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

DH Department of Health

Department of Health

Departmental Report 2003

Departmental Report

The Health and Personal Social Services Programmes

This document is part of a series of Departmental Reports (CM 5901 to 5931) which, along with the Main Estimates, the document Public Expenditure: Statistical analyses 2002-04, and the Supply Estimates 2003-04: Supplementary Budgetary Information, present the Government's Expenditure Plans for 2003-2006.

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

The Government's Expenditure Plans

Departmental Report 2003

Department of Health

DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health

and the Chief Secretary to the Treasury

by Command of Her Majesty

July 2003

Cm 5904

£23.25

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This report and those of 1998, 1999, 2000, 2001 and 2002 are available on the Internet at **http://www.doh.gov.uk/dohreport/**.

The Department of Health also has a Public Enquiry Office which deals with general queries, 0207 210 4850.

Foreword by the Secretary of State

It gives me great pleasure to present the thirteenth annual report of the Department of Health.

The funding announced in the April 2002 Budget represents the largest ever sustained increase in investment in the NHS and provides an unparalleled opportunity to improve health care services for everyone.

The substantial investment we are making in the NHS is already paying dividends through falling waiting times, increased staff numbers, expanded capacity and greater choice. For example:

- only 73 patients were waiting longer than 12 months for an operation at the end of March 2003 compared with 21,869 a year earlier
- just 64 patients were waiting longer than 21 weeks for a first outpatient appointment at the end of March 2003 compared with around 40,000 a year earlier
- nationally 88 per cent of patients now can be offered a GP appointment within two working days and 91 per cent can be offered an appointment with a primary care professional within one working day
- 240,000 (4.5 per cent) more elective NHS hospital admissions in 2002-03
- 17,000 more nurses in 2002
- 2,082 coronary heart disease patients made a choice to be treated at an alternative hospital during 2002-03
- 31,000 patients a year are benefiting from new cancer drugs following NICE recommendations
- 15 diagnostic and treatment centres opened last year.

Investment alone is not sufficient to transform the NHS into the 21st century healthcare system our nation needs – it has to be matched by reform. We are now in the process of moving from a NHS controlled nationally, towards a NHS where standards and inspection are national but delivery and accountability is local. The ultimate aim of the reforms is to improve the quality of service and maximise the benefits to patients and staff.

The first step is through shifting the balance of power to the NHS frontline. The old system of health authorities and regional offices has been replaced by local primary care trusts who, in co-operation with NHS trusts, will plan and provide services for their local community. Strategic Health Authorities will then ensure the quality of service provision and delivery of local priorities within a framework of national standards.

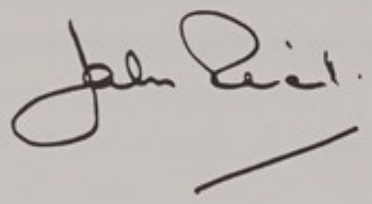
In support of this shift of power to the NHS frontline, the way NHS services are planned locally has been overhauled. Planning in the past has been done annually and constrained by time pressures and the requirement for multiple plans. For the first time ever the NHS is now able to plan over a three-year period through a single local development plan supported by local three-year allocations

We are reforming the system of healthcare delivery though the introduction of payment by results, wider patient choice and the arrival of new providers. Primary care trusts will play a pivotal role in implementing these system reforms and in building relationships with the range of new providers, including Diagnosis and Treatment Centres and NHS Foundation Trusts.

In 2003-04 we will begin to rollout pay reform covering the vast majority of NHS staff. This has three main elements, Agenda for Change for non-medical staff, a new GP contract and new consultant incentives. These reforms will deliver improvements in productivity, capacity and skills mix. For example the benefits of the Agenda for Change reforms, when fully implemented, will include an additional 16,000 qualified staff and 22,000 support workers.

These reforms to NHS systems and pay will help create a radically different health service – one that remains true to its values but is changed in its structures.

The public demands a lot from the NHS and have the right to expect delivery of high quality services that are suited to their need. The historic levels of investment we are putting into the NHS coupled to the wide ranging reform programme means we will deliver the NHS needed to meet the growing expectations of patients.



Rt Hon John Reid MP
Secretary of State for Health

Ministerial Responsibilities

Secretary of State:
The Right Honourable John Reid MP

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

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

Responsibilities include: NHS workforce issues including pay; NHS performance and access; capacity expansion; and primary care and NHS IT.

Minister of State, MS:
Rosie Winterton MP

Responsibilities include: emergency care including A&E and ambulance services; NHS Direct; adult mental health services; clinical negligence; patient and public involvement; diabetes services; transplants and organ donation; dentistry and pharmacy issues.

Parliamentary Under-Secretary of State (Lords), PS (L): Lord Warner

Responsibilities include: CHI and the NHS performance ratings; new CHAI; quality and clinical governance; NICE; pharmaceutical industry issues; genetics and biotechnology; departmental agencies and R&D.

Parliamentary Under-Secretary of State for Public Health, PS (PH): Melanie Johnson MP

Responsibilities include: cancer; coronary heart disease; tobacco policy; communicable diseases; immunisation; health inequalities; drug and alcohol misuse; and sexual health issues.

Parliamentary Under-Secretary of State for Community Care, PS (C): Stephen Ladyman MP

Responsibilities include: adult social services; older people's services; policy on carers; children's health services; services for disabled people; autism; and long-term medical conditions.

THE DEPARTMENT OF HEALTH

DH Department of Health

White = Board Directors

Sir Nigel Crisp
Permanent Secretary/NHS Chief Executive

SERVICE, POLICY & PROGRAMMES

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

NHS & SOCIAL CARE INTERFACE

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

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

CORPORATE FUNCTIONS

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

EXECUTIVE AGENCIES

MEDICINES AND HEALTHCARE REGULATORY AGENCY (Chief Executive not yet appointed)	NHS PURCHASING AND SUPPLY Duncan Eaton Chief Executive	NHS ESTATE Peter Wearmouth Chief Executive	NHS PENSIONS Alex Cowan Chief Executive

Contents Summary

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

Chapter 1 – Introduction

Introduces the report and the Department's overarching direction.

Chapter 2 – Delivering Better Public Services

This section outlines the aims and objectives of the Department. We also list the progress against those targets set following the 1998, 2000 and 2002 Spending Reviews. The 2000 Review was also informed by 15 cross-departmental reviews of issues that may benefit from a joint approach involving two or more Government departments. Some of these reviews resulted in targets that appear in our Department's Public Service Agreement. Progress is also shown against these as well as our Modernising Government action plans.

Chapter 3 – Expenditure

Chapter 3 provides information on the Government's expenditure plans up until 2007-08 and includes details of expenditure in 2002-03. Supplementary tables to this chapter can be found in the Annexes A1 to A3.

Chapter 4 – Investment

Investment continues to play a pivotal role in the modernisation of the NHS. The *NHS Plan*[0.1] and the *Departmental Investment Strategy*[0.2] set out a planned programme of investment in the NHS. This chapter serves to highlight those priorities.

Chapter 5 – Delivering the NHS Plan – Next Steps for Investment and Reform

The *NHS Plan* set the direction for modernisation and reform. It set out how an NHS fit for the 21st century will be delivered. The next steps for investment and reform were published in *Delivering the NHS Plan*[0.3] in April 2002. A summary of the progress to date in achieving those aims is given.

Chapter 6 – Breakdown of Spending Programme

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

Chapter 7 – Activity, Performance and Efficiency

Chapter 7 is broken down into 4 main areas: Activity; Performance; Efficiency and Personal Social Services activity, performance and efficiency. It provides such activity data as hospital activity, in-patient and out-patient waiting trends as well as those services provided by General and Personal Medical Services. It also demonstrates how we are making improvements in our performance and efficiency that will enable the effective delivery of services.

Chapter 8 – Managing the Department of Health

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

Annexes

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

1. Introduction

THIS CHAPTER COVERS:

1.1 INTRODUCTION
1.4 DEPARTMENT OF HEALTH
1.6 NATIONAL HEALTH SERVICE (NHS)
1.7 PERSONAL SOCIAL SERVICES (PSS)
1.8 DELIVERING THE NHS PLAN – NEXT STEPS FOR INVESTMENT AND REFORM
1.11 THE MODERNISATION PROGRAMME
1.12 DEPARTMENT OF HEALTH CHANGE PROGRAMME
1.14 PUBLIC SERVICE AGREEMENT

Introduction

1.1 This is the thirteenth annual report of the Department of Health, providing financial information about its spending programme. The Department of Health is responsible for the stewardship of over £72 billion of public funds. It advises Ministers on how best to use funding and other mechanisms to achieve their objectives, implements their decisions and supports Parliamentary and public accountability.

1.2 Chapter 3 of this report provides information on the Government's expenditure plans for 2003-04, Chapter 6 provides a breakdown of the spending programme and Chapter 7 provides an analysis of the activity, performance and efficiency with which these resources have been used.

1.3 This report has been produced and published under the new reporting framework introduced last year. It was developed in consultation with departments, Parliament and others. The new framework is intended to give departments more freedom to produce streamlined reports accessible to a wider audience.

Department of Health

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

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

National Health Service (NHS)

1.6 In his Budget statement of the 17th April 2002 the Chancellor announced additional resources for the health service in England for the five years 2003-04 to 2007-08. This provided the NHS with the largest ever sustained increase in funding of any 5 year period in the history of the NHS. Over the years 2002-03 to 2007-08, the average real terms increase will be 7.4 per cent a year over and above inflation. This means that over the same 5 year period, there will be an increase of £34 billion taking total net NHS expenditure in England to over £90 billion (£109 billion UK).

Personal Social Services (PSS)

1.7 The Chancellor also announced substantial growth in resources for the PSS in England. Over the three years 2003-04 to 2005-06, the average real terms increase will be 5.9 per cent a year over and above inflation. This compares to 3 per cent average annual growth from 1996-97 to 2002-03. This means that over the three years of the Spending Review (2003-04 to 2005-06) there will be an increase of £3 billion taking total net PSS resources to £15 billion.

Delivering the NHS Plan – next steps for Investment and Reform

1.8 The *NHS Plan*[1.1] was announced by the Prime Minister and the Secretary of State for Health on 27 July 2000. This set out the strategy for investment and reform in the NHS, alongside the Public Service Agreement targets for the NHS and Social Services.

1.9 The funding increase announced in the 2002 Budget will enable the Government to take forward the next phase of the NHS Plan. The next steps for investment and reform were published in

Delivering the NHS Plan[1.2] in April 2002. This outlined the improvements in services that the public can expect to see as the Plan is implemented. It sets out how the NHS will operate to secure the best use of resources with services being redesigned around the needs of the patient. The changes outlined in *Delivering the NHS Plan* centre around increasing choice for patients, introducing greater plurality of health service provision, encouraging health and social care to work better together, devolving power to front-line staff, strengthening local accountability and changing the way in which money flows around the NHS.

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

The Modernisation Programme

1.11 The Government is transforming the health and social care system so that it provides faster, fairer services that deliver better health, and narrow health inequalities. Modernising how people access health and social care is the key to achieving the overarching aim of helping people live longer, healthier and more independent lives. Formed in April 2001, the NHS Modernisation Agency is designed to support the NHS and its partner organisations in the task of modernising services and improving experiences and outcomes for patients. In its first year, the Modernisation Agency focused on four areas: improving access, increasing local support, raising standards of care, and capturing and sharing knowledge widely. The Agency's focus for the coming year is to maintain its innovation and to make modernisation move into the mainstream of the NHS.

Department of Health Change Programme – The New Vision for Health and Social Care

1.12 The health and social care system is being reformed to deliver a faster, more modern responsive service. The Department must do the same. Over the next 18 months the Department will become a smaller, more strategic organisation. It will work through the 28 Strategic Health Authorities as the local Headquarters of the NHS and devolve responsibility through the system. Ministers and the Department are leading a radical transformation of the whole of the NHS and social care system. This means that we need to rethink the core purpose of the Department of Health and we need to work differently to support this transformation.

1.13 The new system will place patients and users at the forefront offering them choice, information and control. There will be a clear framework of values and national standards combined with independent inspection and regulation. Clinical teams and front-line staff are increasingly being involved in decision making and planning. The Department of Health will set the direction, provide resources, lead the transformation and oversee the whole system, but it will not attempt to manage service delivery. This is a radical change: far greater devolution than we have at present, taking functions away from the centre, turning around the way we develop and implement policy. The acid test will be whether patients and users experience of getting the services and support they need improves.

Public Service Agreement

1.14 The aims and objectives of the Department of Health are enshrined in the Public Service Agreement (PSA) which was published in the HM Treasury White Paper *Public Services for the Future: Modernisation, Reform, Accountability*[1.3] in December 1998. Chapter 2 of this report sets out the aims and objectives and records progress being made to achieve detailed targets.

1.15 The 2000 and the 2002 Spending Review build on the success of these PSAs by setting further challenging targets. The 2000 Spending Review set spending plans and Public Service Agreements for 2001-02 to 2003-04. The 2002 Spending Review set spending plans and Public Service Agreements for 2003-04 to 2005-06.

1.16 The PSAs are set out in the White Papers:

2000 Spending Review: Public Service Agreements, July 2000[1.4]; *and,*

2002 Spending Review: Public Service Agreement, July 2002[1.5].

1.17 A summary table for the SR 2000 and 2002 PSA targets with progress to date is given in Chapter 2 of this Report.

2. Delivering better public services – progress

THIS CHAPTER COVERS:

2.1 INTRODUCTION

2.3 THE DEPARTMENT OF HEALTH AIMS

2.4 THE DEPARTMENT OF HEALTH OBJECTIVES

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TABLE – DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS (2000)

TABLE – DEPARTMENTAL PUBLIC SERVICE AGREEMENT TARGETS ANALYSIS (2002)

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2.24 SUBSTAINABLE DEVELOPMENT

2.30 ENGLISH REGIONAL ASSEMBLIES

MODERNISING GOVERNMENT ACTION PLANS

2.31 CORPORATE DEVELOPMENT PROGRAMME

2.35 POLICY MAKING

2.37 RACE RELATIONS (AMENDMENT) ACT 2000

2.41 RURAL PROOFING

2.45 BETTER REGULATION AND REGULATORY IMPACT ASSESSMENTS (RIAs)

2.50 RESPONSIVE PUBLIC SERVICES

2.53 E-GOVERNMENT AND IT IN THE NHS

Introduction

2.1 In setting out its spending plans for 1999-2002 in the 1998 Comprehensive Spending Review (CSR), the Government set new priorities for public spending with significant extra resources in key services such as education and health. The Government also made a commitment to link this extra investment to modernisation and reform, to raise standards and improve the quality of public services. The White Paper, *Public Services for the Future: Modernisation, Reform, Accountability* [2.1], December 1998 and its supplement[2.2] published in March 1999, delivered this commitment by publishing for the first time measurable targets (PSAs) for the full range of the Government's objectives.

2.2 A list of the Department of Health's aims and objectives, as set out in the White Paper, followed by a detailed analysis of the PSA targets resulting from the CSR and the SR2000 are set out in the paragraphs and tables below.

The Department of Health Aims and Objectives

Aim

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

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

Objectives

2.4 The key objectives in pursuing these aims are:

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

The Department of Health will do this by:

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

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

The Department of Health will do this by:

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

C. To enable people, who are unable to perform essential activities of daily living, including those with chronic illness, disability or terminal illness, to live as full and normal lives as possible.

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

- Providing care according to individual need regardless of organisational boundaries;
- Helping people to live independently, and supporting them wherever possible in their own homes;
- Giving people who need it access to effective palliative care;

And through Local Authority Social Services, by;

- Securing appropriate and effective social care for those who lack the means or other support to get the help they need.

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

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

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

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

E. To assure performance and support to Ministers in accounting to Parliament and the public for the overall performance of the NHS, Personal Social Services (PSS) and the Department of Health.

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

Departmental Public Service Agreement Targets (CSR 1998) Analysis

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

PSA Target	Measure	Progress
Target 1: Reduction in the death rate from cancer amongst people aged under 75 by at least 20 per cent by 2010 from a baseline of 139.7 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from cancer amongst people aged under 75.	**Early Stages of Delivery:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of Our Healthier Nation and the NHS Cancer Plan. Data for 1998-2000 (3 year average) show a rate of 130.9 deaths per 100,000 population - a reduction of 6.3 per cent from the baseline (1995-97). Target monitoring data for England for 2001 are not yet available because of the need to incorporate the effects of the 2001 Census on the population denominator. Death rates for the years 1995-2000 will then need to be re-based accordingly. Data on the revised basis should be available shortly.
Target 2: Reduction in death rate from heart disease and stroke and related illnesses amongst people aged under 75 years by at least 40 per cent by 2010, from a baseline of 139.6 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from heart disease and stroke and related illnesses amongst people aged under 75.	**Early Stages of Delivery:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the effects of Our Healthier Nation and the Coronary Heart Disease National Service Framework (NSF) and the NHS Plan. Data for 1998-2000 (3 year average) show a rate of 120.5 deaths per 100,000 population - a reduction of 13.7 per cent from the baseline (1995-97). Target monitoring data for England for 2001 are not yet available (for further details see Target 1) but data on the revised basis should be available shortly.
Target 3: Reduction in the death rate from accidents by at least 20 per cent by 2010, from a baseline of 16.2 per 100,000 population for the three years 1995 to 1997.	Death rate from accidents and adverse effects.	**Early Stages of Delivery:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of the strategy. Data for 1998-2000 (3 year average) show a rate of 16.3 deaths per 100,000 population – a very slight rise of 0.5 per cent from the baseline (1995-97). However other datasets (eg from HSE and DfT) indicate a downward trend in certain accidents. The Report of a cross-Government Task Force on Accidental Injuries was published on 11th October 2002, and action is being taken to implement its recommendations. Target monitoring data for England for 2001 are not yet available (for further details see Target 1) In addition, following the tenth revision of the International Classification of Diseases, the coverage of the target will be amended to include purely "accidental deaths" and to exclude deaths from "adverse effects". Data on the revised basis should be available shortly.
Target 4: Reduction in the rate of hospital admission for serious accidental injury by at least 10 per cent by 2010, from a baseline estimate of 314.4 admissions per 100,000 population for the financial year 1995–96.	Rate of hospital admission for serious accidental injury requiring a hospital stay of four or more days.	**Early Stages of Delivery:** These data are single financial year figures, available annually. Latest available data (for financial year 1999-2000) overlap the start of the OHN health strategy in July 1999. Therefore it is too early yet to assess the effects of the strategy. However, movement to date is away from the target. Single year data for financial year 1999-2000 show a rate of 320.9 admissions per 100,000 population – an increase of 2.1 per cent from the baseline estimate (1995-96).

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

PSA Target	Measure	Progress
Target 5: Reduction in the death rate from suicide and undetermined injury by at least 20 per cent by 2010, from a baseline of 9.1 deaths per 100,000 population for the three years 1995 to 1997.	Death rate from suicide and undetermined injury.	**Early Stages of Delivery:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of Our Healthier Nation and the Mental Health National Service Framework (NSF) and the NHS Plan. Data for 1998-2000 (3 year average) show a rate of 9.4 deaths per 100,000 population – a rise of 4.0 per cent from the baseline (1995-97). A National Suicide Prevention Strategy was published in September 2002 led by the National Director for Mental Health. As this is implemented it will contribute to reducing the suicide rate. Target monitoring data for England for 2001 are not yet available (for further details see Target 1) Data on the revised basis should be available shortly.
Target 6: Achieve the Government's commitment to reduce NHS inpatient waiting lists by 100,000 over the lifetime of the Parliament from the March 1997 position of 1.16 million, and deliver a consequential reduction in average waiting times.	Number of patients on NHS waiting lists.	**Met:** 1,027 million, 130,600 below the inherited level, as at the end of February 2003. Average inpatient waiting time is also decreasing – In March 1997 the estimated median wait was 13.2 weeks whereas in February 2003, the average median wait was 12.6 weeks.
Target 7: Ensure everyone with suspected cancer is able to see a specialist within two weeks of their GP deciding they need to be seen urgently and requesting an appointment for: all patients with suspected breast cancer from April 1999 and for all other cases of suspected cancer by 2000.	Percentage of patients with suspected breast cancer and other cancers able to see a specialist within 2 weeks.	**Nearly met:** 97.8 per cent of patients referred urgently with suspected cancer were seen within 2 weeks during October to December 2002. For the same period for breast cancer this figure stands at 98.7 per cent.
Target 8: Establish *NHS Direct*, so that everyone in England has access to a 24-hour telephone advice line staffed by nurses by December 2000.	Percentage of the population with access to *NHS Direct*.	**Met:** *NHS Direct* has been national since 22 September 2000.
Target 9: Improve access to and quality of primary care services through investment in line with locally agreed Primary Care Investment Plans. Key targets are:		
a) Increase equity in the national distribution of GPs. From growth of approximately 0.6 per cent whole-time-equivalent GPs in 1997 over 1996, there will be progress towards a national average annual increase of 1 per cent whole-time-equivalent GPs by 2002, using a range of new initiatives and with local variations to take account of the need to concentrate on deprived and remote areas;	Percentage national average annual increase in GPs.	**Met:** Based on the latest census data growth between September 2000 and September 2001 was 1.1 per cent whole-time equivalent for all general medical practitioners.
b) Increase investment in practice staff – 500 new practice nurses will be appointed by 2002;	Number of new practice nurses.	**Met:** Based on the latest census data there was an increase of 805 (WTE), 952 (headcount) practice nurses between September 1998 and September 2001.
Target 10: Improve the quality of primary care premises targeted towards areas of deprivation, resulting in improvements to 1,000 premises nationally by 2002.	Number of GP premises improved.	**Met:** Year end 1999-2000 indicated that 598 improvements had been made, and year end 2000-01 indicated a further 566. The PSA target was therefore met a year early with 1,164 improvements having taken place by April 2001 with more schemes underway.

PSA Target	Measure	Progress
Target 11: Connect all GP surgeries which use clinical computer systems to the *NHSnet* by the end of 1999 and all other surgeries by the end of 2002, so that more information and services can be offered closer to people's homes. As at November 1998, less than 10 per cent of GP practices were directly connected to *NHSnet*.	Percentage of GP surgeries connected to *NHSnet*.	**Met:** Virtually all computerised GP Practices have been connected. There are likely to be some dispensations agreed for a small number of surgeries where it would not be practical or cost-effective to install a connection for a short period (e.g. where the GP is about to retire, or working from temporary premises). Increased bandwidth is now being provided to make *NHSnet* services more efficient.
Target 12: Improve the quality and effectiveness of treatment and care in the NHS by establishing the National Institute for Clinical Excellence by 1 April 1999, with a view to it producing at least 30 appraisals of new or existing technologies per annum and guidance from 2000-01. The impact of the appraisals and guidance will be assessed by the use of performance indicators.	Number of appraisals of new or existing technologies.	**Met:** NICE completed 31 technology appraisals or reviews of technology appraisals during 2000 and 2001 Between 1 January 2002 and 31 December 2002 NICE completed 23 appraisals (including 1 review of an appraisal) to give a total of 54 completed appraisals, many of which covered more than one technology. There are a further 25 appraisals (of which 4 are reviews) in its work programme for 2003. The Department now assesses the workload of NICE using an improved measure which applies different weights, known as 'appraisal units' to different appraisals. These take account of complexity and the number of technologies covered by individual appraisals. The new measure does not map directly to the 1998 PSA target but NICE is estimated to have produced 31.5 appraisal units in 2002.
Target 13: Improve the responsiveness of NHS services by taking account of the views of patients and other users obtained through annual surveys of patient and carer experience. Surveys of different client groups and services will be repeated at appropriate intervals. The first survey focuses on patient experience of both general practice and hospital services and started during 1998.	Results of surveys.	**Met:** GP Survey results published October 1999. CHD survey results published in December 2000. Cancer survey results were published in Spring/Summer 2002. In 2002, the first survey of acute trusts took place, which led to each of the 176 participating organisations receiving their own results later that year. The 2002 'star ratings' were also informed by the survey results. Trusts are expected to use the results as the basis for local service developments/ improvements and to convey key survey outcomes (and follow-up actions) within the local Patient Prospectus. The primary care survey also took place in 2002. CHI is now the lead organisation for development of the survey programme.
Target 14: Achieve efficiency and other value for money gains in the NHS equivalent to 3 per cent per annum of Health Authority unified allocations a year for the next three years.	Overall delivery of PSA targets.	**Met:** The best measure of health authority efficiency is the extent to which other targets have been achieved.
Target 15: The Department to ensure that all NHS Trusts set a target of at least 3 per cent in 2000-01 for procurement savings and that delivery of these savings is monitored.	Assessed as part of the national efficiency targets (unit costs) and calculated on a regional basis.	**Met:** NHS trusts had their non-pay budgets reduced by an equivalent amount. The NHS Purchasing and Supplies Agency monitored delivery, in conjunction with the Audit Commission.
Target 16: Increase the average generic prescribing rate of all practices in England to 72 per cent by the end of March 2002, compared to the position at the quarter ending September 1998 of 63 per cent.	Percentage generic prescribing rate of GP practices.	**Met:** April to September 2001 the average generic prescribing rate in England was 75.8 per cent. In 2002 this increased to 78 per cent.
Target 17: Move at least half of those practices with a generic prescribing rate currently below 40 per cent to above that level by the end of March 2002, from a baseline of 598 practices < 40 per cent to 295 practices < 40 per cent.	Proportion of GP practices with a generic prescribing rate below 40 per cent moved above 40 per cent.	**Met:** 75 practices < 40 per cent, December 2000 data. 34 practices < 40 per cent, April 02 to January 03 data.
Target 18: A 50 per cent reduction in prescription charge evasion (compared to 1998 levels) by the end of 2002-03.	Percentage reduction in prescription charge evasion.	**On course:** Between November 1998 and July 1999, there was a reduction in patient prescription charge evasion (pharmaceutical patient fraud) of £48 million, around 41 per cent. (A review will be carried out in May 2003, which should show that this target has been met.)

Objective III: To enable people who are unable to perform essential activities of daily living, including those with chronic illness, disability or terminal illness, to live as full and normal lives as possible.

