** gives details of hospital activity levels for each of the main sectors. Between 1983 and 1993-94, the number of general and acute ordinary admissions and day cases grew by an average of 3 per cent a year. Within this increase there is a continuing shift towards treating patients on a day case basis. Since 1983, the number of day cases has grown to 2.1 million in 1993-94, 25 per cent of all general and acute episodes. Information on waiting times is given at paragraphs 4.30 to 4.32.

Table 20 COMMUNITY HEALTH AND PARAMEDICAL SERVICES ACTIVITY STATISTICS [1][2][3]

(Thousands)

Number of episodes [2][3]	1988-89	1989-90	1990-91	1991-92	1992-93
Health visiting	4,300	4,100	3,800	3,700	3,800
Community nursing services (total)	2,900	2,800	2,600	2,700	2,700
District nursing	2,400	2,300	2,100	2,200	2,100
Community psychiatric nursing	270	250	260	270	300
Community mental handicap nursing	27	22	22	20	22
Specialist nursing	195	200	190	220	270
Chiropody services	1,000	1,000	1,000	1,000	1,000
Clinical psychology	150	150	140	150	160
Dietetics	750	620	630	620	610
Occupational Therapy	860	780	730	840	850
Physiotherapy	3,100	3,100	3,100	3,100	3,200
Speech therapy	260	240	260	250	280
Community dental services [4]	na[5]	na[5]	1,155	1,186	1,214

(1) Owing to changes in definitions which occurred in 1988-89, it is not possible to provide comparative statistics prior to 1988-89.

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

(3) Estimated national totals based on those districts supplying data.

(4) Includes a small number of discontinued episodes of care.

(5) Not collected on a comparable basis.

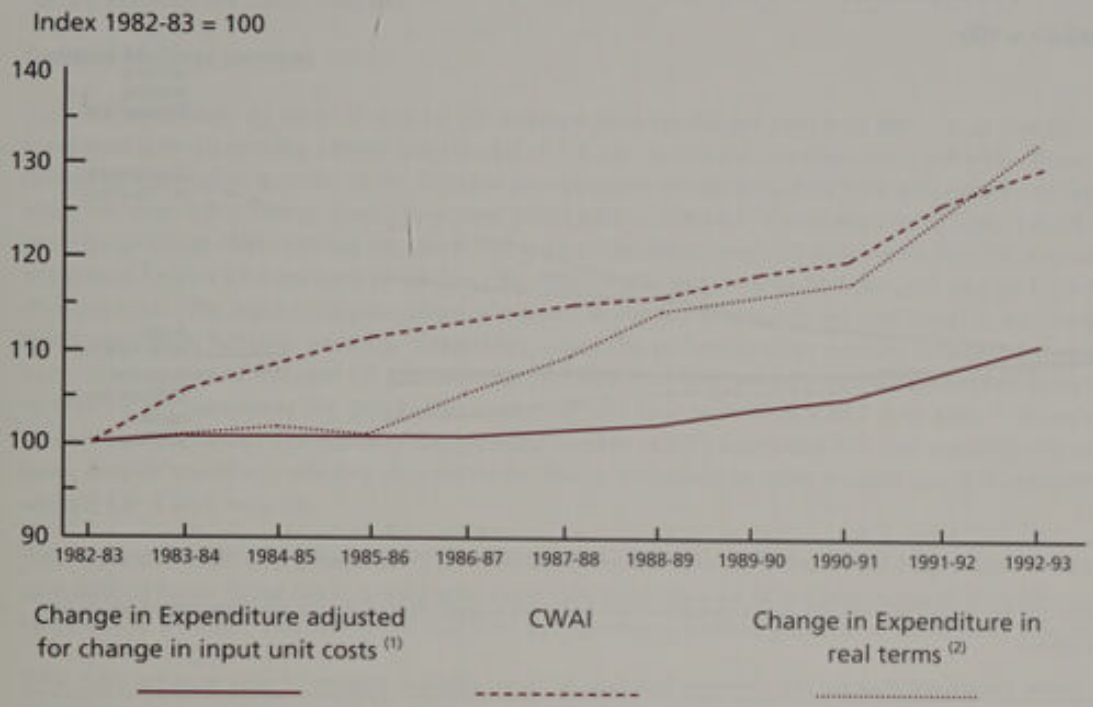
5.24 Statistics on activity in the community health and paramedical services over the period 1988-89 to 1992-93 are reported in **Table 20**. Following a decline in the early part of the period, activity has remained broadly constant with increases in some specialist groups. However, the figures may not fully reflect the increasing complexity of contacts and do not include practice nurse activity. Since 1983-84 the number of practice nurses has increased by 480 per cent.

Overall Activity and Efficiency

5.25 An overall measure of changes in HCHS activity can be obtained by weighting together the activity increases in various areas of HCHS by the proportion of expenditure they receive. The variation in this measure, the Cost Weighted Activity Index (CWAI), over recent years is shown in **Figure 16**. Activities measured include inpatient and day case episodes, outpatient and accident and emergency services. Community Health Services covered include immunisation, district nursing and ambulance services. The CWAI cannot monitor the full range of health service activities and there is some anecdotal evidence that improvements to and increase in the complexity of Community Health Services are not fully reflected. Figure 16 shows that overall activity levels have increased by 30 per cent between 1982-83 and 1992-93 (2.7 per cent per year on average).

5.26 A broad measure of the overall increase in the efficiency of the HCHS can be obtained by comparing increases in activity levels with increases in expenditure. Increases in activity are monitored against increases in expenditure on purchasing patient services. Gains arise both from cash releasing efficiency savings (CRES) and through treating additional patients using the same resources. The total increase in activity of 30 per cent between 1982-83 and 1992-93 is much more than the increase in HCHS expenditure after allowing for changes in HCHS input costs, which over the same period increased by 12 per cent, as shown in Figure 16. The implication is that efficiency has grown by 17 per cent over the period. However, this estimate of efficiency gains does not take account of the changing cost of a unit of output over time.

FIGURE 16 - HCHS COST WEIGHTED ACTIVITY INDEX



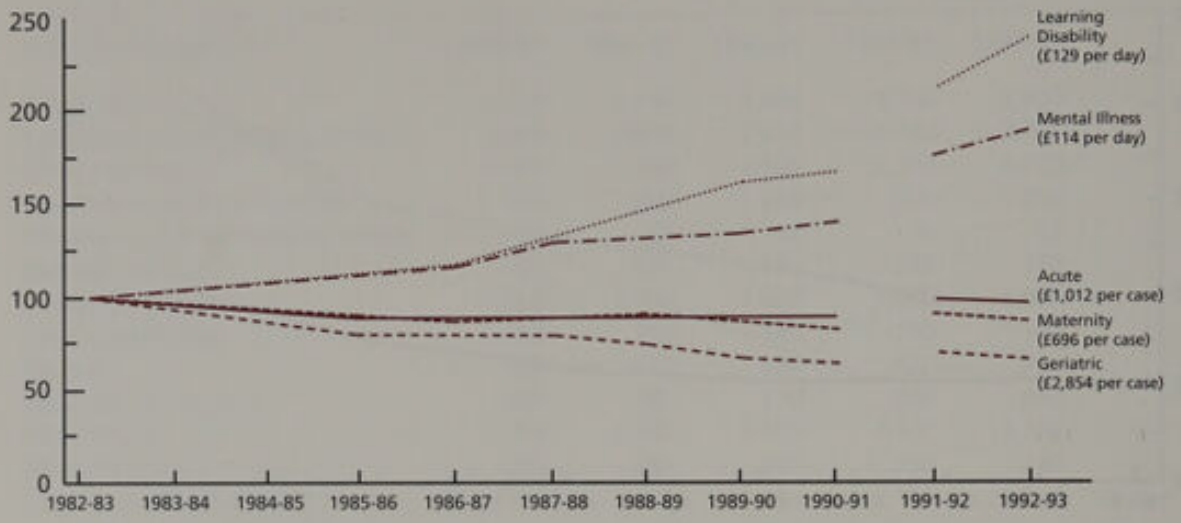
(1) That is, pay and price rises in the HCHS.

(2) Thatis, adjusted for movements in output costs in the economy as a whole, as measured by GDP deflator. Output costs reflect not just input costs but also the efficiency with which inputs are used.

5.27 Because components of the CWAI based efficiency measure require data from a number of sources, it is not available until after detailed data for the financial year have been analysed. Final estimates for the efficiency gain in 1993-94 are not yet available. However, since 1992-93, provisional estimates from the Purchasing Efficiency Index, produced on a different basis, have been used in addition to this retrospective measure, to monitor progress in-year towards efficiency targets. Data quality problems in the first year of the new index mean that its initial estimates for 1992-93 now appear to have overstated the gain in that year. However provisional figures suggest the 1993-94 efficiency target of 2 per cent was exceeded, and preliminary indications are that Health Authorities are well on course to deliver their 2¼ per cent target for 1994-95. For 1995-96, it has been possible to set a headline efficiency target of 3 per cent, taking account of savings from streamlining health service management. For the first time, this is to be pursued through negotiation of individual targets with DHAs, to deliver in aggregate at least a 3 per cent gain. This will make it possible to take better account of local progress and opportunities, setting realistic but challenging targets in each case.

FIGURE 17 - AVERAGE COST PER INPATIENT OR DAY CASE BY HOSPITAL TYPE 1982-83 TO 1986-87, BY SPECIALTY 1987-88 TO 1992-93 (1)

Index 1982-83 = 100



(1) Expenditure data for 1992-92 and 1992-93 are not comparable with earlier years due to changes in accounting practices introduces with the NHS reforms.

Hospital Unit Costs

5.28 **Figure 17** shows the trend in unit costs in the hospital sector since 1982-83 after allowing for movements in HCHS pay and prices. Costs per case in acute, geriatric and maternity cases have fallen over the period, largely because of declining lengths of stay. Following the 1991 NHS reforms, hospital and community units have completed a new form of accounts, for example including capital charges in financial returns from 1991-92. Because of this, figures from 1991-92 are not comparable with earlier years. There have also been some doubts over the quality of financial returns data received from health authorities in that transitional year and used in these analyses.

5.29 Between 1982-83 and 1990-91 the average cost of treating an acute patient declined by almost 20 per cent. The number of patients treated on a day case basis has increased by on average 10 per cent per year since 1982-83, while the length of stay for patients occupying a bed overnight has been cut by nearly half to an estimated 4.4 days in 1992-93. The average cost of each geriatric case has declined by 42 per cent between 1982-83 and 1990-91, with length of stay falling by a half. The average cost of a maternity case declined by 23 per cent over the same period. Average costs for all these sectors have gone down between 1991-92 and 1992-93.

5.30 Average costs per day for mental illness and learning disability inpatients rose by 33 per cent and 59 per cent respectively between 1982-83 and 1990-91 and by 8 per cent and 15 per cent respectively between 1991-92 and 1992-93. However, the average dependency level of patients remaining in hospital is, inevitably, higher than that of those discharged, and average unit costs tend to become higher as a result. This is reflected in the steady increase in the number of whole time equivalent nursing staff per occupied bed in each of these specialties over the period.

Family Health Services

5.31 The main service statistics are shown in **Tables 21** to **24**. Overall, gross expenditure on the non cash limited family health services increased by 35 per cent in real terms between 1983-84 and 1993-94. Most of this expenditure went towards the cost of prescribed drugs, and the pay and expenses of family doctors and dentists who provide care as independent contractors. Their expenses are made up in large part by the pay of practice staff such as nurses and receptionists plus the cost of their premises and equipment. Although the remuneration systems are designed to encourage efficiency, generally by giving some incentive to encourage contractors to keep their expenses below average, total costs per contractor have risen in real terms over the longer term. This is not unexpected; Government policy has been to develop primary care, for which GPs for example have taken on additional staff and, as elsewhere in the economy, pay has risen

in real terms. In addition, many conditions can now be treated in the community rather than in hospital, either by primary care teams led by the patient's GP or by new drug therapies. This extra emphasis on the FHS makes it even more important constantly to review the opportunities to promote and improve value for money from the resources invested.

General Medical Services

5.32 **GP numbers** As table 22 shows, GP numbers grew by 1.2 per cent over the year to October 1993, compared with an average annual growth rate of 1.3 per cent in the ten years since 1983-84. These figures do not however take account of the fact that an increasing proportion of GPs are part-timers. Average list sizes are now 1,902 - more than 10 per cent lower than in 1983-84. Within the overall figures there has been a significant shift over the decade in the balance between men and women. In 1983-84 women accounted for just 17.6 per cent of all GPs. By 1989-90 this had risen to 22.8 per cent and by 1993-94 to 26.8 per cent. The increasing proportion of women in the workforce has been reflected in an emerging trend away from full-time working. Since 1990, when the present flexible working arrangements were introduced as part of the new GP contract, the proportion of GPs working part-time has risen from 5.5 per cent to 9.7 per cent (over this period the number of GPs rose by 2.6% in total but by only 0.7% on a whole time equivalent basis). The result of the growing number of GPs combined with the changing structure, is a more flexible workforce offering patients more choice. For example, most women can now register with a woman GP if they wish to.

5.33 **Practice staff and premises** The introduction of the new GP contract on 1 April 1990 coincided with cash-limited funds being made available to assist GPs meet the cost of improvements to their premises and employment of staff. This has enabled FHSAs to target the resources available to them more effectively.

5.34 GPs are now able to employ a wider range of staff and enhance the primary healthcare teams which assist them in providing general medical services. Table 21 shows that practice staff have increased by 119 per cent since 1983-84 and, within this group, practice nurses have increased by 480 per cent. Table 9 shows that cash limited expenditure on practice staff increased by 31 per cent in real terms between 1990-91 and 1993-94.

5.35 FHSAs have been encouraging and financially assisting GPs to improve their practice premises in a way which best meets the developing needs of their patients and new models of service delivery. Table 9 shows that cash limited expenditure on premises increased by 6 per cent (12 per cent including non cash limited premises expenditure) in real terms between 1990-91 and 1993-94.

5.36 **Computerisation** In the last six years the use of computers within general practice has increased rapidly, with the aid of the GP Computer Reimbursement Scheme. By 1993 78 per cent of GP practices were computerised. Table 9 shows that cash limited expenditure on GP computing rose by 86 per cent in real terms between 1990-91 and 1993-94, including fundholding computer systems. On 1 April 1994 minimum standards for GP computing known as the Requirements for Accreditation (RFA) were introduced and are annually reviewed. Standards are supporting the increased use of computers within general practice and enabling better sharing of information within the NHS.

5.37 With a view to increasing the use of computers, the Department of Health is taking steps towards legitimising the use of computerised GP medical records so that GPs will not have to keep records on paper. Work on audit trail and security issues is underway and the NHS Executive is considering how to take forward issues surrounding the structure and content of the computerised record in consultation with the profession.

5.38 **Target payments and health promotion** General practice makes an important contribution to the Government's Health of the Nation strategy. GPs receive specific payments for meeting targets in areas forming part of the Health of the Nation programme. Achievement by GPs of the target payments continues to be impressive:

> **Child health**. Over 95 per cent of GPs achieved at least one of the childhood immunisation targets in April 1993, and 86 per cent of GPs the higher target of ninety per cent coverage. For pre-school booster immunisations over 90 per cent of GPs meet at least one target; 79 per cent the higher target. No child has now died from acute measles since 1989 or whooping cough since 1991. From 1 July 1994, Hib vaccination against meningitis, introduced in October 1992, has been included with the other three groups of childhood vaccines. Immunisations quickly reached over 90 per cent, and have continued at that level.

Cervical screening. In 63 FHSA areas, every GP qualified for a cervical cytology target payment. Overall nearly 90 per cent of GPs receiving the higher target for 80 per cent coverage.

Health Promotion. The new health promotion arrangements, introduced from 1 July 1993, continue to provide the major focus for GP Health of the Nation work. Take up of the programmes - structured into three bands of which Band 3 is the most comprehensive - has continued to be very high, with well over 90 per cent of GPs in Band 3, and a similar proportion offering Chronic Disease Management programmes (asthma and diabetes).

5.39 **General Efficiency and Value for Money** For general medical services, the main measure of activity is the number of contacts between patients and members of the primary health care team. However, data currently available on patient contacts are not sufficiently comprehensive or robust to form the basis of an activity index, and would need to be complemented by information on quality of services to provide a comprehensive picture of value for money. The Department is tackling this problem in two ways, firstly by considering ways of exploiting information available at practice level; secondly through the development of quality indicators in general practice.

Table 21 FHS : KEY STATISTICS ON GENERAL MEDICAL SERVICES 1983-84 TO 1993-94

	1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	1983-84 to 1993-94	1992-93 to 1993-94
Number of General Medical Practitioners	23,254	25,608	25,622	25,686	25,968	26,289	13.05%	1.24%
Gross current expenditure on General Medical Services								
per General Medical Practitioner (£ cash)	36,995	61,295	76,045	89,655	94,452	97,233	162.83%	2.94%
Real terms 1993-94 prices (£)	62,429	75,399	86,608	96,074	97,342	97,233	55.75%	-0.11%
Cash Limited expenditure per GMP included in								
gross expenditure above (£)	na	na	18,114	24,933	26,057	27,202	na	4.39%
Real terms 1993-94 prices (£)	na	na	20,630	26,718	26,854	27,202	na	1.29%
Total number of consultations (millions)	185.0	192.50	220.50	214.50	233.00	256.18	38.48%	9.95%
Total number of consultations per GMP	7,956	7,517	8,606	8,351	8,973	9,745	22.48%	8.61%
Real terms cost per consultation (1993-94 prices)	7.86	10.05	12.48	14.72	13.87	12.77	62.44%	-7.91%
Average list size at 1 October each year	2,116	1,971	1,942	1,947	1,922	1,902	-10.11%	-1.04%
Gross current expenditure on General Medical Services								
per patient on list after adjustment for estimated list	16.61	29.37	37.70	44.35	47.59	49.42	197.49%	3.83%
inflation (£ cash)								
Cash limited expenditure per patient on list included in	na	na	9.33	12.80	13.74	14.26	na	3.7%
gross expenditure per patient (£ cash)								
Number of GP practice staff	24,624	37,545	45,575	48,730	51,020	53,952	119.10%	5.75%
Number of practice nurses (included in GP practice staff)	1,657	4,632	7,698	8,776	9,121	9,605	479.66%	5.31%

Notes:
(a) Cash limited expenditure commenced 1990-91.
(b) General Medical Services are the personal medical services provided by General Medical Practitioners.
(c) All cash informationtaken from Appropriation Accounts.

Pharmaceutical Services

5.40 These services consist of the supply of drugs, medicines and listed appliances which are prescribed by general practitioners. About 80 per cent of the gross cost of the services is accounted for by the "drugs bill" with fees to contractors for dispensing prescriptions and to doctors for personally administering some drugs (such as flu jabs) making up the remainder. Offset against these costs is the income from prescription charges collected from patients.

5.41 **Drugs Bill** The drugs bill is the cash amount paid to contractors in respect of drugs, medicines and listed appliances which have been prescribed by GPs. In 1994-95, early indications suggest a real terms increase in the drugs bill of around 7 per cent. This compares with an increase of 8.4 per cent in real terms in 1993-94, almost double the average real terms increase over the last 10 years. The number of prescriptions increased by 5.3 per cent in 1993-94, a significantly higher rate of increase than in the previous year and the largest year on year increase in the last decade. A lower rate of growth, around 4 per cent, is expected for 1994-95. The gross cost of each prescription dispensed (including dispensing fee) rose by 1.9 per cent in real terms. While the rate of growth in the drugs bill is forecast to be lower in 1994-95 than in each of the last two years further action to restrain growth in the drugs bill to more sustainable and affordable levels will continue. This will include addressing inappropriate and uneconomic prescribing, consistent with the policy that all patients should receive the medicines they need. **Figure 18** shows the growth in the drugs bill over the last decade in both cash and real terms. **Figure 19** shows the growth in the drugs bill by volume (number of items prescribed), cost per item and total cost.

FIGURE 18a - FHS DRUGS BILL (CASH)

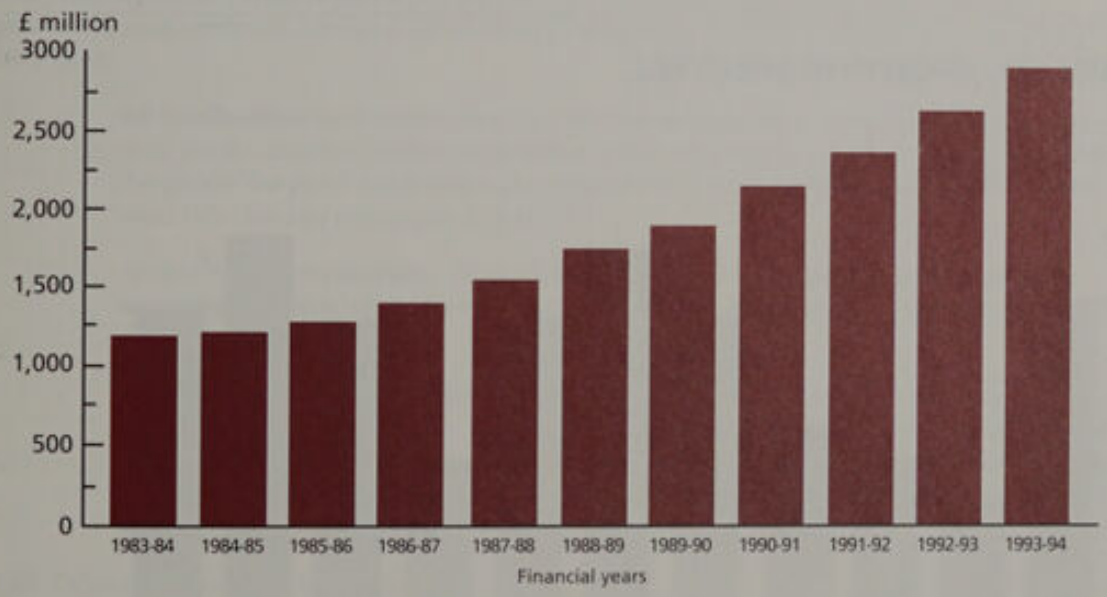


FIGURE 18b - FHS DRUGS BILL (CASH AND REAL TERMS INCREASE)

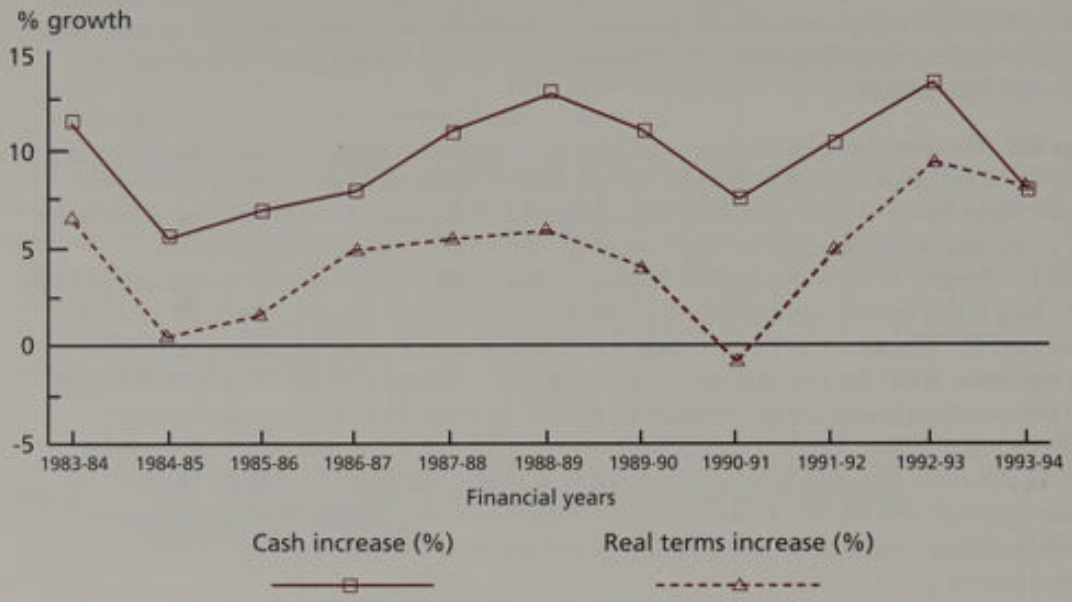


FIGURE 19a - GROWTH IN DRUGS BILL

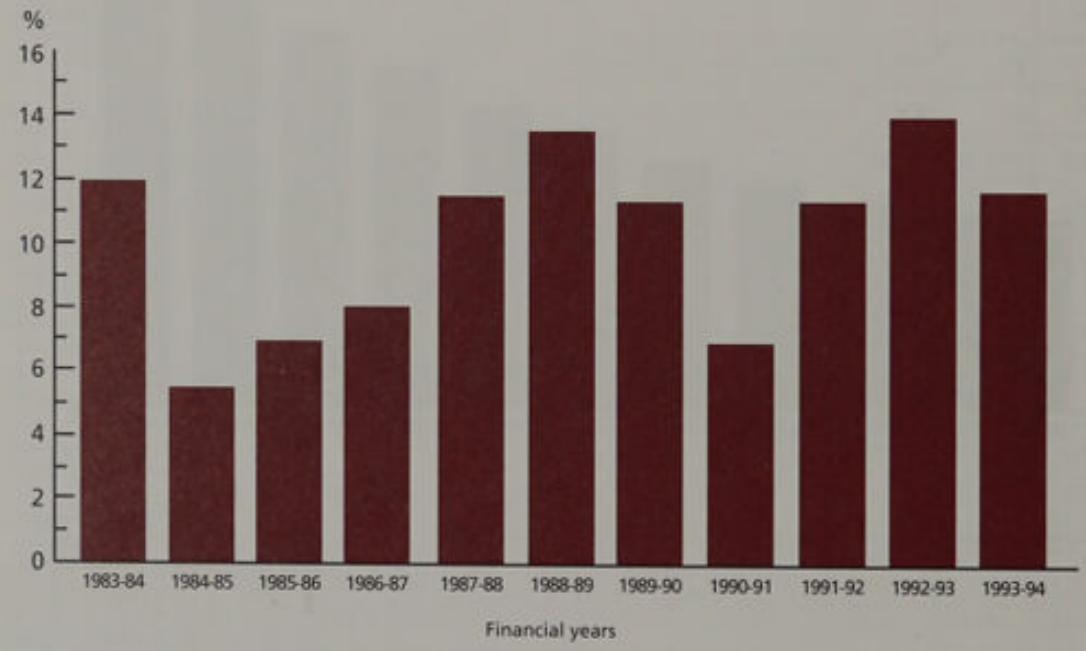
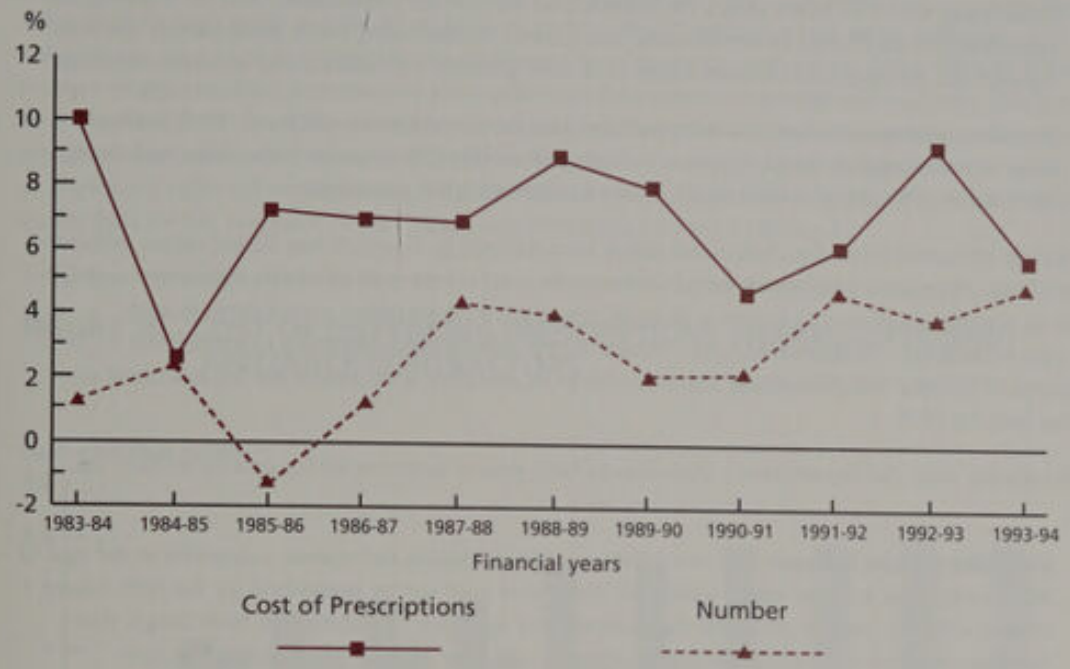


FIGURE 19b - GROWTH IN PRESCRIPTIONS



5.42 **Cost Effective Prescribing** On the demand side, efforts to promote and support rational GP prescribing have continued through a comprehensive programme of work. Among the key developments have been:

- **GP fundholders** have continued to lead the way in demonstrating that growth in prescribing costs can be contained without detriment to patient care. In the first three years of the scheme, the growth rate in GP fundholder's prescribing costs has been between 3-4% lower than that of other GPs (see also paragraphs 5.14 to 5.17).