PSA Target	Measure	Progress
Target 19: £15 million savings from action on contractor fraud (representing £6 million in cash recoveries and £9 million in prevention savings) over the period 1999-00 to 2001-02.	Increase in amount recovered from action on contractor fraud and reduction in money lost through prescription fraud perpetrated by NHS contractors.	**Met:** Between December 1998 and February 2002 £7.47 million was recovered from action on contractor fraud. Prevention savings of £9.3 million have been made between December 1998 and March 2002.
Target 20: Promote independence by reducing nationally the per capita rate of growth in emergency admissions of people aged over 75 to an annual average of 3 per cent over the five years up to 2002-03, compared with an annual average rate of 3.5 per cent over the last five years.	Annual average per capita rate of growth in emergency admissions of over 75 year olds.	**On course:** From year end 1997-98 to year end 2001-02, annual average per capita growth rate of emergency admissions of people aged 75 and over was 0.8 per cent.
Target 21: Improve the delivery of appropriate care and treatment to patients with mental illness who are discharged from hospital and reduce the national average emergency psychiatric re-admission rate by 2 percentage points by 2002 from the 1997-98 baseline of 14.3 per cent.	Average emergency psychiatric admission rate.	**Nearly met:** Psychiatric re-admission rate in 2001-02 was 12.7 per cent narrowly missing the target by 0.4 percentage points. However, with the implementation of new service models such as assertive outreach, early intervention and crisis resolution, further falls in re-admission rates are expected, though this might not manifest itself until 2002-03 and beyond.
Target 22: Achieve efficiency and other value for money gains in Personal Social Services expenditure equivalent of 2 per cent in 1999-00 and 2000-01 and 3 per cent in 2001-02.	Value of efficiency and other value for money savings.	**Nearly met:** The estimated efficiency gains for the three years were 2.1 per cent, 2.3 per cent and 2.5 per cent. The total efficiency gain over the three years was therefore an estimated 7.1 per cent, against a total three-year target of 7.2 per cent.
Target 23: Prevent the unnecessary loss of independence amongst older people by, as a first step, putting in place action plans in all local authorities, to be jointly agreed with the NHS and other local partners, covering prevention services, including respite care, by October 1999.	Percentage of Local Authorities with action plans.	**Met:** All Local Authorities had action plans in place by October 1999 in accordance with the terms of the 'The Promoting Independence Grant'.

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

PSA Target	Measure	Progress
Target 24: Improve the continuity of care given to children looked after by local authorities by reducing to no more than 16 per cent in all authorities, the proportion of such children who have three or more placements in one year by March 2001. As many as 30 per cent of children currently experience 3 or more placements per year in some authorities, within a national average of 20 per cent.	Percentage of authorities with more than 16 per cent of children looked after who have 3 or more placements.	**Met:** Final child level data show that in 2001-02 65 per cent of councils met the 2000-01 target [compared to 49 per cent in the previous year]. The target has been met on a national level, with 15 per cent of children looked after in England having three or more placements during the year.
Target 25: Improve the educational attainment of children looked after by local authorities, by increasing to at least 50 per cent by 2001 the proportion of children leaving care aged 16 or above with a GCSE or GNVQ qualification and to 75 per cent by 2003. Data published for the first time in October 2000 set a baseline figure of 30 per cent.	The percentage of children leaving care at age 16+ with a GCSE or GNVQ qualification.	**Not met (2001 target):** Latest data shows that for year ending 31 March 2002, 41 per cent of young people leaving care aged 16 or over achieved at least one GCSE or GNVQ qualification. Given that the data is captured at the point at which the young person leaves care, this data reflects GCSE performance in summer 2001 and earlier. In the light of the forthcoming SEU report on education for looked after children the equivalent target for 2003-2006 has been revised to: Substantially narrowing the gap between the educational attainment and participation of children in care and that of their peers by 2006.

PSA Target	Measure	Progress
Target 25: continued		**This target wil have been achieved, if by 2006:** • outcomes for 11 year olds in English and maths are at least 60 per cent as good as those of their peers; • the proportion who become disengaged from education is reduced, so that no more than 10 per cent reach school leaving age without having sat a General Certificate of Secondary Education (GCSE) equivalent exam; and • the proportion of those aged 16 who get qualifications equivalent to five GCSEs graded A*-C has risen on average by 4 percentage points each year since 2002; and in all authorities at least 15 per cent of young people in are achieve this level of qualifications.
Target 26: By 2004, the proportion of children aged 10-17 and looked after continuously for at least a year, who have received a final warning or conviction, should be reduced by one-third from September 2000 position. To reduce the proportion from 10.8 per cent to 7.2 per cent.	PAF Performance Indicator C18, which compares the prevalence of final warnings and convictions among looked after children with their peers.	**Target changed:** Following the SR2000, the wording of this target was changed to "Improve the Life Chances for children in care by giving them the care and guidance needed to narrow the gap in offending between looked after children and their peers". By 2004, the proportion of children aged 10-17 and looked after continuously for at least a year, who have received a final warning or conviction, should be reduced by one third from September 2000 position. This provides a target to reduce the proportion from 10.8 per cent to 7.2 per cent. See third bullet of target 7 of the 2000 PSA.
Target 27: Reduce the proportion of children who are re-registered on the child protection register by 10 per cent by 2002 from the baseline for the year ending March 1997 of 18 per cent of children on the child protection register being re-registered (i.e. target of 17.2 per cent re-registrations to be reached by 2002).	The proportion of children registered during the year on the Child Protection Register who had been previously registered.	**Met:** 14 per cent re-registrations, 2001-02 data.

Departmental Operations and PSA Productivity Target Analysis

Objective V: To assure performance and support to Ministers in accounting to Parliament and the public for the overall performance of the NHS, Personal Social Services (PSS) and the Department of Health.

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

PSA Target	Measure	Progress
Target 28: Achieve efficiency and other value for money gains in Departmental operations equivalent of 2.5 per cent in 1999-00, 2000-01 and 2001-02 while fulfilling the Department's business plan within the running costs total (measured by the annual rate of gain).	Delivery of the Business Plan objectives within the running costs settlement.	**Met:** The Department met its Business Plan objectives within the three-year running cost settlement agreed.
Target 29: Payment of all undisputed invoices within 30 days or the agreed contractual terms if otherwise specified (measured by percentage of payments paid on time).	Percentage of payments made on time.	**Partly met:** During 2002-03 the Department paid 94.46 per cent of invoices within 30 days.
Target 30: To continue to regularly and systematically review services and operations over a 5-year period, in line with Government policy in the handbook *Better Quality Services*. It will agree a programme by September 1999 setting out which services will be reviewed each year, with the intention to review at least 60 per cent of services by March 2003.	Percentage of services reviewed.	**Partly met:** Specific Better Quality Services reviews were overtaken by a fundamental review of services and activities within the Department carried out in the spirit of BQS, which generated a programme of incremental and on-going change that focuses on our Delivery Contract and aims to improve efficiency and effectiveness.

PSA Target	Measure	Progress
Target 31: To put forward proposals by 31 March 1999, on measures to increase the proportion of the Department's business undertaken electronically in line with the Government's commitment to increase such business to 25 per cent by 2002.	Percentage of business undertaken electronically.	**Met:** There are currently 41 Electronic Service Delivery (ESD) services identified by the Department as suitable for electronic delivery and progress reports are made on a quarterly basis to the Office of the e-Envoy. Two of these have been transferred to the Home Office, and are no longer the responsibility of the Department of Health. A third was passed to the DWP on 1 April 2003. Of the remaining 38 key ESD services, some 42 per cent (a total of 16 services) were able to be delivered electronically as at 1 April 2003 against the target of 25 per cent to be achieved by 2002.
Target 32: As part of the new Framework for Managing Human Resources in the NHS, targets for managing sickness absence have been set consistent with the Cabinet Office recommendations of a reduction of 20 per cent by April 2000. Performance improvement targets will also be set for NHS Trusts on Managing Violence to Staff in the NHS aimed at reducing the levels of absence due to sickness or injury caused by violence.	Measurement of the time staff are absent from work as a proportion of staff time available.	**No change:** Targets have been set for managing violence and sickness absence: To reduce the number of incidences by 20 per cent by the end of 2001-02; and, To reduce the number of incidences by 30 per cent by the end of 2003-04. Sickness figures collected by calendar year. In 2000, the national sickness absence level was 4.68 per cent, which remained virtually at the same level in 2001. Figures have been published as part of the NHS Performance Ratings. Figures on reported incidents of violence and verbal abuse for 2001-2002 will be published shortly with the results of the NAO survey on violence.
Target 33: To propose targets for reducing staff sickness absence as agreed with the Cabinet Office.	The number of sick days per staff year.	**Met:** The Department agreed with Cabinet Office and the Treasury targets for reducing its levels of sickness absence. We aimed to bring the absence levels down to 7.9 days per staff year by 2001 and down to 6.8 days per staff year by 2003. The Department is currently piloting a new electronic system for sickness reporting which will reduce the level of under reporting in this area.
Target 34: The Department of Health will also be taking steps to improve the effectiveness of internal purchasing, based on the recommendations of the CSR report on improving civil government procurement. New IT systems will be introduced to improve procurement, and better training and guidance will be given to staff. Key targets are:		
a) Decisions on best use of the Government Procurement Card in the Department by January 1999;	Decision made within time scale.	**Met:** Following a pilot scheme, the Government Procurement card is now available to all cost centre managers within the Department.
b) Creation of a procurement database giving information on suppliers to the Department of Health staff by March 1999;	Establishment of a database onto which suppliers can enter details through the Internet.	**Met late:** Database was established by April 2000.
c) Creation of a website giving information on Department of Health procurement to suppliers by December 1999.	Establishment of a website that is accessible, by suppliers, through the Internet.	**Met:** Website went live December 1999.

Departmental Public Service Agreement Targets Analysis (2000)

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

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

Objective I: Improving health outcomes for everyone.

PSA Target	Measure	Progress
Target 1: Reduce substantially the mortality rates from major killers by 2010: from **heart disease** by at least 40 per cent in people under 75; from **cancer** by at least 20 per cent in people under 75; and from **suicide and undetermined injury** by at least 20 per cent. Key to the delivery of this target will be implementing the National Service Frameworks for coronary heart disease and mental health and the National Cancer Plan.	Death rate from heart disease and stroke and related illnesses amongst people aged under 75. Death rate from cancer amongst people aged under 75. Death rate from suicide and undetermined injury	**Heart Disease/Cancer/Suicide & Undetermined Injury** Targets monitoring data for England for 2001 are not yet available because of the need to incorporate the effects of the 2001 Census on the population denominator. Death rates for the years 1995-2000 will then need to be re-based accordingly. Data on the revised basis should be available shortly. In addition, following the tenth revision of the International Classification of Diseases, there will be a descriptive change wherein "suicide" will be replaced with "intentional self-harm" **Heart Disease - Too Soon to Assess:** Latest available data (for the 3 years 1998-2000) overlap the start of the OHN health strategy in July 1999. Therefore too early yet to assess the full effects of Our Healthier Nation and the Coronary Heart Disease National Service Framework (NSF) and the NHS Plan. Data for 1998-2000 (3 year average) show a rate of 120.5 deaths per 100,000 population - **a reduction of 13.7 per cent from the baseline (1995-97)**. Movement to date is towards the target. **Cancer – Too Soon to Assess:** Too early yet to assess the full effects of Our Healthier Nation and the NHS Cancer Plan due to the reasons stated above, but data for 1998-2000 (3 year average) show a rate of 130.9 deaths per 100,000 population – **a reduction of 6.3 per cent from the baseline (1995-97)**. Movement to date is towards the target. **Suicide and Undetermined Injury - Too Soon to Assess:** Too early yet to assess the full effects of Our Healthier Nation and the Mental Health National Service Framework (NSF) and the NHS Plan due to the reasons stated above. A National Suicide Prevention Strategy was published in September 2002 and as this is implemented it will contribute to reducing the suicide rate in line with targets. Data for 1998-2000 (3 year average) show a rate of 9.4 deaths per 100,000 population – **a rise of 4.0 per cent from the 9.1 baseline (1995-97)**.
Target 2: Our objective is to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country. *Specific national targets were announced in February 2001 (based on 1997-99 figures):* 1. Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole.	1. Mortality in infancy by social class.	**Infant Mortality – Too soon to assess:** The data are updated annually, and national data for 2001 were published in November 2002 but these overlap the baseline period, so it is too soon to comment on change. The target is being redefined to take account of the change to a New National Statistics Socio-economic Classification from 2001 onwards, when the target will be reformulated in terms of 'routine and manual' groups. Infant mortality rates are higher among children whose fathers are employed in manual occupations than among the total population, and this gap has widened in the most recent years. Latest figures for England & Wales (1999-01) show that **the overall infant mortality rate (for all social classes) is 5.3 per 1,000 live births, compared with 6.0 per 1,000 for those in manual social groups** (on the old basis). The target aims to narrow this gap by 2010.

PSA Target	Measure	Progress
2. Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.	2. Life expectancy by Local Authority.	**Life Expectancy – Too soon to access:** The data are updated annually. The most recent data, published in February 2002, relate to the period 1998-2000. They pre-date the setting of the target so it is too soon to comment on change. Over the last year, the gap between the quintile of areas with the lowest life expectancy and the national average has stayed the same for both sexes. Changes in NHS structure from April 2002 included the abolition of HAs, so the target has been reformulated in terms of Local Authorities (LAs). **Revised historic data using population estimates based on the 2001 Census will be available later in 2003.** The revisions will result in significant changes in the life expectancy levels and trends for some LAs and for the worst fifth of LAs as a whole.
3. By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15 per cent by 2004 and 50 per cent by 2010, while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter.	3. The under 18 conception rate. (Number of conceptions to under 18 year olds, per thousand females aged 15-17.)	**Under 18 Conception Rate – On Course:** The under 18 conception rate **fell by 10% per cent between 1998 and 2001**. Every top tier local authority is implementing a 10 year local teenage pregnancy strategy. These strategies and annual forward action plans, set out to deliver under 18 conception rate reduction targets of between 40 and 60 per cent by 2010. This will underpin delivery of the national target while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter. The second full year of implementation of local strategies ended in March 2003. All 30 action points set out in the Teenage Pregnancy Strategy will have been implemented. On 27 June 2002, the Government Response to the First Annual Report of the Independent Advisory Group on Teenage Pregnancy was launched, building on the recommendations made by the Advisory Group to set out a new forward action plan for the next phase of implementation. This demonstrates an ongoing collective commitment to continuing a joined-up approach to tackling teenage pregnancy. The Advisory Group's Second Annual Report is due to be published in Spring 2003.

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

PSA Target	Measure	Progress
Target 3: Patients will receive treatment at a time that suits them in accordance with their clinical need: two thirds of all outpatient appointments and inpatient elective admissions will be pre-booked by 2003-04 on the way to 100 per cent pre-booking by 2005.	DH monthly central data collection from January 03. Supersedes the Modernisaton Agency monthly project progress reports.	**On Course:** A monthly DH central data collection has been introduced from January 03. The monthly data collection will capture full bookings and partial bookings as they are added to the waiting list. This will allow more rigorous monitoring of progress towards booking milestones and targets. A Data Set Change Notice is being issued to the service in support of the new monitoring arrangements. The Modernisation Agency National Booking Team is assisting challenged Trusts to work towards achieving key booking milstones and targets. From April 2003, SHAs were responsible for managing and developing booking locally as part of their Local Delivery Plan.
Target 4: Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005.	Number of patients on NHS waiting lists.	**Outpatient Waiting Times:** Interim targets by March 2003: **On Course:** **Maximum wait of 5 months (21 weeks)** • September 2002 – 31,622 • **December 2002 – 19,203** **(NB: Collection of figures for 5 month waiters only began in 2002-03)** **Inpatient Waiting Times:** Interim targets by March 2003:

PSA Target	Measure	Progress
Target 4: continued		**On Course:** **Maximum wait of 12 months** • September 2000 – 50,269 • September 2001 – 44,132 • September 2002 – 16,689 • **February 2003 – 6,717** The NHS Implementation Plan set a target to reduce the maximum inpatient waiting time to 12 months by the end of March 2003. At end February 2003, there were 7 English residents waiting longer than 15 months for inpatient treatment. The vast majority of Trusts have eliminated waiting times of over 15 months and are now concentrating on reducing the number of waiters waiting more than 12 months. The subsequent PPF set a target to reduce 12 month waiters by end March 2003. Trusts are now working towards this target.
Target 5: To secure year-on-year improvements in patient satisfaction/ experience, including: (i) Standards of cleanliness and food, as measured by independently audited local surveys. (ii) PALs coming on-stream (by end April 2002)	Results of Surveys Findings of Surveys 'converted' into summer 2002 Performance Ratings. Patient prospectus to convey local findings. Findings used locally, nationally and within cancer networks. Quarterly Monitoring Compliance by NHS Trusts for 2001 targets.	**Surveys:** The inpatient (acute Trust) and GP Services surveys were completed in late spring and the results will provide a benchmark to measure progress against future survey data and have been used to inform the 2002 'star ratings' on a variety of issues, including hospital food and cleanliness. Trusts were asked to indicate the key findings so that they could be used as the basis for local action plans as well as provide a 'flavour' of such findings for inclusion in the local PCT-produced *Patient Prospectus* leaflets, produced last autumn. In the interim, the Department is measuring progress in cleanliness and hospital food through Patient Environment Action Teams (PEAT) inspections and the Better Hospital Food Programme. Responsibility for administering the **national patient survey programme** has transferred to CHI. This year (in time to inform the 2003 star ratings), surveys will take place in the acute sector (outpatients and A&E), and PCTs. A survey of Mental Health services is also under development. **Cleanliness – On Course:** Standards of cleanliness have improved significantly through the £60 million clean up campaign. Independent inspections teams, that include patients, show that the number of hospitals rated as 'green' (good standards of cleanliness) has increased from 44 per cent to nearly 60 per cent of hospitals (464) since Autumn 2001. The remainder are rated as 'amber'. No hospitals are rated as 'red' which is a significant improvement from three years ago when 35 per cent (253 hospitals) were rated as red. **Hospital Food – Partly Met:** The first set of results from food inspections show that 118 hospitals are rated as having good quality food with 554 (81 per cent) having food rated as acceptable. Food provided at 2 per cent of hospitals is poor and they are receiving support under the Better Hospital Food Programme to raise standards for their patients. **Housekeeping – On Course:** The NHS Plan promised that half of all hospitals would have ward housekeepers in place by 2004. Housekeepers will improve the ward environment by making sure the ward is cleaned properly and is kept clean, making sure patients are provided with food that meets their needs, and ensuring that equipment on the ward works properly. Over £14m has been invested in introducing housekeepers. This has been targeted at trusts who have demonstrated commitment to achieving the target, and has released staff and organisational energy to make rapid progress. This approach follows the principles of Shifting the Balance of Power and earned autonomy – 280 trusts showing commitment to the programme have received non-recurrent funding. As at November 2002, over 31 per cent of hospitals either have an established housekeeping service or have piloted services – for larger hospitals (over 100 beds) this rises to over 40 per cent. **Patient Advocacy Liaison Services (PALs):** 94 per cent of Trusts now have PALs in place.

Objective III: Effective delivery of appropriate care

PSA Target	Measure	Progress
Target 6: Provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over 75 on from hospital. We expect at least 130,000 people to benefit and we shall monitor progress in the Performance Assessment Framework.	i) Reducing preventable hospitalisation: reducing growth of the per capita rate of emergency admissions and ensuring that the rate of emergency re-admissions within 28 days of discharge from hospital does not increase. ii) Reduction in delay: reduction in the average number of beds occupied by people aged 75 and over who have their discharge delayed.	**Emergency Admissions – On Course:** From year-end 1997-98 to year-end 2001-02, annual average per capita growth rate of emergency admissions of people aged 75 and over was 0.8 per cent. **Delayed Transfer of Care and Emergency Re-admissions – Met:** Both elements of this target have been met. In 2002-03 the target for both Delayed Transfer of Care and Emergency Re-admissions shifted from being for over-75s to being for patients of all ages. From March 2000 to December 2002 **the proportion of 'acute' beds occupied by patients aged over 75 for which the patient's transfer was delayed fell by 3.9 percentage points.** Further reductions have occurred in 2002-03 on an all age basis. **The proportion of patients of all ages occupying an 'acute' bed with a Delayed Transfer has fallen by 0.7 percentage points between March and December 2002. From 1999-2000 to 2001-02 the rate of Emergency Re-admission for patients aged over 75 fell by 0.1 per cent.** The forecast rate of emergency readmission for patients of all ages for 2002-03, based on the Quarter 3 2002-03 information, is 0.1 percentage points higher than the 2001-02 rate for patients of all ages.
Target 7: Improve the life chances for children in care by: • Improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004.	The percentage of employment training or education amongst young people aged 19 who were looked after by councils on 1st April in their 17th year as a percentage of all young people of the same age in their area.	**Educational Attainment of Children Leaving Care – On Course:** On course to achieve the 75 per cent set for 2004. Data collected and published for the first time in November 2002. **In year ending 31 March 2002, 46 per cent of care leavers known to be in education training or employment on their 19th birthday compared with 86 per cent of all children. The level for care leavers is therefore 53 per cent of that for all young people in the same area.** This data covers young people who became care leavers prior to the Children (Leaving Care) Act being implemented. Data for year ending March 2003 will be available later in the year.
• Improving the educational attainment of children and young people in care by increasing from 4 per cent in 1998 to 15 per cent by 2003-04 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*–C.	OC1 data collection – the percentage of children leaving care at 16+ with 5 or more GCSEs at grade A*–C.	**Educational Attainment of Children Leaving Care – Slippage:** Latest **data for year ending 31 March 2002 showed that 5 per cent of care leavers achieved 5 or more GCSEs at grade A*–C, no change from the previous year.** Data for year ended March 2003 will be available later in the year. This target has been revised and a new SR2002 (PPF 2003-2006) target was announced on 31 March: • Substantially narrowing the gap between educational attainment and participation of children in care and that of their peers by 2006. The target will have been achieved if, by 2006: • Outcomes for 11 year olds in English and maths are at least 60 per cent as good as those of their peers; • The proportion who become disengaged from education is reduced, so that no more than 10 per cent reach school leaving age without having sat a General Certificate of Secondary Education (GCSE) equivalent exam; and • The proportion of those aged 16 who get qualificaitons equivalent to five GCSEs graded A*-C has risen on average by 4 percentage points each year since 2002; and in all authorities at least 15 per cent of young people in care achieve this level of qualifications.

PSA Target	Measure	Progress
• Giving them the care and guidance needed to narrow the gap in offending between looked after children and their peers. By 2004, the proportion of children aged 10-17 and looked after continuously for at least a year, who have received a final warning or conviction, should be reduced by one third from September 2000 position. This provides a target to reduce the proportion from 10.8 per cent to 7.2 per cent. This target has also been adopted as part of the Department of Health's SR2002 PSA target.	Youth Offending. PAF C18: Final Warnings & Convictions of Children Looked After.	**Youth Offending – On-going:** Target agreed November 2001 of reduction from 10.8 per cent to 7.2 per cent, to be reached by 2004. **September 2001 position showed a reduction to 10.4 per cent.** Data for 2002 will be available in Spring/Summer 2003
• Maximising the contribution adoption can make to providing permanent families for children without compromising on quality, so maintaining current levels of adoptive placement stability. Specifically, by bringing councils' practice up to the level of the best, by 2004: – to increase by 40 per cent the number of looked after children who are adopted, and aim to exceed this by achieving, if possible, a 50 per cent increase, up from 2,700 in 1999-2000; – to increase to 95 per cent the proportion of looked after children placed for adoption within 12 months of the decision that adoption is in the child's best interests, up from 81 per cent in 2000-01.	The number of looked after children adopted during the year. The percentage of those looked after children who are adopted during the year who were placed for adoption within 12 months of the best interest decision. *(Measured using AD1 data collection).* The percentage of those looked after children whose placement for adoption ended during the year, whose placement ended as a result of an adoption order being made. *(Measured through the SSDA 903 return).*	**Adoption – On Course:** **3,400 children were adopted from care in 2001-02, 25 per cent more than in 1999-2000.** There is likely to be a further increase in the number of adoptions in 2002-03. **80 per cent of looked after children adopted during 2001-02 were placed for adoption within 12 months of the decision that adoption is in the child's best interest.** This is a **slight drop from 81 per cent in 2000-01**, however, it was anticipated since the introduction of the Adoption Register would result in achieving adoption for children who had already been waiting for long periods for a suitable family. Placement stability was maintained, with 92 per cent of placements for adoption that ended in 2000-01 doing so as the result of the making of an adoption order – the same rate as 1999-2000. We will have data for 2001-02 in Spring 2003.
Target 8: Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008 and increase year on year the proportion of users successfully sustaining or completing training programmes.	Returns from the National Drug Treatment Monitoring System, which provides details on the number of, drug misusers entering treatment.	**Participation in Drug Treatment Programmes – On Course:** Encouraging progress in first year. The latest position is that **in the period 2001-02 there was an increase of 8 per cent in numbers presenting for treatment.** Data on the proportion of users successfully sustaining or completing training programmes will be available in Summer 2003.

Objective IV: Fair access

PSA Target	Measure	Progress
Target 9: Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.	PCT progress towards meeting the target is measured through the SaFFR process and will be reflected in the PCT star ratings. The SaFFR incorporates the Primary Care Access Survey which requires PCTs to contact all of their practices on a specific day to monitor the national access target.	**Primary Care Access – On Course:** The results of the February 2003 survey showed that nationally: – **86 per cent of patients were able to be offered a GP appointment within 2 working days; and,** – **89 per cent of patients were able to be offered a primary care professional appointment within 1 working day against the milestone for March 2003 of 90 per cent.**

Objective V: Value for money

PSA Target	Measure	Progress
Target 10: The cost of care commissioned from trusts which perform well against indicators of fair access, quality and responsiveness, will become the benchmark for the NHS. Everyone will be expected to reach the level of the best over the next 5 years, with agreed milestones for 2003-04.	Reference Cost Index.	**Reference Cost Index – On Course:** The NHS Trust National Reference Cost Indices for 1999-2000, 2000-01 and 2001-02 provides evidence on the extent to which variation in performance is reducing. The dispersion of costs between NHS Trusts as measured by the standard deviation of the trimmed market forces factor adjusted Reference Cost Index (RCI) for NHS Trusts, has been decreasing. The standard deviation has fallen from 24.6 in 1999-2000 to 21.2 in 2000-01 and to 16.9 in 2001-02. The range between the minimum and maximum RCI scores has also narrowed over this period, from 225 in 1999-2000 to 138 in 2001-02.

Departmental Public Service Agreement Targets Analysis (2002)

Further to the 1998 and the 2000 Spending Reviews the 2002 review continued the process of delivering improvements in services, through the innovation of Public Service Agreement targets (PSAs). The targets from that review are laid out in the table below.

Departmental public service agreement targets (SR 2002) analysis

Objective I: Improve Service Standards

Target 1
Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to 3 months by 2008.

Target 2
Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004; and reduce the proportion waiting over one hour.

Target 3
Guarantee access to a primary care professional within 24 hours and to a primary care doctor within 48 hours from 2004.

Target 4
Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.

Target 5
Enhance accountability to patients and the public and secure sustained national improvements in patient experience as measured by independently validated surveys.

Objective II: Improve Health and Social Care Outcomes for Everyone

Target 6
Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40 per cent in people under 75; from cancer by at least 20 per cent in people under 75.