- Around 500 non-fundholding GPs participated successfully in practice-based **prescribing incentive schemes** which allowed a percentage of the savings made to be spent on improving services to patients.

- The **Prescribing Analysis and Cost System** (PACT), which helps FHSAs and GPs to monitor prescribing behaviour, has been significantly improved. An enhanced version of the electronic prescribing information system is currently being installed in all FHSAs and will allow for a much more detailed examination of prescribing patterns of GP practices. All FHSAs should have the new system installed by the end of March 1995.

5.43 Other measures taken have included:

- The promotion of the increased use of generic products where clinically appropriate. Particularly encouraging progress has been made in generic prescribing, where the rates have increased from 44 per cent in 1992-93 to 48 per cent in 1993-94 and continued to rise in 1994 to reach a level of 52 per cent in September. The percentage of generics prescribed has reached even higher levels within specific therapeutic groups in 1993-94, for example, 67 per cent for antibacterial drugs and 55 per cent for beta-adrenoceptors.

- Repeat prescribing accounts for some 70 per cent of all GP prescribing by cost. FHSAs have increasingly been requiring GPs to audit their repeat prescribing arrangements, in some cases as part of a practice based prescribing incentive scheme. Community pharmacists have increasingly been employed to help practices analyse and review their arrangements. The Requirements for Accreditation for GP computer systems is being amended to include an audit facility for repeat prescribing.

- All FHSAs have medical advisers, and nearly all have pharmaceutical advisers, who can offer professional advice on prescribing issues. Practices, particularly those with abnormal prescribing patterns or costs, are visited on a regular basis. Advice is given on good quality, cost effective prescribing which includes advice on generic and therapeutic substitution, and on reducing the prescribing of ineffective or unnecessary medicines. Furthermore, FHSA professional advisers support the development of shared care protocols, practice formularies and incentive schemes.

- Greater use of practice formularies which are best developed at a local level. Work is also in hand to assess and develop IT systems which will enable GPs to make better informed decisions on rational prescribing at the critical point of completing the prescription.

5.44 It is widely recognised that the choice and usage of medicines in hospitals has an important influence on GP prescribing. Increased attention is therefore being focused on the role of health authorities and GP fundholders as purchasers of care to ensure a strategic approach to prescribing across primary and secondary care boundaries. Guidance has been issued which asks health authorities to ensure the appropriateness of hospital led prescribing and to develop an authority wide policy for the managed entry of new drugs into the NHS.

5.45 On the supply side, the Department's initiatives to help ensure better value for money include the following:

- **The Selected List Scheme** was extended to cover seventeen therapeutic categories at the end of 1992. Under this Scheme drugs within the categories may not be prescribed on the NHS where Ministers decide, on the advice of the independent Advisory Committee on NHS Drugs, that there are effective alternatives available at lower cost. The Advisory Committee has now completed most of its task of reviewing some 1,500 drugs in the ten new categories. Its work has already led to price reductions in about 90 of the drugs reviewed so far.

- **The Pharmaceutical Price Regulation Scheme** (PPRS) was renegotiated during 1993 with the Association of the British Pharmaceutical Industry (ABPI) on behalf of the pharmaceutical companies supplying branded medicines to the NHS. The new Scheme became effective from 1 October 1993. The PPRS controls the profits made by pharmaceutical companies from the supply of medicines to the NHS and so ensures that the prices of branded medicines are reasonable. The new Scheme is planned to run for five years up to 30 September 1998, and will continue to provide support for research and development at existing levels. Thus, the stable conditions necessary for the industry to prosper will be maintained, enabling the industry to continue to provide its contribution to the UK economy. In 1993 this amounted to some 80,000 jobs, £3 billion of exports and £1.5 billion positive balance of trade, with £1.5 billion of expenditure on research and development to help create new and improved medicines for use by patients here in this country and overseas.

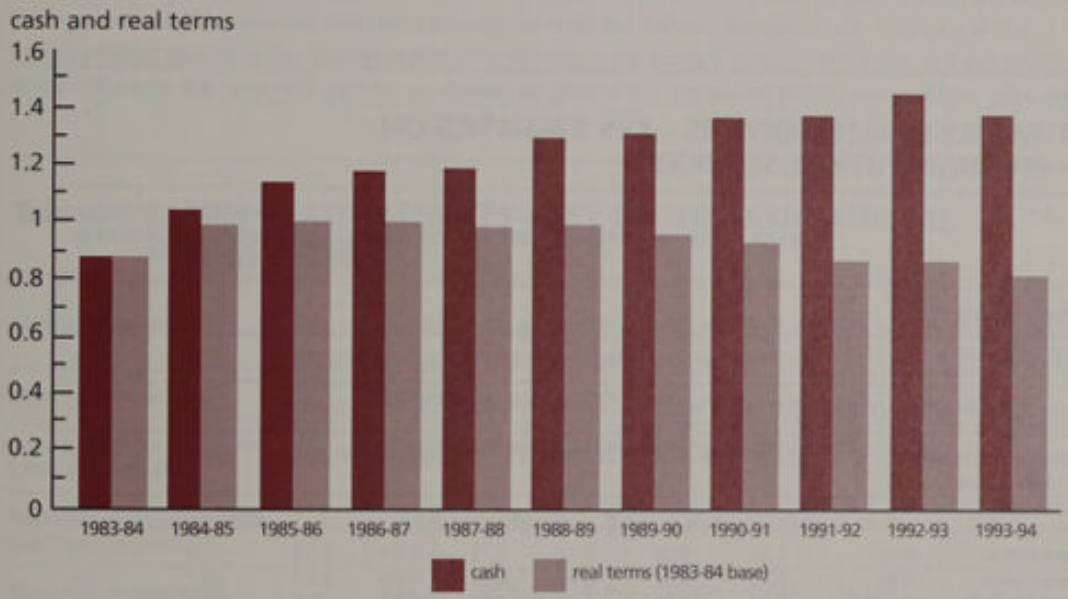
- **Economic evaluation of medicines**. The Department has jointly developed and agreed with the Association of the British Pharmaceutical Industry Guidelines for the Economic Evaluation of Pharmaceuticals, to provide advice that will enable economic studies evaluating medicines to be properly and scientifically conducted. The Department is encouraging purchasers and prescribers to develop a greater understanding of the relevance of economic evaluation.

- **The appropriate purchasing of drugs** Some of the recent growth in primary care drugs bill is attributable to an increase in the amount of high tech health care for patients at home being prescribed by GPs. This includes, for example, some types of dialysis for kidney patients (CAPD), some antibiotics, cancer drugs and nutritional fluids taken in infusions. The provision of the appropriate drugs and equipment as service packages through primary care is inappropriate and probably not cost effective; it also blurs the link between the clinical and financial responsibility for the care of patients. Responsibility for appropriate areas of this expenditure is therefore being transferred to the Hospital and Community Health Services to allow for the development of local or central purchasing arrangements. This will provide the opportunity to specify more clearly what services are provided and at what cost, thereby reducing some of the pressures on the drugs bill and ensuring that the NHS gets value for money in what it spends.

5.46 **Dispensing Services** are provided by about 10,000 community pharmacies and appliance contractors and some 4,000 dispensing doctors. The personal administration of some drugs and vaccines by doctors also forms part of these services.

5.47 **Table 22** gives information on the level of activity and on the gross cost of the pharmaceutical services per prescription broken down to show the drug and dispensing costs separately. It shows that the average cost of dispensing prescriptions has fallen by nearly 6 per cent in real terms since 1992-93 continuing the downward trend of recent years - see **Figure 20**. The dispensing cost per prescription has fallen from its high point in 1986-87 of £1.79 to £1.52 (1994-95 prices), a real terms reduction of 15 per cent. Some 90 per cent of all prescriptions are dispensed by community pharmacies. Since 1985-86, the average number of prescriptions dispensed by each pharmacy has increased steadily and currently stands 31 per cent above that level. (It should be noted that, because of the way the remuneration system works, expenditure in a given year does not necessarily relate to activity in that year nor, for dispensing doctors, is the full cost of dispensing reflected in dispensing fees. The figures given are therefore more useful as an indication of trends than for the purposes of comparing any individual year with another.)

FIGURE 20 - COST OF DISPENSING PRESCRIPTIONS PHARMACISTS AND APPLIANCE CONTRACTORS



5.48 The number of community pharmacies in contract with an FHSA has remained broadly stable since entry controls were introduced in 1987 and stood at 9,766 in March 1994. Measured by the number of prescriptions dispensed, pharmacies have made significant gains in efficiency with steady increases in the average number of prescriptions dispensed per pharmacy. In recent years this increase in activity has also exceeded the real-terms growth in pharmacists' pay as measured by the global sum. Pharmacies are also steadily increasing the range of services available to patients.

5.49 Changes to the pharmacists' fee structure will further encourage the better use of pharmacists' professional skills. A number of important changes have already been made. These include the abolition of "on cost" which was a fee paid as a percentage of the ingredient cost of the prescription item being dispensed. The money from on cost has been used, in part, to fund a new professional allowance. The allowance is intended to recognise the key role of pharmacists in advising patients about all aspects of their medication and to encourage even higher professional standards within pharmacies. The Department is also phasing out the higher rate dispensing fee that is currently paid for the first 1800 prescriptions dispensed by pharmacies each month and is committed to introducing a flat-rate fee in 1995. This higher rate fee has been criticised by the Public Accounts Committee as a hidden subsidy for small pharmacies. In order to maintain good access to pharmacies for patients, the Department has also extended the Essential Small Pharmacies Scheme so that pharmacies which are more than one kilometre from the next nearest pharmacy can claim a special payment to assist them to stay open, therefore helping to maintain easy public access to pharmacies. 1995 will also see the introduction of local pharmacy budgets under which FHSAs will be able to agree their own fees for certain pharmaceutical services. The intention is progressively to increase the size of local budgets within the global sum available for remuneration so that health authorities can match services more closely to the needs of the local population.

5.50 The number of dispensing doctors has continued to rise although the total number of patients they dispense for has remained relatively stable. The proportion of total prescriptions dispensed by dispensing doctors has increased from 6.5 per cent in 1983-84 to 9 per cent in 1993-94. The levels of discount deducted from the reimbursements made to dispensing doctors for the drugs and appliances they purchase are being revised from 1 April 1995 in line with the evidence of an enquiry conducted in 1993-94. This will reduce the overall expenditure on drugs and will release an equivalent level of resources for redistribution within the general medical services. Further consideration of the remuneration and reimbursement arrangements for dispensing doctors are under consideration.

5.51 **Prescription Charge Fraud** Current checks indicate that the level of abuse in this area is relatively low. The Department is, however, concerned that current procedures are not wholly effective in preventing abuse and is considering a number of initiatives designed to reduce the scope for abuse and fraud by both patients and contractors in the pharmaceutical services. These include the extension of the requirement for patient signatures on prescription forms and the introduction of a package of point of prescribing/point of dispensing checks (together with improved post dispensing checks) to improve the current system of checks on prescriptions dispensed free of charge. The scope for similar action in the dental and optical services is also being considered.

Table 22 FAMILY HEALTH SERVICES – KEY STATISTICS ON PHARMACEUTICAL SERVICES

		1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	% change 1983-84 to 1993-94	% change 1992-93 to 1993-94
Pharmaceutical Services (1)									
Prescriptions (thousand) (2)		336,983	387,228	396,579	415,373	432,366	455,318	35.1	5.3
Number of contracting pharmacies (3) (4)		9,057	9,725	9,755	9,765	9,763	9,766	7.8	–
Average number of prescriptions dispensed by pharmacy and appliance contractors		33,063	35,124	35,739	37,782	39,248	41,290	24.9	5.2
Cost of pharmaceutical services per prescription (1994-95 prices) (£) (2) (5)	Gross	7.32	8.00	7.77	7.73	8.04	8.19	11.9	1.9
	Drug	5.79	6.32	6.13	6.14	6.45	6.67	15.2	3.4
	Dispensing	1.53	1.68	1.64	1.59	1.52	-0.7	-4.4	
Cost of drgus and appliances in real terms (1994-95 prices (£m) (2) (6)		1,945	2,437	2,416	2,533	2,777	3,010	54.8	8.4
Percentage of prescriptions chargeable (7)		28.0	22.2	21.6	20.0	19.0	17.9	-36.1	-5.8

(1) Pharmaceutical services are mainly the supply of propoer and sufficient drugs, medicines and listed appliances which are prescibred by general practitioners.

(2) Includes prescriptions dispensed by appliance contractors and dispensing doctors and personally administered prescriptions by both dispensing and non dispensing doctors.

(3) Excludes appliance contractors and dispensing doctors.

(4) From 1991-92 Figures are shown as at 31 March (eg. 1991-92 is number as at 31 March 1992). Figures for earlier years refer to 31 December.

(5) Gross pharmaceutical expenditure is total payments (drug costs and dispensing fees) to contrctors less recvoeries frm health authorities and the Ministry of Defence (in respect of hospital and armed forces prescritpions dispensed in the community) and excluding refunds for charges.

(6) Includes receipts under the Pharmaceutical Price Regulation Scheme.

(7) Chargeable prescirpitons based on a calender year and include items dispensed to holders of prescription prepayment certificates.

General Dental Services

5.52 The number of dentists in contract with FHSAs continues to grow. **Table 23** has been revised to reflect the total number of dentists in the general dental services, including principals, assistants and vocational trainees. It shows that the number of general dental practitioners at September 1993 was 15 per cent higher than in 1983 and 2.3 per cent higher than in 1992. Gross expenditure on general dental services in 1993-94, although lower than in the previous year (primarily because of the continuing effect of the July

1992 fee scale reduction necessary to limit overpayments to dentists), was still 24 per cent higher in real terms than in 1983-84. The proportion of gross costs met from patient charges increased from 27 to 30 per cent over the decade but has declined from a peak of 39 per cent in 1989-90, in large measure due to the introduction of continuing care payments for registered adults (for which there is no patient charge) with the new 1990 contract. Despite some wide variations from one year to the next, overall the number of courses of treatment for adults and the average number per dentist have grown over the last ten years by 22 and 6 per cent respectively. The average number of children registered with each dentist grew by almost a quarter between 1991 and 1992, and by a further 1.7 per cent in 1993. Although the average cost of an adult course of treatment declined in 1993-94 compared with 1992-93, reflecting the continuing effect of the reduced fee scale introduced in July 1992 and a reduction in the number of complex treatments performed, the average cost per dentist in 1993-94 was still 7.4 per cent higher in real terms compared with 1983-84.

5.53 The Department has extensive information on GDS activity and costs. It is more difficult to draw from this itemised data good value for money indicators to demonstrate overall effectiveness and efficiency. One of the main principles underlying the proposals in the Government's Green Paper "Improving NHS Dentistry" for reform of the dental remuneration system (see paragraphs 4.58-4.60) is to ensure that resources are used effectively and efficiently to maintain and improve oral health. Therefore one of the key tasks which the Department will need to address with the Service alongside any changes in the remuneration system is the development of good value for money indicators for use at local and national level. Work in this area will also be an important part of the proposed purchaser/provider pilot studies.

Table 23 FAMILY HEALTH SERVICES – KEY STATISTICS ON GENERAL DENTAL SERVICES

General Dental Services [1]	1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	% change 1983-84 to 1993-94	% change 1992-93 to 1993-94
Gross Expenditure (£m) [2]	584.440	947.690	1039.996	1,245.97	1,305.87	1,221.71	109.0	-6.4
Gross Expenditure in Real Term (1994-95 prices) £m	1,005.997	1,189.067	1,208.163	1,361.970	1,372.740	1,246.153	23.9	-9.2
Proportion of gross Expenditure met from charges (%) [3]	26.6	38.6	26.5	32.4	30.2	30.0	12.8	-0.7
Number of general dental practitioners (GPDs) [4]	13,672	15,351	15,480	15,451	15,411	15,773	15.4	2.3
Adult courses of treatment (thousands)	20,316	22,809	22,559	24,373	25,141	24,848	22.3	-1.2
Adult courses of treatment per GDP	1,486	1,486	1,457	1,571	1,631	1,575	6.0	-3.4
Children registered into capitation (thousands) [5]	–	–	–	5,795	7,103	7,369	–	4.1
Children registered per GDP [6]	–		–	375	461	469	–	1.7
Average gross cost of adult courses of treatment in real terms (1994-95 prices) (£) [7]	38.42	41.78	41.53	43.50	41.11	36.90	-4.0	-10.2
Gross cost of General Dental Services per GDP in real term (1994-95 prices)	73,581	77,459	78,047	88,148,	89,075	79,005	7.4	-11.3

(1) General dental services are the cure and treatment provided by independant dental practitioners, who provide services under arrangements made with local Family Health Services Authorities.

(2) Gross Expenditure includes that proportion of costs met from patient charges. Excludes charge refunds. Appropriation Account Figures.

(3) Charge income cllected from pateints (net of refunds) as a proportion of gross expenditure.

(4) Principals and assistants at 30 September.

(5) Number of children registered as at 30 September. Capitation registration only began with the introduction of the new dental contract from 1 October 1990.

(6) Average number of children registered per dentist, including principals and assistants, although patient registrations are formally attirbuted to principle only.

(7) Average gross cost of adult courses of treatment, as measured by Dental Practice Board data recording only item of service fees payable for such treatments up to 1990-91. From 1990-91 onwards, costs are based on item of service fees payable and adult continuing care payments. Prior to 1986-87, data is only available on a calender year basis.

General Ophthalmic Services

5.54 General ophthalmic services underwent substantial change on 1 April 1989 when NHS sight tests were restricted to certain priority groups, that is, children, students aged under 19 in full time education, adults on low incomes and those with certain special needs. Meaningful comparisons are therefore only possible between 1990-91 and 1993-94, over which period there were rises of 43 per cent in both the number of sight tests paid for and vouchers reimbursed, reflecting a recent growth in the number of people eligible for NHS sight tests and higher take-up. In the same period, gross expenditure increased by 52 per cent in real terms. Year on year growth in the number of sight tests and vouchers between 1992-93 and 1993-94 was 7.4 per cent and 9.4 per cent respectively.

5.55 The number of GOS contractors and the number of optical practices available to the public have continued to increase in recent years: numbers of contractors and optical practices have increased by 0.3 per cent and 1.7 per cent respectively, between December 1992 and December 1993. The rising numbers of sight tests and vouchers in recent years are reflected in a substantial increase of 8.1 per cent in the real terms expenditure on the GOS between 1992-93 and 1993-94. This is despite a 1.6 per cent fall over the same period in the real terms cost of the optometrists' sight test fee.

Table 24 FAMILY HEALTH SERVICES – KEY STATSISTICS ON GENERAL OPTHALMIC SERVICES

General Opthalmic Services (1)	1983-84	1989-90	1990-91	1991-92	1992-93	1993-94	% change 1983-84 to 1993-94	% change 1992-93 to 1993-94
Gross Expenditure (£m) (2)	161.657	108.248	110.932	141.453	172.279	191.987	(8)	11.4
Gross Expenditure in Real Term (1994-95 prices) £m	278.260	135.819	128.870	154.622	181.100	195.827	(8)	8.1
Number of opticians (3)	5,700	6,298	6,431	6,502	6,601	6,619	16.1	0.3
Number of optical practices (4)	(4)	(4)	5,622	5,678	5,759	5,859	–	1.7
Number of NHS sight tests (thousands) (3)	9,270	5,280	4,154	4,979	5,528	5,935	(8)	7.4
Number of vouchers (thousands) (4)	–	2,270	2,432	2,844	3,185	3,485	–	9.4
Opthalmic opticians' sight test fee in real terms (1994-95 prices) (2)	13.77	13.05	13.01	13.28	13.40	13.18	-4.3	-1.6
Average value of voucher in real terms (1994-95 prices) (£) (7)	–	28.22	28.99	29.17	31.29	31.17	–	-0.4

(1) Generakl opthalmic services provide free sight tests and spectacle vouchers, via community based optometrists, to eligible people (children, students aged under 19 in full time education, adults on low incomes and those with certain special needs).

(2) Appropriation Account figures.

(3) Opthalmic opticians and opthalmic medical practitioners at 31 December

(4) As at 31 December. Comprehensive and reliable data is only available from 1990

(5) NHS sight tests were restricted to certain priority groups from 1 April 1989. Figures show number of sight test payments made in the year. 1989-90 total therefore includes payments for some sight tests carried out before the change in Regulations.

(6) Vouchers were introduced to help certain priority groups with the provision of glasses from 1 July 1986. Figures show number of vouchers reimbursed to practitioners in the year, inlcuding payments for complex appliances.

(7) Total cost of vouchers, xomplex appliance payments and supplements divided by the number of voucher and complex appliance payments.

(8) Comparison between 1993-94 and 1983-84 is potentially misleading because of the changes in eligiblity for sight tests and vouchers as described in footnores (5) and (6) above.

Regional Comparisons

5.56 For many years the main focus of performance monitoring and the presentation of comparative information about the NHS has been the regional health authority, though not exclusively. Some annual statistics and the Health Service Indicators (HSIs) make available to all authorities and NHS trusts comparative information on a district and hospital basis. Their use in local analysis and performance monitoring is strongly encouraged.

5.57 The Department has concluded that the aggregation of data on a regional basis does not always give a comprehensive analysis. Important variations from district to district within an individual region can be completely missed if regional figures are the only ones considered. The planned abolition of regional health authorities will eliminate the need to monitor their performance and paves the way for a system based on the comparison of individual districts which will enable comparisons to be made on a more local basis. In the meantime, however, a number of regional indicators are reproduced in Figures 21-26 and discussed below.

Figure 21 Acute activity rates vary from over 140 to over 190 finished consultant episodes per 1,000 population. The variations reflect many factors including patient demand and need (which in turn would be affected by the age/ sex and socioeconomic profiles), primary care referral patterns, technical efficiency and changes in provider capacity (eg increases in day case surgery see figure 24) and shorter hospital stays. To exemplify these **Figure 22** compares the activity with years of life lost through avoidable deaths.