Target 7
Improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20 per cent by 2010.

Target 8
Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30 per cent of the total being supported by social services at home or in residential care.

Target 9
Improve life chances for children, including by:
- Improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area, and at least 15 per cent of children in care attain five good GCSEs by 2004; (The Government will review this target in the light of a Social Exclusion Unit study on improving the educational attainment of children in care).
- Narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted; and
- Reducing the under-18 conception rate by 50 per cent by 2010.

Target 10
Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

Target 11
By 2010 reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

Objective III: Improve Value-for-Money

Target 12
Value-for-money in the NHS and personal social services will improve by at least 2 per cent per annum, with annual improvements of 1 per cent in both cost efficiency and service effectiveness.

Targets from Cross-Departmental Reviews

The 2000 Spending Review was informed by fifteen cross-departmental reviews of issues that might benefit from a joint approach involving two or more Government departments. Some of these reviews resulted in targets which appeared in the Department's Public Service Agreement. The 2002 Spending Review involved a further seven cross-departmental reviews, including a review on health inequalities.

Health Inequalities

2.6 The Government has launched the most comprehensive programme ever mounted in this country to tackle health inequalities. This work is led by the newly established Health Inequalities Unit (HIU) in the Department of Health who have responsibility for driving delivery of the Government's health inequalities strategy working across Departments and agencies at local, regional and national levels, including the NHS.

ON THE GROUND:

- *Bradford Hospitals Trust has been selected as the UK partner in a European initiative aimed at improving hospital services for migrants and ethnic minorities. This will help to develop culturally adequate family support and better patient experiences in using hospital services.*

2.7 Building on earlier work – particularly the Independent Inquiry into Inequalities in Health (Acheson) report – both to understand the health inequalities problem and to consult across sectors on actions to tackle health inequalities, the Government undertook a cross cutting Review on health inequalities. A summary report of the Review was published in November 2002 and can be found at: **http://www.doh.gov.uk/healthinequalities**.

2.8 The HIU is now leading work to develop a cross-Government Delivery Plan focusing on the action needed to deliver the strategy. It will set out what must be achieved on tackling inequalities and by whom, the time-scales involved, and how progress will be monitored. The plan is due to be published in the Summer and will be available on the health inequalities web-site

Action Against Illegal Drugs

2.9 The aim of this initiative is to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs. The latest position is that in the period 2001-02 there was an 8 per cent increase in the numbers presenting for treatment. There needs to be a year on year increase of 7 per cent in those entering treatment to achieve the target of increasing the numbers in treatment by 100 per cent by 2008. The Department of Health and the National Drug Treatment Agency continues to be on track to meet this target. The National Drug Treatment monitoring System (NDTMS) which provides data on trends in the use of drug treatment services is currently being upgraded and its new software will be on-line from April 2003.

Children at Risk

2.10 As part of the last spending review the Government conducted a Cross-Cutting Review (CCR) of Children at Risk to determine spending priorities from 2003-04 to 2005-06. The principal aim of the review was to address the need for better focusing and co-ordination of preventative services in respect of children and young people who face multiple risk factors or difficult points of transition. Success in this area is crucial to fulfilling the Government's objectives of raising educational attainment, reducing youth crime and tackling health inequalities, which underpin the commitment to abolish child poverty in a generation. The review makes recommendations advocating change and improvement to integrate the lessons of targeted initiatives into mainstream services, to better join up services for children and young people, to fill gaps in services and to improve poor services.

Cross-Government Initiatives

Sure Start

2.11 Children need the best possible start in life so they can flourish when they go to school and in their later years. Sure Start provides services for children, parents and communities across the country.

2.12 Sure Start local programmes aim to improve the health and well being of young children under 4 and families, in the most disadvantaged areas.

2.13 Each local programme is tailored to meet local needs, but they all deliver a range of core services: accessible ante-natal contact and support, not focusing only on the birth, but including practical and social support; help accessing advice on child health and development: and enhanced childcare, play and early learning opportunities. Programmes visit all families following the birth of a new baby to explain the services available, which is vital for the early identification of individual needs. Each Programme also offers parents access to help and advice on issues ranging from healthy eating to training for work.

2.14 Sure Start's target was establishing at least 500 Local Programmes by 2004, reaching around 400,000 children under 4, a third of all those living in poverty.

2.15 The target will in fact be exceeded, as 450 programmes are now operational (April 2003) and a further 74 are in development, so 524 will be up and running by Summer 2003. In addition, a further 46 'mini' Sure Start programmes are in place in rural communities and areas with pockets of deprivation and together they are reaching around 7,500 children under 4.

2.16 Parental involvement in planning and management is high in many programmes, though the nature of the participation varies, whilst voluntary organisations are directly involved in delivering services in most programmes.

2.17 It is still early to report on progress against the Sure Start Spending Review 2000 targets. More extensive detail will be available in future years, as more programmes will have been

operating and will have done so for longer, and information will also be gathered from the Sure Start national evaluation.

2.18 The 2002 Spending Review unveiled substantial investment to expand and reform services for young children and families, particularly the most vulnerable, by integrating governmental responsibility for Sure Start local programmes, early years education (3 and 4 year olds) and childcare (0-14 and 0-16 for those with special needs) into a single Unit (now designated as the Sure Start Unit) part of both DfES and DWP, and with a **budget** rising to £1.5bn - including a more than doubling in childcare spending - by 2006.

2.19 The SR 2002 settlement set new aims of increasing the availability of childcare for all children, and working with parents to be, parents and children to promote the physical, intellectual and social development of babies and young children, particularly those who are disadvantaged, so that they can flourish at home and at school, enabling their parents to work and actively contributing to the ending of child poverty. We are also encouraging the further development of integrated childcare, early education, family and health services. Children's centres will be established in the 20 per cent most disadvantaged areas, providing good quality childcare alongside early education, family and health services for at least 650,000 children by 2006, and building on existing successful initiatives such as Sure Start Local Programmes, Neighbourhood Nurseries and Early Excellence Centres.

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

Social Exclusion and Neighbourhood Renewal

2.21 The Department continues to work closely with the Social Exclusion Unit on a range of issues including projects on transport and social exclusion and education of children in care.

2.22 The Department is meeting its' NHS Plan commitment by supporting the Neighbourhood Renewal Unit to implement the Government's National Strategy for Neighbourhood Renewal, which aims to ensure that within 10-20 years no one is seriously disadvantaged by where they live. The focus of a wide range of DH activity is improving health services and tackling poor health and health inequalities in deprived neighbourhoods. The Cross-Cutting Review on Health Inequalities (see paragraph 2.7) identified the Neighbourhood Renewal Strategy as a key programme to support achievement of health inequalities targets. Work on Neighbourhood Statistics is developing small area health and social care data to improve knowledge and understanding at the local level.

2.23 The Department is also working with other departments to develop Local Strategic Partnerships, thereby fulfilling a NHS Plan commitment, which are key to neighbourhood renewal and to Government's intention to rationalise local partnership and planning arrangements, and will have a key role at the local level in tackling health inequalities. The role and capacity of Primary Care Trusts to work within and support Local Strategic Partnerships is being developed, for which organisational competences have been identified. This will support the effective engagement of local communities and the voluntary sector.

Sustainable Development

2.24 The Government's commitment to embedding sustainable development at the heart of all its business remains strong. The profile of this work was further enhanced through the World Summit on Sustainable Development (WSSD), held in Johannesburg, South Africa in September 2002 which marked another important step on the road towards achieving sustainable development globally.

2.25 The Department has sought to develop its sustainable development activity in line with the Government's overall commitment. We are committed to raising the profile of sustainable development at all levels, integrating sustainable development into decision-making wherever possible, as well as maintaining oversight of the Department's environmental performance. The Department now has a sustainable development web page at: **http://www.doh.gov.uk/sustainabledevelopment**.

2.26 This year sustainable development was established as an over-arching aim of the Government's Spending Review process.

2.27 Melanie Johnson MP (whose other responsibilities are detailed at the beginning of this report) is a member of the Cabinet Sub-Committee ENV(G). Dr Gabriel Scally (Regional Director of Public Health, South West Region) is the Department's nominated Senior Official for sustainable development. We have established a Sustainable Development Network of senior Departmental officials to help promote sustainable development throughout the Department and its Agencies and set work programmes for the future. We continue to develop partnership working with the Sustainable Development Commission whose role is to advocate sustainable development across all sectors in the UK, review progress towards it, and build consensus on the actions needed if further progress is to be achieved.

2.28 Health ("*expected healthy years of life*") remains one of the 15 key headline indicators in the Government's Sustainable Development Strategy for the UK. The indicator, which is considered to be a good predictor of mortality, has remained constant over the last decade. The continuing investment in the health service will support the basic pillars of the Government's sustainable development strategy. The health strategy encompasses social, environmental and economic factors such as housing, education and nutrition with specific targets for reducing health inequalities. The strategy, therefore, has sustainable development aims at its heart.

2.29 The Department has been involved in important international initiatives related to sustainable development such as the development of the European Union's Community Environment Action Programme (6TH EAP). We also actively support the WHO European Environment and Health process which aims to protect and improve environment and health in the European region. Ministerial conferences at five-yearly intervals

bring together health Ministers and environment Ministers from WHO's European Member States. The Chief Executive of the Health Protection Agency, Dr Pat Troop, is the UK member of the High Level European Environment and Health Committee (EEHC) which meets twice a year to implement actions agreed at the Ministerial conferences and plan future developments. Officials from the Department are also members of various other sub-committees and working groups.

English Regional Assemblies

2.30 The White Paper, *Your Region, Your Choice, Revitalising the English Regions*[2.31] was issued in May 2002. It sets out the Government's plans to decentralise power, strengthen regional policy and enable directly elected assemblies to be established in regions where people want them. An elected regional assembly will give people more say about the issues that affect their region. It can make government more effective and efficient. And it can enable regions to build on their own strengths, to improve economic performance and quality of life. The White Paper, to which the Department of Health contributed, includes specific public health responsibilities for the elected regional assemblies, including a duty to promote the health of the population of the region; supporting the development and implementation of a health improvement strategy in conjunction with partner organisations; and appointing the relevant Regional Director of Public Health as the assembly's health advisor.

Modernising Government Action Plans

Corporate Development Programme

2.31 The Department has continued to implement the organisational changes described in last year's Departmental Report *(2002 Department Report[2.4], chapter 2, page 24)*, following a wide ranging review of its functions in Spring 2001. Achievements since that time have included:

- a restructuring of the Department into eleven directorates focused around the needs of service users rather than service providers;
- a more unified Department with a single management board, and strategic health authority chief executives part of the Department's top team;
- the introduction of directorate-based corporate development teams to manage corporate functions (human resources, finance and business planning) in a way that is responsive to business needs;
- four Directorates of Health and Social Care providing a streamlined link between the Department and the health and social care services, with more decisions devolved to the frontline, and frontline staff more involved in policy development;
- reformed pay and job selection systems, and success in exceeding Government targets on the proportion of women and ethnic minority staff in senior posts;
- a reconstituted Corporate Development Board, drawn from across the Department, with a remit to drive forward strategic change.

2.32 The Department's Corporate Development Board launched a Corporate Development Programme, which builds on the earlier change initiatives, in October 2002. The Programme aims to strengthen the Department's capability to deliver agreed policies, targets and standards of care, while fulfilling its accountability to Parliament and discharging its duties cost effectively.

2.33 Initially the Programme is focused on improving the Department's policy delivery, its people management and its business systems within a framework of clear roles and responsibilities. These aims are supported by a series of projects that will change over time as improvements are made and new challenges emerge. Plans for 2003 include:

- strengthening the Department's programme and project management capability by bringing in external expertise, training existing staff and introducing a standard approach to programme and project delivery;
- new management development schemes to identify and nurture talent within the organisation (linked to the NHS development programme), including improved career management and development for the 'top 1,000' health service managers including senior Departmental staff;
- a programme to enable staff to develop new ways of working with the health and social care services, following the devolution of decision-making;
- identifying and spreading new, more innovative approaches to policy development and implementation;
- the development of new finance and human resource management systems and the introduction of a 'balanced scorecard' to measure more robustly the Department's performance;
- investment in customer service skills and systems to ensure the organisation is responsive to the needs of service users and the public when they have contact with the Department.

2.34 This activity will be integrated with the plans to make the Department a smaller, more strategic organisation. The Corporate Development Programme will be underpinned by a focus on seven corporate learning priorities, which together aim to provide the Department with excellent customer service skills, robust planning and resource management, a cadre of project management experts, and stronger leadership at all levels.

Policy Making

2.35 The Department continues to work with other government departments to incorporate an assessment of the impact their policies may have on the health of the population and access to NHS services into an integrated policy framework. Piloting of this tool in several government departments began in 2002 and their experience will be evaluated in Summer 2003.

2.36 How to achieve excellence in policy making – not sometimes but always, is the question underpinning the action learning DH collaborative programme – a key part of the DH corporate change programme. Much is known about what good policy making is, much less about how to achieve it, day to day, in a complex and demanding context. Four existing policy teams, each with a high priority objective will work with their stakeholders to experiment with new ways of working. The aim is to identify some simple rules that can be tested more widely in a "learn, adopt, and spread" programme.

Race Relations (Amendment) Act 2000 –

Ensuring the Department meets its responsibilities.

2.37 The Race Relations (Amendment) Act 2000 has extended the scope of the legislation outlawing racial discrimination in **all** functions of public authorities not already covered by the 1976 Act. The Race Relations (Amendment) Act 2000 places key public bodies (including all government departments) under a new statutory general duty to promote race equality which means authorities must have due regard to the need to:

- Eliminate unlawful discrimination;
- Promote equality of opportunity; and
- Promote good relations between people of different racial groups.

2.38 This applies to both internal employment practices and to policy and service delivery. As a result of these changes to the legislation the Department of Health is required to take specific actions to help meet its own obligations. The Department's Race Equality Scheme sets out how the Department will do this. **www.doh.gov.uk/race_equality/**

2.39 *The NHS Plan*[2.5] sets out the Government's ten-year programme of investment and reform for the health service. The Plan is intended to design services around the needs of patients, with crucially, decisions about design and delivery made at the local frontline. One of its key challenges will be to ensure that services meet the needs and aspirations of all in the increasingly diverse society in which we now live. Delivering on this and supporting the NHS in complying with the Act is a core part of the Department's vision of equality and fair treatment for patients and staff.

2.40 The Department's corporate development programme to support modernisation and delivery of reform integrates action on race equality. Progress on delivery of the Department's Race Equality Scheme will be reported annually.

Rural Proofing

2.41 All Government Departments were charged to implement a process of "rural proofing" by the Rural White Paper (Cm 4909 November 2000, para.13.2). This means that as policy is developed and implemented policy makers will systematically:

- Think about whether there will be any significant differential impacts in rural areas.
- If there are such impacts assess what these might be.
- Consider what adjustments/compensations might be made to fit rural circumstances.

2.42 The Department of Health is fully committed to this process. It reports regularly on progress to the Cabinet Committee on Rural Renewal. It also maintains close contacts with the Countryside Agency, which publishes an annual report covering Departments' progress with rural proofing, and with the Department of Environment, Food and Rural Affairs on rural issues.

2.43 This Department's activities in 2002-03 included:

- Initiating a rural proofing of the Mental Health National Service Framework, to be carried out by RuralMinds.
- Funding a project to develop a rural proofing toolkit for local health bodies, which is being carried out at the Institute for Rural Health.

2.44 Full details of the Department's rural proofing activities in 2002-03 are given in *Rural Proofing in 2002/2003: A report to Government by the Countryside Agency (Countryside Agency, June 2003).*[2.6]

Better Regulation and Regulatory Impact Assessments (RIAs)

2.45 There is a strong commitment throughout the Department of Health (including its Agencies) to improving the quality of regulation and to regulation that is necessary, fair, affordable, simple to understand, and which will command public confidence. The importance of publishing good quality Regulatory Impact Assessments is accepted as an integral part of the Department's work. But we continue to maintain a careful balance of interests between protecting public health and safety, the vulnerable and those at risk whilst avoiding unnecessary burdens on business, charities, voluntary organisations or the public sector.

2.46 The Department of Health is not a major regulatory Department. Of the one Bill and 178 regulations (this includes Orders, etc, that are not laid before Parliament) introduced by the end of December 2002, only six regulations imposed costs on business, charities or voluntary bodies and one resulted in cost savings. Seven Regulatory Impact Assessments (RIAs) were published and placed in the House Libraries.

2.47 The Department made good progress with the reform measures it had submitted for inclusion in the Government's

Regulatory Reform Action Plan[2.7] published in February 2002. The Action Plan included over 200 reform measures of which 22 belong to the Department of Health. Eight out of the 22 measures have been delivered. These include the:

- codification of existing European legislation on medicines making it more accessible for pharmaceutical companies thereby reducing burden on businesses which will only need to look in one place for instructions covering licensing and controls on medicines in the UK;
- legislative changes introduced which changed the process by which medicines are reclassified. This change means a reduction in the time taken to license medicines for general sale, down from 18 to 6 months;
- the consolidation of a series of Medical Devices Regulations into a single piece of legislation which will help manufacturers and others better understand the regulatory regime.

2.48 The joint DH and Cabinet Office reports on *Reducing GP Paperwork* (published June 2002)[2.8] and *Reducing Burdens on Hospitals* (published July 2002)[2.9] reported on a sizeable number of outcomes that will need to be implemented over the next two to three years. The Department is taking a robust approach to ensure implementation, evaluation and communication of the outcomes so that a visible and real difference is made out in the field not only for the front-line staff but also patients. A Task Force project was announced for each on 8 January and the first meetings took place during January. The Task Forces will oversee implementation of the outcomes identified and support the evaluation. The Department and the Cabinet Office also began work on a project in May 2002 to look at how burdens can be removed from front-line NHS staff which are attributable to inspection, audit and accreditation activity, which distract them from the delivery of patient care. A report will be published in 2003.

2.49 The Department made good progress following the review of planning requirements it mandates from councils with social services responsibilities. The Plans Rationalisation Project, which reported during 2001, paved the way for significant progress in cutting the number of these plans. During 2002, the Department cut a swathe through the centrally imposed burden of councils preparing complex documents and duplicating statistical returns by abolishing seven of the current nine plans associated with ring fenced grants in 2003-04.

Responsive Public Services

2.50 Care Direct originates from a government cross cutting review to improve services for older people. It provides a single gateway, for older people, to get information about social care, health, housing and benefits and to help them access these services more easily. Care Direct is being piloted in six Local Authorities (LAs) in the South West up to March 2004. The independent interim evaluation shows a very high level of user satisfaction with the service and that Care Direct has reduced demand on Social Services by providing callers with quicker initial assessment and faster routing to practical support. The evaluation also pointed up some areas where the service could be strengthened, including development of outreach to improve access and use of volunteers.

2.51 As part of its drive to improve services for older people, the Government announced in their Manifesto the intention to develop a *Third Age Service*. this will be a development of the Care Direct gateway to enable older people to get access to a much wider range of services than they could from Care Direct. The Government has taken the decision, therefore, not to extend Care Direct beyond the first six pilot sites, but to concentrate instead on building the *Third Age Service*. This will be led by the Department for Work & Pensions and developed using the learning from, and principles of, Care Direct.

2.52 All NHS hospital trusts and PCTs/PCGs are required to carry out regular patient satisfaction surveys from April 2002. They will be expected to publish the results in the annual Patients' Prospectus and to account for what action they are taking to deal with the concerns raised by patients. Financial rewards for trusts will be linked to the survey results. The processed data from 189 trusts will be returned to the Department's 'central data bank' by late May so that it can inform the performance ratings. For next year, the Department proposes to work-up a survey tool that reflects a more comprehensive range of PCT services.

e-Government and IT in the NHS

2.53 The Department has maintained its close working relationship with the Office of the e-Envoy and continues to be fully represented on all e-Government matters, eg through membership of the full Departmental e-Champions Programme Board and related bodies, eg the e-Communications Group.

2.54 The Office of the e-Envoy has introduced new streamlined arrangements for reporting progress on key Electronic Service Delivery (ESD) services across Government Departments. There are currently 41 ESD services identified by the Department as suitable for electronic delivery and progress reports are made on a quarterly basis. Two of these have been transferred to the Home Office and are no longer the responsibility of the Department of Health. Of the remaining 39 key ESD services, some 41 per cent (a total of 16 services) were able to be delivered electronically at the end of the year against the target of 25 per cent to be achieved by 2002.

2.55 In June 2002 the Department published a document entitled *Delivering 21st Century IT Support for the NHS*[2.10] outlining plans for modernising IT services in the NHS. The Department has subsequently also published proposals for a national procurement strategy and a consultation document on the Integrated Care Records Service (ICRS), a key component of the strategy. As part of the arrangements to support successful implementation the Department has:

- nominated a Department of Health Director as Senior Responsible Owner for the National Strategy in line with guidance from the Office of Government Commerce
- appointed a new Director General for NHS IT and nominated

Chief Information Officers in all Strategic Health Authorities to support local planning and implementation

- subjected major parts of the National Programme to the Office of Government Commerce (OGC) Gateway Reviews at all appropriate stages

2.56 The Department has also:

- connected 99 per cent of GP Practices to NHSnet, providing email and internet access
- provided 95 per cent of NHS Consultants with a workplace PC and access to electronic communications and web browsing
- and is providing all healthcare professionals and support staff with NHSnet access for email and systems facilities by March 2003.

3. Expenditure

THIS CHAPTER COVERS:

3.1 INTRODUCTION
3.4 NHS EXPENDITURE PLANS
3.11 HEALTH AND SOCIAL SERVICES PROGRAMMES
3.19 SOURCES OF FINANCE
3.21 COMPLIMENTARY SOURCES OF FUNDING
3.29 PERSONAL SOCIAL SERVICES EXPENDITURE

Introduction

3.1 In 2003-04 the Departmental Expenditure Limit (DEL) for the Department of Health is £65,488 million. In addition, the Department is responsible for managing the NHS Pensions budget of £6 billion;

3.2 **Figure 3.1** summarises the resource plans for the Department of Health for years 1998-99 to 2005-06. More detailed information is provided in **Annexes A2 and A3**.

Figure 3.1: Department of Health Public Spending

£ million

	1998-99 outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 estimated outturn	2003-04 plan	2004-05 plan	2005-06 plan
Consumption of Resources								
NHS	39,233	40,769	44,019	50,906	55,097	60,787	66,536	72,673
Personal Social Services	711	631	650	1,049	2,127	2,102	1,994	2,046
NHS pensions[1]	5,403	7,170	4,803	13,769	7,503	6,188	6,559	6,952
Total Department of Health Resource Budget	**45,347**	**48,570**	**49,472**	**65,723**	**64,727**	**69,077**	**75,088**	**81,672**
Of which								
Department of Health Departmental Expenditure Limit (DEL)[2]	39,944	41,400	44,669	51,955	57,224	62,894	68,529	74,719
Capital Spending								
NHS	700	850	1,173	1,676	1,953	2,892	3,383	4,363
Personal Social Services	60	61	58	92	98	107	107	117
Total Department of Health Capital Budget	**760**	**911**	**1,231**	**1,768**	**2,051**	**2,999**	**3,490**	**4,479**
Of which								
Department of Health Departmental Expenditure Limit (DEL)[2]	760	911	1,231	1,768	2,051	2,999	3,490	4,479
Total Public Spending in Department of Health[3]	45,952	49,116	50,412	67,198	66,445	71,680	78,023	85,494
Of which								
NHS[4][5]	39,778	41,254	44,901	52,289	56,728	63,294	69,374	76,390
Personal Social Services[6]	772	692	708	1,141	2,216	2,199	2,091	2,153
NHS Pensions	5,403	7,170	4,803	13,769	7,503	6,188	6,559	6,952
Spending by Local Authorities on Personal Social Services								
Current	**9,059**	**10,050**	**10,703**	**11,457**	**12,619**			
Of which								
Funded by grants from the Department of Health	1,053	1,000	1,052	1,440	2,371			
Capital	**0**	**22**	**15**	**32**	**34**			
Of which								
Financed by grants from the Department of Health	60	61	58	60	98			

1 'NHS Pensions' is the resource budget of the Department of Health pension scheme, and it is included in the Department of Health tables because it is part of the Department of Health resource budget.

2 Of which, resource "near cash" DEL 38,242 39,937 43,356 48,550 54,386 60,536 65,738 71,513

3 Total public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £155/365/291/292/331/394/554/656m

4 NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £155/365/291/292/322/384/544/646m

5 For a more detailed breakdown of NHS expenditure in England see Figure 3.3a and 3.3b

6 PSS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £0/0/0/0/9/10/10/10m

7 Figures may not sum due to rounding.

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

NHS Expenditure Plans

Budget 2002 Announcement

NHS 5-Year Expenditure Plans

3.4 In his 2002 Budget, the Chancellor announced expenditure plans for the NHS up to 2007-08. For the NHS in England these represent the largest ever sustained increase in any 5 year period in the history of the NHS; an annual average increase of 7.4 per cent in real terms between 2002-03 and 2007-08, a total increase of 43 per cent in real terms over the period.

3.5 The expenditure plans announced by the Chancellor last year are shown in **Figure 3.2**.

Changes to Expenditure Plans: 2003-04 to 2005-06

3.6 Since the budget last year, NHS expenditure plans have been changed and appropriate adjustments made for the following reasons;

Pensions Indexation: From 2003-04 onwards the Departmental Expenditure Limit for the Department of Health has been increased by a switch from the Exchequers AME spending to cover the increased cost of pensions. An addition of over £1.6bn has been made to the NHS DEL to cover these costs.

Free Nursing Care: From 2003-04 the NHS is responsible for paying for the cost of providing Free Nursing Care to those in Nursing Homes.

Figure 3.2: England Net NHS Expenditure Plans (stage 2 Resource Budgeting), 2002-03 to 2007-08, as announced by the Chancellor in Budget 2002

£ billion

	2002-03 plan	2003-04 plan	2004-05 plan	2005-06 plan	2006-07 plan	2007-08 plan
Net Revenue Expenditure[1]	53.5	58.5	64.1	70.0	76.7	84.1
% real terms increase		6.4	6.8	6.7	6.8	7.0
Net Capital Expenditure[2]	2.2	2.8	3.4	4.4	5.2	6.1
% real terms increase		23.7	16.8	25.9	15.5	15.9
Total Net NHS Expenditure	55.8	61.3	67.4	74.4	81.8	90.2
% real terms increase		7.1	7.2	7.6	7.3	7.5

1 Net of planned depreciation of £326/374/445/534/598/673 million.

2 Excludes income from land sale receipts and capital investment generated through the Private Finance Initiative (PFI).

Health Care in Prisons: From 2003-04 the Department of Health is responsible for paying for the cost of providing health care in Prisons. An addition of over £100m to the DH DEL has been made to cover these costs.

3.7 These changes mean that NHS Expenditure figures reported in this chapter are not directly comparable across the period.

3.8 The spending plans have also been adjusted to reflect the reduction in the cost of capital charge from 6 per cent to 3.5 per cent. Under Resource Accounting and Budgeting (RAB), this reflects the opportunity and financing costs of capital; and changes to the discount rate applied to future liabilities. This adjustment has been treated as a classification change by HM Treasury. This means that the expenditure figures reported on a Stage 2 Resource Budgeting basis within this chapter, and in Annex A2 and A3, have been adjusted for this change.

3.9 Whilst all of the changes mentioned above affect the total level of NHS expenditure they do not increase or decrease the spending power of the NHS. They are all cost neutral and are merely definitional changes.

PSS

3.10 As part of his 2002 budget the Chancellor also confirmed central government provision for Personal Social Services (PSS), funded by both the Department of Health and the Office of the Deputy Prime Minister, for years 2003-04 to 2005-06. These plans mean an average annual growth in resources for PSS of 5.9 per cent in real terms over the 3 years. These new spending plans are set out in **Figure 3.3** below.

Figure 3.3: Funding announced for PSS by the Chancellor in the 2002 Budget

£ billion

	2002-03 plan	2003-04 plan	2004-05 plan	2005-06 plan
Total Expenditure	11.4	12.5	13.4	14.6
% real terms increase		7.4	4.2	6.2

The Health and Personal Social Services Programmes

3.11 The health and personal social services programmes consist of:

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

- NHS Hospital and Community Health Services, and discretionary family health services. This covers hospital and community health services, prescribing costs for drugs and appliances and discretionary General Medical Services (which include reimbursements of GMS GPs' practice staff, premises, out of hours and IM&T expenses). It also includes other centrally funded initiatives, services and special allocations managed centrally by the Department of Health (such as service specific levies which fund activities in the areas of education and training and research and development);
- NHS Family Health Service (FHS) non-discretionary. This covers "demand led" family health services, including the remuneration of General Medical Practitioners for demand led items of service payments such as capitation payments, health promotion and basic practice allowance, the cost of general dental and ophthalmic services, dispensing remuneration and income from dental and prescription charges. For comparison purposes, the FHS non-discretionary figures in figure 3.3(a) and (b) also contain FHS discretionary expenditure on Personal Medical Services (PMS) and Personal Dental Services (PDS) spend;
- Central Health and Miscellaneous Services (CHMS), providing services which are administered centrally, for example, certain public health functions and support to the voluntary sector;
- Administration of the Department of Health.

And expenditure on **Personal Social Services** by way of:

- funding provided by the Department of Health; and
- funding provided by the Office of the Deputy Prime Minister.

National Health Service, England – By Area of Expenditure

3.12 **Figure 3.3a** shows the main areas in which funds were spent for years 1999-2000 to 2002-03 on a Stage 1 Resource Budgeting basis.

3.13 **Figure 3.3b** shows the main areas in which funds are spent for years 2002-03 to 2005-06 on a Stage 2 Resource Budgeting basis. Total NHS expenditure figures are consistent with those in **Figure 3.1**.

Figure 3.3a: National Health Service, England – by Area of Expenditure (Stage 1 Resource Budgeting)

£ million

	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 estimated outturn
Departmental Programmes In Departmental Expenditure Limits				
National Health Service Hospitals community health, family health (discretionary) and related services and NHS trusts				
Revenue expenditure				
Gross	36,143	39,548	43,951	48,555
Charges and receipts	–1,987	–2,250	–2,234	–2,378
Net	34,156	37,298	41,718	46,177
Capital expenditure				
Gross	1,464	1,841	2,140	2,453
Charges and receipts	–593	–621	–394	–402
Net	871	1,220	1,747	2,050
Total				
Gross	37,607	41,389	46,092	51,008
Charges and receipts	–2,580	–2,870	–2,627	–2,781
Net	35,027	38,518	43,464	48,227
National Health Service family health services (non-discretionary)[1]				
Revenue expenditure				
Gross	5,168	5,422	5,726	5,986
Charges and receipts	–804	–845	–887	–919
Net	4,365	4,577	4,839	5,067
Central health and miscellaneous services[2]				
Revenue expenditure				
Gross	931	957	1,079	1,197
Charges and receipts	–145	–127	–135	–172
Net	786	830	944	1,025
Capital expenditure				
Gross	40	29	31	39
Charges and receipts	–3	–4	0	–6
Net	37	26	31	33
Total				
Gross	971	986	1,110	1,236
Charges and receipts	–148	–130	–135	–178
Net	823	856	975	1,058
Total National Health Service Revenue expenditure				
Gross	42,242	45,927	50,756	55,738
Charges and receipts	–2,935	–3,221	–3,255	–3,469
Net	39,307	42,706	47,501	52,269
Net percentage real terms change(%)	–	6.2	8.5	6.8
Capital expenditure				
Gross	1,504	1,870	2,171	2,491
Charges and receipts	–596	–624	–394	–408
Net	908	1,246	1,778	2,083
Net percentage real terms change(%)	–	34.1	39.2	13.8
Total				
Gross	43,746	47,797	52,927	58,230
Charges and receipts	–3,531	–3,846	–3,649	–3,877
Net	40,215	43,951	49,279	54,352
Net percentage real terms change(%)	–	6.9	9.4	7.0
GDP as at 11th April 2003	95.4	97.6	100.0	103.0

1 Figures for FHS non-discretionary expenditure between 1999-2000 and 2002-03 include resources (normally funded from FHS Discretionary) to fund successive Personal Medical and Dental Service Pilots.

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

3 Figures may not sum due rounding.

Figure 3.3b: National Health Service, England – by Area of Expenditure (Stage 2 Resource Budgeting)

£ millions

	2002-03 estimated outturn	2003-04 plan	2004-05 plan	2005-06 plan
Departmental Programmes In Departmental Expenditure Limits National Health Service Hospitals community health, family health (discretionary) and related services and NHS trusts[1]				
Revenue expenditure[2]				
Gross	51,033	56,284	61,194	66,508
Charges and receipts	–2,378	–2,604	–2,514	–2,514
Net	48,655	53,679	58,680	63,993
Capital expenditure				
Gross	2,331	3,083	3,536	4,472
Charges and receipts	–402	–227	–185	–140
Net	1,929	2,856	3,351	4,332
Total				
Gross	53,364	59,366	64,730	70,980
Charges and receipts	–2,781	–2,831	–2,699	–2,654
Net	50,583	56,535	62,031	68,325
National Health Service family health services (non-discretionary)[4]				
Revenue expenditure				
Gross	5,986	6,333	6,968	7,636
Charges and receipts	–919	–858	–898	–898
Net	5,067	5,475	6,070	6,738
Central health and miscellaneous services[3][5]				
Revenue expenditure				
Gross	1,053	1,248	1,242	1,296
Charges and receipts	0	0	0	0
Net	1,053	1,248	1,242	1,296
Capital expenditure				
Gross	24	36	31	31
Charges and receipts	0	0	0	0
Net	24	36	31	31
Total				
Gross	1,077	1,284	1,273	1,327
Charges and receipts	0	0	0	0
Net	1,077	1,284	1,273	1,327
Total National Health Service Revenue expenditure				
Gross	58,072	63,865	69,404	75,440
Charges and receipts	–3,297	–3,462	–3,413	–3,413
Net	54,775	60,402	65,992	72,027
Net percentage real terms change (%)	–	7.4	6.5	6.5
Capital expenditure				
Gross	2,355	3,119	3,568	4,503
Charges and receipts	–402	–227	–185	–140
Net	1,953	2,892	3,383	4,363
Net percentage real terms change (%)	–	44.2	14.0	25.8
Total				
Gross	60,427	66,983	72,972	79,942
Charges and receipts	–3,700	–3,689	–3,598	–3,553
Net[6]	56,728	63,294	69,374	76,390
Net percentage real terms change (%)	–	8.7	6.8	7.4
GDP as at 11th April 2003	103.0	105.8	108.5	111.3

1 Includes Departmental Unallocated Provision (DUP) for 2003-04 to 2005-06.

2 Excluding HCHS Depreciation of (£m): 299 354 511 611

3 Excluding CHMS and Dept Admin Depreciation of (£m): 23 30 32 35

4 Figures for FHS non-discretionary expenditure between 2002-03 and 2003-04 include resources (normally voted as HCFHS) to fund successive Personal Medical and Dental Service Pilots.

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

6 Growth in NHS expenditure in 2003-04 is distorted by the definitional changes in paragraph 3.6. Once these are adjusted for, growth in NHS expenditure in 2003-04 is 4.9%

7 Figures may not sum due to rounding.

Expenditure in 2002-03

3.14 **Figure 3.4** compares estimated outturn expenditure in 2002-2003 with planned expenditure published in last year's report.

Figure 3.4: Comparison of NHS Net Expenditure for 2002-2003 with those in last year's Departmental Report (Cm 5403)

			£ million
	Departmental Report 2003 Figure 3.3a	Departmental Report 2002 Cm 5403 Figure 3.4	2002-2003 difference
HCFHS revenue	46,177	46,730	-553
HCFHS capital	2,050	2,367	-317
FHS non discretionary	5,067	3,678	1,389
CHMS	1,058	968	90
NHS Total	54,352	53,743	609

1 Totals may not sum due to rounding.

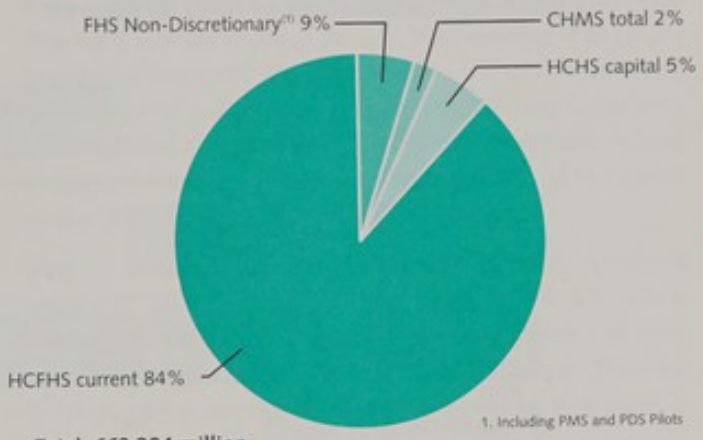
3.15 The main areas of change (£10 million or over) to the spending plans for the various parts of the programme are shown in **Figure 3.5**.

NHS Expenditure Plans in 2003-04

3.16 NHS Net Expenditure in 2003-04 is planned to be over £63 billion.

3.17 The largest part of NHS spending is on Hospital and Community Health Services, discretionary family health services and related services. For 2003-04 the planned revenue expenditure is £53.7 billion. Net capital expenditure is planned to be £2.9 billion. Within overall NHS net expenditure, the total for non-discretionary FHS is expected to account for £5.5 billion in 2003-04. The remainder will be spent on Central Health and Miscellaneous Services. **Figure 3.6** contains the breakdown of NHS Net Expenditure for 2003-04 (Plan).

Figure 3.6: NHS Net Expenditure, 2003-04 (Plan)



Total: £63,294 million

Figure 3.5: Main areas of change (£10 million or over) to the spending plans presented in last year's Departmental Report (Cm 5403)

2002-2003	Difference		
HCFHS current	-553 including:	531	Take up of End Year Flexibility (EYF)
		350	Transfers from HCHS capital
		-277	Transfers to FHS non discretionary
		-1,112	Transfer to FHS non discretionary for revised presentation of PMS +PDS Expenditure
		242	Reclassification of NHS Trusts Depreciation
		-200	Transfers to Personal Social Services
		-79	Transfers to CHMS
HCFHS capital	-317 including:	-350	Transfer to HCHS Revenue
		43	In year addition from Treasury Capital Modernisation Fund
		154	PFI schemes taken on balance sheet as a result of FRS5
		59	Take up of EYF
		-227	Estimated Underspend
FHS non discretionary	1,389 including:	277	Transfer from HCHS Current
		1,112	Transfer from HCHS for revised presentation of PMS +PDS Expenditure
CHMS	90 including:	79	Transfers from HCHS revenue

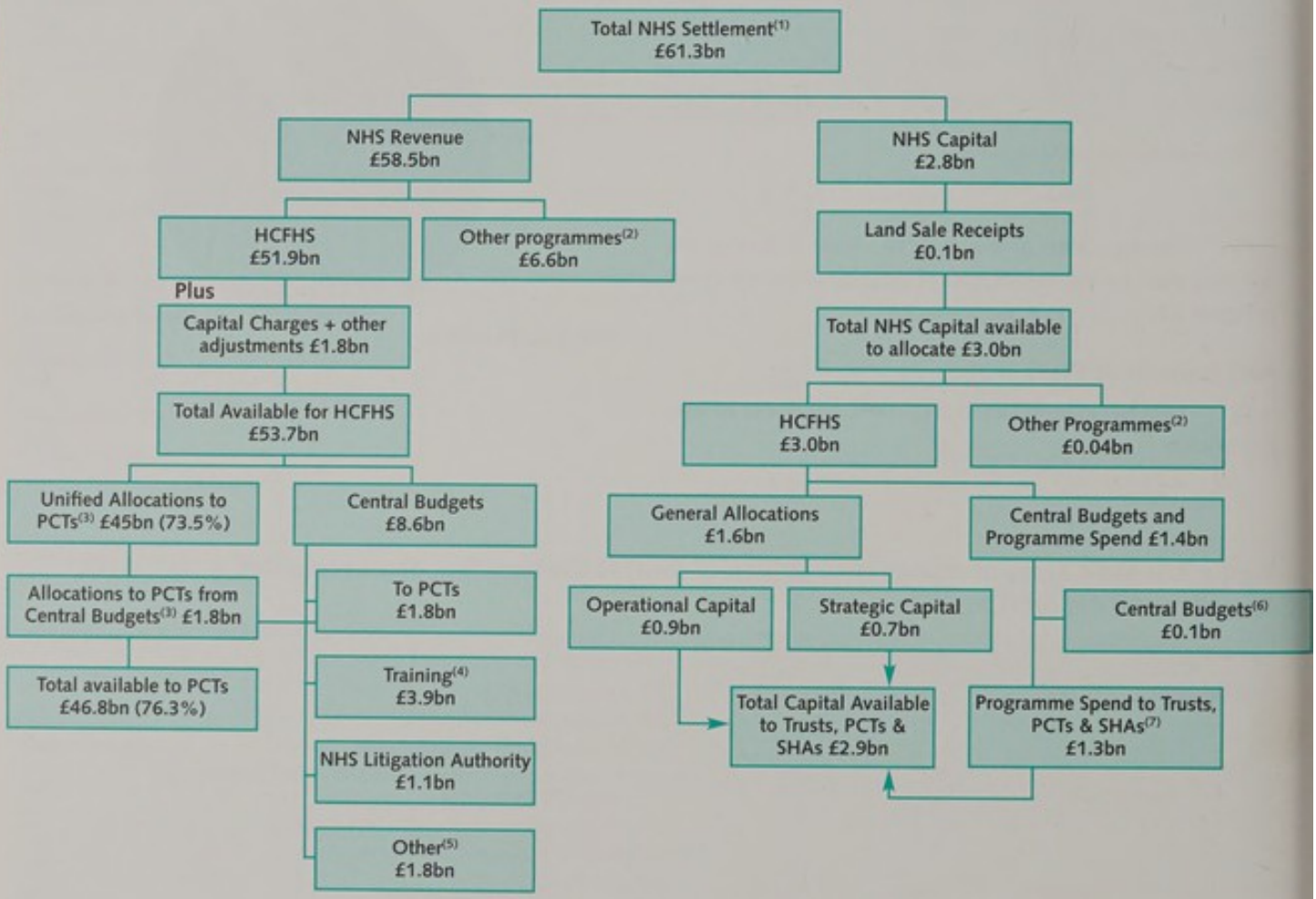
1 Totals may not sum because only those changes over £10 million are included.

3.18 **Figure 3.7** shows how NHS Resources are allocated. It shows that over 75 per cent of the total NHS budget will be controlled by PCTs in 2003-04. Figures are consistent with those shown in Table 1 of HSC 2002/-12 announcing 3 years' PCT revenue allocations. They are therefore consistent with the NHS settlement announced by the Chancellor in his Budget 2002 statement. They do not take account of any subsequent changes in the expenditure plans as a result of changes set out in paragraph 3.6, such as the effect of the change in the discount rate.

Sources of Finance

3.19 The NHS is financed mainly through general taxation with an element of National Insurance contributions. In 2003-04 it is estimated that 93.3 per cent of financing from the NHS in England will be met from these two sources, 73.5 per cent from the Consolidated Fund, that is, from general taxation, and 20.4 per cent from the NHS element of National Insurance Contributions (compared to 81.2 per cent and 10.8 per cent, respectively in 2002-03). The remainder of the NHS expenditure comes from charges and receipts, including land sales and proceeds from income generation schemes.

Figure 3.7: Disposition of NHS Resources



(1) NHS Settlement announced by the Chancellor in his 2002 Budget Statement and therefore before change in discount rate and other definitional changes set out in paragraph 3.6 of this chapter

(2) FHS non Discretionary, CHMS and DH Admin

(3) Unified allocations to PCTs announced on 18th December 2002 gave PCTs control of 73.5% of the NHS Budget. During the year a number of budgets held centrally (e.g. funding for Nursing Care) will be allocated to PCTs. This means PCTs will control more than 75% of the NHS budget in 2003-04.

(4) Funding allocated to the Workforce Development Confederations for the education and training of doctors, nurses and other NHS workers.

(5) Funding allocated to NHS Trusts, the Modernisation Agency, Universities and other Statutory Bodies such as the Prescription Pricing Authority.

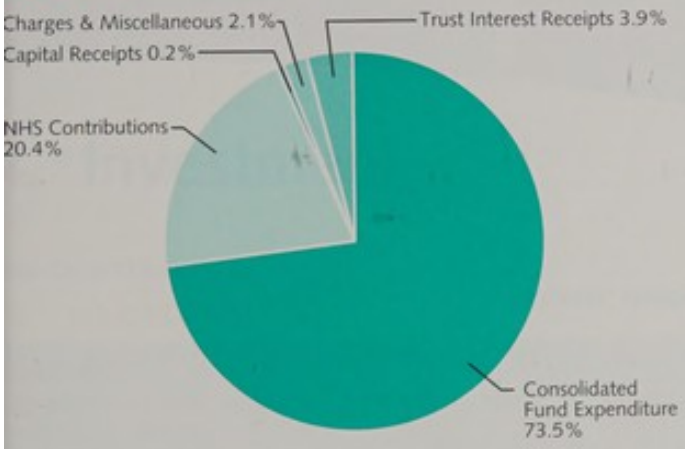
(6) Funding allocated for central spending mainly by NDPBs such as the National Blood Authority

(7) Funding to deliver NHS Plan objectives such as cancer, coronary heart disease, mental health, and improving access and choice for patients

(8) Figures may not sum due to rounding

.20 **Figure 3.8** represents NHS Sources of Finance for 003-04.

Figure 3.8: NHS Sources of Finance 2003-04



Complementary Sources of Funding

New Opportunities Fund (NOF)

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

3.22 The first tranche, was launched in January 1999 with the Healthy Living Centre (HLC) initiative. The initiative has a budget of £232.5 million in England (£300 million UK). The programme targets areas and groups that represent the most disadvantaged sectors of the population and is on course to meet its target of making HLCs accessible to 20 per cent of the population. HLCs influence the wider determinants of health, such as social exclusion, poor access to services, and social and economic aspects of deprivation that can contribute to health inequalities. Projects cover a range of activities including, for example, smoking cessation, dietary advice, physical activity and training and skills schemes. Local communities and users are involved in all aspects of design and delivery of a project. NOF has allocated £267m through the programme across the UK, through 257 awards in England (349 in the UK). The New Opportunities Fund is considering ways in which remaining funds could be used.

3.23 A second tranche of £116 million for England (£150 million UK) was made available from the New Opportunities Fund in September 1999. In England £23 million is to fund palliative care for adults with cancer, and £93 million is to fund the purchase of equipment for the diagnosis and treatment of cancer including linear accelerators, MRI scanners and mammography equipment.

3.24 The third tranche of £232.5 million was announced in November 2000 with the objectives of boosting the fight against cancer, coronary heart disease (CHD), and stroke. It will also be used to provide palliative care for adults and children.

3.25 £110m made available for CHD. Of this £65 million is being used to provide new angiography labs, which provide diagnostic facilities for heart disease. The Department has made available an extra £60 million to enable a total of 77 labs to be installed, which will speed up diagnosis significantly for patients with suspected heart disease. The CHD money will also be used to buy ambulance equipment and defibrillators, and to improve cardiac rehabilitation and heart failure services.

3.26 £52 million is being deployed to fund nutritional projects to reduce heart disease and cancer. Of this, £10 million is to expand the five-a-day initiative, and £42 million is to bring forward the targets of the National School Fruit Scheme. There will be 50-60 pilot projects for the School Fruit Scheme, based in PCTs with the highest levels of deprivation.

3.27 £48 million is being used to improve palliative care for children, and £22 million is to improve community palliative care for adults suffering from life threatening conditions to enable them to die at home if that is their wish.

3.28 Announcements of NOF projects are made regularly and these can be found on the NOF web-site at: **www.nof.org.uk**.

Personal Social Services (PSS) Expenditure

3.29 The Department of Health provides resources for the delivery of high quality social care through local authorities and other agencies. The resources provided for PSS from the Department's public expenditure programme are shown in Chapter 6, section 6.34, which gives details on PSS provision.

3.30 **Figure 3.9** shows total local authority current and capital expenditure on PSS. Between 1992-93 and 2001-02 local authority PSS net current expenditure has increased by 83 per cent in real terms.

Figure 3.9: Expenditure on Local Authority Personal Social Services

£ million

	1992-93 outturn	1997-98 outturn	1998-99 outturn	1999-00 outturn	2000-01 outturn	2001-02 outturn	2002-03 budget
Current expenditure							
gross[1]	5,470	9,984	10,847	12,048	12,848	13,598	–
charges[1]	502	1,530	1,788	1,998	2,152	2,229	–
net							
cash	4,968	8,454	9,059	10,050	10,696	11,369	12,622
real terms[2]	6,413	9,609	10,021	10,855	11,296	11,714	12,622
Capital expenditure[1]							
gross	169	150	140	134	156	151	–
income	38	43	53	51	63	61	–
net	131	107	87	83	93	90	–
Total local authority expenditure							
gross	5,639	10,134	10,987	12,182	13,004	13,749	–
charges/income	540	1,573	1,841	2,049	2,215	2,290	–
net	5,099	8,561	9,146	10,133	10,789	11,459	–

Source: PSS EX1, RO and RA LAs Returns.

1 Gross current expenditure, income from charges and capital figures are not available for 2002-03.
2 At 2002-03 prices using the GDP deflator.

4. Investment

THIS CHAPTER COVERS:

4.1 POLICY CONTEXT

4.4 PRIORITIES FOR CAPITAL INVESTMENT IN 2003-04

4.8 DIRECT CAPITAL ALLOCATIONS

4.11 RESTRICTIONS ON CAPITAL TO REVENUE TRANSFERS

4.12 TREASURY CAPITAL MODERNISATION FUND

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4.22 INVESTMENT TO CONTAIN VCJD RISK-REDUCTION STRATEGY

4.27 ASSET DISPOSAL

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4.29 INVEST TO SAVE BUDGETS

Policy Context

4.1 Investment continues to play a pivotal role in the modernisation of the NHS to produce faster, fairer services that deliver better health and tackle health inequalities. The *NHS Plan*[4.1] and the soon to be updated *Departmental Investment Strategy*[4.2] set out a planned programme of investment in the NHS. During 2003-2004 that programme will be taken forward through the planning and priorities framework to focus on delivery of key priority investment areas covering:

- Expanding capacity to permit achievement of waiting time targets and improving emergency care;
- Tackling cancer, cadiovascular disease, mental health, and narrowing the health gap by improving services;
- Modernising primary care;
- Improving older people's care; and
- Improving the patient experience;

4.2 In addition, investment in local prioritised capital programmes will increase and there will be a major programme of underpinning investments to support improvement to service standards and efficiency, including major investment in IM&T.

4.3 To meet these investment challenges, NHS capital investment is set to rise to over £4 billion in 2003-04, including land sale receipts and investment generated through the Private Finance Initiative.

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

Figure 4.1: NHS Capital Spending 2002-03 to 2005-06 (Resources)

				£ million
	2002-2003 Forecast Outturn	2003-2004 Plan	2004-2005 Plan	2005-2006 Plan
Government Spending	2,050	2,892	3,383	4,363
Percentage Real Terms Growth		*37.4*	*14.0*	*25.8*
Receipts from Land Sales	402	227	185	140
Percentage Real Terms Growth		*-45.0*	*-20.6*	*-26.2*
PFI Investment	556	901	1,511	1,549
Percentage Real Terms Growth		*57.8*	*63.5*	*0.0*
Total	**3,008**	**4,020**	**5,079**	**6,052**
Percentage Real Terms Growth		*30.1*	*23.2*	*16.3*

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

ON THE GROUND:

The Countess of Chester Hospital has opened a new £4.7m day surgery centre. The planning and development of the centre took into account patient views. Patients are reviewed for their fitness for surgery in six pre-assessment rooms. The theatre complex includes three theatres and anaesthetic rooms and a local anaesthetic theatre. The centre also contains a three-room endoscopy suite together with recovery rooms. After surgery, patients are moved to a post-anaesthetic recovery area after which they are taken to the main ward and later to two recovery 'recliner' lounges. Counselling rooms are also provided and the centre has camera links between theatres and seminar rooms for training junior doctors, nurses and other clinical staff. The centre will be offering patients the convenience and certainty of a booked admission from the offset. All patients will go home with a full printout of their treatment, medication and follow-up care from the centre's electronic discharge system.