FIGURE 21 - PURCHASES OF GENERAL & ACUTE ACTIVITY 1993-94

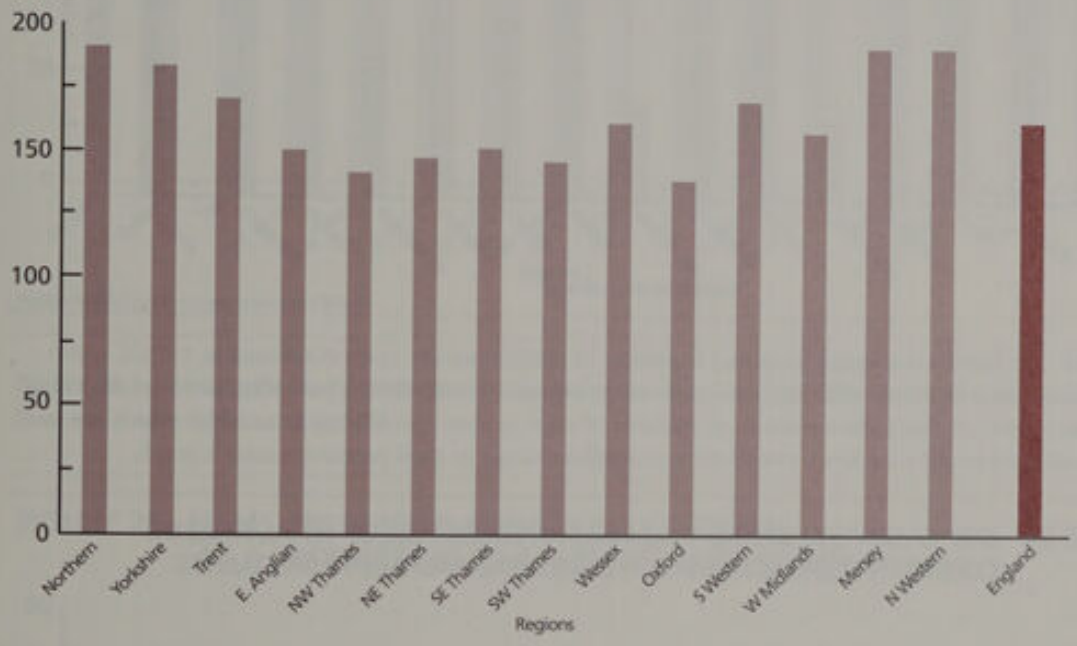


FIGURE 22 - AVOIDABLE DEATHS 1988-1992

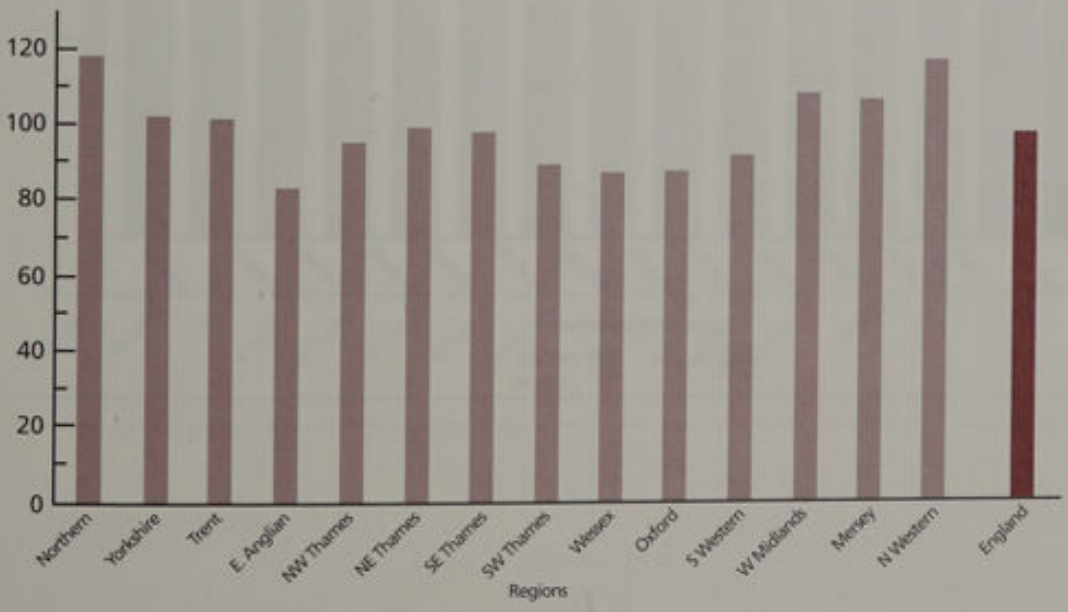


Figure 23 All regions have experienced a growth in the number of finished consultant episodes in the general and acute specialties ranging from less than 2% to over 8½% when comparing 1992/3 with 1993/4, after adjustments for definitional changes over time.

FIGURE 23 - GROWTH IN GENERAL AND ACUTE FINISHED CONSULTANT EPISODES IN 1993-94 COMPARED TO 1992-93

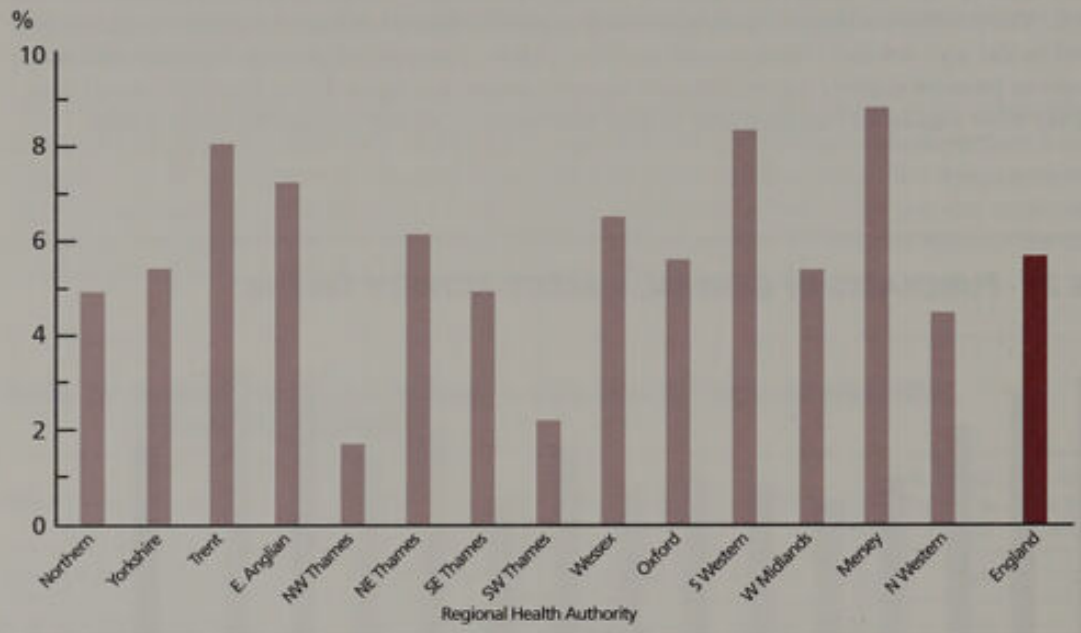


Figure 24 The trend towards the increased treatment of patients as day cases continued in 1993/4. All regions have again increased their day case percentage compared with 1992/3 but differences remain. This figure also reflects changes and variations in patterns of care: centres specialising in activities which are less easily transferred to day case work would show a smaller change in their profile on such a graph.

FIGURE 24 - DAY CASES 1992-93 AND 1993-94 AS A PERCENTAGE OF TOTAL FINISHED CONSULTANT EPISAODES FOR THE GENERAL AND ACUTE SPECIALISTS

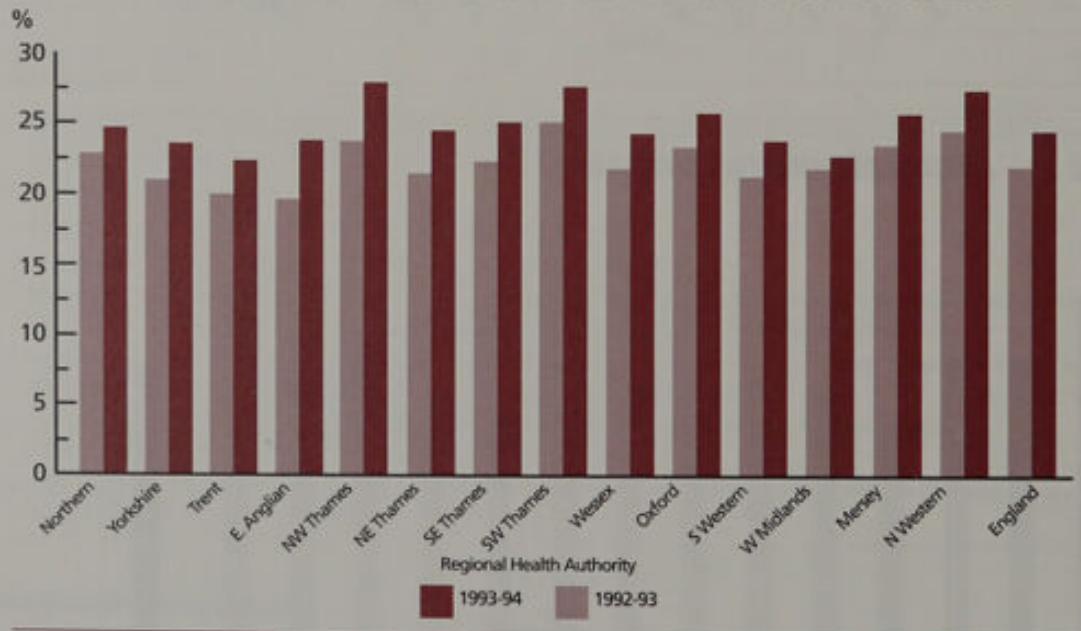
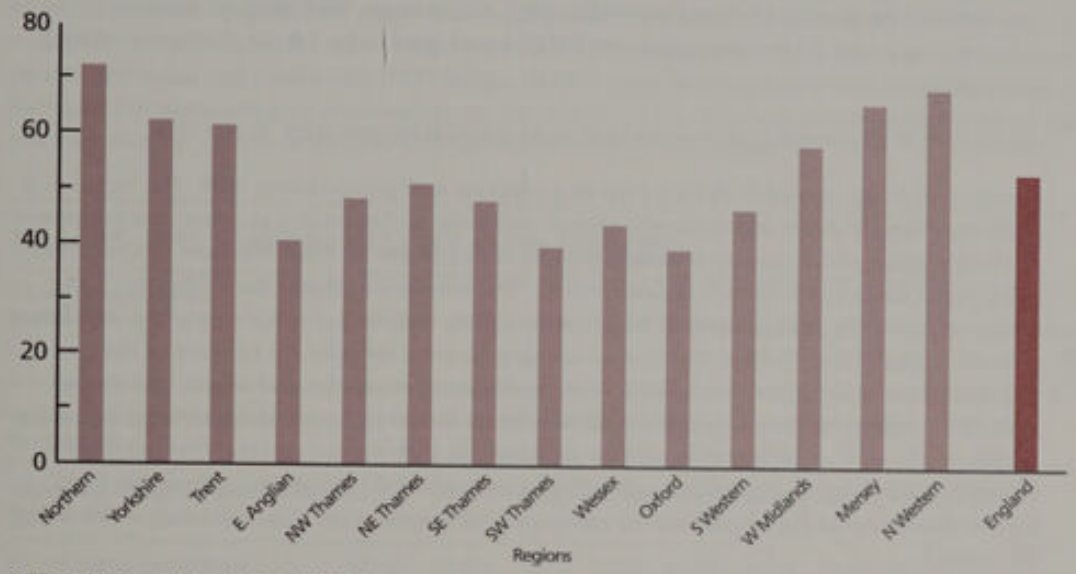


Figure 25 This figure, based on standard mortality rates, shows a well known distribution, with northern parts of the country having higher death from coronary heart disease. This graph relates directly to a Health of the Nation target. It is important to recognise, however, that health care intervention and alterations in lifestyle needed to combat CHD will not result in reduced death rates until several years later.

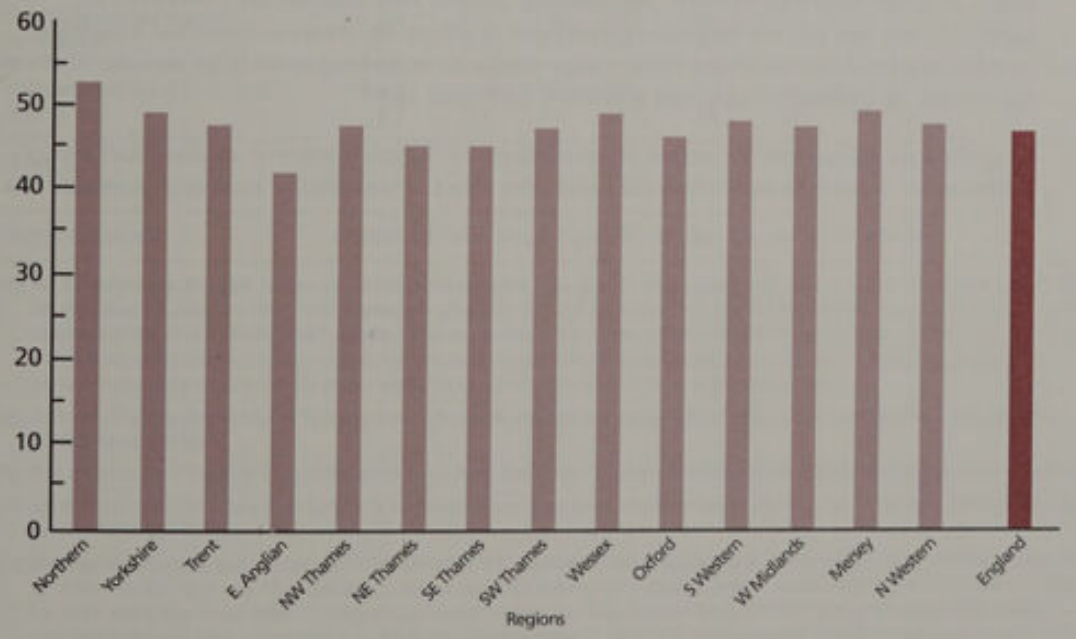
FIGURE 25 - DEATHS FROM CORONARY HEART DISEASE & STROKE PER 100,000 POPULATION UNDER 65 1990-92



Public Health Comon Dataset indicator HON-A1

Figure 26 In 1993/4 generic prescribing rates increased nationally to over 48% and the regional range was from just under 42% to nearly 53%

FIGURE 26 - ITEMS PRESCRIBED GENERICALLY 1993-94 AS A PROPORTION OF ALL ITEMS PRESCRIBED



Staffing

5.58 The NHS is one of the largest employers in the world. In September 1993, staff in post in England (excluding FHS contractors) totalled 773,900 whole-time equivalents. Staff costs account for two-thirds of total NHS expenditure. **Table 25** and **Figure 27** show how the numbers of staff in post for each of the main HCHS staff groups in England have changed since 1983 (the reduction in the working week for nurses distorts comparisons with earlier years). Some of the main features of change are:

- the numbers of whole time equivalent (WTE) HCHS medical and dental staff increased by 21 per cent between September 1983 and September 1993. On average, WTE hospital medical consultants grew by 2.5 per cent a year, and WTE junior doctors by 1.8 per cent a year during this period.

- numbers of WTE scientific, professional and technical staff increased by 33 per cent.

- general and senior managers did not exist as a separate staff group before 1986. The increase in numbers is largely due to the reclassification of staff from professional and administrative groups (including many senior nurses) as managers; almost half of the increase between 1992 and 1993 in particular is the result of such reclassification. The remainder reflects the deliberate strengthening of the management of corporate functions and clinical support, and the devolution of work to local level. General and senior managers account for only 2.6 per cent of the total NHS workforce and 3.6 per cent of total NHS expenditure on salaries and wages. In October 1994, the Secretary of State announced that NHS trusts would be required to publish a figure for management costs, according to an agreed definition, in their annual reports. First publication will be in 1995. Trust management costs will also be published centrally in comparable form. Precise definitions and arrangements for publication of management costs information are being considered.

- the number of administrative and clerical staff increased in recent years up until 1992, reflecting both the strengthening of functions such as information technology and personnel together with increased support to clinical services. The latest figures, however, show a drop from 135,010 (1992) to 132,650 (1993). Over a quarter of administrative staff work in direct support to clinicians (for example, as ward clerks, in medical records and as medical secretarial staff) so allowing them to concentrate their skills and experience on direct patient care.

- nursing and midwifery staff numbers decreased by 8 per cent since 1983. Traditional training of nurses is being replaced by Project 2000 training. Project 2000 students are considered as supernumerary and are not included in workforce numbers. By contrast, traditional learners are counted as part of the workforce. This change masks an underlying trend of an increase of 8% in the number of qualified nursing and midwifery staff since 1983.

- the sharp falls throughout the period in the numbers of directly employed ancillary staff and of maintenance and works staff reflect the continuing effect of competitive tendering exercises.

Pay

5.59 The Pay Review Bodies were free to make recommendations in the normal way for awards operative from April 1995. The Chancellor again made public the Government's economic evidence which was included in the Department's written evidence to the NHS Review Bodies. The evidence made clear that continued moderation in pay settlements throughout the economy was essential to sustain the recovery, improve the public finances and maintain control of inflation. Increases in pay will have to be offset, or more than offset, by improvements in productivity, measured by efficiency improvements at the level of the service. NHS Review Bodies were urged to have full regard to this element when formulating their recommendations. A similar approach will be adopted for staff within the remit of the Whitley Councils and will apply to staff whose pay is not subject to central arrangements (staff on NHS trust or other locally determined terms and conditions). NHS Review Bodies were also urged not to recommend across the board increases but instead to give a strong steer to the continued development and implementation of local pay arrangements by leaving employers with maximum scope for local action.

Table 25 NHS STAFF IN PAST BY MAIN GROUP (1)

Whole time equivalents

Staff Group	1983	1986	1987	1988	1989	1990	1991	1992	1993	percentage change 1983-93
Nursing Midwifery (including agency)	397,100	402,700	404,000	403,900	405,300	402,100	396,100	382,000	366,200	-7.8
% of all staff	47.8	50.2	50.5	50.9	50.9	50.5	49.5	48.0	47.3	
Medical and Dental(2) (including locum)	42,300	43,300	43,500	44,800	46,300	47,400	48,600	49,600	51,100	20.9
% of all staff	5.1	5.4	5.4	5.6	5.8	5.9	6.1	6.2	6.6	
All professional and technical (3.4) (excluding works)	68,700	76,100	79,00	79,800	81,200	84,000	86,900	89,800	91,100	32.7
% of all staff	8.3	9.5	9.9	10.1	10.2	10.5	10.9	11.3	11.8	
Ancillary	166,200	124,300	115,100	107,600	102,400	95,700	85,900	79,000	77,800	-53.2
% of all staff	20.0	15.5	14.4	13.6	12.9	12.0	10.7	9.9	10.0	
Administration and Clerical	110,000	110,800	113,900	114,700	116,800	120,000	127,400	135,000	132,600	20.6
% of all staff	13.3	13.8	14.2	14.5	14.7	15.1	15.9	17.0	17.1	
Maintenance and Works	26,800	25,000	24,200	22,700	21,200	19,900	18,300	17,900	16,700	-37.8
% of all staff	3.2	3.1	3.0	2.9	2.7	2.5	2.3	2.3	2.2	
General/Senior Managers(5)	n/a	500	700	1,200	4,600	9,700	14,500	17,700	20,000	
% of all staff		0.1	0.1	0.2	0.6	1.2	1.8	2.2	2.6	
Ambulane (incldiuing Officers)(4)	18,400	19,000	19,000	18,800	18,900	18,100	17,600	17,700	17,500	-4.9
% of all staff	2.2	2.4	2.4	2.4	2.4	2.3	2.2	2.2	2.3	
Others (5)	–	–	–	–	–	–	4,900	6,300	800	
% of all staff							0.6	0.8	0.1	
Total employed staff	829,500	801,600	799,300	796,600	796,900	800,200	795,100	773,900	-6.7	

(1) At 30 September, includes staff at the Dental Practice Board, Prescriptions Prising Authority, Special Health Authorities and Family Health Service Authorities From 1987 onwards, figures also include the Other Statutory Authorities (eg PILS and HEA) not previously collected in the Annual Workforce Consensus Figures are therefore nmot comparable with those from earlier years. All figures are also subsequently rounded to the nearest 1 whole time equivalents. Percentages are calculated on unrounded figures. Figures exclude independent family health service contractors and practice staff directly employed by them.

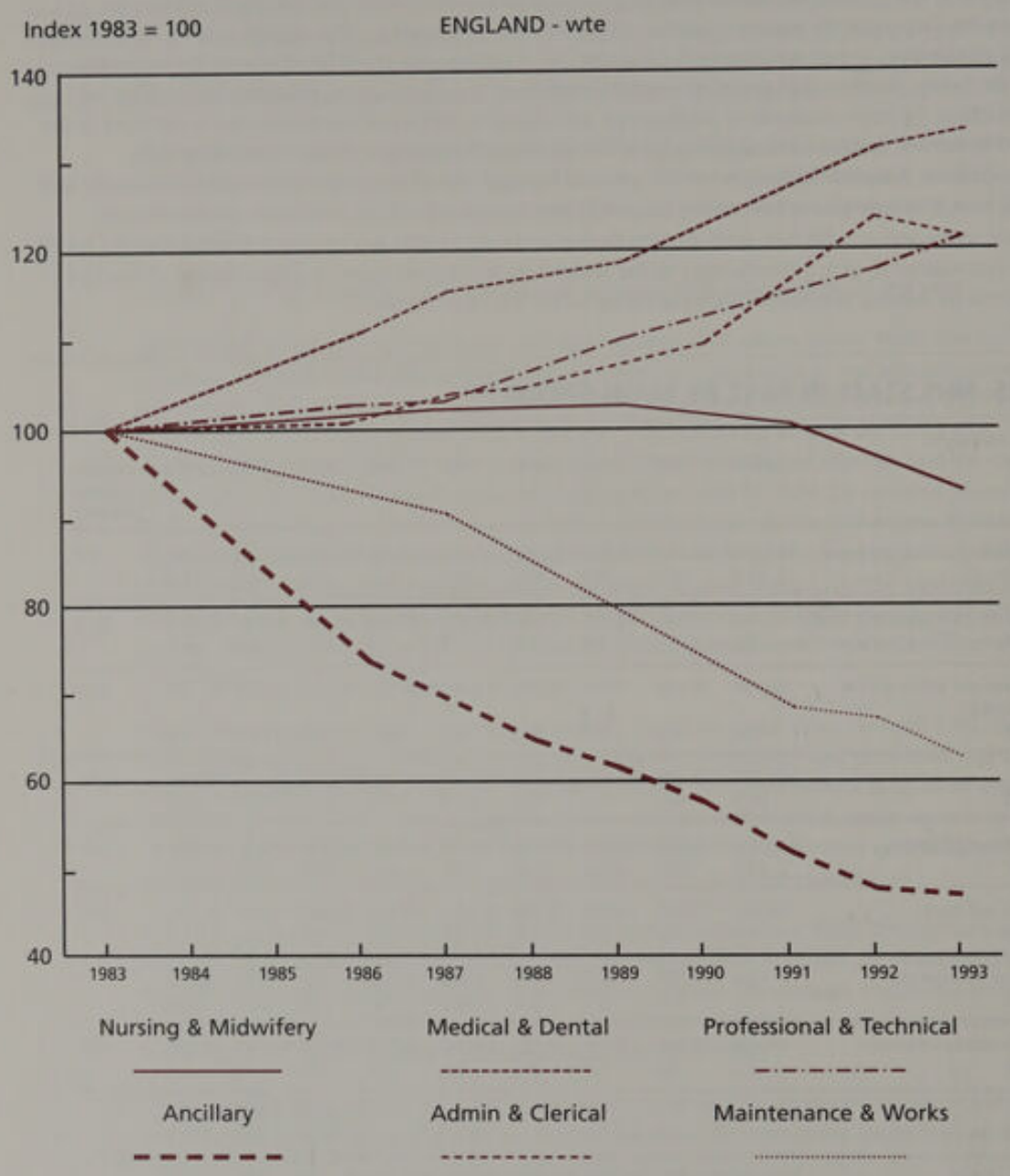
(2) Includes all permanent paid and honoury staff in hospitals and community health services, hospital practitioners and part time medical/dental officers.

(3) Not adjusted for transfer of Operating Department Assistants from Ancillary to Professional & Technical staff groups on 1 April 1984.

(4) Validation of the 1993 date for Scientific & Professional and ambulance staff uncovered errors in the 1992 data. These errors have been corrected in the above table.

(5) A dhage in data collection procedures in September 1993 resulted in thereoutegoriatioes of many staff who would have been coses as 'others' in the 1991 nad 1992 consensus. To put the 1993 figures in its correct context, ammended figures have been estimated for 1991 and 1992, these differ from figures published as previous Departmental Reports. The trend as managemnet numbers between 1990 and 1993 is unaffected by these adjustments. Table 24 NHS staff in port by main group (1) whole time equivalents.

FIGURE 27 - INDICES OF STAFF IN POST BY MAIN STAFF GROUP



5.60 **Flexibility in pay and conditions: developments in 1994** The Government's objective throughout the service is progressively to introduce greater pay flexibility, to allow managers to relate pay rates to local markets and reward performance. The NHS Review Bodies in their reports in February 1994 recognised the move towards devolved pay and work has continued to take forward the move towards local pay arrangements in the Service. Discussions took place in 1994 with representatives of the professional bodies about provisions in national pay agreements enabling local pay, and evidence was subsequently presented to the NHS Review Bodies. A provision enabling local pay was an integral part of the offers made to non-Review Body groups as part of the 1994-95 pay negotiations and settlement has been reached on those offers in the major non-Review Body groups. That represents a significant step towards local pay schemes for over 40 per cent of the total NHS workforce.

5.61 The enabling provision in national agreements has been designed to allow contributions made by teams, as well as individuals, to be rewarded and for all staff to participate (including those who enjoy protected terms and conditions). It would enable all NHS bodies, not just trusts, to introduce local pay schemes. All trust Chief Executives were asked to produce action plans by October 1994 and to set up local pay machinery by February 1995. A major support programme has been arranged by the NHS Executive to assist trusts to implement local pay.

EQUAL OPPORTUNITIES IN 1994-95

The General Whitley Council has issued a new agreement on Recruitment and Selection Procedures as part of its encouragement of Equal Opportunities in the NHS. It has also made important revisions to its agreement on Maternity Leave and Pay to take account of recent changes to the statutory provisions.

Ethnic Minority Staff

Implementation of the Programme of Action for Ethnic Minority Staff in the NHS has continued. £250,000 has been earmarked in 1994-95 to support NHS employers in this, and funding has already been approved for several projects including management development for ethnic minority staff, encouraging ethnic minorities into the speech therapy profession, and developing an equal opportunities training package for primary care staff. The NHS Executive will be monitoring centrally to ensure that progress towards the goals is built into NHS employers' mainstream business planning.

Opportunity 2000

Further progress continues to be made in the NHS with Opportunity 2000 - the campaign to increase the quality and quantity of women's participation in the workforce. One of the goals for 1994 has been exceeded and significant progress is being made with the other seven 38 per cent of vacant chief executive/general manager posts were filled by women from March 1992 to September 1994 (target: 30%). 31 per cent of qualified accountants (target: 35%) and almost 50 per cent of trainee accountants are women. In September 1993 17 per cent of consultants were women (target: 20%) and over the last two years £3.6 million has been allocated to create 146 part-time consultant posts to encourage flexibility in the medical career. 270 nurses and PAMs are being sponsored to undertake management degrees as part of the £2.1 million Bursary Scheme encouraging professionals into management. The NHS has made significant investment in management and personal development targeted at women in more junior levels within the NHS and women from ethnic minority groups.