Figure 4.2: Disposition of 2003-04 Capital Resources

		£ million
Total NHS Capital Investment		**4,020**
Less: PFI Investment		-901
Gross NHS Capital		**3,119**
Less:		
Costs associated with the retained estate	25	
NHS Trust Receipts	102	
Other NHS Capital	37	-164
HCHS Capital available for allocation		**2,955**
To be allocated as follows:		
Central Budgets		**64**
NHS Trusts/Strategic Health Authorities/ Primary Care Trusts		
General Allocations	1,528	
Access Fund	100	
Delivery of ICT Strategy	370	
Junior Doctors Working Hours	2	
SIFT - Medical & Dental Undergraduate Support	55	
Improving the provision of decontamination services in the NHS	40	
PFI Batching schemes	10	
Nursing Home Care Strategy	23	
Neo-natal Intensive Care	20	
NHS Direct Gateway	8	
Ambulance Radio Networks	7	
Walk in Centres	20	
Primary Care Facilities/Infrastructure	120	
Diagnostic Treatment Centres	184	
National Orthopaedic Intervention Programme	50	
Reducing Waiting Times	37	
Audiology	25	
Accelerated Discharge Programme	14	
Mental Health (DSPD)	15	
Renal	9	
Diabetes NSF	5	
Coronary Heart Disease	103	
Cancer Equipment	100	
Pathology Modernisation	7	
To be allocated later	47	
Total to NHS Trusts/Health Authorities/ Primary Care Trusts		**2,891**

Priorities for Capital Investment in 2003-04

4.4 A key investment priority for 2003-04 is to expand capacity so that waiting times for acute elective care and care in A&E can be further reduced. The key element of this stragegy is the Diagonsis and Treatement Centre (DTC) Programme. DTCs provide safe, fast, pre-booked surgery and diagnostic tests for patients, by separating scheduled treatment from emergency pressures, in some of the specialties with the highest waiting times (for example orthopaedics and ophthalmology). They are at the heart of the drive to modernise the NHS.

4.5 £184m of public capital has been made available for 2003-04 to progress this programme. Further details on DTCs can be found in Chapter 5.

4.6 Examples of capital investments, which will be targeted at specific health areas in 2003-04 include:

Cancer

£100 million is available in 2003-2004 to continue the programme of investment in new and replacement equipment, to improve diagnosis and treatment of cancer. This investment will permit delivery of new diagnostic equipment (50 MRI scanners, 200 CT scanners and 45 linear accelerators) and the continuation of replacement programmes so that the improved age profile of equipment can be maintained. This investment is key to delivering the cancer access targets, improving quality, and ultimately to delivering the target on improved outcomes.

ON THE GROUND:

Two new MRI scanner suites and a mobile scanner unit are being provided at three North East hospitals which are set to make diagnosis faster and more accessible. Patients in that area currently have to travel to a non-NHS hospital in Newcastle for an MRI scan. The new equipment will cost £2 million. An extra 2,000 patients each year are expected to benefit from this equipment.

Coronary Heart Disease

£103 million is available in 2003-2004 to continue the expansion in cardiac capacity. Funding will go into revascularisation schemes to expand cardiac services with around 12 additional cardiac theatres and 380 extra beds. This investment will reduce waiting times for heart surgery patients in the areas served by the units receiving funding. Capital will also be targeted at expanding diagnostic angiography to reduce waiting times for tests and inpatient admissions. The expansion of revascularisation services will be underpinned by long-term capacity building. The Department of Health has announced a modernisation and expansion programme for eight cardiac centres at a cost of £170m over four years, bringing the number of centres undergoing major improvements up to 12 costing £251m. Treasury Capital Modernisation Fund money will provide CHD equipment for Primary Care. This money (totalling £35m) will also fund cardiac rehabilitation and treatment of heart failure.

Mental Health

£29 million of public capital is available centrally in 2003-04. Funding will be invested in improving security at the three high security psychiatric hospitals and developing DSPD (Dangerous people with Severe Personality Disorder) facilities and for the transfer of some patients into more appropriate care settings. There will also be funding to continue the programme of refurbishment of acute psychiatric wards, to provide a better environment for patients to receive treatment.

Primary Care

£120 million is available to support the implementation of NHS LIFT and for other investments that are necessary to ensure that the planning and priorities framework targets for modernising primary care premises and establishing additional One-Stop Primary Care Centres is met. NHS LIFT is explained in more detail later in this chapter.

4.7 Examples from the Department's programme of vital underpinning investments include:

IM&T – £370 million is available in 2003-2004 for investment in the NHS' ambitious IM&T programme, which, over the next few years, will deliver:

- Continuing development of the IM&T infrastructure, to improve connection of NHS organisations and NHS staff;
- Further development of electronic clinical communications, including radiology reports, discharge summaries and electronic prescribing;
- Electronic booking of patient care; and,
- Electronic patient records.

This programme supports practically the whole range of service objectives, from care booked around the needs of the patient to improved value for money. Milestones that will be met during 2003-2004 include: electronic transfer of all radiology reports (transfer of pathology results will already have been delivered), every patient with cancer having pre-planned and pre-booked care and all staff having access to e-mail.

Decontamination and Sterilisation Facilities

£40 million will be spent in 2003-04 on continued improvement to NHS disinfection facilities. This funding will be spent on state-of-the-art decontamination equipment and improvements to the environment in which disinfection takes place. This investment, coupled with a programme of training, standards and inspections will enable the NHS to achieve uniform high standards of disinfection, lessening the risk of transmitting vCJD and other infectious diseases.

Direct Capital Allocations

4.8 Allocations direct to NHS organisations have been announced totalling £1,628m under 3 new classifications, Operational Capital (formerly known as "Block"), Strategic Capital (formerly "Discretionary") and an Access Fund, which supersedes last year's Local Capital Modernisation fund.

4.9 At £844m, the amount of Operational Capital is 10 per cent higher than in 2002-2003. For the first time, Operational Capital was allocated directly to NHS Trusts and PCTs according to a national needs-based formula. £684m has been allocated as Strategic Capital to the new Strategic Health Authorities to fund schemes that they prioritise.

4.10 The £100m Access Fund has also been allocated to Strategic Health Authorities for use to incentivise Trusts and PCTs to improve performance. The SHAs will devise schemes whereby the access capital is distributed to the Trusts and PCTs for which they are responsible only on achievement of significant, pre-agreed improvements in Access. It is a condition of the Access Fund that at least 50 per cent of any funds awarded must be spent on schemes put forward by the clinical teams that achieved the performance improvement.

Restrictions on Capital to Revenue Transfers

4.11 As in previous years, a limit will be set on capital to revenue transfers in 2003-04 to control the amount of capital which can be transferred to support revenue expenditure. This will ensure that capital resources are expended on capital investment as intended.

Treasury Capital Modernisation Fund

4.12 There is £80 million available from the Treasury's Capital Modernisation Fund in 2003-04 to support innovative capital investment projects. The funds available from TCMF are shown in **Table 4.3**.

Figure 4.3: Treasury Capital Modernisation Fund

	£ million				
	1999-2000	2000-01	2001-02	2002-03	2003-04
A&E Modernisation	85	35			
Coronary Heart Disease			70	10	20
Decontamination		5		100	
Reducing Waiting Times				31	37
Looked After Children				10	10
Chlamydia				1.67	2.93
Primary Care of which:					
Walk in Centres	15	40			
Dental Access		15	50		
Modernising Premises		15	30		
NHS Direct	14		20		
NHS LIFT				10	10
Joint ventures with private sector			50		
Cataract Treatment		12	8		
Total	**114**	**122**	**228**	**162.67**	**79.93**

Capital Prioritisation

4.13 All major investment schemes are submitted to the Capital Prioritisation Advisory Group (CPAG) for consideration. The schemes are assessed and prioritised on the criteria of where health need is greatest. Since the start of its work in 1997, 68 major hospital developments worth over £8.8 billion have been given the go-ahead, 64 under the PFI and 4 using public capital (see **Figure 4.4**).

Public Private Partnerships

4.14 PFI continues to help to deliver the biggest hospital building programme in the history of the NHS. The NHS Plan committed us to increasing capacity through the delivery of over 100 new hospital schemes between 2000 and 2010. Currently there are 114 hospitals schemes counting towards the 100 target – 104 PFI and 10 under Public capital. The latest tranche of 13 major PFI schemes approved to go out to tender over 2002 and 2003 will bring 1,500 more beds and 4,500 additional NHS clinical staff.

4.15 The NHS Plan stated that of the 34 major PFI hospital schemes approved between 1997 and 2000, half will be open to the public by 2003-04, with the remainder under construction. 17 of these schemes with capital values ranging from £22 million to £158 million are already open (two schemes have opened this year already at Bromley and Hull). Four more are expected to be completed and opened by the end of 2003. Of the 30 major new schemes given the go-ahead under PFI in February 2001, 18 have now completed their Outline Business Cases (OBCs) and in 2002 were given approval to go out to tender. 13 of these did so during 2002; the balance will do so during 2003. The remaining 12 are also expected to follow suit by the end of this year.

4.16 PFI continues to successfully deliver medium sized projects, which include many mental health and community schemes. 40 medium sized schemes with a total capital value of over £780 million have been approved of which 11 are already operational. So far in 2003 one scheme at Wansbeck has become operational with another 6 expected before the end of the year.

4.17 In total, 31 of the 100 hospitals schemes announced in the NHS Plan are already operational. 27 of these have been delivered under the PFI.

NHS Lift

4.18 One of the newly established Public Private Partnerships (PPPs) outlined in the NHS Plan is NHS Local Improvement Finance Trust (NHS LIFT). At a national level a 50:50 joint venture company was established with Partnerships UK (PUK) in September 2001. The company, "Partnerships for Health" (PfH) are continuing to support the development of local NHS LIFT schemes by (e.g. developing and implementing a standard approach to procurement) as well as providing some equity investment into local LIFTs. The Department and PUK have both agreed to provide an initial £5 million equity investment to PfH.

4.19 Local LIFTs will be set up as a limited company with the local NHS, PfH and the private sector as shareholders. Priority for investment has been initially in those parts of the country, such as inner cities, where primary care premises are in most need of improvement. There are now a mixture of both rural and inner-city LIFT schemes being developed. NHS LIFT is already helping to empower and assist the regeneration of local communities by providing better healthcare facilities.

4.20 There are currently 42 LIFT schemes in various stages of development across the country. In addition to the 18 schemes announced within waves 1 and 2 (detailed in last year's Departmental Report), a third wave of twenty-four schemes was announced in August 2002: Ashfield (North Notts), Ashton, Leigh and Wigan, Barnet, Enfield and Haringey, Brent and Harrow, Bristol, Bromley, Bexley and Greenwich, Colchester and Tendring, Derby, Doncaster, Dudley, Ealing, Hammersmith and Hounslow, East Hampshire and Fareham and Gosport, Gedling (Nottingham), Lambeth, Southwark and Lewisham, Leeds, Norfolk, Oldham, Oxford, Plymouth, South East Sheffield, St Helens, Knowsley and Warrington, Tees, Wandsworth, Kingston, Richmond and Twickenham, Wolverhampton.

4.21 LIFT has made good progress, and all schemes have completed their Strategic Service Development Plans and issued their OJEC notices. The initial capital investment across the 42 schemes is estimated to be around £1 billion. It is anticipated that the East London and City schemes will become the first LIFT to reach financial close in the spring of 2003.

Investment to Contain vCJD Risk-Reduction Strategy

4.22 As an example of innovative approaches to solving issues affecting clinical care, the Department of Health announced in December 2002 that it had purchased the largest remaining independent US plasma collector, Life Resources Incorporated to secure long-term supplies of non-UK blood plasma for the benefit of NHS patients. This transaction was undertaken to ensure that the current global plasma shortage will not reduce the availability to NHS patients of life-saving plasma products such as immunoglobulins and clotting factors. An independent option appraisal conducted for the Department of Health had shown the purchase of Life Resources Incorporated to be the most cost-effective means of securing the sustainable long-term supplies of non-UK plasma the NHS needs.

4.23 The Department of Health purchased the trade and assets of Life Resources for an up front payment of £48.8m with a further £21m tied into the performance of the company up until the end of 2006. The Department of Health paid a commercial price for the business assets based on the same analysis as a private sector purchaser would have undertaken.

4.24 A US Holding Company – DCI Biologicals Inc – has been established to manage the business. DCI Biologicals reports to the UK Parent Company – Plasma Resources UK Ltd – owned by the Secretary of State for Health.

4.25 The current owners and management team of Life Resources remain with the company to manage the business on a day-to-day basis. The key individuals are secured on long-term employment contracts and there have been no senior staff changes since the acquisition. Life Resources continues to run as a separate company with all staff remaining on their existing terms and conditions. They are not employees of the Department of Health or the NHS.

Figure 4.4: Major Capital Schemes approved to go ahead since May 1997 – (England)

DHSC	Scheme	£ million Capital Value
PFI Schemes reached Financial Close which are completed and operational:		
South	Dartford & Gravesham NHS Trust	94
North	North Cumbria Acute Hospitals NHS Trust	67
South	South Buckinghamshire NHS Trust	45
London	Queen Elizabeth Hospital NHS Trust	96
North	Calderdale & Huddersfield NHS Trust	65
North	North Durham Health Care NHS Trust	61
North	South Manchester University Hospitals NHS Trust	67
Midlands & Eastern	Norfolk & Norwich NHS Trust	158
Midlands & Eastern	Hereford Hospitals NHS Trust	64
Midlands & Eastern	Worcestershire Acute Hospitals NHS Trust	87
London	Barnet & Chase Farm Hospitals NHS Trust	54
North	South Durham Healthcare NHS Trust	48
London	King's Healthcare NHS Trust	76
South	Swindon & Marlborough NHS Trust	100
North	Leeds Community & Mental Health Services Teaching NHS Trust	47
London	Bromley Healthcare NHS Trust	118
North	Hull & East Yorkshire Hospitals NHS Trust	22
17	**Total PFI Schemes at Financial Close which are completed**	**1,269**
PFI Schemes reached Financial Close with work started on site		
North	South Tees Acute Hospitals NHS Trust	122
London	St George's Hospital NHS Trust	46
London	University College London Hospitals NHS Trust	422
London	West Middlesex University Hospitals NHS Trust	60
Midlands & Eastern	Dudley Group of Hospitals NHS Trust	137
South	Berkshire Healthcare NHS Trust	30
South	Gloucestershire Royal NHS Trust	32
Midlands & Eastern	University Hospitals Coventry & Warwickshire NHS Trust	344
8	**Total PFI Schemes reached Financial Close with work started on site**	**1,193**
25	**Total PFI Schemes Reached Financial Close with work started on site or completed**	**2,462**
PFI Schemes in procurement but not reached financial close		
Wave 1A		
London	Barts & The London NHS Trust	620
1	**Total Wave 1A Schemes**	**620**
2nd Wave Schemes Prioritised		
North	Central Manchester Healthcare/Manchester Children's Hospitals NHS Trusts	251
North	Newcastle Upon Tyne Hospitals/Newcastle City Health NHS Trusts	124
2	**Total 2nd Wave Schemes Prioritised**	**375**
3rd Wave Schemes Prioritised[3,20]		
North	Leeds Teaching Hospitals NHS Trust	125
South	Oxford Radcliffe Hospitals NHS Trust	127
London	Barking, Havering & Redbridge Hospitals NHS Trust	185
South	Portsmouth Hospitals NHS Trust	173
North	Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust	109
Midlands & Eastern	Southern Derbyshire Acute Hospitals NHS Trust	177
6	**Total 3rd Wave Schemes Prioritised**	**896**

DHSC	Scheme	£ million Capital Value
4th Wave Schemes Prioritised[1,2]		
Midlands & Eastern	University Hospital Birmingham/South Birmingham Mental Health NHS Trusts	306
North	Bradford Hospitals NHS Trust	116
South	Avon & Western Wiltshire Mental Health NHS Trust	68
London	North West London Hospitals NHS Trust	60
South	East Kent Hospitals NHS Trust	200
Midlands & Eastern	University Hospitals of Leicester NHS Trust	363
London	Lewisham Hospital NHS Trust	44
Midlands & Eastern	Peterborough Hospitals NHS Trust	250
North	Salford Royal Hospitals NHS Trusts	190
South	Maidstone & Tunbridge Wells/Invicta Community Care NHS Trusts	290
North	Pinderfield & Pontefract Hospitals/Wakefield & Pontefract Community NHS Trusts	200
London	Whipps Cross Hospitals NHS Trust	313
12	**Total 4th Wave Schemes Prioritised**	**2,400**
5th Wave Schemes Prioritised[1,2]		
South	Brighton Health Care NHS Trust	31
South	United Bristol Healthcare NHS Trust	104
Midlands & Eastern	Sherwood Forest Hospitals NHS Trust	66
London	Barnet & Chase Farm Hospitals NHS Trust	41
Midlands & Eastern	Mid Essex Hospitals NHS Trust	110
Midlands & Eastern	Essex Rivers Healthcare NHS Trust	79
North	Hull & East Yorkshire Hospitals NHS Trust	53
London	North Middlesex Hospitals NHS Trust	73
Midlands & Eastern	North Staffordshire Hospital NHS Trusts	269
South	Plymouth Hospitals NHS Trust	101
North	St Helens & Knowsley Hospitals NHS Trust	229
Midlands & Eastern	Walsall Hospitals/Walsall Community Health NHS Trusts	44
London	Paddington Basin	327
Midlands & Eastern	Royal Wolverhampton Hospitals NHS Trust	110
14	**Total 5th Wave Schemes Prioritised**	**1,637**
6th Wave Schemes Prioritised[1,2]		
South	Oxford Radcliffe Hospitals NHS Trust	66
South	Southampton University Hospitals NHS Trust	60
South	South Devon Healthcare NHS Trust	65
North	Tameside & Glossop Acute Services NHS Trust	85
4	**Total 6th Wave Schemes Prioritised**	**276**
64	**Total PFI**	**8,666**
Publicly Funded Schemes		
Publicly Funded Schemes which are completed		
North	Rochdale Healthcare NHS Trust	24
Midlands & Eastern	Central Sheffield University Hospitals NHS Trust	24
South	Royal Berkshire & Battle Hospital NHS Trust	84
3	**Total Publicly Funded Schemes with work started on site**	**132**
Publicly Funded Schemes with work started on site		
London	Guys & St.Thomas NHS Trust	50
1	**Publicly Funded Schemes with work started on site**	**50**
4	**Total Publicly Funded Schemes with work started on site or completed**	**182**
68	**Total Major Capital Investment given go ahead**	**8,848**

1 Figures may not sum due to rounding.

2 The capital value of PFI schemes are approximate and defined as: Total Capital Cost to the Private Sector includes the costs of land, construction, equipment and professional fees but excludes VAT, rolled up interest and financing costs such as bank arrangement fees, bank due diligence fees, banks' lawyers fees and third party equity costs. As PFI procures a service rather than the underlying asset, capital values shown are necessarily estimates.

4.26 Since its acquisition the company has continued to trade well and there have been no major business issues following the change of ownership.

Asset Disposal

4.27 The *Sold on Health Report*[4.3] was launched in May 2000 as part of HMT's Public Services Productivity Panel initiative. The recommendations in the report, produced by NHS Estates through an expert panel from both the public and private sectors, were based on a whole estate lifestyle review approach, including strategy, procurement, operation and disposal. The recommendations are intended to increase efficiency within the processes, reduce waste and generate both savings and accelerated income for the NHS. A major programme of work continues in implementing the recommendations, which include:

- A National framework and regional overviews for the procurement, operation and disposal of the NHS estate. Estate and Investment Plans have been prepared by NHS Estates for all Strategic Health Authorities to be updated annually. All Trusts are to have Estate Strategies by 31st December 2002;
- A corporate approach to the disposal of surplus estate and the achievement of best value. NHS Estates now act as the informed client for all disposals by NHS trusts;
- A performance management framework and incentives for NHS Trusts to get the best out of their estate and invest resources where the need is greatest. Earned autonomy has now been introduced and NHS Foundation Trusts are also to be introduced;
- A programme for better capital procurement including new partnering relationships with the private sector to structure the process and deliver better value for money. *NHS ProCure21* has been launched and preferred partners selected. It includes four key elements partnering, enabling the NHS schemes (HRH Prince Charles is the Design Champion for the NHS) and benchmarking and cost intelligence; and
- An acceleration of the disposal of surplus land and buildings, reducing costs and releasing additional funds for the NHS. NHS Estates has selected a preferred partner for a one-off sale of over 100 properties, which is expected to achieve in excess of £400m. The sale is due to be concluded later this year.

Pooled Budget Arrangements

4.28 The 1999 Health Act Partnership Arrangements are key powers, which enable: pooled funds; lead commissioning; integrated provision; and money transfer powers. All these have been taken up as new forms of investment in joint services, incorporating a mix of health and social services, and also housing and education. For social care, new investment has been primarily in revenue, which allows Local Authorities to commission, develop or purchase services, to launch joint funded partnerships and to develop innovation through the successful launch of the Private Finance Initiative in social care.

Invest to Save Budget

4.29 The Invest to Save Budget (ISB) was introduced by the Government in 1999 to encourage partnership and cross-boundary working by Government Departments, it was subsequently extended to Local Authorities and the NHS.

4.30 The aim of ISB is to provide more assistance towards the cost of innovative projects, which may need up front funding not otherwise available. The ISB will seek to realise the gains, which should be in the form of efficiency savings and/or benefits to the public. Invest to Save is a practical example of the Government's commitment to Modernisation.

Round 5

4.31 Over the next three years the Department will receive £1,505,000 in funding with £538,993 being received in 2003-04 to support the following projects:

Somerset Partnership NHS & Social Care Trust (In total £400,000 with £200,000 being for 2003-04) – To implement, in electronic form, across specialist mental health care, education and social services: multi-agency assessment/referral templates that communicate clinical information: multi-agency care plans: multi-agency care pathways.

Department of Health – Public Health Division (In total £720,000 with £220,000 being for 2003-04) – To apply proven defence technology at Southampton Hospital to provide significantly more rapid detection of Methicillin Resistant Staphylococcus (MRSA).

Bolton Primary Care Trust (In total £385,000 with £118,993 being for 2003-04) – In partnership with Manchester Metropolitan University, Bolton Metropolitan Borough and Arts Council North West. To provide art and design services to the health sector in situations where health needs can be specified and health gains expected within the context of previous research and practice.

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

THIS CHAPTER COVERS:

5.1 SUMMARY OF THE NHS PLAN

5.7 WHAT DOES THE PLAN AIM TO ACHIEVE?

IMPLEMENTING REFORM

5.11 INCREASING DEVOLUTION
- Planning Priorities
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5.22 PATIENT CHOICE
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5.29 INCREASING PLURALITY OF PROVISION
- Diagnosis and Treatment Centres
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5.61 FINANCIAL FLOWS

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ACTIONS ACHIEVED TO DATE

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- Public Agreement Targets
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5.157 PHARMACY IN THE FUTURE

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Summary of the NHS Plan

5.1 The *NHS Plan*[5.1] sets out measures to modernise the NHS to make it a health service fit for the 21st century. The NHS Plan puts the needs of the patient at the centre.

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

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

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

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

5.6 Progress against the NHS Plan and strategy for implementation were updated in Delivering the NHS Plan in April 2002.

What does the Plan aim to achieve?

5.7 The NHS Plan sets out a programme of change, underpinned by ten core principles, which aims to tackle the systemic problems which have undermined the effectiveness of the NHS. The NHS Plan sets out practical step-by-step reforms, which will improve care, treatment and service right across the board.

5.8 *Improvement Expansion and Reform – the Priorities and Planning Framework (PPF) 2003-2006*[5.2] was issued in October 2002 and describes the vision for services over the next three years. This takes forward the objectives of the NHS Plan and other national commitments and sets targets that the NHS and social services need to meet during the period 2003-04 to 2005-06.

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

- Recruit and retain increasing numbers of key staff. By 2008 the NHS is expected to have net increases over the September 2001 census of at least:
  - 15,000 consultants and GPs;
  - 35,000 nurses, midwives and health visitors; and
  - 30,000 therapists and scientists.
- Expand and make better use of hospital capacity through a combination of measures. By 2008, it is expected that the NHS will have:
  - increased the number of operations carried out as same day cases to over 75 per cent of all operations – the equivalent of adding an extra 1,700 general and acute beds in hospitals;
  - opened 42 additional major hospital schemes mostly delivered through PFI with 13 more major schemes under construction; and
  - additional fully operational Diagnosis and Treatment Centres (DTC's) – the new generation of fast-track surgery centres which separate routine from emergency surgery.
- Modernise the way services are delivered in order to expand the choices available to patients. For example:
  - establishing around 750 primary care one-stop centres across the country to offer a broader range of services, backed by more primary care nurses and specialist GPs, pharmacists, therapists and diagnostic services;
  - expanding the capacity of NHS Direct from 7.5 million callers per year to 30 million callers per year to provide advice, and direct patients to the most appropriate service for their needs; and
  - all outpatient appointments and inpatient elective admissions, including day cases, to be pre-booked by the end of 2005 and electronic patient records in all Primary Care Trusts by 2008.

5.10 The funding increase announced in the 2002 Budget will enable the Government to take forward the next phase of the NHS Plan. The next steps for investment and reform were published in *Delivering the NHS Plan* (April 2002).[5.3] This document outlines what the public can expect to see in improved services as the Plan is implemented, and how these improvements will be secured. It sets out how the NHS will operate to secure the best use of resources and be redesigned around the needs of the patient. The changes outlined in *Delivering the NHS Plan* centre around increasing choice for patients, introducing greater plurality of health service provision, devolving power to frontline staff, strengthening local accountability and changing the way in which money flows around the NHS.

IMPLEMENTING REFORM

Increasing Devolution – Driving extra provision locally

Planning and Priorities

5.11 In the past planning was done annually and constrained by time pressures and the requirement for multiple plans. For the first time health services are now able to plan over a three-year period supported by three-year budgets. This allows organisations to look in-depth at their services, plan change with confidence and implement improvements year on year.

5.12 Issued in October 2002, the *Improvement, Expansion, Reform – the Priorities and Planning Framework (PPF) 2003-2006*[5.4] describes how national commitments translate into targets for the NHS and social services. It also sets out a summary of the new system for planning and performance management. The new planning framework has been designed to:

- Focus planning guidance on fewer, smarter national targets;
- Develop a streamlined monitoring system which focuses on that smaller set of national targets;
- Create a clear linkage between national targets and the performance ratings systems;
- Provide greater flexibility at a local level to determine the pace at which some targets should be delivered; and
- Reduce planning bureaucracy.

5.13 Together they represent a major change in the way the NHS is asked to plan for and deliver requirements. With the introduction of these changes from 2003-04, there will be a much lighter touch approach to local planning – the Department of

Health will specify what needs to be achieved whilst the NHS in their local delivery plans will decide how priorities will be delivered.

5.14 Key elements of the new process are the introduction of three-year planning and financial allocation cycles, and also the greater emphasis placed on the development of trajectories and the increased flexibility that the NHS has to agree milestones at a local level.

5.15 The new planning system is based on a single, three-year local delivery plan (LDP), which covers NHS and joint NHS/social care priorities. The LDP will address each of the priority areas, cross-cutting themes and underpinning strategies set out within *Improvement, Expansion and Reform*. Plans will, wherever possible, contain quantified trajectories describing how progress to achieving targets will be delivered over the three years. This trajectory will define the agreement between the service and the Department of Health – in abolishing the requirement for annual planning, the national system will rely on these longer-term programme plans as the basis for monitoring local progress.

5.16 In general, SHA LDPs will be the only plan the Department of Health will formally sign-off. Inevitably from time to time plans will be needed for other purposes – eg to provide additional accountability for national budgets or to agree major changes such as PFI schemes and franchises for failing organisations. The intention is, however, to keep these additional requirements to an absolute minimum.

5.17 Under the new LDP arrangements, it will be much more important for local organisations to have good monitoring arrangements in place so that they can amend their plans and take action where necessary during the course of these three years. Wherever possible individual organisations should be taking action themselves rather than waiting for intervention to be initiated by others. Monitoring and performance management will focus on the targets for the next three years. There will also be routine monitoring of national standards and past targets where appropriate to ensure they continue to be met.

Financial Allocations

5.18 From 2003-04 three-year revenue allocations have been made direct to PCTs to put resources and responsibilities in the hands of front line services. It will also enable health communities to plan their finances and provides a surer foundation for PCTs to commission services in a way which will deliver improvement in performance. The allocations have been based on a new funding formula so that there is a better balance between high health need areas and those with high labour costs. Likewise, capital allocations for building and equipment have been made for three years, direct to PCTs, NHS Trusts and Strategic Health Authorities.

NHS Foundation Trusts

5.19 *Delivering the NHS Plan*[5.5] set out plans to introduce NHS Foundation Trusts for NHS Trusts. In November 2002, as part of the Queen's Speech, the Department announced that it would establish Foundation Trusts as locally owned public benefit organisations, modelled on co-operative societies and mutual organisations. Their primary purpose will be to provide health and health-related services for the benefit of NHS patients and the community, on the basis of clinical need and according to national standards, and they will be subject to inspection by the Commission for Healthcare Audit and Inspection. Details on proposals are set out in *A Guide to NHS Foundation Trusts*[5.6] published by the Department in December 2002. This document invites preliminary applications, subject to criteria laid down by the Department, from acute and specialist NHS Trusts that were successful in gaining three stars in the July 2002 NHS Performance Ratings. Subject to legislation, the first NHS Foundation Trusts will be established from April 2004, with the first NHS Foundation Trusts existing in "shadow" form from 2003-2004.

Pay Modernisation

5.20 On 28 November 2002, negotiators from the UK Health Departments, NHS employers and staff organisations successfully concluded negotiations on a new pay system for the NHS covering all staff except for very senior managers and staff within the remit of the Doctors' and Dentists' review body. The package has now gone forward for consultation with NHS staff covered by the new system. The proposed investment will support the most radical modernisation of the NHS pay system since its foundation in 1948. The new system will be fairer for staff and better for patients. In essence, it is about paying more to get more so that staff who take on new responsibilities get extra rewards. The new pay system will also give NHS organisations greater flexibility to design jobs around the needs of patients, flexibility to define the core skills and knowledge that staff should apply in their jobs and flexibility to pay extra in response to recruitment and retention pressures.

5.21 Subject to the outcome of consultation, the new system will begin to be introduced in some 'Early Implementer' sites in England from June 2003. These sites will help establish best practice in using the system and delivering intended benefits for staff and patients. The system will then be implemented across the NHS from October 2004.

Patient Choice – Redesigning NHS services around the needs of patients

5.22 "Choice" is central to the Government's agenda for modernising and improving the delivery of all public services, including health care. At its core is treating people as active citizens – not passive recipients of services – enabled and informed to exercise genuine choice over key aspects of their lives.

5.23 The vision for Choice is that by 2005 patients should be able to exercise much greater choice as to when, by whom and where they are treated. The development of innovative clinical pathways and extended practitioner roles should also widen patient choice for treatments, for example with alternative treatments. Patients who exercise choice are much more likely to feel empowered in their dealings with health and other care professionals, exercising self and shared care.

5.24 Specifically, patients will be able to:

- Access comprehensive, reliable information and advice on services, waiting times and other key aspects of quality, and options. All this information will be accessible via the net and potentially other channels such as touch screen kiosks, telephone helplines and digital TV;
- Choose their GP;
- Choose other services in primary care;
- Choose the hospital/service to which they will be referred to (for elective surgical treatment). This might include a local NHS hospital or one elsewhere, a DTC certain private hospitals or even overseas; and,
- Book appointments (electronic if they wish) with their GPs, hospitals and other services at a time and place that is convenient to them.

5.25 Implementing booking, particularly **electronic booking systems** is key to delivering the vision of patient choice for 2005. By 2005 all patients and their GPs will be able to book hospital appointments not just at the time of the patient's convenience but at the place of the patient's convenience too. The systems supporting these booked appointments will let GPs and patients look at a range of options across NHS Trusts, the private sector and potentially overseas. They will let them compare, for example, different waiting times for patients at different Trusts and across different specialties. There will also be information on accessibility, hospital services and clinical indicators to help inform patient choice. This will work through a variety of electronic delivery channels, including direct on-line booking as well as a call centre based bookings management system and potentially using new technologies such as digital TV.

5.26 The key outcomes required are that by end of 2005 we will deliver:

- Pre-booking for all outpatient appointments and inpatient elective admissions including daycases;
- Choice of the hospital/elective service to which they will be referred;
- Guaranteed access to a primary care professional within 24 hours and to a GP within 48 hours;
- Six-month maximum wait for inpatient treatment; and
- Three-month maximum wait for outpatient treatment.

5.27 What has already been achieved (by the end of financial year 2002-03);

- Choice for coronary heart disease has been rolled out nationally for all patients waiting more than six months for heart surgery; and
- Choice for London patients waiting more than six months has been rolled out for ophthalmology from October 2002 and for orthopaedics, ENT and general surgery for March 2003.

Next steps

- Choice projects are being established in other areas of the country to address both choice for long waiters (where a patient has been waiting for more than six months for elective treatment) and for choice at the point of referral.
- London patient choice will be extended to almost all elective surgery in London.
- From the summer of 2004, these choices will be offered to all elective surgery patients waiting over 6 months nationwide.
- The delivery plans for choice for long waiters and choice at the point of referral on a national basis will be agreed and implementation started.

Choice for People with Coronary Heart Disease

5.28 From July 2001 all patients in England who have been waiting more than six months for heart surgery have been eligible to choose to have treatment in a hospital which can do the operation more quickly whether this is in the public sector or private sector. Patients waiting six months have been contacted by an independent Patient Care Advisor to discuss their options within the scheme. By March this year, 1,746 of those eligible for choice had opted for treatment elsewhere. In order to build on the success of the scheme, in December 2002 an extra £10.8 million was allocated to those areas with the highest levels of coronary heart disease. Contracts have been negotiated for patients to be offered the further option of treatment abroad.

Increasing Plurality of Provision – Patients need a range of different services to exercise choice

Diagnosis and Treatment Centres

5.29 Diagnosis and Treatment Centres (DTCs) provide safe, fast, pre-booked surgery and diagnostic tests for patients, by separating scheduled treatment from emergency pressures, in some of the specialties with the highest waiting times (for example orthopaedics and ophthalmology). They are at the heart of the drive to modernise the NHS.

5.30 The core objectives of the DTC programme are to:

- improve access to acute elective care (by contributing an additional 250,000 first order finished consultant episodes – FFCEs – to the activity growth needed to achieve maximum six-month waits by 2005). This builds on the NHS Plan aim of 20 Diagnosis and Treatment Centres to be developed by 2004 including 8 to be fully operational treating approximately 200,000 patients a year;
- spearhead diversity in the provision of NHS clinical services by letting contracts for independent sector companies to run some DTCs, adding their expertise, staff and resources to those of NHS providers and, through these two objectives:
  - modernise the way the NHS provides diagnostic and elective care; and

– drive productivity gain by stimulating new models of service delivery.

5.31 14 DTCs are now open and these will provide over 40,000 extra FFCEs when they are fully operational. They include the first independent sector run DTC at Redhill, Surrey managed by BUPA. A further 33 NHS run DTCs are in development and will all be fully operational by 2005. In all, we expect NHS-run DTCs to be providing 150,000 FFCE's a year by 2005.

5.32 Significant capital investment, over £350m, has been made in the NHS to develop this programme. Alongside the NHS investment, in December 2002, a procurement process was launched for 11 independent sector DTC projects which invited expressions of interest from both UK and overseas independent healthcare providers. The independent providers will either work alone or in a joint venture with the NHS, creating capacity to provide 39,500 FCEs a year by 2005. Independent providers were also invited to propose innovative options for a series of 'chains' of DTCs where one organisation will provide a number of DTCs for cataracts, simple day-case surgery and orthopaedic procedures. There has been a very strong response from independent providers to the Pre-Qualification Questionnaire exercise (PQQ) and these are being evaluated prior to the issues of 'Invitations to Negotiate' to short-listed bidders.

Use of Spare Capacity in the UK Independent Sector

5.33 Building on the Concordat agreed with the private and voluntary healthcare sector in October 2000, the Department is also continuing to encourage the NHS to make use of spare capacity in the existing UK independent sector in a more planned and co-ordinated way. According to figures supplied by the Independent Healthcare Association at least 86,000 NHS patients were treated by their members' hospitals on an in-patient, out-patient or day-case basis during 2002-03.

Overseas Treatment

5.34 *Delivering the NHS Plan*[5.7] set out the Government's intention to make greater use of overseas providers to treat NHS patients and to bring about greater diversity and pluralism in the provision of NHS services. Overseas treatment offers a means to add to the capacity of the NHS, and reduce waiting times. An overseas treatment pilot was set up between January and April 2002, with patients from three NHS pilot sites (East Kent, Portsmouth/Isle of Wight and West Sussex/East Surrey) receiving treatment in France and Germany. An independent evaluation of the pilot was conducted by the Health Economics Consortium at York University; patients' reactions were very positive.

5.35 In the light of the pilot, the Department of Health established two "lead commissioners" who are responsible on behalf of the NHS in England for selecting overseas providers and contracting with them for treatment for NHS patients. A procurement exercise was run after the pilot, producing 170 expressions of interest from potential overseas providers. Guidance has now been published for primary care and acute trusts considering the referral of NHS patients abroad, and this is available on the Department's website. Nearly 300 patients have received treatment abroad in 2002-03 under the overseas treatment initiative. This number is expected to increase in 2003-04.

5.36 Independently of this initiative, approximately 1,100 patients were authorised this year to receive specific treatment in other European Economic Area member states under the longstanding E112 referral arrangements. This is the mechanism which entitles patients to seek treatment in other member states at NHS expense, subject to receiving prior authorisation from the Department of Health.

Strengthened Accountability – Confidence in health service delivery

NHS Performance "star" Ratings

5.37 In September 2001 NHS Performance Ratings were produced for acute hospital trusts; in July 2002 acute trusts received their second annual star ratings, alongside the first ratings for specialist and ambulance trusts. Mental health trusts received indicative baseline ratings.

5.38 In summer 2003 the ratings will be repeated for all trust types, including first full ratings for mental health trusts and PCTs.

5.39 The performance ratings system awards three stars to the highest performing trust, down to zero stars for the worst performing. The rating awarded is based on the trust's performance against a number of key targets and a wider set of balanced scorecard performance indicators; Commission for Health Improvement (CHI) reviews which have occurred within the year in question also form part of the rating assessment.

5.40 Overall there were 304 NHS Trusts that have been rated for their performance in 2001-02. The overall results are as follows:

68	★★★
171	★★
53	★
12	0

5.41 For NHS Acute trusts, the results were as follows:

45	★★★
77	★★
34	★
10	0

5.42 Overall 46 acute trusts received an improved performance rating, 75 were unchanged and 37 received a lower rating.

5.43 For Summer 2003 responsibility for the development and publication of the performance ratings will pass to CHI. DH officials are working closely with CHI during this transitional year to prepare for the 2003 publication.

2003 Performance Ratings Indicators

5.44 On the 31 March the Department of Health and the Commission for Health Improvement announced the key targets and indicators which would be used for 2003. This list covers acute specialist, ambulance, Mental Health and PCTs.

5.45 Further details of the indicators published in July 2002 and the indicators announced to the health service for 2003, can be viewed at the NHS Performance Indicators 2002-03 website; **www.doh.gov.uk/performanceratings/2003**

2004 Performance Ratings Indicators

5.46 The Department will continue to work with the Commission for Health Improvement, NHS organisations and professional bodies to ensure that new and improved indicators are developed.

5.47 It is the intention of the Secretary of State and the Commission for Health Improvement to notify to the NHS in advance the key targets and indicators to be used in the summer 2004 performance ratings.

5.48 A series of expert service reference groups have been set up by Commission for Health Improvement to inform the content of the 2004 performance ratings.

NHS Franchising

5.49 NHS Trust franchising is a new approach to finding the best available managers to take on the role of Chief Executive and supporting teams in some of the most poorly performing NHS Trusts. The prime concern under new management arrangements is to address the particular areas where a Trust has performed poorly and to demonstrate the capacity to improve performance.

5.50 Following the 2001 performance ratings six NHS Trusts have had their management franchised to experienced NHS managers with a proven track record for delivery. In order to widen the pool of experitse from which good quality managers can be sought, the NHS Franchising Register of Experise was published on 19 December 2002. The Register contains a list of organisations effectively pre-qualified to bid for franchises and includes the 62 three star NHS Trusts whose star status gives them automatic inclusion, eight private sector organisations and the Trent Strategic Health Authority.

5.51 The Good Hope Hospital NHS Trust, Birmingham, is being franchised after it was classified as zero star in 2002.

5.52 All organisations on the NHS Franchising Register of Expertise were invited to bid for the franchise. Initial bids were evaluated by a panel comprising the Trust Chair, the Director of Health and Social Care – Midlands and East, the Strategic Health Authority chief executive and an independent assessor nominated by the NHS Appointments Commission. The organisations who were shortlisted by the panel have been invited to prepare full bids for the next stage in the process – Invitation to Negotiate. The outcome of this process is expected in Summer 2003.

NHS Franchising Register of Expertise

5.53 In order to expand NHS Franchising, a Register of Expertise was set up which contains an approved list of organisations which may subsequently be invited to bid for specific management franchises.

5.54 The Register includes organisations from inside and outside the NHS which are effectively pre-qualified to tender for NHS franchises. The NHS Appointments Commission set up an independent panel under the chairmanship of Sir William Wells to assess all applications for the Register against a given set of criteria. The criteria include an expertise in managing and improving performance in large and complex service delivery organisations; an excellent track record in both financial and human resource management; and a commitment to the public service ethos.

5.55 The Register includes 62 NHS Trusts whose three star status gives them automatic inclusion on the Register and eight private sector organisations. The Register is available at **www.doh.gov.uk/nhsfranchising**

Patient Prospectus – "Your Guide to Local Health Services"

5.56 The concept of local NHS organisations producing a 'Patient Prospectus' was first outlined in the *NHS Plan*,[5.8] as part of the Government's drive to strengthen local accountability, provide better information for local people about their local NHS and to place patient views at the centre of service improvement.

5.57 To clearly demonstrate that the NHS is acting on information gained from patients and reporting back to the local public on the performance of the healthcare providers in their areas, every PCT has published a new 'Patient Prospectus'. The 'prospectus' is set to play a leading role in PCT and Trust patient and public involvement strategies and will be one of a number of the ways the local NHS engages with patients/public. The leaflet contains information on health services across individual PCTs, ranging from where they can be found to hospital star ratings. Producing feedback on local trust ratings supports patient choice and accountability. Improving the quality of information in this way gives patients' better decision-making power, and more choice over their own care.

The Commission for Healthcare Audit and Inspection (CHAI)

5.58 Announced in *Delivering the NHS Plan*[5.9] the Commission for Healthcare Audit and Inspection (CHAI) will become the health watchdog which the public can trust as the independent commentator on the quality of NHS and independent health care and on how the additional funding announced in the Budget is being used to benefit patients. The current fragmentation in the system of NHS inspection means the same NHS organisation can face multiple uncoordinated inspection visits and demands for information from a number of different bodies. Fragmentation not only makes for unnecessary bureaucracy it also weakens the system of inspection. CHAI will help to reduce burdens and

maximise the benefits to the NHS in helping to identify how the quality of health services can be improved.

5.59 The Government accepted the Bristol Royal Infirmary Inquiry recommendations that the number of bodies inspecting and regulating health care should be rationalised and that the regulation of the public and private health sectors should be brought together. CHAI will encompass all of the current and proposed work of the Commission for Health Improvement (CHI) and the Mental Health Act Commission (MHAC) with the national NHS value-for-money work of the Audit Commission and the independent healthcare work of the National Care Standards Commission (NCSC).

5.60 CHAI will have responsibility for inspecting both the NHS and private health care sectors and will help to promote continuous improvement in the quality of services for patients and ensure value for money is achieved. Its principal roles will include:

- inspecting all NHS health care providers with the ability where there are serious problems, to recommend special measures are taken;
- licensing private health care provision;
- conducting NHS value-for-money studies;
- publishing reports on the performance of NHS organisations both locally and nationally; and,
- publishing an annual report to Parliament on national progress on health care and how resources have been used.

Financial Flows – Making sure money moves between commissioners and different healthcare providers

5.61 The changes announced in *Delivering the NHS Plan*[5.10] to the way that money will flow around the NHS were set out in more detail in October 2002 in *Reforming NHS Financial Flows: introducing payment by results*[5.11]. This document also sought feedback on a number of key issues raised by these reforms. A response to the comments we received has been published on the Department's website.

- Comments made in response to this document were taken into account in the more detailed guidance on implementing the scheme and the national tariff for 2003-04, which was issued alongside allocations in December 2002. This guidance is also available on the Departments of Health's website, along with a number of tools – such as a model Service Level Agreement – to help organisations to implement changes.
- The changes to the financial flows system will start in 2003-04 with a small proportion of inpatient activity and expenditure and will gradually roll out to other areas such as outpatient activity, accident and emergency and ambulance, and mental health and community health as appropriate casemix tools can be developed over a number of years. The areas covered in 2003-04 are focused on services with high volume, high cost, long waits, and link to the choice pilots. In 2005-06 the new system of financial flow will cover the majority of HCHS expenditure. There will be a transition process to ensure there is no undue financial destabilisation.
- Improving our casemix tools is a key priority and casemix measures (in particular HRGs) will be further developed to ensure that they are robust and fit to support a reimbursement system. The HRG (Healthcare Resource Group) version 3.5 revision programme is underway with clinical working groups examining the current HRGs to consider whether refinements can be made to current code groupings to improve the HRGs.

Next Steps:

- The development of HRG version 3.5 should be complete by the summer of 2003. This will be followed with preparatory work to implement the new HRGs, and work on developing casemix tools will continue.
- There will be continued consultation with NHS bodies and other organisations, alongside further analysis and modelling, to develop the system for implementation in 2005-06.
- Working to improve the quality of reference cost information; and
- Continuing to work with the National Primary and Care Trust Development Programme (NatPaCT) and others to prepare PCTs and other organisations for the phased implementation of *Payment by Results*.

NHS Bank

5.62 Since the NHS Bank was announced in *Delivering the NHS Plan*, a Shadow Bank has been established overseen by four SHA CEs and chaired by the Department's Finance Director. In 2002-03 the shadow bank has worked to administer a £100 million special assistance fund to support NHS organisations.

5.63 2003-04 will see the Shadow Bank arrangements develop with Strategic Health Authorities taking a greater role. The £100 million special assistance fund will continue and the Bank will also assist in managing the profile of capital expenditure across the NHS and across years, to ensure that the NHS as a whole makes optimum use of total resources on an annual basis.

ACTIONS ACHIEVED TO DATE

ACCESS

Primary Care

5.64 The March 2003 milestone of 90 per cent delivery was achieved for access to a primary care professional:

At March 2003 nationally:

- 88 per cent of patients were able to be offered a GP appointment within two working days; and

- 91 per cent were able to be offered a primary care professional appointment within one working day.

5.65 Both results show progress over 2001-02. Further details on Access can be found in Chapter 7.

ON THE GROUND:

In the past six months, Daventry and South Northants Primary Care Trust has made a dramatic leap in access to GPs and nurses.
In October last year, patients were only able to see a nurse within 24 hours in 67% of practices and only 58% were able to offer access to a GP within 48 hours.
But now all practices can offer an appointment with a nurse within 24 hours and 92% are offering access to a GP within 48 hours.

- Forty-two NHS Walk-in Centres are now established as a convenient service which is complementary to general practice. The independent National Evaluation report published in July 2002 by Bristol University shows that NHS Walk-in Centres are a safe and popular addition to the NHS family with high levels of patient satisfaction.

Secondary Care

- Figures published for the end of February 2003 show the total number of patients waiting for a hospital operation has fallen by 26,000 with the number waiting for over a year having consistently fallen for a year and and a half, indicating the NHS is on course to deliver its target of no-one waiting more than a year for inpatient treatment at the end of March 2003.
- At the end of December 2002, 51 per cent of Trusts were already meeting the March 2003 target of having no 21 week waiters and its fully expected that this target will be met by all Trusts as planned.
- By the end of March 2002, more than five million patients had booked their appointment at a date and time of their choice.

Workforce –

Increase numbers of staff within the service and modernise jobs

5.66 Provisional figures for September 2002 show that since September 1999 there has been an increase of around 40,000 nurses and since September 1997 there has been an increase of almost 50,000 nurses. This means that the NHS Plan commitment for 20,000 more nurses by 2004 (over 1999 levels) and the manifesto commitment for 20,000 more nurses by 2005 (over 2000 levels) have been achieved well ahead of schedule.

5.67 Provisional figures for September 2002 show that since September 1999 there has been an increase of around 5,500 therapists. This puts us on target to achieve the NHS Plan target for 6,500 more therapists and other health professionals by 2004. The number of applications for social work courses in 2002 increased by 8.3 per cent over the previous year.

5.68 Provisional figures for September 2002 show that since September 1997, consultant numbers have increased by 5,500, GP numbers by 1,200 and specialist registrar and GP registrar numbers by 2,500. From March 1996 to 2001 there has been an increase of 9 per cent in the numbers of whole time social workers for local councils.

ON THE GROUND:

It was found that up to 60 per cent of newly-qualified nurses moved jobs or left the profession altogether within their first year because of difficulties making the transition from student to staff nurse, learning the system, developing clinical judgement or forging professional relationships.
Royal Wolverhampton Hospitals NHS Trust has appointed a clinical skills facilitator to tackle the high turnover of junior staff. The facilitator is responsbile for assessing and teaching new staff nurses.

5.69 Provisional figures for September 2002 show that since September 1999, the number of consultants working in the NHS has increased by 3,700 and the number of GPs increased by 700. The NHS Plan target is for 7,500 more consultants and 2,000 more GPs by 2004.

Capital and Capacity –

Increase and improve capital and infrastructure within the system

5.71 Since May 1997, 68 major hospital developments (64 PFI and four Public) worth over £8.8 billion have been approved to proceed. The latest of these to become operational are located at Leeds Community, Bromley and Hull.

5.72 114 hospital schemes (104 PFI and 10 public capital) counting towards the NHS Plan aim of "100 new hospital schemes in total between 2000 and 2010" have been approved to proceed to date. Of these all but three are timetabled to open by 2010. We are therefore on course to exceed the target set out in the NHS Plan.

ON THE GROUND:

A new critical care unit, costing £2.5m, is to be built at New Cross Hospital, Wolverhampton. It will boast the latest life-saving technology, 85 nurses and eight specialist consultants. The unit will integrate the intensive care and high dependency units. There will be an extra 19 critical care beds.
It will lead to a reduction in cancelled operations.

5.73 General & acute beds increased by over 1,500 in last two years – over two-thirds of the NHS Plan target to increase beds by 2,100 by 2004 already achieved. This is the first time G&A bed numbers have increased in two consecutive years since records began in 1960.

5.74 30 per cent increase in adult critical care beds since January 2000 – NHS Plan target met early.

Primary Care

5.75 Impressive progress has already been made towards the NHS Plan targets of replacing or improving 3,000 GP premises and providing 500 One-Stop Primary Care Centres by 2004.

- By 2004, up to £1 billion in total will have been invested to modernise the primary care estate.
- Over 1,300 premises have already been modernised (through substantial refurbishment or replacement with new buildings), helping GPs to provide highest quality services in the highest quality settings.
- Some 200 one-stop primary care centres have already been bringing primary and community services and, where possible, social services and other primary care providers together on one site to make access more convenient for patients.
- 42 areas have begun the process of establishing NHS local improvement finance trusts (NHS LIFTs) to use public and private partnership (PPP) principles to support wholesale refurbishment or replacement of the local primary and community care estate to support delivery of modernised primary care services.
- £30 million of public capital has been targeted on investment in the most under-doctored areas to develop training practices in deprived and most needy communities. This should lead to at least 400 premises being improved to provide accommodation for an extra 550 GP Registrars.
- An additional £15 million was approved to improve workforce accommodation in GP premises. This is well advanced and around 200 expanded and improved premises should be provided once the programme is completed.
- In August 2002 an extra £22 million of public capital was targeted at providing a further 100 one-stop primary care centres to be completed by 2003 in under-doctored areas serving both rural and urban communities.

Quality –
Improve the quality of clinical care and ensure a more patient centred-service

5.76 Listening to patients' views is essential to delivering the commitments for a patient centred service. Every NHS and PCT trust is required to regularly obtain feedback from patients about their experiences of care. This is through a national survey programme, where the views of patients form part of the assessment of NHS service providers for our star ratings system.

5.77 PCTs publish a summary Patient Prospectus called 'Your Guide to Local Health Services'. This contains a summary of the results of the annual survey of patients at the local acute hospital(s) and information on the on the shape, quality and performance of local services. This will be a regular publication. All PCTs produced this document in autumn 2002 for distribution to each household by end of November 2002.

5.78 The majority of trusts now have in place Patient Advice and Liaison Services (PALS). They are dealing with patient concerns on the spot, picking up information all the time about people's experiences of the NHS – both good and bad. This is fed back to the Trust board to highlight gaps and ensure services continue to meet patients' needs.

ON THE GROUND:

A cancer patient who received treatment at Doncaster Royal Infirmary is now working with a clinical management team at the hospital.

Dennis Atkin (55), a retired police officer, works with clinical staff to give a patient's perspective on future plans and running of the special surgery services. This includes ENT (disorders of the ear, nose and throat), oral and maxillo-facial surgery, and orthodontics. Dennis is a laryngectomee, after his treatment for cancer of the larynx in June 2000.

He is a member of the Doncaster Cancer Support Group, Cancer Voices, and also a representative for cancer patients on the Doncaster Community Health Action Forum.

Staff are increasingly involving patients in all new developments and proposed service changes. This gives users of healthcare services the opportunity to influence developments.

5.79 From 1 January 2003, all local authorities with social services responsibilities (county councils, London Borough Councils and unitary authorities) have the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants, and should lead to improvements both in quality and in creating a patient-centred NHS.