The results of monitoring exercises are expected to be published in Spring 1995. Ministers will review policy in mid 1995 and consider what new goals should be set for the second three year period to 31 December 1997.

Disability

The NHS Executive has corporate membership of the Employers' Forum on Disability, an organisation of private and public sector employers keen to promote good practice in the employment of people with disabilities.

An informal advisory group of NHS managers, practitioners and others interested in disability and employment issues was convened by the NHS Executive in June 1994. In addition, the Executive agreed to fund two seminars for undergraduates and careers advisors, plus role model publicity, designed to attract high calibre disabled candidates to the fast - track NHS Management Training Scheme.

During October 1994, the Employment Service in Yorkshire held the first of what is planned to be a series of seminars for NHS managers on employing disabled staff.

Other Value for Money Initiatives

5.62 **Clinical Negligence Central Scheme.** The Department is setting up a central scheme to assist NHS trusts with the financial management of clinical negligence, which now costs the NHS around £150 million a year. To test demand for such a scheme, the Minister for Health issued a consultation document in March 1994 seeking the views of NHS trusts and other interested parties; responses from trusts showed an almost unanimous interest in the proposal. A special health authority is being established to administer the scheme, with the day to day running contracted out to a scheme manager. Following a tender process the Medical Protection Society (MPS) and Willis Corroon Ltd (WCL) have been appointed on an interim basis to develop and implement the scheme for launch on 1 April 1995.

5.63 The scheme has been designed to give an additional incentive to trusts to strive for higher standards of patient care; help to reduce still further the number of untoward incidents; encourage trusts to do all they can to minimize grief and suffering when, regrettably, such incidents do occur; and enable NHS Trusts to plan ahead with greater security and thus achieve the best possible patient care with the resources available to them.

5.64 The **National Blood Authority** (NBA), a special health authority, is responsible for the operation and strategic direction of the blood services in England. This includes the network of Regional Transfusion Centres (The National Blood Service) and the Bio Products Laboratory (BPL), which manufactures therapeutic products, such as Factor VIII used in the treatment of Haemophilia, from blood plasma.

5.65 A strategic review of the National Blood Service, undertaken by the NBA with a view to improving the service to patients, hospitals and donors, has led to proposals for reorganisation. These have recently been the subject of a widespread consultation exercise. The main elements of the proposals, which primarily concern the administration and processing functions, are the creation of three administrative zones; consolidation of testing and processing activities leading to an amalgamation of centres; and establishment of a network of stockholding bloodbanks to improve emergency delivery times to hospitals. The NBA expects to produce its final proposals in the Spring of 1995 after consideration of the results of the consultation exercise.

5.66 **Audit Commission reports** Since it formally assumed responsibility for the external audit of the NHS in October 1990, the Audit Commission has undertaken a programme of four to five national VFM projects a year. Each study can take eighteen months or more from inception to report, and is followed by local studies of each site. The benefits can take time to achieve, and often involve higher levels of service or quality improvements rather than specific cash savings. Examples of studies which have focused on quality of care are those on co-ordinating child health and social services for children in need, and services for the mentally ill. Others have focused on efficiency - for example, the studies of IT Management and GP Prescribing. In December 1994 the Commission published a report "Ensuring Probity in the NHS" which identified that the level of detected fraud in the NHS over the last three years was very low. The survey found, however, that controls for preventing and detecting fraud by patients and independent contractors were weak especially in the pharmaceutical areas. A review of these is underway.

5.67 **The Value for Money Unit.** Prior to April 1994, the NHS Executive's Value for Money Unit undertook a defined programme of work in the NHS in key areas, including studies into the cost effectiveness of patient hotels, nursing skill mix and space utilisation. Reports published by the VFMU between 1990 and 1992 have generated actual savings of around £100 million. During 1993-94 the VFMU withdrew from detailed hands on studies, which are now within the remit of the Audit Commission, and the Unit now concentrates on the dissemination of achieved local good practice guidance through its publications VFM Update and VFM Update Plus. Published at six weekly intervals, and with each edition concentrating on one specific area of concern, these publications seek to draw together "stepping stones" or checklists of good practice based on case studies, to enable managers at operational levels to assess their own performance and take remedial action as necessary.

5.68 **NHS Supplies** An independent assessment of the progress and options for the Authority was carried out following setting up in October 1991. The outcome was an agreed action programme for improving the infrastructure of NHS Supplies up to the standards of best commercial practice by 1997, whilst maintaining continuity of services to all NHS customers. Private sector skills and resources will be brought in to assist the process wherever it will add value to do so, for example in the development of warehousing and distribution services to the NHS.

5.69 The NHS Supplies Authority met or exceeded the performance targets that were set for 1993-94. In particular, purchasing savings of £71.6 million (or 5% of relevant spending) were achieved on the contracts negotiated in the year, against a target of £57 million. In addition operating costs were reduced whilst service improvements were made on service delivery levels and stock turnover rates. A customer survey was undertaken and the findings used to identify areas for improvement in customer services. Though NHS trusts are free to make their own or other alternative provision for supplies services on a value for money basis, some 98 per cent continued to have a service contract with NHS Supplies, and NHS Supplies contracts covered an estimated 50 per cent of the total supplies spend in the hospital and community health services. The NHSSA is on course to achieve its savings target of £80 million (or 5% of relevant spending) for 1994-95 and it is expected to achieve further savings of a similar order in 1995-96.

5.70 **Market Testing** Following the Government White Paper "Competing for Quality" the NHS continues to extend its market testing programme. Progress to date is shown in the box below.

PROGRESS ON MARKET TESTING

Guidance

The Department plans to update the procedural guidance on Transfer of Undertakings (Protection of Employees) Regulations 1981 (TUPE), originally issued to the NHS in November 1993. Guidance for purchasers is due to be published in Spring 1995.

Management Requirement

The requirement to market test all catering, laundry and domestic services was set out in HC(83)18 and this requirement will be restated in an EL on market testing due to be published in Spring 1995.

Packages and Ranges of Services

The range of services now covers almost all non clinical services and an increasing number of clinical services. The NHS continues to introduce more imaginative packages of services, including facilities management and negotiated contracts.

Reporting

The NHS is required to continue to report to the NHS Executive the results of all market testing exercises and to provide an annual report on proposals for renewing existing service contracts and extending market testing programmes. This requirement will be set out in the EL due to be published in Spring 1995.

Analysis of the previous reporting round shows for 1992-93, a total annual value £964m, representing for outside suppliers: 39% by value and 69% by volume and for in house teams: 61% by value and 31% by volume

For 1993-94, over a sample of 112 contracts worth £13 million a 14% saving was recorded.

Information desk and Database

The NHS Executive intend to formally open (Spring 1995) an information desk to handle NHS and commercial sector queries on all aspects of NHS market testing guidance. The database is now available to provide information on the extent of market testing and the commercial contractors involved.

Approved Contractors

The NHS Supplies Authority continues to provides lists of approved contractors for a wide range of services.

The NHS Estate

5.71 NHS estate consists of approximately 17,000 hectares, containing some 1,600 hospitals and a range of smaller buildings, such as clinics, health centres, ambulance stations, and offices, together with a residential estate of 12,000 houses and flats and 53,000 hostel places. The total value of the estate is approximately £24 billion. Policy for the estate is to:

- facilitate long term improvements in efficiency and effectiveness;
- maintain adequate standards;
- ensure that only land and buildings required at the present day and in the foreseeable future are retained; and
- maximise disposal proceeds.

5.72 Progress continues to be made in the disposal of surplus land and property. Between 1983-84 and 1993-94 a total of over £1 billion has been realised from this source. Health authorities are able to retain and spend capital receipts as an addition to their cash limits, which provides them with an incentive to maximise receipts. Trusts can use capital receipts rather than borrowing for approved spending within the EFL. The NHS disposed of about 1,400 hectares of the surplus estate from 1988-89 to 1991-92, sold a further 400 hectares in 1992-93 and an estimated 275 hectares in 1993-94. It is estimated that over the next ten years about 7,000 hectares of the NHS estate will become surplus as a result of changes in service provision and rationalisation of the existing estate.

THE PERSONAL SOCIAL SERVICES PROGRAMME

Overall Efficiency

5.73 The responsibility for ensuring that personal social services are delivered efficiently lies with local authorities. Authorities are expected to make the most effective use possible of the resources available to them.

Unit Costs

5.74 **Figure 28** shows how unit costs in selected PSS services have changed since 1987-88 after allowing for movement in PSS pay and prices. Unit costs of local authority supported residential care for elderly people have risen. This may reflect higher average dependency levels among supported residents and/or improvements in quality of care. The proportion of supported residents aged 85 and over has increased, suggesting dependency levels have probably increased.

5.75 Unit costs for children in care, both in foster placements and in local authority residential (community) homes, rose in the years prior to the implementation in 1991 of the Children Act (1989). There appears to have been a similar increase following the implementation of this Act. Some of this increase may be illusory, as the increasing numbers of short-term "respite " placements are included in expenditure figures but not in the current calculation of activity. Methods of estimating this activity in the formula are being investigated. These increases are believed to be linked, at least in part, to the shift towards fewer children being accommodated in homes, and keeping a higher proportion in a family context (with a consequent effect on the cost of caring for children in each care setting). In particular, a greater proportion of those in care are now fostered, and a larger proportion of those in residential homes are older and have more serious problems. The increased unit costs reflect a more community orientated service, with rising quality of care and better value for money (as the unit cost of foster placements remains markedly lower than that of residential placements).

FIGURE 28 - AVERAGE NET WEEKLY COST PER RECIPIENT OF PERSONAL SOCIAL SERVICES

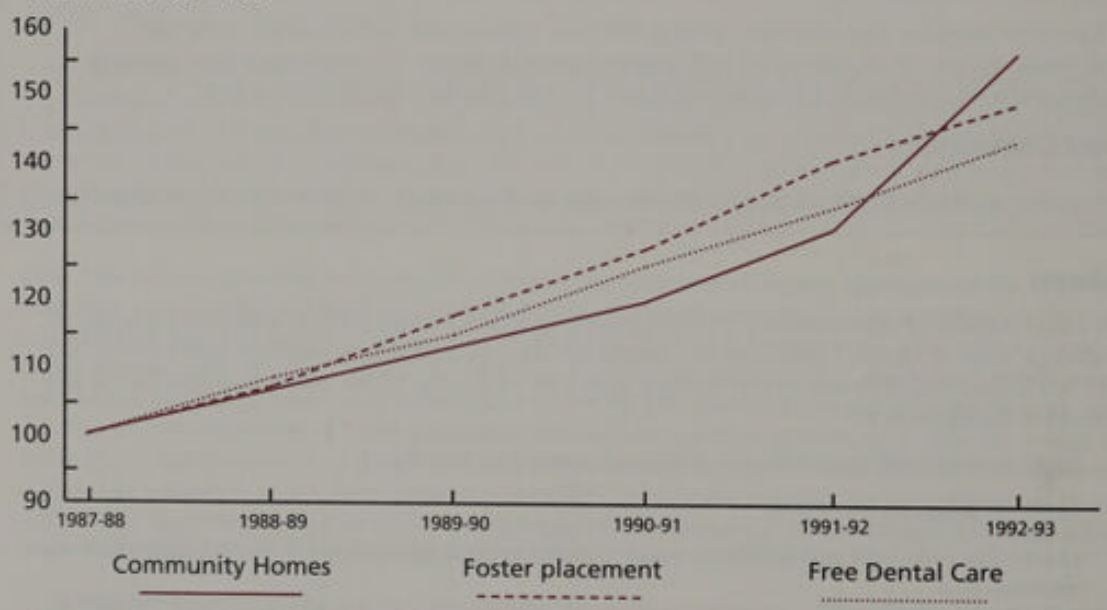


Table 26 PERSONAL SOCIAL SERVICES STAFF [1] WTE STAFF (000s)

	1982-83	1988-89	1989-90	1990-91	1991-92	1992-93
Management, administration and ancillary staff [2]	21	25	26	27	28	29
Social work staff	23	28	29	30	31	32
Home help service and other support staff	52	63	63	63	62	63
Staff in day care establishments for adults	22	28	29	29	28	28
Staff in residential establishments for adults	60	70	71	71	67	63
Staff in residential establishments for children	23	18	18	17	16	15
All other staff	2	4	4	4	5	5
Total	203	236	239	240	237	235

(1) Figures are wte staff directly employed by social services departments at 30 September each year.

(2) Ancillary staff include such staff only at HQ or area office.

Figures may not sum exactly because of rounding.

5.76 Existing unit costs for Personal Social Services (PSS) derive from a return known as form RO3, completed annually by local authority Treasurers' departments as part of the monitoring of all LA current expenditure by DoE. In the past few years, it has proved increasingly difficult to match up the expenditure figures on form RO3 with the relevant activity and staffing data reported to DH by Local Authority Social Services; and the accounting conventions for the treatment of overheads have varied widely across authorities. As a result, PSS unit costs have become increasingly unreliable.

5.77 Work has been proceeding on revising the RO3 form to accord with the new CIPFA accounting guidelines in `Accounting for Social Services'. This work, taken forward as part of the PSS Information Strategy, has involved very extensive consultation with LAs, DoE, and others with an interest in LA finance, notably CIPFA and Audit Commission. The new form will enable the Department to have figures for individual authorities on a comparable basis by client group, including consistent treatment of overheads. This information will be used, amongst other things, to construct meaningful unit costs both nationally for England and for individual authorities in respect of PSS provision.'

5.78 In 1992-93 (the latest year for which full financial figures are available), employee costs accounted for some 65 per cent of gross current local authority spending on the social services.Table 26 shows the staffing figures for the main PSS staffing groups. PSS staff increased by 16 per cent between 1982-83 and 1992-93. The most significant increases have been in social work staff, day care staff, and home helps. Numbers of staff in residential establishments for children have declined steadily in the last decade.

DEPARTMENTAL ADMINISTRATION

Change Management in the Department of Health

5.79 The **Review of the Wider Department of Health**, undertaken by Mrs Terri Banks, acknowledged the distinguished record of the Department, and made a number of proposals to build on this success to improve the coherence, flexibility and efficiency of its work. A number of recommendations were were made concerning the future structure and working methods of the wider Department of Health (broadly, this covers policy work health and social services and management of the Department's resources, excluding the NHS Executive). The underlying rationale was to strengthen support to Ministers and, wherever possible, to bring policy making and implementation closer together.

5.80 The report recommended restructuring the majority of the Department into three business areas: the Social Care Group (to cover the whole range of social care functions); the Public Health Group (dealing with wider public health functions, from Health of the Nation to food policy); and the existing NHS Executive (which will also take on policy responsibility from the wider Department for services delivered by the NHS, such as dentistry, or services for the mentally ill). As now, the new business areas will be supported by the Departmental Resources and Services Group. The aim is to complete this restructuring by the spring of 1995.

5.81 The report also recommended the streamlining of management structures, improvement of business planning and coordination, and the development of more efficient ways of working across the Department. A number of changes have already been, or are in process of being implemented: the Policy Management Unit - a small, high level unit running the business planning system and identifying major issues likely to affect the Department's work - was established in October 1994. The development of better ways of working will begin with pilot projects in early 1995 and will take perhaps two years to implement across the Department. The projects will be participative, with much of the work, impetus and ideas for change coming from the staff actually doing the work.

5.82 In October 1994, a Department-wide **voluntary early retirement/severance scheme** was launched to help reduce surpluses expected to arise as a result of restructuring. Staff wishing to leave will be released during the period March 1995 to July 1996. The overall aim of the changes is to produce a smaller, but more efficient and effective Department which continues to provide a high quality public service.

5.83 The Department will implement a new **pay and grading** system from April 1996 to complement more flexible ways of working; and new training and development schemes for managers and staff at all levels will be introduced to equip them with any new skills they will need.

5.84 **Taking Forward "Next Steps".** The Medical Devices Agency was launched on 27 September 1994. A review of the Medicines Control Agency was carried out during 1994, covering both evaluation of the Agency's performance and reconsideration of prior options. A prior options review of the NHS Pensions Agency was undertaken, and the NHS Estates Agency has undergone its first review. During 1995/96 work will be set in hand to take forward the recommendations of all three reviews.

5.85 The NHS Estates Agency is moving to net running cost control from 1 April 1995. This type of financial regime will give the agency greater flexibility, allowing it to vary its expenditure in line with its receipts from the service it provides to the NHS and other clients.

Other Initiatives

5.86 **Efficiency Plans.** The Civil Service White Paper announced that from 1995, central departments would be required to submit Efficiency Plans. The main aim of these plans is to enable departments to demonstrate how they intend to keep within their running cost limits for the next three financial years as agreed in the PES. In broad terms, this Department's planned efficiency improvements will fall largely into two sub-sets: those arising from, and contributing to, the major organisational change that the Department of Health is undergoing consequent upon the Banks and Functions and Manpower Reviews; and those falling under the Competing for Quality umbrella.

5.87 **Competing for Quality.** As mentioned in paragraph 5.86, market testing will come, in future, within the broad umbrella of Efficiency Plans. A programme up to 30 September 1996 has been developed and agreed with the Efficiency Unit. For the period October 1994 to September 1995, a further 15 per cent of net departmental running costs covering 300 staff will come within the programme with a further 5 per cent of running costs (covering 440 staff) for the remaining period to September 1996. Consideration is being given to developing a programme which will cover the remainder of the 1995 Efficiency Plan period.

5.88 **Purchasing and Supply.** The Department is on schedule to have a fully qualified professional purchasing unit by the end of 1996. The unit will continue to provide training courses in basic purchasing skills to appropriate staff and it will out-place its qualified personnel into designated purchasing posts; in this way the Department will continue to improve value for money from purchasing. The day to day duties of the purchasing unit will be to support all major Department of Health procurements and their policies together with those of its agencies, Regional Offices, and non-departmental public bodies.

5.89 **London Accommodation.** Friars House was vacated and the lease terminated in February 1995. Staff moved into vacant accommodation in Hannibal House, another building in the same area already on the Government Estate. Russell Square will be vacated and the lease terminated by September 1995, with the Medical Devices Agency also moving into refurbished accomodation in Hannibal House. A number of options for the future location of the Medical Devices Agency have been evaluated in depth and are now being considered. Following acceptance of the recommendations made by the Efficiency Scrutiny into the Management of the Civil Estate, the Department is now preparing to take over full responsibility for the property that it occupies from Property Holdings on 1 April 1996. The first environmental action plan is being implemented. This includes an energy audit of three major buildings which will identify areas where further energy savings can be made.

5.90 **Information Technology.** Plans have been developed to upgrade the Office Information System (OIS) which were approved by the Treasury in November 1994. The implementation of the project will maintain the high level of electronic support required by the Department to service its geographically dispersed work; improve the IT support Divisions need as the Department is re-organised following the FMR and Wider Department Review; and provide electronic connections to the NHS and other institutions with which the Department has regular communications. The NHS Executive regional offices will be brought into the Department's OIS and telecommunications networks by April 1996.

5.91 **Use of Staff** Evaluations of the revised Appraisal system have been completed. Revised guidance containing a sample of the new appraisal form was issued to all staff. A pilot programme began in 1994 for the introduction of National Vocational Qualifications (NVQ) into the Department for Administrative Assistants and typists with a view to extending NVQs to other grades. An internal review of the Department's equal opportunities policy in 1994 identified a need to embed equal opportunities more firmly into the culture and business of the Department, and this will form the basis of the 1995-96 action plan.

5.92 **Environmental Stewardship** The Department is committed to sound environmental stewardship and action has been taken and is planned to further develop its environmental performance. Significant achievements in the past year include publication of the Department's first environmental action plan; complete reviews of recycling facilities and water conservation measures with improvements made; reviews of the use of refrigerated gases and halon in air conditioning, fridges and fire fighting equipment; energy audit and survey of three major buildings completed; and an invitation to non departmental public bodies to join the Department of the Environment's campaign "Making Corporate Commitment", with a positive response.

5.93 **Payment of Bills** Following publication of the White Paper "Competitiveness: Helping Business to Win" (Cm 2563), the Department issued guidance to those responsible for the payment of invoices, stressing the importance of prompt payment and drawing their attention to the requirement to make payments within the prescribed time limits. The percentage of invoices paid within the contracted period or, where no terms were set, within 30 days of the presentation of a valid invoice rose from 87.1% in 1993-94 to 91.9% in 1994-95.

III OFFICE OF POPULATION CENSUSES AND SURVEYS

CONTENTS

OFFICE OF POPULATION CENSUSES AND SURVEYS

6 STATUS AND LOCATION

6.1 OPCS is a separate Government Department, accountable directly to the Secretary of State for Health.

6.2 OPCS has three main sites in London , Titchfield (Hampshire) and Southport. This will continue. Ministers have agreed that the London based staff of OPCS should be co-located with the London based staff of the Central Statistical Office at Drummond Gate, Pimlico. The purpose of co-locating the two main arms of the Government Statistical Service (GSS) is to improve the efficiency and quality of Government statistics through closer collaboration. The co-ordination of Government statistics will also be improved as it will be easier to develop common standards, classifications and definitions across the GSS.

6.3 CSO and OPCS will remain separate organisations, but will increase efficiency by sharing services wherever possible.

6.4 Further work has been commissioned by Ministers to establish what additional benefits would arise from merging CSO and OPCS. If a merger were agreed, it would take effect from 1 April 1996.

6.5 These are important recent developments which may affect some of OPCS's future plans, as laid out in this report.

7. AIMS, BUSINESSES AND ORGANISATION

Key aims

7.1 OPCS's key aims are:

- to secure the provision of a high quality, cost-effective Civil Registration and Civil Marriage service; and
- to provide high quality demographic, social and health information and analysis
  - to enable the number and condition of the population to be monitored, and changes over time to be identified, and
  - as a basis for informed policy and decision making and for the effective planning and running of public and other services.

Other OPCS work

7.2 We also:

- support the administration of the NHS by running the NHS Central Register on behalf of the NHS Executive, and
- provide the Secretariats of the Parliamentary Boundary Commissions for England and Wales.

OPCS's businesses

7.3 OPCS has four main businesses:

- Registration, covering Civil Registration and Marriages, and the NHS Central Register;
- Population and Health Statistics;
- Census - the planning, taking and publication of results from the decennial census of population and housing; and
- Social Survey - the provision of a social research service to Government and other public bodies.

7.4 These businesses are supported by four common service Divisions:

- Information Technology;
- Data Services;

- Marketing; and
- Finance, Personnel and Administration.

Organisation

7.5 An organisation chart is at Annex J.

8. BUSINESS STRATEGY

8.1 OPCS has a wide range of customers, of which the largest are:

- Central Government;
- Local Government;
- the NHS;
- the general public (mainly for Civil Registration); and
- academic and other researchers and secondary analysts.

Our markets are changing rapidly, in terms both of their structure and of their needs.

8.2 We are funded by the Exchequer to produce a range of core outputs, but we look to our customers to fund non-core outputs. We are having to compete for an increasing proportion of our customer-funded business. Both we and many of our customers are facing resource constraints.

8.3 Against this background, our business strategy is:

- to continue to provide our core outputs to the maximum extent possible within the funds allocated to us;
- to develop our customer-funded products and services to meet the changing needs of our customers, and to supply them in the form and to the quality which customers want;
- to realise additional income from customers to supplement our core Exchequer funding; and
- to improve our efficiency, so as to maximise our outputs within available resources, and to keep our prices competitive.

8.4 We aim to maintain and enhance our reputation for integrity and objectivity, for the quality of the services which we provide, and for ensuring the confidentiality and security of the personal data which we hold.

9. RESOURCES

Finance

9.1 OPCS's annual gross budget is some £68m. There are receipts of some £37m, mainly from payments by other public sector bodies for specific services but also from sales of certificates and other registration products to the general public. Expenditure is borne on Class XII, Vote 6.

9.2 **Table 27** gives information about the running costs of OPCS. **Table 28** gives information on manpower.

Table 27 RUNNING COSTS

	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans	1996-97 plans	£ million 1997-98 plans
Office of Population Censuses Surveys									
Gross running costs: (1)									
Civil Service paybill (2)	28	33	49	41	37	41			
Other	20	34	73	30	30	29			
Total	48	67	121	71	66	70	68	71	72
Related receipts	-19	-24	-26	-31	-37	-38	-34	-36	-36
Net expenditure	28	43	95	40	29	32	34	35	36
Running costs by control area:									
Gross control	38	56	107	52	46	51	50	50	51
Net control area:									
Social Survey Division									
Gross expenditure	10	11	15	19	20	19	18	20	20
Net expenditure	1	1	2	1					

(1) The gross figures are net of any VAT refunds on contracted out services.

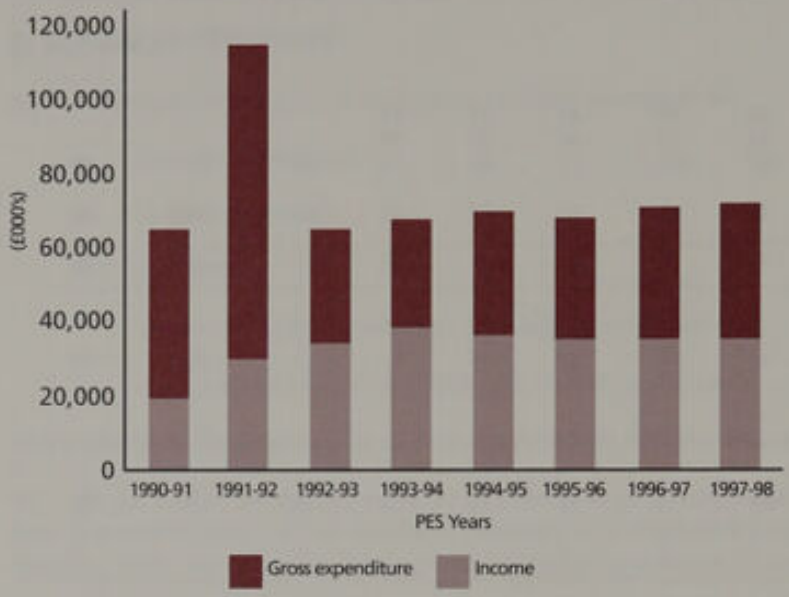
(2) This covers the pay costs, including employers' earnings related national insurance contributions, of civil servants in running costs (as given in the table on departmental staffing).