5.80 Also from 1 January 2003, Section 11 of the Health and Social Care Act 2001 placed a new duty on NHS trusts, Primary Care Trusts and Strategic Health Authorities. This is a duty for NHS bodies to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes to the way services are provided.

5.81 The Commission for Patient and Public Involvement in Health was established on 1 January 2003, with responsibility for overseeing the new patient and public involvement system. The Commission will support, fund and performance manage Patients' Forums and the delivery of Independent Complaints Advocacy Services (ICAS). It will advise the Secretary of State on public and patient involvement issues. The Commission will champion and promote the involvement of the public in decisions that affect their health, putting them at the heart of decision making in local NHS services.

5.82 The Department will be working with the Commission to set up Patients' Forums throughout 2003-04. Patients' Forums, being set up for every trust and PCT will be responsible for monitoring and reviewing NHS services from a patient's perspective.

5.83 Independent support will be available for patients wishing to make a complaint about their NHS care or treatment. The service has now been piloted and will be provided and/or commissioned by PCT Patients' Forums.

5.84 Patients' Forums will be a powerful vehicle for enabling patients to have a louder and more effective voice in the way the NHS works. By empowering more people to get involved by

putting in place formal mechanisms and equipping them with the skills to be able to do this effectively, we are reinforcing the culture of "trust me I am a patient".

5.85 The new system for patient and public involvement aims to bring about a cultural change in the way the NHS deals with patients and the public to shift the balance of power in their favour, to give them real influence and power and to modernise the NHS around patients.

5.86 The Department intends to set out the way forward for introducing improvements to the current complaints system shortly. A key plank of the reforms will place responsibility for the new Independent Review stage of the complaints process with CHAI. Work is also underway on developing a good practice toolkit for local resolution and an improved clinical assessor's database, which should also be available early this year, as well as a specification for training of people dealing with complaints. In addition, a set of "principles" will be developed that will allow the NHS and social services complaints systems to operate effectively in Care Trusts and Section 31 Partnerships.

5.87 The Chief Medical Officer has produced a report for the government about options for reforming the present system for handling clinical negligence claims. This has been presented to Ministers, and will form the basis for published proposals later on this year. The aim of reforms are to develop improved ways of responding to complaints and clinical negligence claims that are simpler to use, more accessible and more responsive to patients, have ownership and the support of staff and encourages learning from errors. These improvements should make the NHS more responsive to the needs of patients who suffer as a result of poor quality care.

5.88 The Department undertook to end mixed-sex accommodation in 95 per cent of NHS trusts by December 2002. We set clear objectives designed to provide separate sleeping areas, separate toilet and washing facilities and safe facilities for the mentally ill:

- 98 per cent of NHS trusts provide single-sex sleeping accommodation for planned admissions and have robust operational policies in place to protect patients' privacy and dignity;
- 95 per cent of NHS trusts meet the additional criteria set for mental health facilities; and
- 93 per cent of NHS trusts provide properly segregated bathroom and toilet facilities for men and women. A further 2 per cent of NHS trusts have works underway to deliver the required standard, affecting just 34 wards out of 10,000.

Over 98 per cent of NHS wards meet our guidelines, which is a significant achievement. The remainder will comply once PFI and other building projects currently underway are completed.

Clinical Governance

5.89 Clinical Governance is the local mechanism for ensuring the delivery of safe, high quality patient care. Chief Executives and Boards are responsible for ensuring that the duty of quality, set out within the Health Act 1999, is properly discharged by putting and keeping in place arrangements for continuously monitoring and improving the quality of health care that the organisation provides.

5.90 Following the publication of Shifting the Balance of Power, guidance on clinical governance reporting processes was issued in November 2002 to ensure that clinical governance reports and performance monitoring is aligned to the work of the Commission for Health Improvement (CHI).

5.91 CHI has published 262 clinical governance review reports to date.

5.92 The NHS Modernisation Agency-Clinical Governance Support Team has supported 433 teams from NHS organisations that have been or are going through its Clinical Governance Development Programme.

ON THE GROUND:

Before patients were given automatic appointments every six to 12 weeks. But often patients felt this unnecessary and only need an appointment when problems arise.

A scheme to give diabetics the power to book their own podiatry appointments has been launched at North Tyneside General Hospital. Now the patient can choose the time and date of their next appointment.

This is not only more convenient for the patient but is also helping to ease the pressure on the service and make it more responsive to patient needs.

New consent processes

5.93 Patient leaflets on consent to examination or treatment (setting out patients' rights when their consent is sought, and encouraging them to ask questions and take the time they need to come to a decision) were published in July 2001; guidance plus a new consent to treatment form and model consent policy issued November 2001. This is part of the 'Good Practice in Consent Initiative' set out in the NHS Plan.

5.94 The Department has consulted on a draft code of practice on families and post mortems and consent to post mortem forms. Final versions will be published shortly.

Patient Safety

5.95 The National Patient Safety Agency (NPSA) was established in July 2001 – its core function is specifically to improve the safety of NHS patient care by promoting a culture of reporting and learning from adverse events, and to manage the national reporting system to support this function. Following from piloting this system in 28 hospitals and in primary care, the reporting system will undergo further testing and development in early 2003 prior to being implemented across the NHS from 2003. The NPSA issued its first Patient Safety Alert to the NHS on 23 July 2002, on preventing accidental overdose of intravenous potassium in hospitals.

National Clinical Audit

5.96 The NHS Reform and Health Care Professions Act 2002 establishes an Office for Information on Health Care Performance within the Commission for Health Improvement (CHI). As part of its work the Office will work in partnership with the clinical professions and others to promote the development of a programme of clinically relevant, locally owned clinical audits. As part of this work CHI took over, in autumn 2002, the programme of national clinical audits initiated by the National Institute for Clinical Excellence. CHI have also agreed to take over the management of the National Clinical Audit Support Programme from the Department in April 2003. These two strands of work will be integrated into the national clinical audit programme to be developed by CHI during 2003.

Controls Assurance

5.97 A constituent process of clinical governance which underpins the provision of quality outcomes through assuring effective risk and control systems, is now largely in place and developing in all NHS bodies.

Modernisation Agency

5.98 The Clinical Governance Support Team part of the NHS Modernisation Agency runs a number of programmes that address quality, safety and Clinical Governance. These are:

- The clinical governance development programme engages front line multidisciplinary teams in the implementation of clinical governance in NHS organisations. It provides a framework that ensures the provision of safe and high quality patient care. The programme enables a wide variety of organisations to involve staff and patients in improving services;
- The Board Development programme addresses the strategic leadership of clinical governance in NHS organisations. It supports the development of boards and individuals to ensure: accountable care; top-level commitment; whole organisation engagement; whole system involvement and development of strategic capacity; and,
- The Large Group Programme facilitates accelerated implementation of clinical governance and service modernisation. They work with large groups of people in a variety of ways to achieve sustainable improvement.

ON THE GROUND:

The Gateshead and South Tyneside Smoking Cessation Service has topped the league of services in England.
Last year record numbers of people were accessing the service and the numbers quitting (691) were four times higher than the national average (196). Jarrow taxidriver Russell Walker was the service's 10,000th client. He saw an advisor from the service every week and was prescribed the drug Zyban.

Health Inequalities – Improve public health services and reduce level of inequalities in health status

5.99 Two national health inequalities targets were set in February 2001 and as part of the Spending Review 2002 these were combined to form one single PSA target:

> *By 2010 reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.*

5.100 An overview of the Government's national health inequalities programme is provided in chapter two.

5.101 During the period April 2001 to March 2002, around 227,300 people set a quit date through the NHS smoking cessation services, and 119,800 (53 per cent) were successful at the four-week follow-up. This is well ahead of the 2001-02 target for 50,000 people to have quit at four-week follow-up through smoking cessation services.

5.102 During the same period, 4,037 pregnant women set a quit date through the services and 1,941 (48 per cent) had successfully quit based on self report at the four-week follow-up stage.

5.103 The under 18 and under 16 conception rates both fell by 10 per cent between 1998 and 2001, making progress towards the targets of 15 per cent by 2004 and 50 per cent reduction by 2010.

5.104 A new action plan for the next phase of implementation of the Teenage Pregnancy Strategy was launched in June 2002. This sets out further cross-Government action to underpin delivery of the under 18 conception rate reduction targets and the aspirational target to increase teenage mothers' participation in education, training or employment to 60 per cent by 2010. The current rate is 33.5 per cent (2002), compared to 16 per cent in 1997.

5.105 The Sexual Health and HIV Strategy Implementation Action Plan was published in June 2002, detailing interventions and setting out milestones towards the goals of better prevention, better services and better support for people with sexually transmitted infections and HIV and reducing unintended pregnancy rates.

5.106 In the period 2001-02 there was an increase of 8 per cent in the numbers presenting for treatment for drug misuse. This means that the Department are on track to meet the target of increasing the numbers in treatment by 100 per cent by 2008.

5.107 Work is progressing on developing a number of antenatal and child health screening programmes. By 2004-05, all pregnant women will be offered antenatal screening for Down Syndrome. By 2005 all areas of England will be participating in testing babies for hearing defects using the otoacoustic emissions test and/or auditory brainstem response.

5.108 The National School Fruit Scheme will benefit from £42 million from the New Opportunities Fund to support further testing and expansion of the scheme over the next two years.

5.109 600,000 children are already receiving a free piece of fruit each school day, and every child aged 4-6 will be entitled to one by 2004.

5.110 Work continues on the Five-a-day programme to increase awareness of, and access to, fruit and vegetables in deprived communities. A further 66 local initiatives are being supported by the New Opportunities Fund over the next two years. Led by PCTs, the initiatives will be based on lessons from five successful pilot initiatives.

5.111 Health Action Zones were established to tackle inequalities in health in the most deprived areas of England and to address other interdependent and wider determinants of health such as housing, education and employment. Since April 2002 they have aligned locally with Primary Care Trusts (PCTs) and Local Strategic Partnerships (LSPs), in order to mainstream their working and support PCT and LSP development.

Cancer –

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

5.112 The *NHS Cancer Plan*[5.12] was published on 27 September 2000. It provides a comprehensive framework for the development of cancer services over the next five to eight years.

5.113 Significant progress is being made in cancer care including:

- NHS breast screening programme has started to be extended to include routine invitations to women aged 65 to 70 alongside improvements in the way mammography images are checked. An extra 150,000 women aged 65-70 have been invited to be screened since April 2001 as a result;
- 97.8 per cent of patients referred urgently with suspected cancer were seen within two weeks during October to December 2002;
- 96.5 per cent of women with breast cancer received their first treatment within one month of diagnosis during October to December 2002;
- Upgrading and expansion of equipment: new and replacement cancer equipment provided through central programmes includes, up to the end of March 2003, 41 new MRI Scanners, 60 Linear Accelerators, 129 CT Scanners and over 570 items of breast screening equipment, all delivered since April 2000. This means 39 per cent of MRI, 59 per cent of CT, and 45 per cent of linear accelerators now in use in the NHS are new since April 2000;

ON THE GROUND:

Two new state of the art scanners at the University Hospital of North Tees were formally opened on 8 November by John Hutton. *The first (a CT scanner) was installed by the North Tees and Hartlepool NHS Trust at the University Hospital of North Tees in March 2002 as part of the Department of Health's capital investment programme for CT Scanners at a cost of £490,000. The second scanner (a new MRI scanner costing £850,000) was installed at the University Hospital of North Tees in May 2002 by Alliance Medical. This scanner provides more detailed information than CT scanners and does not use radiation. It also provides scanning techniques, such as, angiography, which produces images of the blood vessels, as well as being a more patient friendly design that is less claustrophobic than the old system.*

- Smoking Cessation Services: in 2001-02 119,800 smokers had quit at the four-week follow-up stage. In the first six months of 2002-03, 55,000 smokers had quit at four-week follow-up;
- Extra 500 cancer consultants appointed between September 1999 and March 2002. We are on target to appoint nearly an extra 1,000 cancer consultants by 2006 (in addition to extra surgeons, urologists, gastro-enterologists and other specialists involved in cancer care);
- Over 600 Cancer Services Collaborative projects are now making progress across all cancer networks and Trusts and have already yielded over 1,500 real improvements in cancer services for patients;
- 31,000 patients each year are now able to benefit from new anti-cancer drugs following NICE appraisals;
- During October to December 95.5 per cent of patients diagnosed with children's cancer and 99 per cent diagnosed with acute leukaemia received their first treatment within a month of urgent referral from their GP. The figure for testicular cancer is 92.1 per cent; and
- Over 10,000 district nurses are receiving training to help them support people with cancer at home for as long as possible during their illness.

ON THE GROUND:

A rapid access clinic in Bolton Hospitals NHS Trust allows patients with suspected prostate cancer to be able to see a specialist more quickly. In addition they are better informed about what will happen and when. They also now have access to a dedicated nurse specialist who can offer information and support in relation to their treatment and care. Patients now receive their management plan, supported with good quality information within five weeks compared to 12 to 28 weeks previously.

Prevention

5.114 A target has been set to reduce smoking among manual groups from 32 per cent in 1998 to 26 per cent by 2010 to narrow the health gap between manual and non-manual groups. Local targets will be introduced to cut smoking rates in the 20 health authorities with the highest smoking rates.

5.115 Diet plays an important part in cancer prevention. The Government launched the National School Fruit Scheme in 2000 to increase fruit consumption. The scheme is being expanded over the next two years and will cover all school children aged between four and six years old from 2004. Children in the West Midlands, London and the North West are currently receiving a piece of fruit each school day. When the scheme is rolled out to the next region (the East Midlands) 1 million children will be eligible to receive fruit each day by the end of this school year.

5.116 Five-a-day pilot projects have shown that the declining trend in fruit and vegetable consumption can be halted – with those whose consumption was lowest at the outset showing the greatest increase in consumption. The New Opportunities Fund is providing funding to set up 66 PCT-led Five-a-day community initiatives based in deprived areas. These will be backed by a major communications campaign.

Screening and early detection

5.117 The breast screening programme is being extended to cover women aged 65-70. Two-view mammography will be introduced at every screen. Screening for women over 70 will be available on request. These changes will be phased in and all breast screening units will be inviting women aged 65-70 by the end of 2004. An extra 150,000 women aged 65-70 have been invited to be screened since April 2001 as a result.

5.118 New screening technologies are being piloted in the cervical screening programme.

ON THE GROUND:

A £200,000 campaign to encourage more Asian women to take part in breast and cervical cancer screening programmes has been launched in Birmingham. Historically, there is a low take-up and there are fears that deaths from breast and cervical in these communities may rise. 14 outreach workers have been trained to take the message into the community.

5.119 Other screening programmes will be introduced if and when they are proven to be effective. In November 2002 Alan Milburn reaffirmed his commitment to introduce a national screening programme for colorectal cancer screening and to improve services for symptomatic patients. This work is being taken forward by the National Cancer Director by way of the NHS Bowel Cancer Programme, which was launched in February 2003.

5.120 There is as yet no evidence for screening for prostate cancer. Evidence based primary care resource packs were sent to all GPs in England in September 2002 to aid them in counselling men who are worried about prostate cancer, helping men to an informed choice on whether or not to be tested for prostate cancer.

5.121 £2.5 million is being used to provide endoscopy training for GPs, nurses, surgeons and gastro-enterologists. Endoscopy is a key diagnostic procedure for colorectal stomach cancers.

Treatment

5.122 New and challenging waiting times targets have been set out. By 2004, every patient diagnosed with cancer will benefit from pre-planned and pre-booked care. By 2005 there will be a maximum one-month wait from diagnosis to treatment for all cancers. Also by 2005 there will be a maximum two-month wait from urgent GP referral to treatment for all cancers. Achieving these targets will depend on continued NHS reform, and the recruitment of the necessary staff.

5.123 £15 million is being used to support the extension of the Cancer Services Collaboratives (CSC) to all cancer networks in 2002-03. Over 600 collaborative projects across the country are working to streamline care, and reduce delays for patients at all stages of diagnosis and treatment. To date there have been 1,500 real improvements in cancer services for patients. We estimate that by the end of March 2003 30 per cent of diagnosed cancer patients will benefit from redesign work in breast, colorectal, lung, gynaecology and urology. In addition to the tumour specific work the CSC has also started new projects across services in radiotherapy, radiology, chemotherapy and endoscopy.

5.124 Working in partnership with Macmillan Cancer Relief, the Department are investing £3m (£2m DH for the funding of the leads, £1m MCR for the development and funding of the support programme) each year over three years to support a lead clinician in each PCT in the country. This funding is helping lead clinicians to have dedicated time to contribute to the development of cancer networks and to raise standards of cancer care within the PCT. This will improve communication and understanding across primary, secondary and tertiary care, leading to better co-ordination of care for patients.

Palliative Care

5.125 By 2004 NHS funding for specialist palliative care will have increased to £50 million per annum compared with 2000-01. The increase will be used to tackle inequalities in access to specialist palliative care and to enable the NHS to make a more realistic contribution to the costs of hospices in providing agreed levels of service. A new £50m central budget for specialist palliative care has been set up and will run from 2003-04 to 2005-06. A joint NHS and voluntary sector national partnership group will approve local specialist palliative care plans submitted by SHAs.

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

5.127 Working with palliative care key stakeholders the DH has allocated £6m over three years on providing additional training for district and community based nurses on the principles and practice of palliative care provision.

Staffing

5.128 By 2006 there will be nearly 1,000 extra cancer specialists – an increase of nearly one-third. Between September 1999 and September 2001 there was a net increase in nurses

working in the NHS of 20,740 – the NHS Plan target has been reached two years early. The increase in nurse numbers will enable the recruitment of additional cancer-site specific nurse specialists, chemotherapy nurses, district nurses, palliative care nurse specialists and additional nurses on wards caring for cancer patients.

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

5.130 In 2000-01, in line with the commitment in *The NHS Cancer Plan*,[5.13] the Department of Health provided funding for three histopathology training schools to attract more SHOs to pursue a career in histopathology and to design innovative teaching methods. Based in Leeds, Leicester and Southampton and each training six SHOs per year, the schools were initially funded for three years. The initial evaluation of the pilot training centres has proved positive and the Department announced the expansion of the scheme to 12 schools each training 12 SHOs each year.

Equipment

5.132 41 new MRI Scanners, 60 Linear Accelerators and 129 CT Scanners which are used to diagnose, plan and treat cancer as well as over 570 pieces of equipment for the NHS breast screening programme have been delivered under central investment programmes over the last two years. A further 66 MRI scanners, 71 CT scanners and 42 linear accelerators will be delivered to the NHS over the next two years.

ON THE GROUND:

- *The impact of new MRI scanner at Chesterfield and North Derbyshire Royal Hospital has reduced waiting times from 52 weeks to four weeks.*
- *Following the delivery of a replacement MRI scanner at Royal Lancaster Infirmary waiting time for access to scanning have reduced from 11 months to under one month. The trust is now able to undertake a wider range of examinations and perform accurate staging of rectal carcinoma which has facilitated much faster decision making about appropriate clinical management.*

Coronory Heart Disease – Improve the care of patients with CHD and reduce mortality and morbidity of CHD

5.133 There has been continued progress on implementation of the National Service Framework, with improved and faster care at all stages of the patient pathway.

5.134 In primary care, the number of statins (a key drug in preventing and treating coronary heart disease) prescribed continues to rise by around 30 per cent a year. Reseach suggests that about 1.1 million people (two per cent of the population) are currently receiving statin therapy and that this is potentially saving 4000 to 6000 lives a year as well as reducing the number of heart attacks. The National Primary Care Collaborative and the Coronary Heart Disease Collaborative are also supporting primary care in improving care for CHD patients and improving death rates.

5.135 In emergency care there have been improvements in the treatment of heart attacks. Over the last three years, the Defibrillators in Public Places initiative has installed defibrillators in railway stations, airports, shopping centres and bus stations to increase the chances of survival for those who suffer a heart attack in a public place. By the end of 2002, 681 defibrillators had been installed across 110 sites, and it is planned to deliver 3,000 defibrillators by the end of 2004. So far, evidence suggests that 21 lives have been saved.

5.136 The NSF goal is that eligible heart attack patients should receive clot-busting drug treatment thrombolysis, within 60 minutes of calling for help. Nearly 80 per cent of heart attack victims now receive thrombolysis within 30 minutes compared to only 38 per cent in March 2000.

5.137 The NHS Plan target of 6,000 extra heart operations by April 2003 was achieved one year early. In 2001-02, the NHS performed 9,000 more heart operations than in 1999-2000. Waiting times are also falling. No patients are currently waiting 12 months for a heart operation, compared with 719 in March 2001, and new planning guidance issued to the NHS in October 2002 brought forward the target date for a maximum three months wait for a heart operation to March 2005 or sooner.

5.138 This progress has been supported by continued growth in the workforce. At the end of March 2002, there were 590 consultant cardiologists in post, compared with 467 in 1999. The Department of Health is working with professional bodies and the NHS to improve in recruitment, retention, training and development of staff in key areas, including cardiac physiologists, perfusionists, critical care nurses and primary care. A competency framework for CHD is under development, focussing initially on prevention, rehabilitation and heart failure.

ON THE GROUND:

The intermediate care unit is now handling an increasing number of referrals - all of which would have gone into hospital before. The service offers residential/nursing home rehabilitation and treatment and community support via a rehab community team and rapid response.

Intermediate care in Salford is cutting hospital admissions, enabling early discharge from hospital, and providing a whole person approach looking at all the patient's needs not just their acute medical needs. Three out of four patients admitted to the unit are now being discharged home and only 15 per cent need a hospital admission.

ON THE GROUND:

Patients suffering a heart attack in Southampton were experiencing long waits for outpatient follow-up appointments and uncertainty about when diagnostic tests would be carried out.

The cardiology department, working with the CHD collaborative, was reorganised so heart attack patients had their cardiac assessment before they went home. Patients no longer have to come to outpatients for a six-week follow-up and are instead given a follow-up date with their own GP.

This approach provides the patient with a clear diagnosis of the problem and a treatment plan before they go home. This is reducing readmissions and outpatient slots have been freed up.

5.139 An additional £204 million revenue was made available in 2002-03 to sustain and build on improvements in heart disease services.

5.140 In addition, there has been continued long term investment in the capital infrastructure needed to support further expansion of cardiac surgery. In March 2001 the Secretary of State announced major capital development at Papworth, Wolverhampton, South Tees and Bristol, and a plan to expand and modernise a further eight cardiac centres (in Blackpool, Liverpool, Manchester (South and Central), Southampton, Sheffield, Leeds and Plymouth.) were announced in November 2001. The total cost of these developments is £300 million.

ON THE GROUND:

The Blackpool, Fylde and Wyre Hospitals NHS Trust is achieving ambitious Government targets aimed at improving the treatment of heart attack patients. The National Service Framework for Coronary Heart Disease states that by April 2002, 75 per cent of patients should receive thrombolysis treatment within half an hour of arrival at hospital. Since April 2002, the Trust has consistently exceeded this target and at the end of January 2003 85 per cent of heart attack patients received thrombolysis treatment within 30 minutes. This success has been due to the introduction of a new nurse-led thrombolysis service which has helped dramatically to reduce the time patients wait. Patients admitted through A&E, Medical Admissions or medical wards who have suffered a heart attack now receive immediate treatment by one of five specialist Thrombolysis nurses.

5.141 Last year the New Opportunites Fund announced £110 million funding for coronary heart disease of which £65 million is being used to provide new angiography labs, which provide diagnostic facilities for heart disease. The Department has made available an extra £60 million to enable over 80 labs to be installed, which will speed up diagnosis significantly for patients with suspected heart disease.

Older People's Services – Improve the care provided to older people

5.142 The National Service Framework for Older People:

- Most of the infrastructure and organisational requirements for local delivery of the NSF are in place (NSF milestones);
- Over 80 per cent of hospitals have structures in place to identify nursing leaders for older people (NSF milestone);
- Over 80 per cent of hospitals that care for people with stroke have plans to introduce a specialised stroke service from 2004 (NSF milestone);
- Around three quarters of all hospitals have identified specialist multi-disciplinary teams for the care of older people (NSF milestone); and,
- By the end of December 2002, compared to the baseline of 1999-2000, there was an additional 3,300 intermediate care beds (2004 target: 5,000). The target of an extra 1,700 supported intermediate care places has already been achieved. 134,500 more people are in receipt of intermediate care.

Wider programme

- The New PSA includes: *"Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported to live at home to 30 per cent of the total being supported by social services at home or in residential care"*.
- And new targets set: by December 2004, all assessments will be within 48 hours of first contact with social services and all assessments will be completed within four weeks (and 70 per cent within two weeks); by December 2004, following assessment, all services for older people will be provided within four weeks (and 70 per cent within two weeks).
- The Change Agent Team was established as part of the 'Cash for Change' initiative to tackle delayed hospital discharges and has been operational since March 2002. It offers a range of practical support to health and social care systems to reduce delayed discharges and to support the implementation of the National Service Framework for Older People. A team to look at integrating community equipment services has also been established.
- An Older People Programme Board has been established to monitor progress against delivery of the older people programme, try to resolve problems the local NHS and social services may be facing and discuss interventions and other forms of persuasion to encourage the field to make progress against targets.
- Good progress being made to shift the balance of the provision of social care to the home. For example:
  - The number of people receiving intensive home care increased by 5,100 from 72,300 to 77,400 between 2000-01 and 2001-02; and,
  - Councils with Social Services Responsibilities (CSSRs) purchased or provided 2,975,800 contact hours of home help or home care during a survey week in September 2002. This represents a 3 per cent increase from the 2001 figure.

- *Guidance on Fair Access to Care*[5.14] was issued to councils in May 2002 which outlines a common framework to ensure that older people access social care on the basis of need and that the eligibility criteria do not unjustly discriminate against older people
- Single Assessment Process guidance was issued in January 2002 and places older people at the heart of the assessment of their needs and subsequent service planning and delivery.
- The Community Care (Delayed Discharges etc) Act 2003 received Royal Assent on 8 April 2003. The Act will introduce a system of reimbursement for delayed transfers of care in shadow form in October 2003, with liability for charges from January 2004. Regulations made under the Act will remove charging from community equipment services and intermediate care in May 2003.
- Nursing care for all care home residents funded by the NHS began on 1 April 2003.
- On course to meet the 2002-03 targets of no more than 2 per cent growth in emergency admissions and no growth in emergency re-admissions.
- On course to transfer the Residential Allowance to councils and to wind up the Preserved Rights scheme and give councils responsibility for assessment and care management of everyone with preserved rights.
- The conversation of 316 Nighingale wards, 236 for the care of older people, at a cost of £120 million has begun. 100 have already been completed and the rest are due for completion by the end of April 2004.