Table 28 STAFF NUMBERS

Department		1989-90 Actual	1990-91 Actual	1991-92 Actual	1992-93 Actual	1993-94 Actual	1994-95 estimated outturn	1995-96 plans	1996-97 plans	Staff-years 1997-98 plans
Office of Population	CS FTEs	2,019	1,988	1,970	1,802	1,695	1,591	1611	1674	1702
Censuses and Surveys	Overtime	24	42	77	38	24	32	32	32	32
(Gross Control Area)	Casuals	82	204	1,180	402	153	150	25	25	25
	Total	2,125	2,234	3,227	2,242	1,872	1,773	1,668	1,731	1,759
Social Survey Division	CS FTEs	135	135	179	194	188	170	182	182	182
(Net Control Area)	Overtime	0	0	0	0	0	0	0	0	0
	Casuals	17	27	31	32	42	23	5	5	5
	Total	152	162	210	226	230	193	187	187	187
Total OPCS		2,277	2,396	3,437	2,468	2,102	1,966	1,855	1,918	1,946

Figure 29 shows total expenditure, income and net expenditure from 1990-91 to 1994-95, and projected until 1997-98. Figures 29 and 30 also show the nature of OPCS's finances with expenditure reaching a peak in 1991-92 because of the 1991 Census.

FIGURE 29 - OPCS EXPENDITURE AND INCOME (1990-91 TO 1997-98)



9.3 Figures 30 and 31 illustrate total expenditure on, and income from, the four distinct areas of work undertaken by OPCS over the survey period, divided between:

- core work, ie funded gross by the Exchequer;
- Exchequer allocations 'ring-fenced' for census purposes (note that some census expenditure is core);
- Social Survey net control area (wholly customer-financed); and
- other customer-financed work.

(See Annex K for more detail.)

FIGURE 30 - EXPENDITURE BY TYPE OF ACTIVITY (1990-91 TO 1997-98)

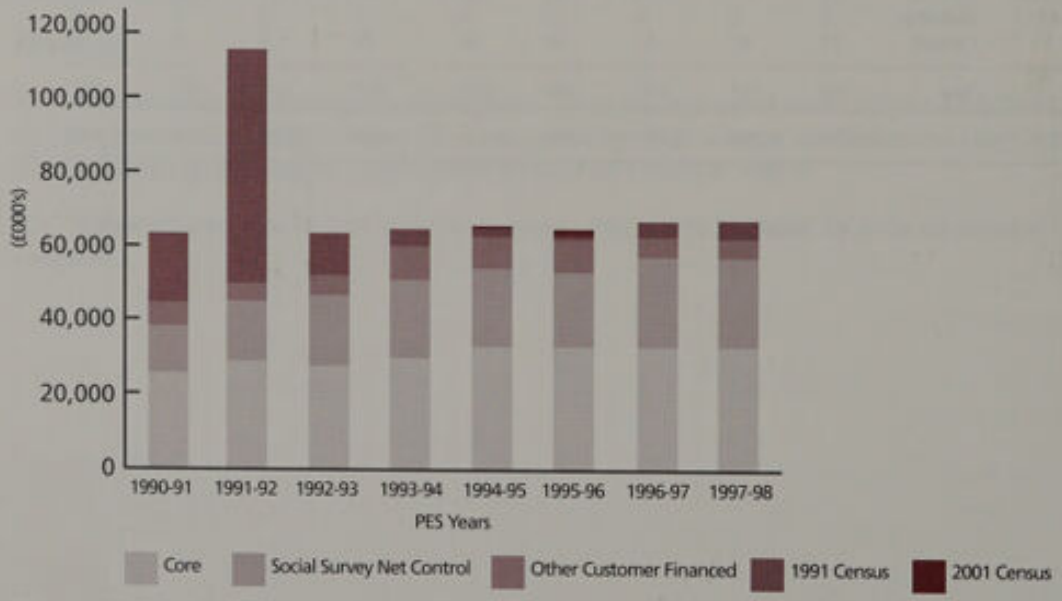
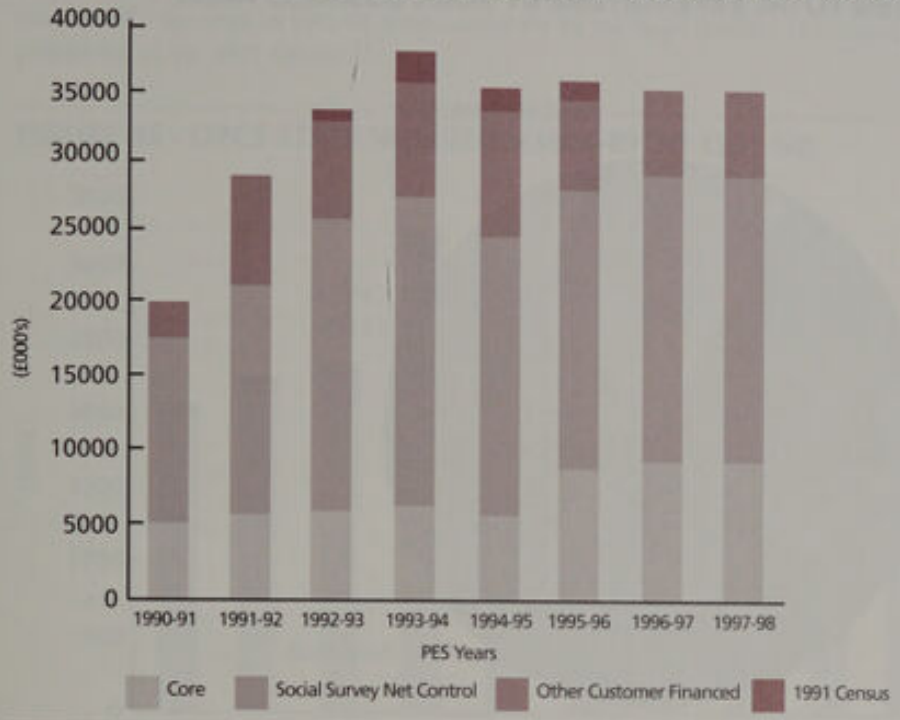


FIGURE 31 - INCOME BY TYPE OF ACTIVITY (1990-91 TO 1997-98)



9.4 Figures 32 and 33 show total expenditure by main business areas in 1993-94, and those projected for 1994-95. Costs of central support services have been allocated to business areas.

FIGURE 32 - TOTAL EXPENDITURE BY MAIN BUSINESS AREA 1993-94

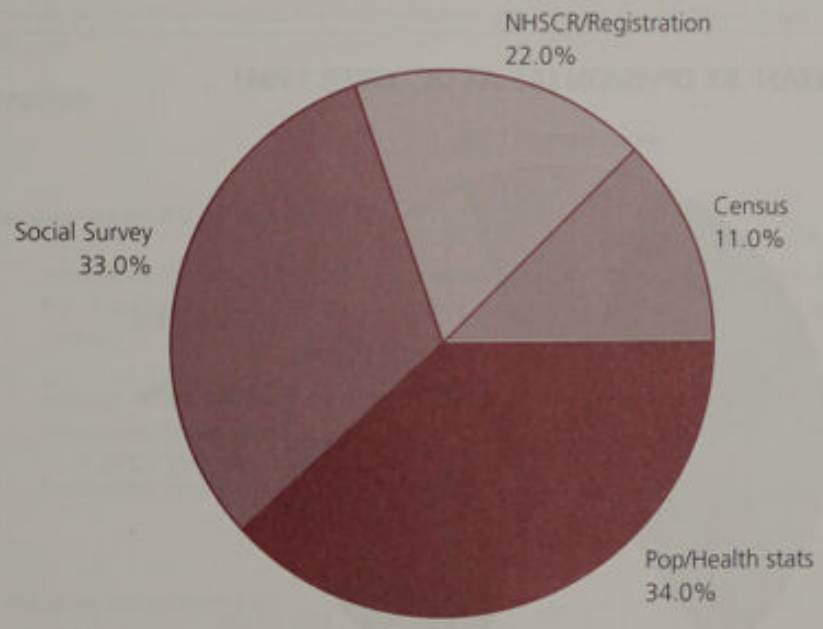
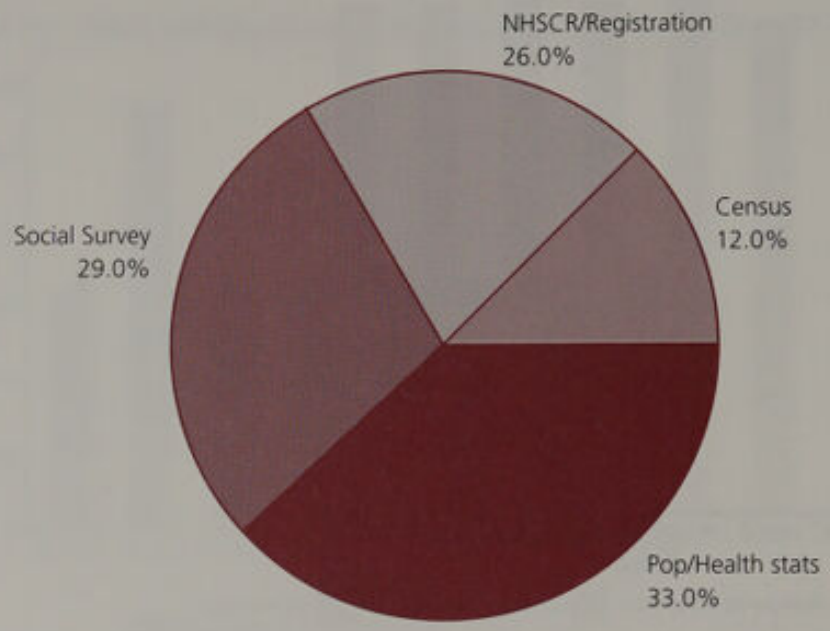


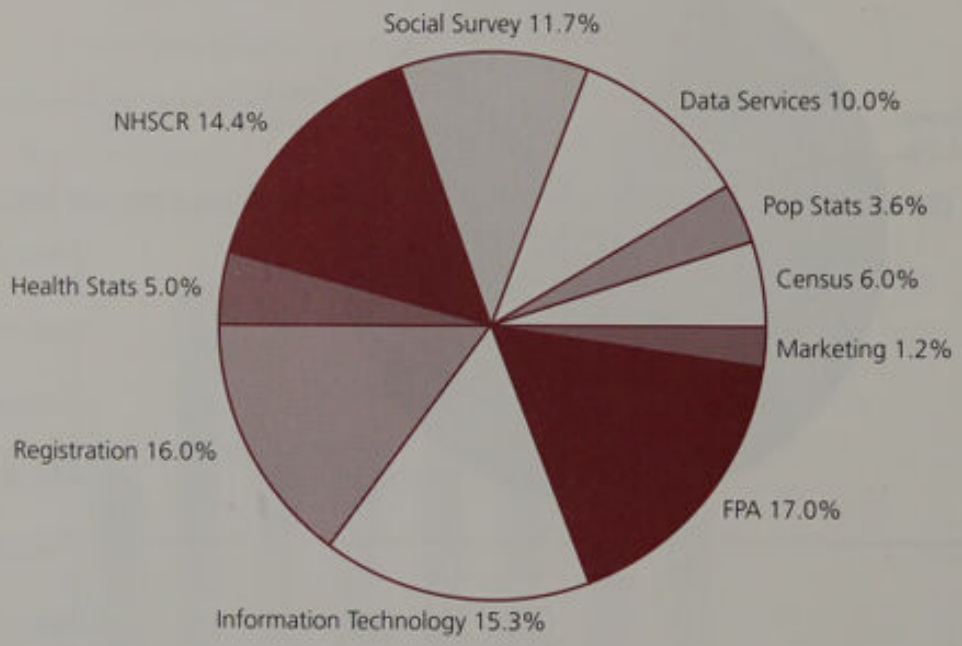
FIGURE 33 - PROJECTED TOTAL EXPENDITURE BY MAIN BUSINESS AREA 1994-95



Staffing

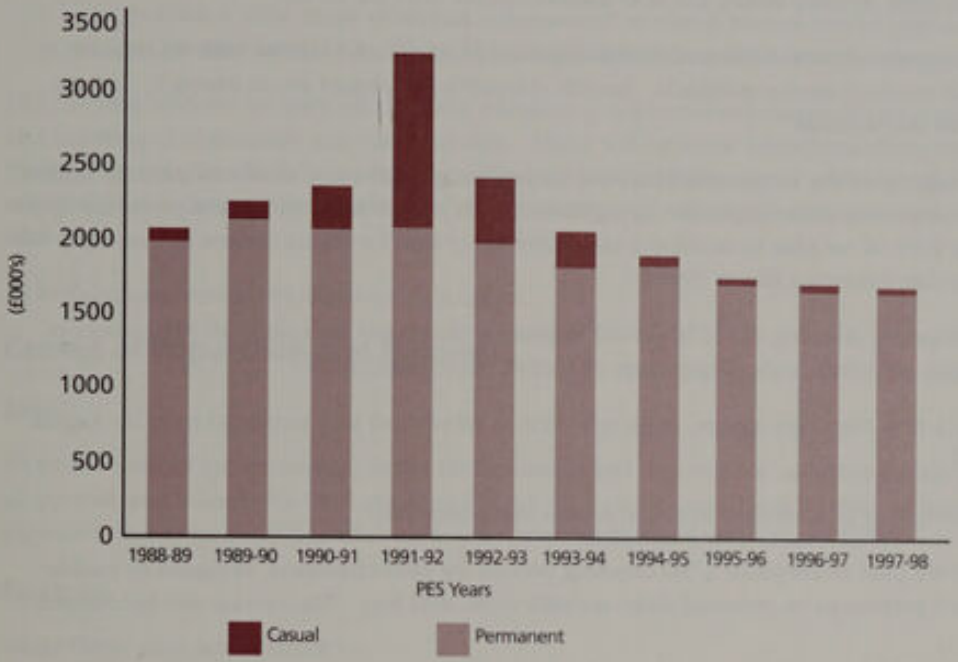
9.5 OPCS has approximately 1,700 permanent staff on 3 main sites: London, Titchfield (near Fareham, Hampshire), and Southport. Annex J contains an organisation chart. Figure 34 shows the proportion of staff (full time and casual) in the various work areas.

FIGURE 34 - OPCS STAFF BY DIVISION (AS AT OCTOBER 1994)



9.6 Figure 35 shows the total number of departmental staff (excluding census field staff and social survey interviewers) employed by OPCS over an 10 year period, and the relative proportions of permanent and casual staff. the peak in 1991-92 is accounted for by the large number of casual staff recruited to handle the processing of the 1991 Census.

FIGURE 35 - OPCS STAFF NUMBERS (1988-89 TO 1997-98)



10. OBJECTIVES BY BUSINESS AREA

10.1 Specific performance targets for each business area are set out in detail in OPCS's Business Plan and Annual Report.

Registration

Aims

10.2 The aims are to:

- administer the marriage laws and to secure the provision of an efficient and effective system for the registration of events such as births, marriages, and deaths (known as 'key life' or 'vital' events);
- support effective patient care requirements in the NHS by the collection, maintenance and dissemination of administrative data on patients; and
- from these operational sources, supply information for OPCS's statistical purposes.

Functions

10.3 These aims are achieved by:

- administering the Marriage Laws and maintaining the Adopted Children's Register and Adoption Contact Register and records of certain births, marriages, and deaths which occur abroad;
- controlling the systems provided by local authorities for celebrating civil marriages, and for registering births, deaths and marriages, in England and Wales;
- providing an advisory service to local Registrars and dealing centrally with some non-delegated registration matters, notably corrections of errors and late registrations and re-registrations of births;
- supplying to order copies of certificates of key life events; and
- maintaining and operating the NHS Central Register.

Objectives for 1995-96 and beyond

10.4 A major task in 1995 will be to secure the implementation of the Marriage Act 1994, whose main purpose is to give customers greater choice of marriage venue. We expect to have completed all necessary central action by April 1995.

10.5 Another major task for 1995-96 and beyond will be to approve registration schemes for newly-created local authorities. This must be done before the new authorities take over the service.

10.6 We plan to manage the expected increase in civil registration case work volumes with no increase in staff. We shall at least maintain service standards. Specific standards and targets are in Annex L. Income from sale of certificates will increase.

10.7 We expect the take-up of the computerised system for registering births and deaths to increase further in 1995-96 so that 90 percent of these events are so registered by 31 March 1996 (84 percent projected by 31 March 1995). During 1995-96 we plan to develop a computerised system for taking notices of marriage. We should be able to start implementing this in 1996-97.

10.8 The main development affecting the NHS Central Register is the project to replace all NHS numbers, which we are managing on behalf of the Department of Health. Key targets are to:

- introduce a new computer system, issue new NHS numbers and start workload trials by August 1995; and
- commence testing of additional in-house system enhancements.

10.9 During 1995-96 we plan to introduce a 'list cleaning' service for NHS customers, designed to enable the names of deceased persons to be removed more speedily from NHS lists. This service will be charged for.

10.10 We shall continue to improve the efficiency and quality of service which NHSCR offers to NHS customers and to medical researchers.

Population and Health Statistics

Aim

10.11 The aim is to provide high quality demographic, social and health information and analysis for the purposes stated in paragraph 7.1.

Functions

10.12 We produce statistics on population numbers, fertility, births, deaths, abortions, marriages, divorces, families and households, morbidity, and other demographic, social and health matters.

10.13 We supply these partly through a wide-ranging publications programme and partly direct to customers. Some of the work is 'core', and so funded from the Exchequer. Some of it is charged to customers. Annex M gives an extract from our 1993 - 94 publications programme.

Objectives for 1995-96 and beyond

10.14 Ongoing objectives are to:

- improve our knowledge of our customers' future needs, and adapt and extend our product range accordingly;
- increase our ability to supply statistics tailored to the needs of particular customers, including customers for small area data, and so to increase our income;
- improve data collection and data handling systems with a view to improving the timeliness of supply to customers; and
- improve dissemination methods, by use of new media and electronic transmission systems.

10.15 An objective towards which we are working is to publish all Annual Reference Volumes within a year of the end of the period to which they relate.

10.16 Specific objectives for 1995-96 are to:

- publish national and local population estimates for mid-1994 by July 1995;
- provide to customers' timetables key data analysis and interpretation to support the Chief Medical Officer's Annual Report, the Public Health Common Dataset, and the Health of the Nation Strategy; and
- publish a wide range of annual volumes and monitors, journal articles and review monographs to planned timetables. (Our publication programme will be set out in our annual Business Plan.)

10.17 During 1995-96 we shall substantially complete a major redevelopment of our systems for collection and handling of registration and statistical data. There will be some transitional disruption to timetables, but the new systems should then improve the efficiency and timeliness of our routine outputs. Our next task, which we have already begun, is to develop the wider range of outputs envisaged in the ongoing objectives above.

10.18 Customer service standards are in Annex L.

Census of Population and Housing

Aims

10.19 The aims of the decennial Census of Population and Housing are to obtain a wide range of data about all persons and households in England and Wales on a chosen day, most recently 21 April 1991 and expected next to be in 2001; and to ensure that the results are widely disseminated.

Functions

10.20 These aims are achieved by:

- consulting users to establish their needs for the census;
- carrying out a research and development programme to identify and test changes in requirements to ensure best value for money;
- carrying out a series of question wording tests to help decide on the content of the census;
- setting up arrangements to issue questionnaires and to collect completed forms from all households and other establishments;
- designing and implementing systems to capture, collate and process the data and publishing replies in a series of pre - planned products;
- undertaking special analyses to order and at cost; and
- licensing private sector census agencies to market census statistics in value added form.

Objectives for 1995-96 and beyond

10.21 The standard outputs from the 1991 Census are now almost complete. We are already planning for a 2001 Census. Our main immediate target is a full operational trial to be held in 1997, during which we shall try out various innovations planned in the light of the 1991 experience, and of known changes in customer requirements. By mid-1998 we shall have settled the content of the 2001 Census, in consultation with customers.

Social Survey

Aims

10.22 Social Survey Division aims to make available to Government Departments and other public bodies, survey advice and a survey facility of the highest available quality; to win survey business, in competition with other suppliers where required; and to cover expenditure by income with no more than a 2 per cent surplus, year on year.

Current business

10.23 Our business in 1994-95 consists of 9 continuous surveys, including an Omnibus Survey which we run monthly; some 30 ad hoc surveys in hand at some stage during the year; an advisory service provided on request; and a methodological research programme. The value of this business is over £21m, of which £18m is in respect of the continuous surveys and £3m ad hoc surveys.

Market testing

10.24 Over the last few years we have had to obtain an increasing proportion of our business by competitive tendering. This trend will continue.

Objectives for 1995-96 and beyond

10.25 We are aiming to maintain roughly the same level of business which the Division currently carries out.

10.26 Specific objectives for 1995-96 are to:

- bid for, and win, competitive tenders for continuous surveys - Family Expenditure Survey, Family Resources Survey, Labour Force Survey, and National Travel Survey - as they are market tested, and for others such as the National Food Survey which the Division does not currently undertake, and ad hoc surveys which are appropriate for the Division to carry out;
- maintain quality standards in data collection and processing including achieving minimum response rates agreed with customers for the continuous surveys;
- deliver all survey reports to customers to the timescale agreed and to improve the format and style of the reports; and
- to keep customers in touch with new surveys, developments in survey methods and published reports by producing at least three issues of the customer newsletter, Social Survey News.

11. SUPPORT SERVICES

11.1 We invest substantially in the support services supplied by our four common service Divisions. The aims, functions and objectives of these services are not separately identified in this report. They do, however, have key roles in ensuring that:

- we are appropriately resourced and these resources are appropriately allocated and controlled;
- we are appropriately staffed and skilled for our businesses;
- we are properly accommodated;
- we are supplied with the technology and technical advice and support which we need to fulfil our business objectives;
- we have cost-effective systems for collecting, handling, storing and transmitting the billions of items of data which are our raw material, and for the output of the products which are based on them; and
- we are properly informed about and in touch with our markets and customers.

11.2 Nevertheless, the cost of these Divisions are overheads, and we shall continue to strive to ensure that they consume only the amount of resources necessary to enable the Office to discharge its functions efficiently and effectively. Many of the major efficiency savings made over recent years and planned over the next 2 years (as set out in Annex N) are from within these support services.

Payment Performance

11.3 As an indicator of the improvements made in the efficiency of OPCS support services the following performance figures for the payment of invoices to suppliers, show a significant improvement in 1994-95.

Table 29

	Financial Year	
	1993-94	1994-95
Percentage of invoices paid by due date	84.1	88.0

12. MEASURES TO IMPROVE EFFICIENCY AND COST-EFFECTIVENESS

12.1 Efficiency plans for 1995-96 to 1997-98 are currently being produced. In the meantime we are continuing our announced programme of market tests and implementing a range of other efficiency measures to enable us to deliver our agreed outputs.

12.2 We have set up a Business Efficiency Steering Group chaired by the Director of Statistics, which will plan for and ensure the delivery of a programme of efficiency improvements, including market tests.

Annex N sets out the major efficiency savings made by OPCS over the last few years and some of those planned.

13. CITIZEN'S CHARTER AND OPEN GOVERNMENT

13.1 Appropriate policies are in place. Objectives will be shown in our Business Plan. See Annex L for our customer service standards.

ANNEXES

General

A Cash Plans Table

B UK Health Spending

Department of Health

C Allocation of Ministerial Responsibilities

D Organisation of the Department of Health

E Organisation of the National Health Service

F The Secretary of State's Statement of Priorities and Key Challenges for the Department of Health for 1994-95 to 1997-98, with notes on achievement

G Executive Agencies of the Department of Health

H Central Health and Miscellaneous Services

I Long-term Capital Projects

Office of Population Censuses and Surveys

J Organisation of the OPCS

K OPCS Finances

L Customer Service Standards

M OPCS Publications

N Efficiency Improvements in OPCS

ANNEX A
CASH PLANS

£ million

	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans	1996-97 plans	1997-98 plans
Department of Health									
Central government expenditure									
Health Services									
Voted in Estimates									
National Health Service hospital, community health, family health (cash limited) and related services [2] [3]									
Current expenditure	13,806	15,551	18,102	20,137	21,568	23,231	23,216	23,780	24,347
Capital expenditure [3]	1,191	1,375	1,219	1,063	526	281	82	84	85
Total	14,997	16,925	19,321	21,201	22,095	23,512	23,298	23,864	24,432
National Health Service trusts [3]									
National Health Service family health services (non-cash limited) [1]									
current expenditure	4,229	4,699	5,219	5,613	5,622	5,620	7,024	7,363	7,718
Departmental administration [4] [5]									
Current expenditure	161	197	210	250	239	246	233	289	278
Capital expenditure	9	21	23	43	16	11	8	8	8
Total	170	219	233	294	255	257	241	297	286
MCA Trading Fund [5]									
Current expenditure					5				
Capital expenditure						2	1	1	1
Total					5	2	1	1	1
Central health and miscellaneous services									
current expenditure	423	450	563	590	618	674	702	740	769
capital expenditure	22	32	31	37	31	27	31	31	31
Total	445	482	594	627	649	701	732	770	800
General Practice Finance Corporation [6] [7]									
Total voted in Estimates	**19,842**	**22,326**	**25,406**	**27,960**	**28,959**	**30,716**	**31,968**	**32,935**	**33,777**
Of which:									
Central government's own expenditure	*19,842*	*22,326*	*25,367*	*27,735*	*28,621*	*30,090*	*31,296*	*32,294*	*33,235*
Public corporations			*39*	*225*	*333*	*624*	*671*	*640*	*541*
Trading funds					*5*	*2*	*1*	*1*	*1*
Other (non-voted)									
National Helath Service hospital, community health, family health (cash limited) and related services									
Current expenditure		-3							
Capital expenditure		-3							
Total			-64	-2	-30	-36	-23	-25	-25
National Health Service trusts									
National Health Service family health services (non-cash limited) [1] [3]									
Current expenditure	-1	-10							
Departmental administration									
Current expenditure	15	15	14	16	17	17	17	17	17
Total	15	15	14	16	17	17	17	17	17
MCA Trading Fund [5]									
Current expenditure					9	9	10	10	10

Central health and miscellaneous services									
Current expenditure	-1	-1		-1	-1				
Capital expenditure									
Total	-1	-1		-1	-1				
General Practice Finance Corporation[6][7]									
Total other (non-voted)	13	2	-50	13	-6	-10	4	2	2
Of which:									
Central government's own expenditure	*13*	*2*	*14*	*16*	*24*	*26*	*27*	*27*	*27*
Public corporations (excluding nationalised industries)			*-64*	*-2*	*-30*	*-36*	*-23*	*-25*	*-25*
Total Health Services									
Current expenditure	18,633	20,902	24,107	26,606	28,076	29,798	31,202	32,198	33,138
Capital expenditure	1,222	1,426	1,249	1,367	877	909	769	738	640
Total	19,855	22,328	25,356	27,973	28,953	30,706	31,971	32,937	33,779
Of which:									
Central government's own expenditure	*19,855*	*22,328*	*25,381*	*27,750*	*28,645*	*30,116*	*21,323*	*32,321*	*33,262*
Public corporations (excluding nationalised industries)			*-24*	*223*	*303*	*588*	*648*	*615*	*516*
Trading funds					*5*	*2*	*1*	*1*	*1*
Other Services									
Voted in Estimates									
Personal social services									
Current expenditure	20	24	32	38	40	45	43	42	42
Capital expenditure	-2	-1	-1	2	3				
Total	18	24	31	40	43	45	43	42	42
Civil defence	2	1	1	1	2	3	3	3	3
Total voted in Estimates	20	24	33	41	45	48	46	45	45
Of which:									
Central government's own expenditure	*20*	*24*	*33*	*41*	*45*	*48*	*46*	*45*	*45*
Total other (non-voted)									
Of which:									
Central government's own expenditure									
Public corporations (excluding nationalised industries)									
Total central government expenditure	19,875	22,353	25,389	28,014	28,998	30,754	32,018	32,982	33,824
Of which:									
Central government's own expenditure	*19,875*	*22,353*	*25,413*	*27,792*	*28,690*	*30,164*	*31,369*	*32,366*	*33,307*
Public corporations (excluding nationalised industries)			*-24*	*223*	*303*	*588*	*648*	*615*	*516*
Trading funds					*5*	*2*	*1*	*1*	*1*
Central government grants to local authorities									
Voted in Estimates									
Current grants within AEF[8]									
Training support programme for Social services staff	14	19	25	29	32	33	35	35	35
Services for people wth HIV and AIDS	7	10	10	15	12	13	13	14	14
Services for alcohol and drug misuers			1	2	2	2	2	2	2
Services for people with mental illness			19	30	34	36	47	48	48
Guardian ad litema nd reporting officer service				6	6	6	6	6	6
Aid for the homeless[7]									
Community care grant[8]					565	736	648		
Capital grants									
Provision of secure accommodation	2	2	2	1	2	9	8	8	8
Rehousing of displaced families[7]									

Total central government grants to local authorities	24	31	58	83	654	835	760	114	114
Of which:									
Current within AEF[8]	*21*	*29*	*56*	*82*	*652*	*826*	*752*	*106*	*106*
Capital	*2*	*2*	*2*	*1*	*2*	*9*	*8*	*8*	*8*
Credit approvals	67	84	106	126	132	140	144	137	137
Total central government support to local authorities	91	115	164	210	786	976	904	252	252
Total Department of Health	19,996	22,468	25,552	28,224	29,784	31,730	32,921	33,234	34,076
Of which:									
Current expenditure	*18,676*	*20,957*	*24,196*	*26,727*	*28,770*	*30,672*	*32,000*	*32,350*	*33,290*
Capital expenditure	*1,290*	*1,511*	*,1356*	*1,497*	*1,014*	*1,058*	*921*	*884*	*786*
Of which:									
Voted in Estimates	*19,886*	*22,382*	*25,497*	*28,084*	*29,658*	*31,599*	*32,773*	*33,094*	*33,937*
Office of Population Censuses and Surveys									
Central government's own expenditure									
Voted in Estimates									
Records, registrations and surveys	34	53	101	40	32	36	36	38	38
Other (non-voted)									
Records, registrations and surveys[7]									
Total Office of Population Censuses and surveys	34	53	101	40	32	36	36	38	38
Total Department of Health and Office of Population Censuses and Surveys	20,000	22,521	25,653	28,264	29,816	31,765	32,957	33,271	34,114

(1) In 1991-92, 1992-93, 1993-94 and 1994-95 provision of £125, £295, £628 and £1,058 million respectively for drugs prescribed by GP fundholders is included in HCHS current expenditure. However, for other years all provision for FHS drug costs is included in FHS non-cash limited provision. This reflects the fact that there is no basis for adjusting previous years' figures because GP fundholders did not exist before 1 April 1991 and for future years decisions on the number of GP fundholders have not yet been taken.

(2) HCHS current expenditure includes that element of trust capital expnediture which they fund from their charges to health care purchasers (£231 million in 1991-92, £363 million in 1992-93, £696 million in 1993-94, £975 million in 1994-95 and provisional figures for 1995-96, 1996-97 and 1997-98).

(3) Figures for forward years are provisional estimates.

(4) Includes net provision for the Youth Treatment Service.

(5) Prior to 1993-94 MCA figures are included in departmental administration. MCA figures from 1993-94 reflect the reclassification of expenditure following themove to Trading Fund status.

(6) Covers GB.

(7) Cash amounts below £0.5 million are not shown.

(8) Aggregate External Finance.

(9) The Special Transitional Grant for Community Care for 1996-97 will be announced later.

ANNEX B
NATIONAL HEALTH SERVICE,UNITED KINGDOM – GROSS EXPENDITURE

	1989-90 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans	1996-97 plans	£ million 1997-98 plans
Central government expenditure									
National Health Service hospital, community health, family health (cash limited) and related services [2] [3]	19,405	21,667	24,595	26,829	27,953	29,294	29,304	30,002	20,693
National Health Service trusts			-24	222	313	617	706	647	536
National Health Service family health services (non-cash limited) [2] [3]	5,872	6,492	7,229	7,741	7,808	7,857	9,503	9,927	10,387
Departmental administration [4]	217	273	304	363	323	326	311	368	356
MCA Trading Fund [5]					5	2	1	1	1
Central health and miscellaneous services	713	799	960	1,053	930	997	1,028	1,075	1,108
General Practice Finance Corporation [6] [7]									
Total National Health Service	**26,208**	**29,231**	**33,061**	**36,209**	**37,331**	**39,093**	**40,853**	**42,020**	**43,082**
Total at 1993-94 prices (using GDP deflater) [8]	**32,242**	**33,294**	**35,429**	**37,317**	**37,331**	**38,326**	**38,791**	**38,926**	**39,032**
Percentage change		**+3.3**	**+6.4**	**+5.3**	**0.0**	**+2.7**	**+1.2**	**+.3**	**+.3**

(1) The allocation between services of the provision for Wales from 1994-95 is provisional.

(2) HCHS, PSS and FHS are on an integrated basis in Northern Ireland, so Northern Ireland figures are estimated apportionments.

(3) HCHS current for ENgland, Scotland and Wales includes expenditure on drugs prescribed by GP fundholders in 1991/92, 1992/93, 1993/94 and 1994/95 (£125 million, £295 million, £628 million and £1,058 million for England, £7 million, £8 million and £38 million for Scotland and £16 million and £42 million for Wales and £12 million for Northern Ireland in 1993-94). In other years for England, Scotland and Wales, all FHS drug costs are in FHS non-cash limited provision.

(4) Excludes departmental administration of health programme in Scotland and Wales.

(5) Prior to 1993-94 MCA figures are included in departmental administration. MCA figures 1993-94 reflect the reclassification of expenditure following the move to Trading Fund status.

(6) Covers Great Britain.

(7) Cash amounts below £0.5 million are not shown.

(8) As in Budget.

ANNEX C

MINISTERIAL RESPONSIBILITIES (HEALTH)

SECRETARY OF STATE FOR HEALTH (S of S) - The Rt Hon Virginia Bottomley JP MP

The Secretary of State has overall responsibility for the work of the Department and that of the Office of Population, Census and Surveys. In particular, she takes the lead on issues arising from change management and major political strategies and policy matters affecting health and personal social services, including the public expenditure survey.

MINISTER FOR HEALTH (M(H)) - Mr Gerald Malone MP

Community Health Councils
Complaints
Disciplinary issues
European Union and international affairs
General Ophthalmic Services
General Medical Services
General Dental Services
GP fundholding
Health Education Authority (HEA)
Health exports
London
Medical and dental manpower and education (including junior doctors' hours)
NHS general
NHS appointments - Overview and North Thames, South Thames, Trent, and West Midlands Regions
NHS management
NHS pay and personnel
Patient's Charter Pharmaceutical services and the NHS drugs bill
Primary Care services
Research Tobacco advertising controls
Waiting lists

PARLIAMENTARY SECRETARY (PS(C)) - Mr John Bowis OBE MP

Alcohol
All services for:
- elderly
- mentally ill
- people with learning disabilities
- disabled (including sensorily disabled)
- Children's services/YTS
- Community care
- Drugs Crown immunity
- Homeless people
- NHS Appointments - Anglia & Oxford, South & West Regions
- Personal social services
- Special hospitals
- Voluntary sector (including S64 grants)

PARLIAMENTARY SECRETARY (PS(H)) - The Hon Tom Sackville MP

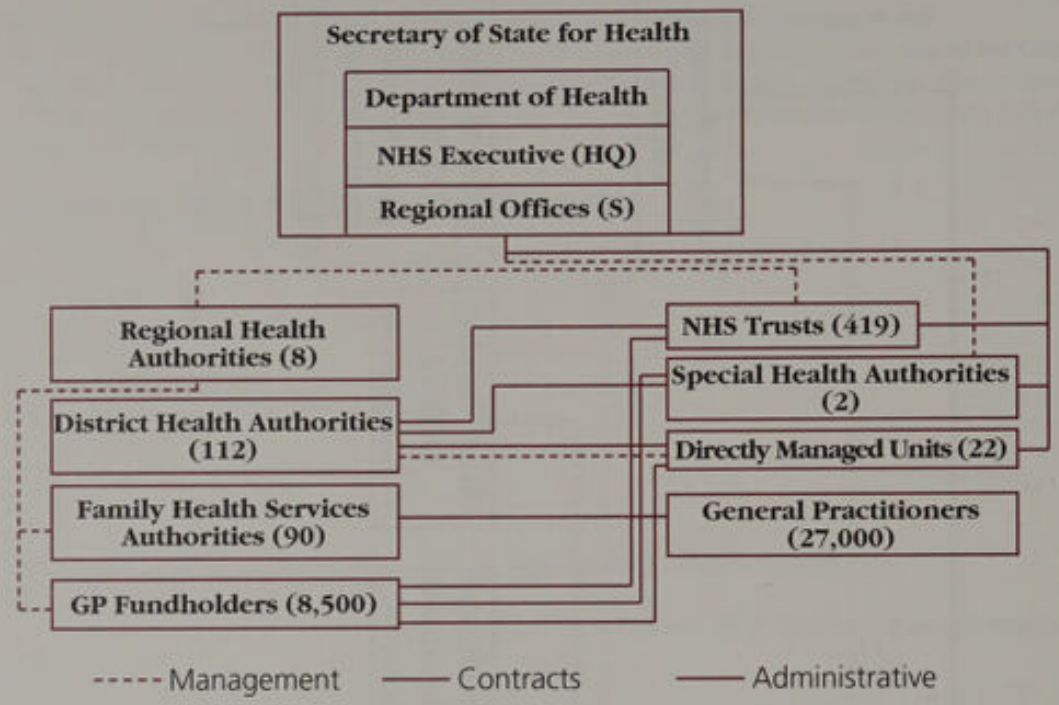
Acute services (including cancer)
Ambulances
Blood
Capital investments
Civil Defence
Clinical Standards Advisory Group (CSAG)
Confidentiality
Hospices
Deregulation
DH management (including Next Steps)
Family planning
Hospital security
Human Fertilisation & Embryology Authority (HFEA)
Income generation
Laboratories
Information & information systems
Information technology
Medicines Control Agency (MCA)
NHS appointments - North West, Northern & Yorkshire Regions
NHS casework: closures, mergers, AIPs, Trusts
NHS Estates
OPCS
Pharmaceutical industry
Private finance initiative
Private sector
Statistics
Supplies
Transplantation
VFM/competitive tendering

PARLIAMENTARY SECRETARY (PS(L)) - Baroness Cumberlege CBE

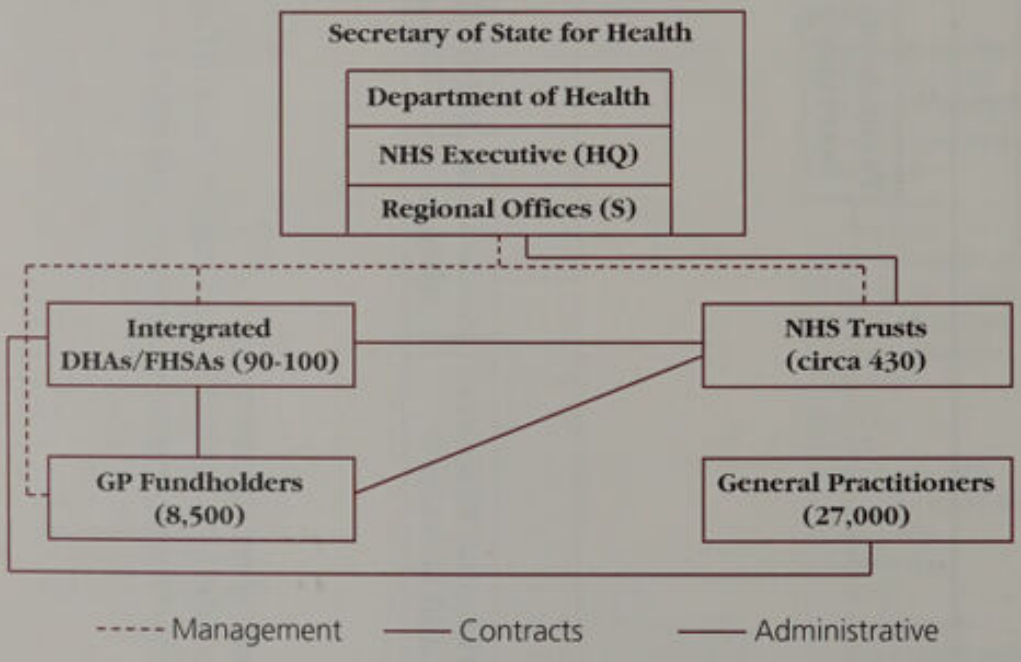
Abortion Aids/HIV
Alternative therapies
Environmental health
Ethnic issues
Food hygiene
Green issues
Health Education and Promotion
Health of the Nation
Hospital Chaplaincy
Infectious diseases
Inner cities
Nursing
Nutrition
Opportunity 2000
Professions allied to medicine
Public health
Health strategy
Smoking
Vaccine damage
Women's health including: maternity services breast and cervical cancer services (including screening)

ANNEX D
CURRENT STRUCTURE OF THE DEPARTMENT OF HEALTH

ANNEX E
CURRENT STRUCTURE OF THE NHS



PROPOSED STRUCTURE OF THE NHS



ANNEX F
PRIORITIES AND KEY CHALLENGES: 1994/95 to 1997/98

1. To protect, promote and improve the health of the nation

1994-95 Priorities and Key Challenges	1994-95 Key Achievements
Promote better health by developing and securing action on the national strategy for health in the Health of the Nation White Paper.	See paras 4.2 to 4.16
Raise public awareness of factors affecting good health through effective public education on healthy lifestyles, with particular reference to the key areas identified in the Health of the Nation White Paper and secure the adoption by individuals, other government departments, local authorities, corporate bodies, and employer and employee organisations of strategies and plans of action to raise standards of physical and mental health.	See paras 4.4 to 4.5
Take forward Health of Nation initiative with NHS and the Health Professions to ensure an effective contribution to achieving targets, monitoring performance towards them through suitable indicators.	
Monitor the Health of the Nation through the Department's Health Survey Programme.	See paras 4.13
Ensure a strong input to the development of environmental health and related consumer protection policies, including food safety, and secure their effective implementation.	With Departments for Environment, set health-based air quality standards for benzene and ozone. UK established key position in health related areas of biotechnology and genetic modification within the international arena (OECD/WHO). Review of vertical food hygiene directives. Consultation completed on major UK initiative likely to influence EC activity.
Seek to strengthen the arrangements for controlling communicable diseases and other health hazards, and for providing information about them.	Nationwide school-based campaign offering immunisation against measles and rubella to children from 5 to 16 in order to prevent a measles epidemic predicted for 1995 (see para 4.18). The replacement of tetanus vaccine for school leavers by a combined tetanus and low-dose diptheria vaccine in order to increase immunity and provide extra protection. The publication of authoritative, up-to-date information on immunisation against infectious diseases, and of advice to people travelling abroad.

	Revised guidance issued on management of HIV infected health care workers.
	The Medical Devices Agency was launched in September 1994 (see Annex G).
Safeguard public health by ensuring that medicines and medical devices sold or in use in the UK meet appropriate standards of safety, quality and efficacy.	Regulations made to regulate most medical devices from 1 Janaury 1995.

2.To ensure high quality health care through the NHS, and high quality social care through local authorities and other agencies

1994/95 Priorities and Key Challenges	1994/95 Key Achievements
Achieve the objectives and targets for improving health, community care, quality of care, efficiency and value for money and purchasing and organisational development set for the NHS in the priorities and planning guidance for 1994-95 in EL(93)54.	Corporate contracts agreed between RHAs and NHS Executive with region specific targets. Improving health: see para 4.8; community care: see paras 4.65 - 4.70; quality of care: see paras 4.27 - 4.32; efficiency and vfm: see paras 5.25 - 5.27; purchasing: see paras 5.9 - 5.12
Maintain and where necessary improve joint working between health and local authorities, and encourage them to keep effective joint working where local structures change.	Guidance to assist new Social Services Authorities published by May 1995.
Encourage the NHS to achieve the standards of quality of service to individuals set out in the Patient's Charter and subsequent extensions of the Charter, and develop the Health Information Service following its evaluation, together with other initiatives to facilitate patient empowerment and develop and introduce a code of practice on openness in the NHS.	See para 4.27 - 4.32
Promote the continued development of Clinical Audit, as a vehicle for improving the quality of health care and the efficiency of its delivery.	See para 4.25
Improve the effectiveness of the internal market in securing improvements in patient care and consumer choice by strengthening purchasing, mergers of DHAs and preparing legislation to enable DHAs and FHSAs to merge, completing the move to Trust status of providers, promoting fundholding so that all GPs who are able and wish to can become fundholders and ensuring that the internal market operates to increase competition between providers.	See para 5.1 - 5.17
Implement ministerial decisions on "Making London Better", continue to promote the development of primary and community services appropriate to the needs of the diverse population in London and develop and agree plans to implement strategic changes in acute services and medical education institutions.	See paras 4.49 - 4.52

Take forward implementation of the Expert Maternity Group report "Changing Childbirth".	See paras 4.36 - 4.38
Increase the effectiveness of the NHS by strengthening through the Research and Development programme the scientific basis for defining strategies in health care, operational policy and management.	See Chapter 4. In addition: Jenner Institute for Vaccine Research launched on 5 December 1994 – innovative partnership between Government and industry in line with White Paper on Science and Technology.
Ensure that the NHS can secure the staff resources it needs to achieve its goals; that it uses these resources as productively as possible; that equal opportunities programmes are effectively implemented, with particular emphasis on the achievement of Opportunity 2000 Targets, that staff are properly motivated and treated fairly and responsibly; and that individual potential and skills are developed to contribute as fully as possible to the work of the NHS.	See paras 5.58 - 5.61
Plan and provide for an adequate and affordable supply of appropriately trained doctors; including action required to increase the overall supply of qualified medical staff to the NHS by implementing the recommendations of the Medical Manpower Standing Advisory Committee, to monitor the adequacy of supply against projected demand; and implement the recommendations in the Report on Specialist training in the UK, within an overall framework of cost-neutrality.	See box following para 4.64
Carry forward plans for the improvement of the remuneration system for general dental practitioners.	See paras 4.58 - 4.60
Ensure that the Information Management and Technology strategy for the NHS continues to be maintained, developed, and implemented throughout the NHS to support better care and communications.	Business cases for NHS wide Networking and NHS number projects agreed with treasury. NHS wide clearing services agreed with NHS Executive
Following the report of the Complaints Review Committee implement revised complaints procedures in the NHS which are fair to both complainants and staff.	See para 4.33
Improve corporate governance in the NHS by the implementation of Codes of Conduct and Accountability throughout the NHS.	See paras 5.18 - 5.19
Introduce revised arrangements for the appointment and induction of NHS Chairmen and non-executives.	Initial research into induction and development requirements for board members; plans for further development in 1995-96.
Monitor and develop community care for all client groups.	Framework for Local Community Care Charters launched in November 1994.

Monitor and develop children's services, reinforcing child protection services where necessary and carrying forward the reforms of children's residential care.	New self monitoring questionnaire developed. Issued to Social Services Departments in July 1994.
Strengthen social services provision for young offenders and those at risk of offending and encourage the increase in local authority secure accommodation necessary to implement angovernment juvenile justice policy.	See paras 4.71 - 4.75. in addition: Second Children Act Report presented to Parliament in May 1994, confirming that the number of children in local authority care and on child protection orders continued to decline New guidelines for doctors on medical responsibilities in child protection were issued inOctober 1994. Supply plan for the provision of an additional 170 local authority secure places for criminal justice purposes presented to Parliament in April 1994. Pilot project commissioned to develop training materials for staff working with difficult adolescents.
Introduce new adoption legislation if possible.	See paras 4.81 - 4.82
Carry forward the change agenda in social services regulation and inspection including the development of joint SSI/Audit Commission Reviews of Social Services Authorities.	Guidance on applying Citizen's Charter principles to social services inspection issued April 1994. See para 4.69. Proposals for improving the regulation of residential care and nursing homes issued for consultation in August 1994. Format and content of joint SSI/Audit Commision Reviews to be published early in 1995 for full consultation.
Strengthen through research and development the scientific basis and evaluation of social care policy and delivery.	See paras 4.19 –4.21. In addition, new centre for Research and Development in Primary Health Care set up at Manchester University to foster knowledge based primary health care.
Seek to improve standards of training, management and practice throughout the PSS.	A new initiative has been introduced under the Training Support Programme to encourage Social Service Departments to increase their provision of practice placements for DipSW students. A further 130 students were seconded to professional DipSW training under the Residential Child Care Initiative. Increasing numbers of staff are registering for and achieving national vocational qualifications.

Implement Ministerial decisions on the reform of social work training and changes to the Central Requirements for the Diploma in Social Work.	CCETSW has reviewed the Rules and Council for Education and Training in Social Work. New system to be available for 1995 student intake. New business structure for CCETSW introduced April 1994, supported by a new streamlined committee structure, with smaller, more strategic Council from September 1994. Clear statement of knowledge, skills and professional standards required of newly-qualified social workers was published in June 1994.
Carry forward the Secretary of State's 10-point plan for improving services in the community for hose who are mentally ill, including amendments to the mental Helath Act 1983 if legislative time can be found.	See paras 4.94 - 4.46. In addition: In April supervision registers were introduced for new patients of the specialist psychiatric services. New guidance on the discharge of psychiatric patients was issued in May 1994. The Mental Health Task Force has led a review of services in London, and facilitated the development of local action plans agreed between health, social services and other key agencies in each part of the capital.
Develop services for mentally ill people, people with Mental Illness Key Area Handbook published offenders in the light of Health of the Nation and the reports of the Working Group on services for people with learning disability and challenging behaviour, the reports of the Health Advisory Service, the Mental Illness Task Force and the Review of Services for Mentally Disordered Offenders.	See paras 4.44 - 4.46. In addition: A revised edition of the Health of the Nation learning disabilities and mentally disordered New guide to inter-agency working issued for consultation. NHS required to develop services for mentally disordered offenders as a first order priority in 1994-95. £45 million from central capital funds allocated between 1991 and 1995 to support the development of more than 500 new medium secure places.
Develop communication strategies to promote public understanding of the progress and achievements of the NHS and ensure effective communication channels are in place with related agencies involved in planning and providing health and social services.	To be completed

3.To enable the UK to play an effective part in the work of the European Community and other international health and social services bodies

1994-95 Priorities and Key Challenges	1994-95 Key Achievements
Make a full contribution to consideration of future EC Directives in policy areas relevant to the Department and seek to ensure EC action in	Amendments to the Young Workers' Directive and Data Protection Directive.

these areas is consistent with the principle of subsidiarity and does not go beyond what is necessary to achieve the objectives of the treaties.	Secured more coherence between public health activities and EC biomedical research programme.
Contribute to further work on public health in the EC and ensure effective implementation in the UK of EC Directives in areas of policy in which the Department has the lead interest.	A favourable Health Council resolution reflecting UK prioritis and goals for the future of the EC framework for Action in the Field of Public Health.
Provide an effective UK input on health and social care issues to the work of the WHO and Council of Europe and other international bodies.	The UK was successful in obtaining one of the six places on the newly-formed Administration, Budget and Finance Sub-Committee of the Executive Board which has a leading role in the reform of WHO now under way.
Promote, as the sponsoring Government Department, UK health care exports.	Overseas Projects Board Health Sector Group established for the promotion of health care exports. Major British healthcare seminar and exhibition in Bangkok in October 1994. Department of Health sponsored stand at the Taipei Medical Equipment Exhibition in November 1994.
Foster productive co-operation with other countries in respect of Health and Social Services.	The UK continued to foster links with central and Eastern Europe under Health Co-operation Agreements and to offer assistance to health programmes. A plan of co-operation under the Health Co-operation Agreement signed with Russia in 1993 was agreed, and revised plans were signed with Hungary and Poland covering the exchange of specialists over the next few years.
Take forward UK aspects of EC (Helios II), Council of Europe, and UK disability programmes.	See para 4.80

4.To ensure that programme expenditure has a clear purpose which is right for the 1990s, that it is used cost-effectively and that value for money is achieved

1994-95 Priorities and Key Challenges	1994-95 Key Achievements
Complete and follow through fundamental review of health expenditure to ensure that resources for the NHS are used ever more efficiently and effectively, and that the potential for savings is exploited energetically.	Fundamental review completed in 1994-95. The Department will continue to exploit every opportunity to make effective use of resources and make savngs to be ploughed back into the NHS.
Manage the NHS effectively and efficiently within the resources provided for 1994-95. Secure increases in activity or improvements in quality in line with the growth in resources adjusted for GDP and health service specific inflation, plus an addition reflecting overall efficiency gains of at least 2%.	See Chapter 3 and Chapter 5.
Continue to develop the enabling role of local authorities by promoting more independent (private and voluntary) provision, seeking more joint commissioning of services by health and local authorities and through the vigorous pursuit of value for money.	Direction on consultation requres local authorities to consult the independent sector on plans for day and domiciliary care. Joint commissioning development project established.

Ensure that the policies pursued by the Department, the NHS and local authorities pay due regard to the need to avoid unnecessary regulatory burdens on business and on others.	Most proposals from Business Task Forces implemented, and work under way on proposals from the Voluntary Organsiations Task Force. Assessments of potential costs to business and the voluntary sector now built in to policy making. Reviews of existing legislation complete or under way.
Ensure that the Department obtains the information, analysis and advice it requires to support policy development, to control expenditure and to monitor ministerial policies.	Redevelopment of Hospital Episodes Statistics system on target. Further reductions and rationalisation of existing central returns from hospital and community health services. An Executive Information System implemented to give senior managers in the NHS Executive headquarters and in regional offices access to key performance measures.

5.To secure value for money from the resources available for the Department's running costs

1994-95 Priorities and Key Challenges	1994-95 Key Achievements
Implement the 'Managing the New NHS' changes to ensure that the Department is organised and resourced to manage the NHS efficiently, effectively and economically; following the review of the wider Department of Health implement Ministerial decisions on its outcome, and ensure that effective links are maintained between the NHS Executive and the wider Department.	See paras 5.2 - 5.8.
Develop and implement personnel policies to ensure that all DH managers maintain the quality and quantity of output, and maximise the potential of their staff; and take the necessary action to meet the national standards of Investors in People. Promote further links between performance and pay, introducing necessary changes to the new appraisal system, and implement equal opportunities programmes.	Completed diagnostic review comparing DH position against the Investors in People standard and developed action plan to achieve compliance with the standard by October 1996. Initiated study of terms and ocnditions of service for RHA employees who may transfer to the NHS Executive in April 1996.
Implement the Open Government Code of Practice throughout the Department of Health.	See para 5.20
Identify ways in which the OIS achieves maximum benefits and plan for its enhancements in the Department and links to the NHS.	See para 5.90
Establish the Medical Devices Directorate as a Next Steps Agency; initiate review of the Medicines Control Agency.	See ANNEX G
Complete, to time, the market testing programme for 1993-94 and begin implementation of the 1994-95 programme; and, as appropriate, introduce internal charging into selected areas. Implement strategies to meet the personnel consequences of market testing.	See paras 5.86 - 5.87

PRIORITIES AND KEY CHALLENGES 1995-96 - 1997-98

The Secretary of State's priorities for the following three years are:-

a) To protect, promote and improve the health of the nation

i. Promote better health by developing and securing action on the national strategy for health in the Health of the Nation White Paper.

ii. Implement NHS aspects of the Health of the Nation White Paper so as to achieve the health targets set by the Government.

iii. Respond effectively to demographic pressure, advance in care and treatment and other developments, especially in the fields of care of the elderly, ethnic groups, perinatal, infant and child health, tobacco, drug and alcohol misuse, HIV/AIDS and sexual health, and mental health.

iv. Carry forward measures to prevent or contain communicable diseases, including food and waterborne infections, to minimise the effect on health of environmental pollution and to ensure the safety of food.

v. Safeguard Public Health through maintenance of appropriate quality standards for medicines and medical devices for human use.

vi. Review mental health legislation to keep up to date legal powers in respect of patients.

b) To ensure high quality health care through the NHS, and high quality social care through local authorities and other agencies

i. Extend the programme of improvements in consumer based quality standards initiated in the Patient's Charter.

ii. Ensure that health and social services care objectives continue to be effectively delivered, jointly where necessary, as NHS and local government structures develop.

iii. Secure further developments in the internal market.

iv. Implement the strategic changes of health services in London following ministerial decisions on "Making London Better".

v. Ensure implementation of the Expert Maternity Group report "Changing Childbirth" will be completed by the end of 1988.

vi. Continue to monitor the quality and supply of medical staff against the requirements of the NHS and in particular appropriate action to ensure that measures are introduced by the GMC to safeguard the quality of medical performance.

vii. Increase the effectiveness of the NHS by strengthening through the Research and Development programme the scientific basis for defining strategies in health care, operational policy and management.

viii. Ensure the appropriate provision is available for the education and training of professionals in order to provide high quality care.

ix. Ensure that there is appropriate development of the skills base allowing erosion of professional boundaries without loss of professional identity where this is in the interest of patient care, efficiency and effectiveness.

x. Encourage and where necessary make central provision for the extension of performance pay in the NHS, particularly amongst health professionals, in the light of the Citizen's Charter commitments.

xi. Implement the policies set out in the report of the expert Maternity Group.

xii. Develop Health Care Strategy Unit work on exploring strategic NHS/Health Care issues.

xiii. Implement policies on the development of high security psychiatric care, especially in the light of decisions on the report about psychopathic offenders.

xiv. Implement adoption legislation after enactment; pursue further improvements in child protection and children's residential care and the further development of the social services role in juvenile justice issues.

xv. Monitor the implementation of the new arrangements for community care set out in Caring for People and the NHS and Community Care Act 1990 and seek to raise further standards of care.

xvi. Develop work on community care and its effects on people who are old, disabled and/or mentally disordered, bearing in mind current developments in local Government reorganisation.

xvii. Conduct a fundamental review of social services inspection in 1995.

c) To enable the UK to play an effective part in the work of the European Community and other international health and social services bodies

i. Maintain an appropriate and effective UK contribution to the health, and other relevant policies of the EC, WHO and other international organisations.

ii. Establish MDA as the Competent Authority for the UK in implementing the Directive for in vitro diagnostic devices.

d) To ensure that programme expenditure has a clear purpose which is right for the 1990s, that it is used cost-effectively and that value for money is achieved

i. Continue to improve value for money in health expenditure, with better targeting of resources, setting and achieving measurable improvements year on year in NHS efficiency.

ii. Ensure that the Department obtains the information, analysis and advice it requires to support policy development, to control expenditure and to monitor the Health of the Nation and the personal social services.

e) To secure value for money from the resources available for the Department's running costs

i. Keep the Department's organisation and structure and working methods under review in the light of the "Managing the New NHS" changes, and work on the functions and structure of the wider Department.

ii. Keep personnel policies under constant review to reflect the change happening in the Department as a whole; develop and implement policies for the terms and conditions of DH staff as powers are delegated from the Treasury to Departments; continue to carry out initiatives to implement equal opportunities policies and health programmes to promote the health of staff and gain accreditation as an Investor in People by 1995-96.

iii. Continue to implement VFM initiatives, including purchasing, market testing, privatisation, and development of Next Steps Agencies.

iv. Implement decisions arising from the three-yearly review of the MCA Framework Document and initiative framework reviews of the NHS Pensions Agency and the Medical Devices Agency.

v. Continue to exploit the opportunities offered by the Office Information Strategy to manage the business of the Department more efficiently and effectively; implement a new IT agenda including electronic mail connection into the NHS and other institutions.

ANNEX G
EXECUTIVE AGENCIES OF THE DEPARTMENT OF HEALTH

Estates Management and Health Building Agency ("NHS Estates")

1. The Department's former Estates Directorate was launched as an executive agency on 1 April 1991. The Agency's task is to support Ministers, the NHS Executive and the NHS in the management of its £24 billion estate and annual capital investment programme of over £1.5 billion. It employs about 130 staff with a total annual expenditure of about £9.2 million.

2. The Agency's main objectives are to encourage effective, efficient and economical management of the property used for healthcare and to promote excellence of design, with value for money, in new buildings. As property advisers and consultants to the healthcare industry, the Agency provides advice to Government on health estate policy. It also offers professional consultancy services to all branches of the NHS, the private sector, and overseas clients.

3. **Key tasks and targets 1994-95**

- To quickly develop relationships with redefined clients, following the reviews of the wider Department and the central management of the NHS.
- To demonstrate an increasing degree of customer satisfaction through contract reviews and customer surveys.
- To assist the NHS Executive and Ministers in achieving their key estate objectives.
- Following the reviews of the wider Department and the central management of the NHS, to make any necessary amendments to the new agreement with the NHS Executive and to establish key service level agreements (SLAs) with redefined clients.
- To increase revenues from the NHS and private sector to 95% (100% in 1995-96) of the cost of services provided, equivalent to 49% (51% in 1995-96) of total agency costs.
- To increase revenues from both UK consultancy and publications by 5% each per annum.
- To achieve final BS5750 quality assurance accreditation by 31 December 1994.
- To develop output/unit cost measures and monitor trends during 1994-95 as the basis for implementing a cost - weighted activity index from 1 April 1995.
- While at least maintaining output, to keep within allocated cash limits making a minimum saving of 4% on running costs expenditure, and 2% on other expenditure.
- To untie to NHS customers a further £971,000 of resources during 1994-95.

4. The 1993-94 Annual Report and Accounts were published in July 1994 and contain more information on the Agency's activities. Copies of this document are available from Lisa North, NHS Estates, Trevelyan Square, 1 Boar Lane, Leeds LS1 6AE. Tel: 0532-547076.

The NHS Pensions Agency

1. The NHS Pensions Agency, launched on 20 November 1992 employs 524 staff with running costs of around £20 million. The Agency administers the NHS occupational pension scheme for England and Wales which, with over one million members is the largest - and probably the most complex of its kind in Europe.

2. The Agency's main objectives are to provide a timely, accurate and helpful service to its customers - health authorities and pension scheme members; to ensure that the annual turnover of income and expenditure, amounting to some £3.1 billion, is properly handled: to maximise value for money from its running costs; and to provide Ministers, the NHS Executive and other interests with timely and high quality advice and information on pension matters. The Agency is based at Hesketh House, 200-220 Broadway, Fleetwood, Lancashire, FY7 8LG.

Key Targets 1994-95

SERVICE STANDARDS

Product	Clearance Standard	Long Term Target	Key Targets 1994-95
Pension Awards For incapacity awards the period starts from confirmation of medical incapacity	within 4 weeks of receiving application from employer	95%	95%
	within 8 weeks of receiving application from employer	99%	99%
Pension Estimates (Non-Practitioner)	within 4 weeks of receiving request	95%	95%
	within 8 weeks of receiving request	99%	99%
Pension Estimates (Practitioner)	within 5 weeks of receiving request	95%	80%
	within 8 weeks of receiving request	99%	99%
Transfer Payments	within 8 weeks of receiving application	99%	99%
Transfer Estimates	within 8 weeks of receiving application	99%	99%
Correspondence	all replies to be sent within 4 weeks	100%	100%

Efficiency Gains

Ensure that the Agency's expenditure is contained within running costs and other cash limits and deliver at least 5% efficiency gains.

Medical Devices Agency

1. The Medical Devices Agency was launched in September 1994. It safeguards public health by ensuring that medical devices and equipment for sale or for use in the United Kingdom meet appropriate standards of safety, quality and performance. It has 170 staff, mainly in London but with some in Blackpool and Surrey, and running costs of £12 million.

2. The Agency audits manufacturers' quality assurance systems, investigates adverse incidents with devices in use and issues safety warnings, manages an evaluation programme, helps set safety and performance Standards, and offers advice on medical device safety to a wide range of customers. It leads for the UK in negotiating and implementing a series of European Directives. Acting as the Competent Authority for the UK, it enforces the Directives, appoints and monitors Notified Bodies who ensure that manufacturers comply with certain requirements of the Directives, and assesses applications from manufacturers for clinical investigations.

Key Targets 1994-95

3. The Agency's key targets for the current year are to:

- Establish a programme of proactive investigations of serious device-related safety problems and report outcomes.
- Establish investigations of adverse incidents with devices undergoing clinical investigations.
- Implement a Service Level Agreement with the Secretary of State, for Public Health and Competent Authority functions.
- Develop a marketing and sales strategy for the evaluation programme and establish an advisory customer group.
- Operate within a variety of time limits for processes of the Manufacturers' Registration Scheme.
- Issue 65% of Hazard Notices within 30 days and 100% within 3 months.

- Remain within running costs and other cash limits.
- Develop systems for accruals accounts for 1995-96.
- Recover 40% of MRS costs in 1994-95 and develop mechanisms to recover 65% in 1995-96.
- Introduce charges for services to Notified Bodies and for applications for clinical investigations.
- Develop mechanisms for untying 20% of evaluation programme funds.
- Develop information systems to improve management control and target setting and to enable development of a corporate efficiency index.
- Develop a market testing programme; renegotiate Evaluation Centre contracts and develop new tendering procedures.

Medicines Control Agency

1. The Medicines Control Agency (MCA) was launched as an executive agency on 11 July 1991 and became a trading fund on 1 April 1993. The MCA is the UK regulatory authority charged with protecting public health through the control of human medicines. It carries out this task through a system of licensing, inspection, monitoring and enforcement and operates under the Medicines Act and European legislation. The Agency employs 400 staff and has an annual turnover of about £20 million derived from fees charged to the pharmaceutical industry. These fees wholly cover the Agency's costs.

Key Tasks and Targets 1993-94

2. The Agency met virtually all its high level targets for 1993-94 and in many instances exceeded them, whilst achieving an efficiency saving of over 3%. All EC multi-state and concertation applications were processed within EC timetables and there was no backlog in abridged licensing.

Key Tasks and Targets 1993-94

3. The MCA is required to meet a series of key tasks and targets, details of which are contained in its Annual Report. They include enhanced monitoring of new medicines to ensure their safety and quality, and targets for the assessment of licence applications within tight timetables and to develop agreements in Europe for greater public access to information.

Financial targets require the Agency to operate within budget (which incorporates a 2% efficiency saving) and within an external financing limit of £4.7m for 1994-95. The Agency has also to achieve a return of 6% on capital employed.

Forward Plans

4. The Agency has been closely involved in the development of the European future systems for medicines control. Its Corporate Plan addresses the changes in organisation and procedures which will be needed in order to meet the challenges of the new systems and the financial consequence of the European procedures.

The Agency has continued to invest in state of the art information technology systems. Phase I of BLIS - the manufacturing licence and inspection system - came on line and the design stage of PLUS (Product Licence User System) was successfully completed. The AEGIS network gave companies access to adverse drug reaction data and the Clinical Trials database was enhanced.

Ministers will be considering the Agency's key targets for 1995-96 in the New Year and these will be published in the Agency's 1995-96 Business Plan.

Reports and Accounts

5. The MCA's Annual Report and Accounts for 1993/94 and the Business Plan for 1994/95 may be obtained from the office of the Chief Executive. The address is Room 1628, Market Towers, 1 Nine Elms Lane, London, SW8 5NQ.

Youth Treatment Service

1. The Youth Treatment Service (YTS) was established as an Executive Unit of the Department of Health on 1 April 1992. The YTS is headed by a Chief Executive who reports directly to the Secretary of State. The YTS employs 230 staff and its total annual expenditure is around £9 million. The Service's Headquarters are at the Glenthorne Centre, Kingsbury Road, Erdington, Birmingham B24 9SA.

2. The YTS manages two specialised child care facilities at Glenthorne in Birmingham and St Charles in Brentwood, Essex, with places for up to seventy young people. The centres were set up under Section 82(5) of the Children Act 1989. The Service's aim is to help extremely disturbed young persons whose needs are unlikely to be readily available elsewhere.

3. A full accruals accounting system was introduced from 1 April 1994, and with effect from that date the accounts are subject to audit by the National Audit Office. The accounting procedures in operation are supported by vote and management accounting systems. The YTS currently recovers the costs of caring for young people placed by local authorities.

4. The YTS will aim to provide high quality care for the young people in its care, whilst ensuring value for money. Its Service Annual Plan for 1994-95 sets out key strategies and objectives which are both challenging yet realistic. The Service Annual Plan is available from the office of the Chief Executive.

Forward Plans and Future Targets

5. Forward plans, including key targets for 1995-96 will be considered by Ministers early in 1995.

Publication of Reports and Accounts

6. Each year the Chief Executive produces and signs an Annual Report and Account of the Service's activities for the approval of the Secretary of State. It is then placed in the Library of both Houses of Parliament. The report for 1993/94 was published in July 1994; that for 1994/95 will be available in July 1995.

ANNEX H
CENTRAL HEALTH AND MISCELLANEOUS SERVICES

The main central services funded through the CHMS are described below.

DENTAL PRACTICE BOARD: The DPB's role is to check and price some 38 million remuneration claims from dentists in the General Dental Service; make the resultant payments (of some £75 million per month) to 22,000 dentists' contracts; maintain the registration of over 30 million patients; monitor dentists' activities for quality and probity and take action where necessary. Its administration costs in 1993-94 were £24.5 million. The Board's performance is regularly reviewed with the Department. The Board plans to continue to reduce unit costs, year on year, over a 5 year cycle. Investment in an Electronic Data Interchange programme now means that some 21 per cent (6.5 million) of claims are received by computer. To date, market testing of some £8 million of the DPB's activities has been completed.

SPECIAL HOSPITALS SERVICE AUTHORITY: The Authority is responsible for running the three special hospitals at Ashworth, Broadmoor and Rampton which provide a statutory service of care and treatment for about 1,600 patients under conditions of special security. The Authority's other responsibilities include rehabilitation services, promoting research into forensic psychiatry and developing links with other NHS psychiatric services. The £120 million expenditure relates principally to the cost of 3,600 staff, administration and the headquarters establishment. The Authority is continuing with the policy of changing the emphasis of the culture from a custodial to a more therapeutic regime and is making significant progress on the issues which arose from the Inquiry into complaints at Ashworth Hospital. 24-hour nursing care is now available in 50 per cent of wards and is planned to extend to all wards by April 1996. Following a thorough review of security at special hospitals, the Authority has agreed a programme of changes to meet the recommendations made, including work on physical security. An Action Plan for the Authority has been agreed at this year's Ministerial Review with tasks for the coming year for : quality of care/security, joint action with other agencies, openness to other views and influences, staff development, and managing the business. In 1994-95 the Authority aims to achieve overall efficiency savings of 2.25 per cent of the revenue budget (amounting in total to over £2 million). Market testing was undertaken for all hotel services. Elsewhere estate management services have been put out to tender and at one hospital the contract has been awarded.

PRESCRIPTION PRICING AUTHORITY: The Authority calculates the amounts due for supplying drugs and appliances prescribed under the NHS. Over 480 million prescriptions are issued each year. The Authority also produces detailed information to GPs and health authorities about prescribing trends and drug usage and is responsible for issuing the monthly Drug Tariff. Under the NHS Low Income Scheme, the PPA assesses some 1.2 million claims for the remission of NHS charges in respect of prescription, dental and other chargeable services. The Authority's costs for 1993-94 were £42 million. Various performance targets have been set for the Authority's work; the cost per priced prescription is continuing to decrease steadily and numbers of prescriptions priced per pricing staff member has increased from 234,000 in 1988-89 to 257,000 in 1993-94. Savings have been made in the operation of the Low Income Scheme and more are expected as the Authority take on more directly recruited staff. Further efficiency savings are being pursued through a rolling programme of market testing. The first contracts, for the prescription pricing service, covering 75 per cent of the PPA's staff, are due to take effect during 1995.

VOLUNTARY SECTOR SUPPORT: The aim of the £50 million annual funding by the Department of Health of the voluntary sector is to support and promote Ministers' policies, priorities and objectives across the entire spectrum of HPSS activity. Funding goes primarily to national voluntary organisations and is not designed to supplement or replace statutory funding for local voluntary groups. Voluntary sector funding is an effective means of developing models of good practice in particular areas of provision, encouraging voluntary sector involvement in the delivery of health and personal social services, and reducing dependence on public sector funding of these services. The largest of the current schemes with a provision of £19.5 million in 1994-95 is the Section 64 General Scheme, but there are also some time-limited schemes which have been launched to promote specific Ministerial initiatives. Each scheme has its own set of objectives and output, and performance is measured against these. Grants awarded under the Section 64 General Scheme are monitored and reviewed in accordance with guidance agreed with H M Treasury. Every year the Treasury selects for review six voluntary organisations, grant aided under the Scheme, to satisfy itself that the agreed criteria have been properly applied.

CENTRAL COUNCIL FOR EDUCATION AND TRAINING IN SOCIAL WORK: CCETSW has a statutory remit to promote and regulate training for social services staff at all levels and across all sectors. Its main functions are to approve and validate courses conferring social work qualifications and post qualifying programmes, approve assessment centres and the arrangement for the delivery of vocational training, and to administer

bursaries for post-graduate social work students. CCETSW receives a grant of £30 million of which £19.5 million is used for student grants. The student intake is about 5,500 a year and by the end of 1994-95 more than 16,000 are expected to be registered for vocational qualifications. Following a review by the Department of Health CCETSW, which employs about 250 staff, implemented a major programme of business and financial restructuring, which included the introduction of a set of corporate performance indicators.

HEALTH EDUCATION AUTHORITY: The HEA is required to provide information and advice about health directly to the public; support other organisations, health professionals and other people who provide health education to the public; and advise the Secretary of State on matters relating to health education. The Authority is contributing fully to promoting health in the five key areas outlined in the Government's Health of the Nation strategy. The Authority currently employs around 200 staff and has a budget of about £36 million. In 1993-94 the Authority's publishing function was launched as a simulated trading company. The improved management information systems that have been introduced resulted in savings of £700,000. Savings are also expected following the competitive tendering of the publishing warehouse and internal audit contracts. The Authority is subject to an annual accountability review.

Following a review of the HEA's role and functions, in December 1994 a radical change in how the Authority will be funded was announced. the HEA will essentially be funded on a contract basis, seeking contracts from the Department and other organisations to deliver health promotion programmes and projects for the supply of health promotion material, research and expertise. The new arrangements, which will enable the HEA to be more responsive to the needs of its customers and to provide cost effective services, will come into effect on 1 April 1996, after a year of shadow operation in 1995-96.

THE NATIONAL BIOLOGICAL STANDARDS BOARD: The NBSB has a statutory duty to maintain the high standards of quality and reliability of biological substances used in medicine, such as vaccines, hormones, blood products and immunologicals, to develop biological standards and to conduct associated research and development . It does this through its management of the National Institute for Biological Standards and Control (NIBSC). The cost to DH is £9.3 million. The NIBSC has some 300 staff and tests more than 2,000 batches of biological medicines per year (- a single batch can represent up to 500,000 doses).

During 1994 the number of batches of viral vaccines and blood products tested increased by 41 per cent and 34 per cent respectively. Nine of NIBSC's biological preparations have been established by the World Health Organisation as International Standards or Reference Reagents. From April to September 120 batches of influenza vaccine were tested in order to support increased levels of vaccination. A new measles vaccination programme was introduced in 1994 to prevent a predicted epidemic (see para 4.xx); NIBSC completed testing of 15 million doses of vaccine within 15 days of receipt of samples. Following public concern on the safety of blood products, NIBSC were able to give firm assurances on the quality of products imported into the UK as a result of the comprehensive testing carried out by the Institute.

The NBSB's performance is reviewed annually by Health Ministers. During 1993 the Board made efficiency gains of 3.5 per cent and further gains of 6 per cent are projected for 1994. The NBSB's policy of contracting-out services and market testing resulted in savings of over £150,000.

NATIONAL RADIOLOGICAL PROTECTION BOARD: The Board has the statutory duty to advance through research the acquisition of knowledge about the protection of mankind from radiation hazards and to advise accordingly. The Board provides technical services for which it levies charges. Its annual budget is about £14 million of which DH and SOHHD provide £6 million. It employs around 340 staff.

The Board participated in the development of radiation safety standards for use throughout the EU and coordinated research on radiation protection in member states. It issued formal advice on a range of issues in the UK, including the restriction of food and water after radiological accidents, radiology standards for dental care, health effects of VDUs and electromagnetic fields and the risk of cancer. The Board assessed the risk of leukaemia and other cancers from nuclear discharges of radioactivity and other sources of exposure. It promoted the reduction of patient exposure in diagnostic radiology and pursued a programme to reduce radon exposure in houses. It also studied the effects of ultraviolet radiation in support of the "Health of the Nation" campaign to prevent skin cancer.

The Boards' performance is subject to formal review annually by Health Ministers. During 1993-94 and 1994-95, efficiency savings of 2.0 per cent were achieved in each year with further cumulative cost efficiencies required for the next few years. A market testing programme resulted in savings of about £40,000 in 1993-94 and £100,000 in 1994-5.

PUBLIC HEALTH LABORATORY SERVICE BOARD: The role of the PHLSB is to improve the health of the population through the diagnosis, prevention and control of infections and communicable diseases. It does this through a network of 53 laboratories located in NHS trust hospitals together with its Central Public Health Laboratory, Communicable Disease Surveillance Centre and PHLS Headquarters at a cost of £100 million. The 3,500 staff examined almost 10 million microbiological specimens during the year. In 1993-94 PHLSB achieved efficiency savings of 2.0 per cent and further savings are being pursued for subsequent years. The Board's performance is reviewed annually by Ministers when the business plan and corporate strategies are agreed. Scientific achievements in 1994-95 include the identification of a national outbreak of a multiple-drug resistant salmonella infection, a key role in the investigation of a cluster of cases of necrotising fasciitis, advice to the DH on precautions in relation to the plague in India (see para 4.17) and the provision of scientific evidence in support of the need for a national measles campaign (see para 4.18).

ANNEX I
LONG TERM CAPITAL PROJECTS – DETAILS OF CAPITAL PROJECTS COSTING OVER £15 MILLION

			£000 at 1995-96 prices (1)				
				Current estimate of expenditure			
Project/Scheme (2)	Year of start/ original estimate of year of completion (3)	Current estimate of year of completion (3)	Original estimate of expenditure(4)	Total	Spent in past years	Estaimate provision for 1995-96	To be spent in future years
ANGLIA & OXFORD							
Stoke Manderville – future developments	1995-96/1998-99	1998-99	28.273	28.273		3.244	25.029
NORTH THAMES							
Barnet General redevelopment Phase 1A (nucleus)	1994-95/1996-97	1996-97	29.965	29.965	3.574	14.561	11,830
Southend DGH – new nucleus wards	1993-94/1995-96	1995-96	15.132	15.305	14.747	434	124
Mid Essex Orthopaedics, plastic & burns	1995-96/1997-98	1997-98	32.458	32.458		6.183	26.275
SOUTH THAMES							
Lewisham Phase 2	1994-95/1996-97	1996-97	35.437	35.438	12.155	12.298	10.985
Thanet DGH	1993-94/1995-96	1995-96	18.934	19.755	10.110	8.318	1.237
Medway DGH development	1995-96/1997-98	1997-98	49.386	49.387	554	16.486	32.347
Worthing Acute & Elderly services – main contract	1993-94/1996-97	1996-97	47.984	45.045	13.720	12.027	19.298
St Richard's redevelopment Phase 2	1994-95/1996-97	1996-97	32.320	32.094	9.046	16.234	6.454
Royal Sussex County Hospital development	1994-95/1997-98	1997-98	39.220	39.220	2.075	13.665	23.480
South Western Hospital redevelopment	1994-95/1995-96	1995-96	16.442	16.462	14.944	1.420	98
SOUTH AND WEST							
Royal Devon & Exeter Priority 2 (nucleus)	1992-93/1995-96	1995-96	39.940	39.109	36.949	1.432	728
Royal Cornwall Treliske Ph 5 contract (nucleus)	1993-94/1995-96	1995-96	16.309	22.638	16.603	5.358	677
Derriford Phase 4 accommodation main hospital	1995-96/1997-98	1997-98	27.281	27.280	407	3.383	23.490
West Dorset DGH Phase 2	1994-95/1997-98	1997-98	42.331	42.331	3.285	14.363	24.683
WEST MIDLANDS							
Kidderminster DGH Ph 6 (nucleus)	1992-93/1995-96	1995-96	14.621	15.849	12.401	2.258	1.190
Stoke City General orthopaedic development	1994-95/1996-97	1996-97	16.917	16.917	1.860	7.278	7.779
QE Hospital rationalisation of women's hospital	1993-94/1995-96	1995-96	15,200	16,416	11,140	4,657	619
Children's Hospital – relocation to Brminham GH	1995-96/1997-98	1997-98	27.100	27.100		7.878	19.222
NORTH WEST							
Hope Hospital Phase 2 Development (main phase)	1992-93/1995-96	1995-96	15.036	13.379	9.476	2.646	1.257
Royal Lancaster Infirmary Phase 3	1992-93/1995-96	1995-96	28.694	26.687	19.868	5.420	1.399
Bolton DGH major development (main phase)	1992-93/1995-96	1995-96	40.396	42.641	25.224	11.471	5.946
Stepping Hill Hospital Phase 1	1993-94/1995-96	1995-96	16.608	16.976	10.221	4.933	1.822
NORTHERN & YORKSHIRE							
North Tyneside Scheme 3 Phase 1	1993-94/1995-96	1995-96	22.225	21.400	14.679	5.408	1.313
Leeds General Infirmary redevelopment (main phase)	1994-95/1996-97	1996-97	77.481	86.231	26.250	35.418	24.563
Harrogate rationalisation of acute services	1994-95/1998-99	1998-99	35.626	35.626	3.809	8.461	23.356
TRENT							
Derby City Hospital paediatrics	1994-95/1996-97	1996-97	14,819	15,829	5,631	8,016	2,182
Northern General Phase 3A cardiothoracic	1995-96/1996-97	1996-97	20.047	20.047	895	7,807	11,345
Leicester RI oncology and opthalmology	1995-96/1997-98	1997-98	18.714	18.714		3,678	15,036
SPECIAL HOSPITALS							
Broadmoor Ward Block replacement	1991-92/1996-97	1996-97	20.800	20.800	120	50	20.630
SUMAMRY							
Schemes in progress at 31.3.95			652.437	666.113	278.247	196.126	191.740
Schemes due to start in 1995-96			203.259	203.259	1.856	48,659	152.744
TOTAL (1) (7)			855.696	869.372	280.103	244.785	344.484

(1) The original estimates of expenditure and the current estimates of expenditure on the main contract and on fees and equipment have been brought to 1995-96 prices using the GDP deflator. The expected expenditure on the main contracts has been revalued from tender base year prices using hte APSAB/FORVOP index published by PSA (Quantity Surveyor Information Notes), which reimburse a contractor for price fluctations occuring between the base date for the tender and the month in which the work is carried out on site.

(2) Included if costs together with other sources of funds e.g. University Funding Council are £15m or more.

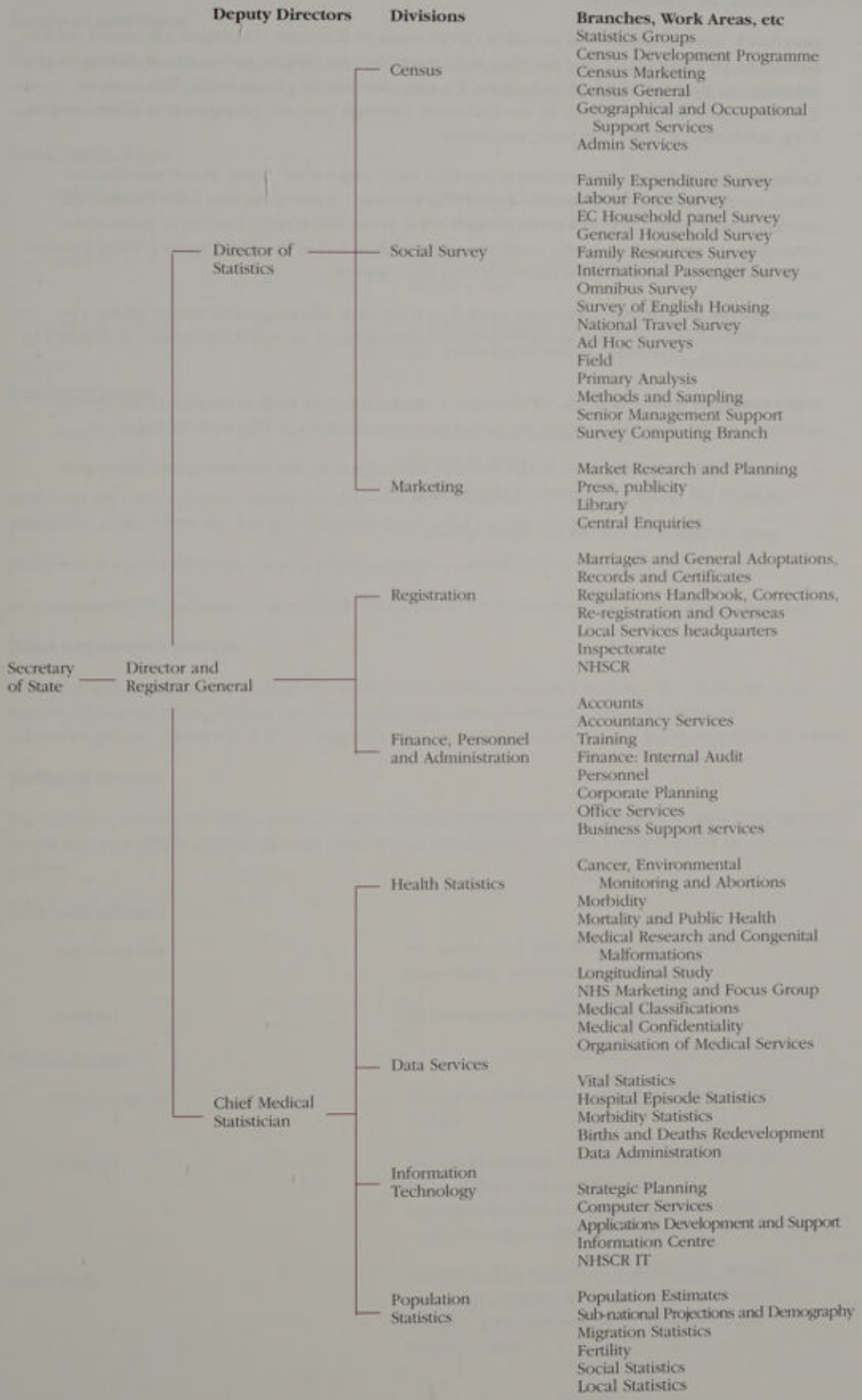
(3) The dates shown for year of start/completion refer to the main contracts or where this is not available to a provisional estimate of start/completion date. Only schemes on site during 1994-95 are itemised in the first part of the table. Schemes which will reach practical completion before the start of 1995-96 or which are due to start on site after 1995-96 are not shown there, though they may be expenditure on the latter schemes in the form of fees, equipment costs, enabling works etc.

(4) Based on accepted tender price, or if not available budget cost reconciled to expected tender date. Covers all project costs including VAT.

(5) Comparing the above projects with previous years' Estimates tables, the trend is:-

	1993-94	1994-95	1995-96
% projects with later current completion date than original	5	8	0
% projects with higher current estimate of expenditure than original	42	17	33

ANNEX J
OPCS ORGANISATION CHART (JANUARY 1995)



ANNEX K

OPCS finances fall into four sections:

- **core work**: this is undertaken in pursuit of OPCS's statutory functions. In general it is carried out for Parliament, the Government, and for "the public good", and the number and variety of customers are generally too great to make it possible (even if it were desirable) to charge for it. This work is therefore largely financed directly by the Exchequer, although there are paying customers for some of it, eg. certificates of births, marriages, and deaths.

- **Censuses**: money for specific censuses is provided on a "ring-fenced" basis. Funds provided for census are not intended to be used for other OPCS activities. Some of the data from censuses are provided under Section 4(1) of the 1920 Census Act at prices which cover the cost of publication. Other data are provided to specific customers under Section 4(2) of the 1920 Census Act and for these items the basic production cost is recovered from the customer.

- **Social Survey net control**: surveys are funded on a net basis, allowing Social Survey Division to increase its current expenditure in response to increased demand, provided the increase is matched by additional income.

- **other customer financed work**: OPCS's other customer financed work is undertaken for specific customers on the basis that they pay the cost of providing the service. This work includes:

  - most of NHSCR, some other health statistics, and support for the national cancer registration scheme (all for the Department of Health); and

  - parts of NHSCR's work (for the Welsh Office).

ANNEX L
CUSTOMER SERVICE STANDARDS

Supply of certificates

We have published a leaflet 'Tracing Records of Births, Marriages and Deaths' to help our customers and answer the most commonly asked questions. It contains the following information about our customer service standards in this area.

Public Search Room:

collect in person	certificate available on fourth working day following day of application
send by post	certificate sent by first class post within four working days
priority service	certificate available for collection on working day following receipt of application

Postal applications:

send by post	certificate sent by post within 28 days of the receipt of the letter

In general we aim to meet the targets for response in 95-96 percent of cases, except in the certificate production areas, where the aim is to meet the target in 99 percent of cases.

Performance against these standards is posted weekly in the Public Search Room.

In a separate leaflet, information is available for visitors to the Public Search Room on how to complain.

Other Registration services

We aim to give a substantive reply to casework correspondence within 5 working days of receipt of the request. However, some requests can be complex and subject to investigation. For these, an acknowledgement is sent within 3 working days with an indication as to when a full reply will be provided.

Statistical services

The statistical areas in the Office receive a great number of requests for information, ranging from questions which require a simple answer, through references to publications, to work which requires special data and analyses.

Telephone requests:

simple/routine	we aim to deal with these on the same day, immediately whenever possible.
complex	by arrangement with the caller

Written requests:

simple/routine	we aim to deal with these within 5 days of receipt
complex	we aim to provide a substantive reply within 10 days. If this is not possible, an acknowledgement is sent indicating when the customer might expect the information.
Complaints:	we aim to deal with these straightaway. Where this is not possible, an acknowledgement is sent within 3 days, followed by a substantive reply within 10 days.

ANNEX M
PUBLICATION PROGRAMME
OPCS PUBLICATIONS 1993-94

Title	Series	Publication target as at 1 April 1993	Published
Census 1991			
1991 Census Topic Report: Historical Tables Great Britain	CEN 91 HT	April 1993	14/04/93
Report on review of statistical information on population and housing (1996 - 2016)	Occ. Paper 40	not set	12/05/93
Census 1991 Topic Report: Limiting Long-term Illness. Great Britain	CEN 91 LLI	Summer 1993	06/07/93
Census 1991 Topic Report: Persons aged 60 and over. Great Britain	CEN 91 PEN	Spring 1993	14/07/93
1991 Census National Report: Great Britain. Part 2	CEN 91 CR 56	Summer 1993	31/08/93
Census 1991 Topic Report: Usual Residence. Great Britain	CEN 91 UR	Spring 1993	01/09/93
The 1991 Census User's Guide		June 1993	12/10/93
1991 Census Topic Report: Housing and the availability of cars	CEN 91 HAC	Summer 1993	04/11/93
1991 Census Topic Report: Ethnic group and country of birth	CEN 91 EGCB	Summer 1993	06/01/94
1991 Census Topic Report: Communal establishments	CEN 91 CE	Summer 1993	16/12/93
1991 Census Report for England: Regional Health Authoritites. Part 2	CEN 91 RERHA	Summer 1993	20/12/93
1991 Census Topic Report: Household composition	CEN 91 HC	1994	21/12/93
Health Statistics			
Mortality statistics: cause 1991	DH2 no 18	April 1993	29/04/93
Mortality statistics: childhood 1991	DH6 no 5	April 1993	08/07/93
Uses of OPCS Records for Medical Research	Occasional Paper 41	–	13/07/93
Congenital malformations 1991	MB3 no 7	April 1993	27/07/93
Mortality statistics: injury and poisoning 1991	DH4 no 17	April 1993	29/07/93
Mortality statistics: general 1991	DH1 no 26	June 1993	02/09/93
Mortality statistics: perinatal and infant 1991	DH3 no 25	June 1993	21/12/93
Cancer statistics: registrations 1988	MB1 no 21	August 1993	16/02/94
Mortality statistics: cause 1992	DH2 no 19	October 1993	22/12/93
Marketing			
Population Trends 72 Summer 1993	PT	June 1993	16/06/93
Population Trends 73 Autumn 1993	PT	Sept 1993	16/09/93
Population Trends 74 Winter 1993	PT	December 1993	09/12/93
Population Trends 75 Spring 1994	PT	March 1994	24/03/94
Population Statistics			
Electoral statistics 1993	EL no 20	July 1993	09/09/93
National population projections 1991 – based	PP2 no 18	May 1993	15/09/93
New Perspectives on Fertility in Britain	SMPS no 55	June 1993	07/10/93
Marriage and divorce statistics 1991	FM2 no 19	August 1993	26/10/93
National population projections: a new methodology for determining migration assumptions	OP no 42	June/July 1993	11/01/94
International migration 1992	MN no 19	December 1993	03/03/94
Social Survey			
General Household Survey 1991	GHS no 22	April 1993	28/04/93
Health Survey for England 1991	HS no 1	June 1993	01/07/93
Older people and community care	SS 1368	–	23/09/93
Essays on Blaise 1993, 2nd International Blaise Users Conference	–	October 1993	13/10/93
Smoking among secondary school children in 1992	SS 1349	July 1993	18/10/93
Day visits 1991/2	SS 1339	August 1993	25/11/93
Electoral registration in 1991	SS 1301	June 1993	16/06/93
General Household Survey 1992	GHS no 23	–	25/01/94
Health Survey for England 1992	HS no 2	Dec 93/Jan 94	17/03/94

ANNEX N
EFFICIENCY IMPROVEMENTS IN OPCS

ACHIEVED

Activity	Savings	Notes
Relocation of Registration Division from London to Southport	£1.6m p.a. from 1991-92	
Computerisation of NHSCR	£1.5m p.a. from 1991-92 (80% of saving to Dept of Health)	
Data and Voice Communication	£120,000 p.a. from 1994-95	Efficiency Review
Reprographics	£110,000 p.a. from 1994-95	Market Test
London Housekeeping Services	£80,000 p.a. from 1994-95	Efficiency Review
Social Survey Division	£2.2m (cumulative) from 1990-91 (about 2% p.a.)	Sum of recorded efficiency savings, including those arising from Computer Assisted Survey Methods
Energy Savings	£17,000 p.a. from 1993-94 (about 2.6%)	Mainly resulting from incentive contract
Purchase of Goods & Services	1990-91 £1.365m (4.7%) 1991-92 £0.896m (2.9%) 1992-93 £0.934 (3%) 1993-94 £0.595m (2%)	Savings reported annually to CUP
Reductions in Senior Staffing	£200,000 p.a.	4 posts at G3 to G6(1.4.90 to 1.1.95)

General
National Audit Office carried out a preliminary audit of OPCS's conduct of the 1991 Census. They concluded that the census operation had, for the most part, been conducted economically and efficiently. As a result they decided not to proceed with a full study.

IN HAND

Activity	Expected Savings	Notes
Redevelopment of statistical databases	£1.5m p.a. from 1995-96	Identified savings only. Improvements in functionality, quality etc. not quantifiable.
Relocation of staff from London to Titchfield	£0.2m p.a. from 1995-96	
Automated Cause Coding of Deaths	£80,000 p.a. from 1996-97	
Mainframe Operations		Market Test in progress
Housekeeping Services in Titchfield and Southport		Market Test in progress
Payroll Services		Market Test in progress

PLANNED

Activity	Current Costs/ Expected Savings	Notes
Financial Management System	Savings of £50,000 p.a. from 1996-97	Reductions in licence fees. Improvements in functionality and quality not costed
General Household Survey		Market Test in 1995-96
IT Information Centres and P.C. Support		Market Test in 1995-96
Building Management		Market Test in 1996-97
Electronic Data Interchange with Register Offices	Not yet costed	Under trial
Conversion of Registration indexes to electronic medium	Not yet costed	Under trial
Reduction in cost of storing census records	Not yet costed	For consideration in 1995
Outsourcing of 2001 Census work	Not yet costed	
Further efficiency gains in survey operations	Approx £600,000 in 1995-96	

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OPCS

See Annex M

GLOSSARY

Acute Services

Medical and surgical intervention provided in hospitals.

Business Plans

Trusts' annual plans for three years ahead.

Capital

Tangible and intangible assets or groups of assets which are capable of being used for a period which exceeds one year and have a replacement cost equal to or greater than £5,000.

Capital Charges

Capital charges are made up of depreciation and interest. Designed to provide incentives for the efficient use of capital and ensure that the prices for hospital and community services reflect the capital value of that provider's assests.

Cash Limit

A set limit on the amount of money the Government proposes to spend or authorise on certain services or blocks of services during one financial year. Cash limiting enables the Government to maintain firm control over public sector cash expenditure. For health authorities, the cash limit is the sum of initial revenue and capital cash limits and in year adjustments. It sets the limit on the total cash which may be requisitioned from the Executive for Hospital and Community Health Services in any year.

Central Health and Miscellaneous Services

These are a wide range of activities funded from the Department of Health and personal Social Services programmes whose only common feature is that they receive funding direct from the Department, and not via health authorities. Some of these services are managed directly by Departmental staff, others are run by separate executive organisations.

Community Care

Care for elderly people, people with learning or physical disabilities or a mental illness, which is provided outside a hospital setting, ie in the community.

Consolidated Fund

The Government's tax revenues and other current receipts are paid into this Fund and the largest part of central government expenditure is financed from it.

Credit Approvals

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

Depreciation

Depreciation is the annual cost of a capital asset. It is calculated by spreading the replacement cost of the asset over its estimated life.

District Health Authority (DHA)

The DHA is responsible within the resources available, for identifying the health care needs of its resident population and for securing through its contracts with providers a package of hospital and community health services to reflect those needs. The DHA has a responsibility - with the local authority and family health services authority - to ensure satisfactory collaboration and joint planning with other agencies. It is at present accountable to the regional offices for the satisfactory discharge of its responsibilities. Proposals to change the management structure of the NHS, currently before Parliament, are intended to consolidate joint working between DHAs and FHSAs to create a single health authority at local level with responsibility for implementing national health policy.

Directly Managed Unit (DMU)

An NHS hospital or unit which remains within district health authority control and has not acquired NHS trust status.

Estimates

See "Supply Estimates".

Executive Agencies

Executive agencies are self-contained units established under the "Next Steps" initiative aimed at improved management in Government. They carry out specific executive functions on behalf of the parent Department within an operational framework agreed by Ministers.

External Financing Limits (EFLs)

Cash limits imposed by the Government on net external finance for a trust. External financing is the difference between agreed capital spending by a trust and internally generated resources.

Family Health Services (FHS)

Services provided generally through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department following consultation with representatives of the relevant professions, and administered locally by FHSAs. Funding of the FHS is demand-led and not subject to in-year cash limits. The exceptions to this are certain payments to doctors in general practice (GMS cash limited spending), and expenditure by GP fundholders on drugs. Funding for these items is included in (cash limited) HCHS funds.

Family Health Services Authorities (FHSA)

FHSAs are responsible for managing the services provided under the NHS by family doctors, dentists, community pharmacists and Authority ophthalmic opticians. FHSAs are at present accountable to RHAs and work in close collaboration with DHAs. Proposals to change the management structure of the NHS, currently before Parliament, are intended to consolidate joint working between DHAs and FHSAs to create a single health authority at local level with responsibility for implementing national health policy.

General Medical Services (GMS)

Personal medical services provided by general medical practitioners: for example, giving appropriate health promotion advice; offering consultations and physical examinations: offering appropriate examinations and immunisations; arranging

GP Fundholders

Family doctors (GPs) whose practices have chosen to accept an agreed budget for part of their practice activity (covering practice staff, some hospital referrals, drug costs, and from April 1993 community nursing services) and to manage that budget themselves. These budgets are within the cash limited part of HCHS spending.

GDP Deflator

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms.

Gross/Net

Net expenditure in the context of this report is public expenditure. Gross expenditure is public expenditure plus expenditure financed from other sources, such as charges for services, receipts from land sales and income generation schemes.

Guardian Ad Litem (GAL)

A guardian ad litem is an independent social worker appointed by the court in care and related proceedings. The guardian's role is to represent the child's interests and to make a recommendation on what outcome is in the best interests of the child.

Hospital and Community Health Services (HCHS)

The main elements of these are the provision of hospital services, and certain community health services, such as district nurses, which are not provided by the FHS. These services are purchased by DHAs and provided by NHS trusts and directly managed units. HCHS provision is cash limited and also includes FHSA administration costs and funding for those elements of FHS spending which are cash limited (GMS cash limited expenditure).

NHS Trust

An NHS trust is a unit run by its own Board of Directors independently of health authority management. It has wide ranging freedoms not available to units which remain under health authority control. Trusts remain fully within the NHS. Trusts are directly accountable to Ministers via the NHS Executive and (at present) its Outposts.

National Insurance Fund

The statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid, and from which expenditure on most contributory social security benefits is met. A supplement from the consolidated Fund covers the difference between payments and receipts.

Outposts

There are currently six NHSME Outposts whose role is to monitor NHS trusts and to provide a channel of communication between the rest of the NHSME and the Department of Health. Under proposals currently before Parliament the responsibilities of the Outposts will be undertaken by the provider arm of regional offices.

Outturn

Actual expenditure.

Performance Measures:

Measures and Indicators

A measure is a direct quantification of output of some aspect of performance. An indicator is a statistic which gives some information about output or performance. For many services, performance would be described better in terms of outcome (such as improvement in health) than output (such as numbers of patients treated), but valid and reliable outcome measures are difficult to construct.

Economy

An economy measure describes the extent to which the cost of inputs in minimised. Economy is usually measured in terms of money saved by switching to cheaper inputs.

Efficiency

An efficiency measure describes the relationship between the output of an organisation and the associated inputs. Limitations in output measures are reflected in any efficiency measures derived from them.

Quality

A quality measure describes the usefulness or value of a service. A quality of service measure relates to the delivery of that service to the recipient. Outcome measures are quality measures.

Effectiveness

An effectiveness measure reveals the extent to which non-financial objectives have been met, it makes no reference to cost.

Target

A target is quantified objective set by management to be attained at a specified future date.

Personal Social Services (PSS)

Personal care services for vulnerable people, including those with special needs because of old age or physical or mental disability and children in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and social workers who provide help and support for a wide range of people.

Primary care

Non acute care which covers community and family health services.

Project 2000

Project 2000 moves pre-registration training of nurses from a work based programme in which student nurses perform rostered duties and are paid a salary to a diploma level higher education based course with work experience concentrated in the latter part of training. Project 2000 student nurses are given bursaries. Their courses of training are designed to produce registered nurse who will be better able to respond to demanding changes in nursing and in the health care environment.

Real terms

Figures adjusted for the effect of general inflation as measured by the GDP market price deflator.

Regional Health Authority (RHA)

RHAs allocate resources to DHAs and FHSAs and monitor their performance in achieving agreed objectives. They are the Department's agents for managing change and for ensuring the implementation of Government policies in the HCHS and FHS. Recent Proposals, subject to legislation include the abolition of RHAs and there replacement by eight regional offices of the NHSME.

Revenue

Expenditure other than capital. For example, staff salaries, drug budgets etc.

Secondary care

Care provided in hospitals.

Service Increment for Teaching and Research (SIFTR)

The Service Increment for Teaching and Research (SIFTR) is funding intended to compensate hospitals for the extra NHS costs of providing facilities for clinical undergraduate medical and dental education and research.

Supply Estimate

A request by the Executive to Parliament for funds required in a financial year to meet most expenditure by Government Departments and certain related bodies. The published Supply Estimates are sub-divided into groups (Classes) which contain provision (usually by a single Department) covering services of a broadly similar nature. A sub-division of a Class in known as a "Vote" and covers a narrower range of services. It is the net provision which is authorised (or "voted") by Parliament.

Specific Grants

Grants (usually for current expenditure) allocated by central government to local authorities for expenditure on specified services, reflecting ministerial priorities.

Trading Fund

A trading fund provides a financing framework which covers operating costs and receipts, capital expenditure, borrowing and net cash flow. It has powers to meet capital expenditure and working capital requirements, and to establish reserves out of surpluses. Within the framework it can meet outgoings without detailed cashflows passing through Vote accounting arrangements. 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, where he thinks this will lead to improved management efficiency and effectiveness, to set up as a trading fund a body which is performing a statutory and monopoly service whose fees are fixed by or under statute.

Vote

See "Supply Estimate".

Weighted capitation

The principle of weighted capitation is to distribute resources equitably based on the health care needs of different resident populations. A national formula is used as the basis for allocating Hospital and Community Health Services (HCHS) revenue to RHAs. The formula uses forecast resident population figures which are then weighed for the cost of care by age group, for relative health which takes the form of two separate needs indices (one for general and acute services and another for psychiatric services), and to take account of the geographical variation in the cost of providing services.

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