Mental Health –

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

5.143 Targets Achieved:

- Almost 500 extra secure beds have been provided to meet the demand for placements for people requiring therapy and security in combination;
- Over 320 24-hour staffed beds have been provided to support people in less acute phases of their mental illness;
- Encouraging progress has been made towards achieving the targets set for assertive outreach teams and establishing new workers and new ways of working. For example, 170 assertive outreach teams have been established to meet the needs of people who find it difficult to engage with traditional services. Returns from Strategic Health Authorities of Local Delivery Plans show they are on target to deliver 96 per cent of gateway workers. In addition, 12 new programmes of primary care training have been commissioned to support new graduate primary care workers. We expect good progress to continue to be made over the course of this year to meet targets by December 2004;
- Access to services 24 hours a day, 7 days a week for all those with complex mental health needs;
- £15m in 2001-02 and another £25m in 2002-03 investment to improve the physical environments in psychiatric wards;
- The safety, privacy and dignity of mental health patients has been improved as guidance in acute inpatient care is implemented;
- Action has been taken to eradicate ligature points in acute psychiatric wards in line with our Suicide Prevention Strategy;
- Progress on developing 50 new early intervention teams by December 2004 is also very encouraging. 22 early intervention teams are now in place. Progress on developing 335 crisis resolution teams is slower with only 62 teams currently in place. However, as this approach requires a significant change in service culture in addition to reconfiguration, we are confident that with support to build capacity through NIMH(E) and the Modernisation Agency, improvements in mental health will continue to be made across the country in line with NHS Plan expectations;
- Pilots have begun to provide a different workforce in mental health including new kinds of workers to provide support, time and recovery;
- Pilots have also commenced in support of a national outcomes programme so that mental health care can be measured in terms of what is achieved for the service user;
- A major programme of development in prison mental health care has begun in earnest including new services for dangerous and severe personality disorder and prison in-reach;
- The Accelerated Discharge Programme has been put in place and inappropriately placed people are being discharged from high secure services;
- 900 Nurse Advisors at NHS Direct have received mental health training including the assessment of risk, to enable them to support callers with mental health problems 24 hours a day; and,
- NHS Direct receives around 600,000 calls logged as mental health a year. In addition Nurse Advisors report anecdotally that over 40 per cent of all calls have a mental health component.

ON THE GROUND:

NHS staff and social services have now joined forces in South Essex to provide mental health care services under one organisation. The new organisation is already introducing improvements since its launch in April, including the appointment of four new consultant psychiatrists for adult mental health services; a new psychologist to help people with anxiety, emotional crisis, bereavement, depression; £500,000 is being invested in an innovative home treatment service in Southend; five new consultant psychiatrists have been employed in Southend.

They are already making a significant reduction in how long people are waiting for appointments after GP referral.

Children – Improve children's health and social care services

Public Service Agreement (PSA) Targets

5.144 The NHS Plan contained a number of PSA targets to improve the life chances of children in the care of Local Authorities, agreed in SR2000. Targets were subsequently also set in SR2002 in these priority areas.

- The Children (Leaving Care) Act 2000 was implemented on 1 October 2001, placing significant new duties on local authorities to improve the long-term outcomes for care leavers. The data for care leavers aged 19 in education training or employment shows that at 53 per cent, the Department has fallen slightly short of the target of getting education, training and employment rates for care leavers up to 60 per cent of the level for all young people by 2002. However, this data refers to those who left care prior to implementation of the Act and the target of 75 per cent by 2004 should be achievable.
- In the year ending 31 March 2002, 5 per cent of those leaving care at age 16 or over achieved at least five GCSEs at grades A*-C, and 41 per cent achieved at least one GCSE or GNVQ qualification – up from 37 per cent on the previous year. A significant proportion of the total cohort had sat their exams prior to the introduction of Government initiatives to raise attainment and it is reasonable to expect a more significant improvement in GCSE outcomes over the coming two to three years.
- Up to September 2001, children looked after continuously for a year or more and of the age of criminal responsibility were three times more likely to be cautioned than their peers. The required reduction of 3.6 per cent will be met if an average of 0.9 per cent reduction is achieved each year from 2001. A 0.8 per cent reduction was achieved at September 2001, though performance is masked this year because data has been rounded.
- Figures for the year ending 31 March 2002 show that excellent progress is being made towards the achievement of the target on the number of adoptions. We are currently on course to meet the target of a 50 per cent increase. 80 per cent of children adopted from care during the year ending 31 March 2002 were placed for adoption within 12 months of the decision that adoption is in the child's best interests, a very slight drop on the previous year (81 per cent). This is in line with our expectation that improvements in the adoption service would initially result in the placement for adoption of children who had been waiting for longer periods for a suitable family.

Children's NSF

- The Children's NSF is developing national standards across the NHS and social services for children and young people. The first part of the NSF, covering care for children in hospital, was published on 10 April 2003. External Working Groups are developing standards in the following areas: Acute (phase two – Ill Child), Maternity, Mental Health and Psychological Well-being of Children and Young People, Children in Special Circumstances, Disabled Children, Healthy Child and Young Person. Emerging findings from this work were also published on 10 April. There are also a number of groups looking at underpinning strategies, including workforce, built environment, research, information, clinical effectiveness, primary care, implementability and medicines management.
- Five conferences have been held around the country to provide professional stakeholders with the opportunity to comment on the emerging work of the EWGs and to input into the development of the NSF. A series of children's participation events is underway to seek out and address the views of children and young people on the range of areas covered by the NSF.

Children's Trusts

5.145 The NHS Plan emphasised the importance of multi-agency working to provide integrated care. Following SR2002 the Government announced its intention to pilot Children's Trusts to improve local delivery of services for children. Children's Trusts will enable health, education and social service organisations jointly to plan, commission, finance and, where appropriate, provide services in order to improve the co-ordination and quality of services provided for children. The Department of Health is developing this programme of pilots jointly with DfES. A call for applications from interested local partners has resulted in a range of proposals which are currently being considered.

Pathology Modernisation

5.146 The Government's programme to modernise NHS pathology services recognises the vital role they play in the effective treatment and care of patients, and in providing fast and effective diagnoses to support improved access to services. Pathology is key to delivery of the NHS Plan and Cancer Plan, in achieving National Service Framework standards and in protecting the public health. Up to 70 per cent of all diagnoses depend on pathology.

5.147 The Department of Health identified a need for more detailed guidance on modernising pathology services and last year launched draft guidance for full public consultation. The

Department's response to the consultation was published in January 2003. After the guidance has been revised in the light of the consultation responses and discussions with key stakeholders and experts, the Department plans to launch it in early Summer 2003. Specific funding to support modernising pathology services will be available, almost £7m revenue and over £53m capital over the next 3 years.

5.148 This guidance is intended to help trust chief executives, primary care trust commissioners, Strategic Health Authorities, senior managers and pathology providers deliver modernised pathology services, built around the needs of patients and their healthcare workers, and offering improved working environments and career opportunities for pathologists themselves.

Modernising NHS Dentistry

5.149 *NHS Dentistry – Options for Change*[5.15] was published in August 2002. The key themes and priorities that emerged were the need for:

- Local commissioning and funding;
- New methods of remuneration for general dental practitioners;
- Greater emphasis on prevention and oral health assessment for patients, with better experience for patients, enhanced transparency;
- Clinical pathways using Information and Communication Technology, as in other areas of health, to determine the treatment received by patients; and,
- New practice structure, with an increased role for the professions complementary to dentistry.

5.150 These ideas need practical testing and field sites are being established across the country with the assistance of the Modernisation Agency. Some 140 applications were received for Field Site Status from all parts of the country and all sectors of Health care.

5.151 In the current session of Parliament the Government is proposing to legislate to give Primary Care Trusts a duty to commission NHS dental services to meet reasonable needs and they will be given the financial resources to do this.

Support to PCTs

5.152 The Department has been working with the National Primary and Care Trust Development Programme to develop the dental competencies of PCTs and a series of national workshops is planned to raise awareness of dental modernisation and to engage with PCT and SHA management.

5.153 £992,000 has been made available to support PCTs in undertaking a Disability and Discrimination Act audit of dental practices and a further £490,000 to provide occupational health services for general dental practice staff.

Dental IT Strategy

5.154 The ideas and proposals in *Options for Change*[5.16] that will be tested need IT infrastructure support and so developing IT within dentistry is an essential component of the Options for Change programme.

5.155 A national Dental IT strategy will be published shortly as part of the wider National IT programme which will address all these areas. In particular it focuses on:

- Connecting dentists to NHS Net or its successor;
- Development of a dental electronic record;
- Use of the NHS number by dentists; and
- Accreditation of dental systems.

5.156 Implementation of the IT strategy is being focused initially on the Field Sites and Personal Dental Service pilots then rolled out to the rest of dentistry.

Pharmacy in the Future

5.157 The Department's programme for pharmacy was published in *Pharmacy in the Future – Implementing the NHS Plan* (September 2000).[5.17] That set an ambitious programme for the role of pharmacy in the NHS, including measures to improve access to medicines, to promote high quality pharmacy services, and to reduce waste by promoting better use of medicines within the NHS.

5.158 During 2002-03 a new legislative framework and process for reclassifying the legal status of medicines was set in place, making it easier (where it is safe to do so) for medicines to be sold by pharmacists, rather than needing a prescription. The option of referring people to their community pharmacist for help has been rolled out nationally by NHS Direct. In 32 PCT areas repeat dispensing has begun. This means that patients will be able to get their medicines supplied in instalments from their pharmacy, without having to go back to their GP's surgery each time they need a new prescription. The Department will be considering options for rolling repeat dispensing schemes out nationwide. Three pilot schemes began under which prescriptions are transmitted electronically between GPs' surgeries, pharmacies and the Prescription Pricing Authority (PPA). The first three waves of the medicines management collaborative are helping people make better use of their medicines, a fourth wave is due to start later in the year. The community pharmacists' medicine management research project, funded by the Department, is under way where people with coronary heart disease are given advice on their medicines in community parmacists medicine. A guide to medication review – *Room for Review*[5.18] – was published. This will promote medicines partnership between patients and health professionals and support effective medicine taking. The first Local Pharmaceutical Services (LPS) pilots were approved. Eight pilots covering 17 providers are already under way with 10 further pilots due to start in the next few months. LPS provides flexibility for PCTs to contract locally for provision of pharmacy and a broad

range of other services within a single contract. Pilots, so far, include schemes that target areas of under-provision, services for specific patient groups and improve access to and quality of healthcare provision. Further pilot proposals have been invited by 1 September 2003. A report was received from the Office of Fair Trading in January 2003 proposing significant changes to the arrangements for controlling the number and location of pharmacies dispensing NHS prescriptions. The Government published an interim response in March 2003 and will come forward with final proposals in the summer. That response will inform completion of discussions which have already begun with the Pharmaceutical Services Negotiating Committee on a new contractual framework for community pharmacy, planned to be in place in 2004, and in which the NHS Confederation is also now actively involved. A discussion paper was published in September 2002, proposing significant changes in the roles and responsibilities of pharmacists and their staff.

5.159 In 2003-04 the first pharmacists will become supplementary prescribers. Supplementary prescribing is a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific Clinical Management Plan, with the patient's agreement. "Ask About Medicines Week" will spread the message that patients should be fully involved in decisions on their medicines.

Independent Reconfiguration Panel (IRP)

5.160 From Spring 2003 the Independent Reconfiguration Panel will provide independent advice to the Secretary of State on contested proposals for NHS service changes. The present system, under which the Secretary of State for Health makes decisions on contested proposals, is perceived as being insensitive, opaque and not sufficiently independent. Too little attention is paid to the impact on the total health care system.

5.161 The Panel's job will be to offer advice to the Secretary of State to assist him in making decisions. The final decision, as now, will continue to be made by Secretary of State. Only contested proposals, where is it clear that all options for resolution have been exhausted are likely to be considered in detail by the Panel. Where changes have been agreed locally – through an inclusive process of planning and proper local consultation – there is no need for the Panel to become involved.

5.162 The Panel will take account of all relevant Department policy guidance in formulating its advice. In particular, *Keeping the NHS Local – A New Direction of Travel*[5.159] and the route map described in that document will be a central feature of its consideration of contested proposals. *Keeping the NHS Local* offers support to the NHS and partner organisations engaged in service change. It also stresses the importance of local stakeholder involvement from the outset. In providing advice to the Secretary of State, the IRP will take specific account of the extent of public and patient involvement.

5.163 The Panel will operate in as open a way as possible. Its advice and the evidence it considered in providing that advice, will be published.

Modernisation Agency

5.164 The NHS Modernisation Agency is part of the Department of Health. It was formed in April 2001 to support the NHS and its partner organisations in modernising services and improving experience and outcomes for patients.

5.165 The Modernisation Agency's focus is on delivery. It demonstrates added value through measurable improvements in services for users and patients. Its methods are systematic and evidence based. The Agency uses a wide range of improvement tools and approaches. It gains strength and added learning from this. It draws expertise from around 500 practising clinicians and managers who form its staff. Nearly all work in, or have daily contact with, the NHS. These staff do not "modernise the NHS": rather they act as a catalyst for significant and sustained improvement in every healthcare community.

5.166 Modernising the NHS means:

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

5.167 The NHS Modernisation Agency has supported major improvements in healthcare over the last year focused on four priorities:

- Improving access: assisting every part of the NHS in delivering national waiting and booking targets, introducing choice and improving emergency care;
- Increasing local support: supporting organisations and leaders into new roles, helping to join modernisation activity up at a local level, building networks and working towards the establishment of local modernisation support teams and networks in every community;
- Raising standards of care: providing rapid support to under-performing parts of the NHS and promoting leading edge practice for those wanting to accelerate improvements; and,
- Capturing and sharing knowledge widely: delivering measurable added value from all national programmes, spreading good practice and helping everyone share their knowledge and learning.

5.168 Some areas where the NHS Modernisation Agency has made a difference to healthcare include:

- Over 19 million patients now have quicker access to their family doctor;

- 40,000 NHS staff will have undertaken leadership skills training by March 2003;
- All zero-star trusts are supported through a programme of co-ordinated action, enabling them to develop sustainable solutions and local capacity for improvement;
- The continued growth in the numbers of all bookings at a date and time of the patient's choice, with over 9 million patients having benefited by September 2002;
- All hospitals are now in one of the 29 Critical Care Networks across the whole of England, introducing an increasing number of improvements in the world's biggest critical care improvement programme;
- 3,000 patients per month are benefiting from collaborative action on cancer, with 30 per cent of all diagnosed cancer patients expected to benefit by April 2003; and,
- Early benefits from pilot sites in the Changing Workforce programme show a 50 per cent reduction in unnecessary transfers of patients from one staff member to another in community care and a 40 per cent reduction in the time taken for prescriptions in mental health.

5.169 As the NHS Modernisation Agency matures, the next phase in development is to move modernisation into the mainstream, to provide high quality leadership, support and expertise in helping local leaders and teams to deliver sustainable change. The challenges for the future will be:

- To champion the discipline of health care improvement throughout the NHS;
- To achieve sustainability of our work within health communities supporting them by offering customised services;
- To develop expertise and intellectual capital with knowledge management systems to support the sharing of best practise;
- To be a vehicle for innovation and piloting for new initiatives; and,
- To be a torchbearer of improvement.

5.170 Specific examples of the future direction of the NHS Modernisation Agency include:

- Developing the whole healthcare community approach, as demonstrated by the Pursuing Perfection approach in involving local health and social care communities in a two-year intensive programme to achieve levels of service far above any attained in the country so far;
- Building strong links with all 28 Strategic Health Authorities through partnership agreements and the joint commitment to spread and sustain the healthcare improvement delivery; and,
- The Hospital Improvement Partnership, a new initiative aimed at achieving better care without delay along whole hospital pathways. It will contribute to substantial reductions in

6. Breakdown of spending programme

THIS CHAPTER COVERS:

6.1 HCHS RESOURCES BY SECTOR
6.5 HCHS CURRENT RESOURCES BY AGE GROUP
6.9 ALLOCATION OF HCHS RESOURCES
6.12 CENTRALLY FUNDED INITIATIVES AND SERVICES AND SPECIAL ALLOCATIONS
6.13 UNIFIED ALLOCATIONS
6.17 REVIEW OF RESOURCE ALLOCATIONS
6.20 FAMILY HEALTH SERVICES
6.25 DRUGS BILL
6.32 CENTRAL HEALTH AND MISCELLANEOUS SERVICES
6.34 PERSONAL SOCIAL SERVICES

Hospital and Community Health Services

HCHS Resources by Sector

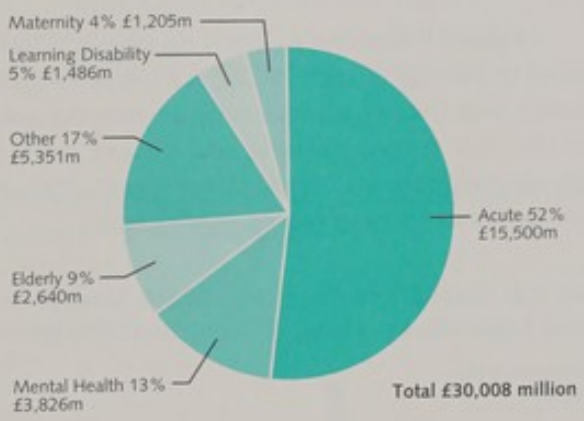
6.1 **Figure 6.1** shows the breakdown by service sector of health authority gross current expenditure on the Hospital and Community Health Services (HCHS) in 2000-01, the latest year for which disaggregated data are available. (The figure includes capital charges, but does not include spending on General Medical Services (GMS) discretionary, Family Health Service (FHS) prescribing and other related services). For this reason the total differs from the figure shown in **Figure 3.3a**.

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

- Acute services 52 per cent;
- Mental health 13 per cent;
- Services intended primarily for the elderly 9 per cent;
- Learning disabilities 5 per cent;
- Maternity 4 per cent; and,
- Other services 17 per cent.

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

Figure 6.1: Hospital and Community Health Services Gross Current Expenditure by Sector, 2000-01

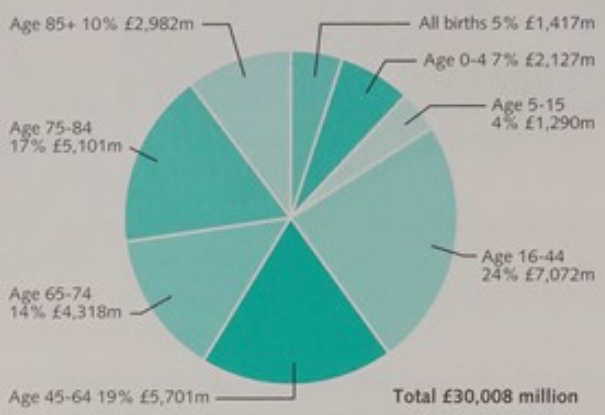


6.4 Of the total HCHS spend, i.e. £30 billion, £1.6 billion (5.6 per cent) is spent on administration, leaving £28.4 billion (94.4 per cent) for patient services. From this, hospital expenditure accounts for 83 per cent (£23.6 billion) and community services 17 per cent (£4.8 billion).

HCHS Current Resources by Age Group

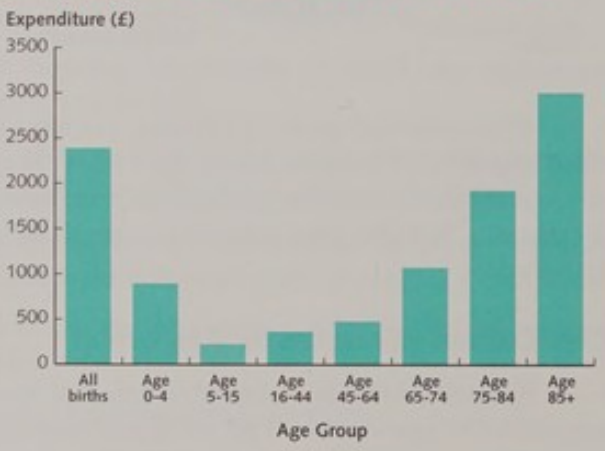
6.5 **Figure 6.2** shows that in 2000-01 people aged 65 and over accounted for approximately 41 per cent of total expenditure, a group however that comprises around 16 per cent of the population. This is primarily because approximately 46 per cent of acute expenditure and significant proportions of expenditure on services for mentally ill people and other community services are for people aged 65 and over.

Figure 6.2: Hospital and Community Health Services Gross Current Expenditure by Age, 2000-01



6.6 **Figure 6.3** shows the estimated expenditure in 2000-01 on HCHS for each age group, expressed as a cost per head of the population. High costs are associated with each birth, but costs per head then falls steeply, remaining low through young and middle age groups, before rising sharply from age 65. This reflects the greater use of health services by elderly people.

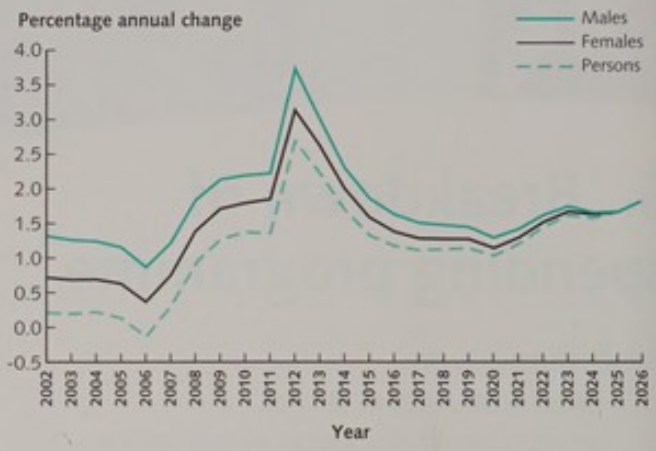
Figure 6.3: Hospital and Community Health Services Gross Current Expenditure per Head of Population 2000-01



6.7 The changing demographic make up of the population affects the demand for NHS care. The elderly, in particular, have an impact. **Figure 6.4** shows that over the next 10 years the increase in the population, aged 65 and over, is expected to average 1.2 per cent per year. Over the next 20 years, the growth rate becomes more pronounced at 1.4 per cent per year. To date the NHS has been able to manage the increase in the use of its services caused by an ageing population. But the pattern of service delivery may need to change in the future.

6.8 The current trend is for reductions in the growth rate of people aged 65 and over, but this will end in three years time. Starting from 2006, the post-war baby boom will boost the year on year growth rates in the elderly populations, with growth rates peaking in 2012.

Figure 6.4: Estimated Growth in People Aged 65 and over: Year on Year Percentage Increases



Allocation of HCHS Resources

6.9 Revenue allocations to Primary Care Trusts for 2003 to 2006 were announced in December 2002. For the first time allocations have been made direct to Primary Care Trusts. Also for the first time allocations have been made for three years rather than one single year. More details of the allocations can be found in *2003-04, 2004-05 & 2005-06 Primary Care Trust Revenue Resource Limits Exposition Book.*[6.1]

6.10 The sum available for HCHS for 2003-04 is £51,950 million, for 2004-05 is £56,998 million and for 2005-06 is £62,391 million.

6.11 **Figure 6.5** summarises the way in which resources for 2003 to 2006 translate into Primary Care Trust allocations.

Figure 6.5: Distribution of Resources for 2003-06

	2003-04		2004-05		2005-06	
	£m	% increase	£m	% increase	£m	% increase
HCHS	51,950		56,998		62,391	
Capital charges and other funding adjustments	1,722		1,799		1,899	
Total available	53,672		58,797		64,290	
CFISSA[1]	8,645		9,469		10,365	
Total for PCTs	45,027	9.24	49,328	9.55	53,925	9.32

1 Centrally funded initiatives and services and special allocations.

Centrally Funded Initiatives and Services and Special Allocations (CFISSA)

6.12 The CFISSA programme provides central revenue funding to implement the NHS Plan and other initiatives. **Figure 6.6** provides details of the CFISSA budget programme for 2003-04 to 2005-06

Figure 6.6: Centrally Funded Initiatives and Services and Special Allocations (CFISSA), 2003-04 to 2005-06

Budgets	2003-04	2004-05	£000s 2005-06
Improving Access to all Services:			
* Better emergency care	131,494	139,511	185,594
* Waiting, booking and choice	313,545	288,773	179,057
Improving Services & Outcomes in:			
* Cancer	108,944	108,333	112,644
* Coronary Heart Disease	43,737	47,006	51,062
* Mental Health	33,672	97,682	117,103
* Older People	209,000	210,367	211,850
* Children	12,399	20,256	20,399
Improving Patient Experience	85,551	74,340	64,350
Reducing Health Inequalities	180,488	178,394	355,807
Contributing to a Reduction in Drug Misuse	253,829	258,702	311,829
Building Capacity			
* Workforce	3,889,395	4,472,971	5,090,836
* IM&T	174,865	173,641	166,865
Other CFISSA budgets:			
R&D	544,684	567,502	589,040
Statutory Bodies	270,315	286,736	298,628
Specialist Health Services (eg Audiology Services, Dentistry, Ophthalmic)	195,002	220,546	242,782
Modernisation Agency*	89,001	91,754	79,101
Primary Care	81,179	98,948	106,200
Public Health	24,542	31,329	72,379
Central Payments made on behalf of the DH (eg Injury Allowances)	60,214	68,196	76,896
Residual CFISSA budgets (eg SHA Running Costs, NHS Bank)	335,819	436,898	412,333
CFISSA budgets issued with PCT allocations	207,262	234,027	271,018
Cost of Living Supplement	108,765	108,765	108,765
Non Cash CFISSA budgets (including Capital Charges, Provisions etc)	1,291,298	1,254,323	1,240,462
TOTAL	**8,645,000**	**9,469,000**	**10,365,000**

** Funding for core activities not included in any other budget categories.*

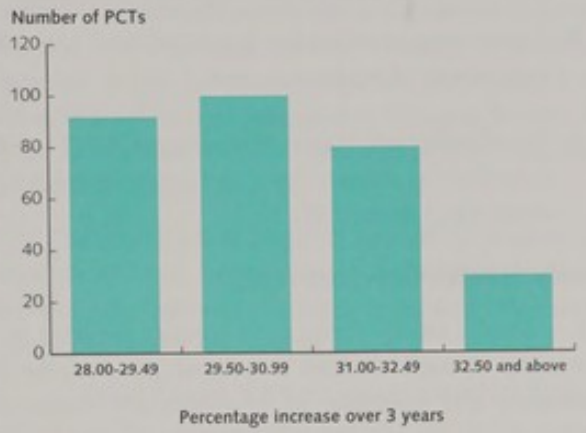
Unified Allocations

6.13 The total unified allocations for Primary Care Trusts are £45,027 million for 2003-04, £49,328 million for 2004-05 and £53,925 million for 2005-06.

6.14 The range of PCT cash increases is between 28.1 per cent and 42.6 per cent over the three years, with an average of 30.8 per cent.

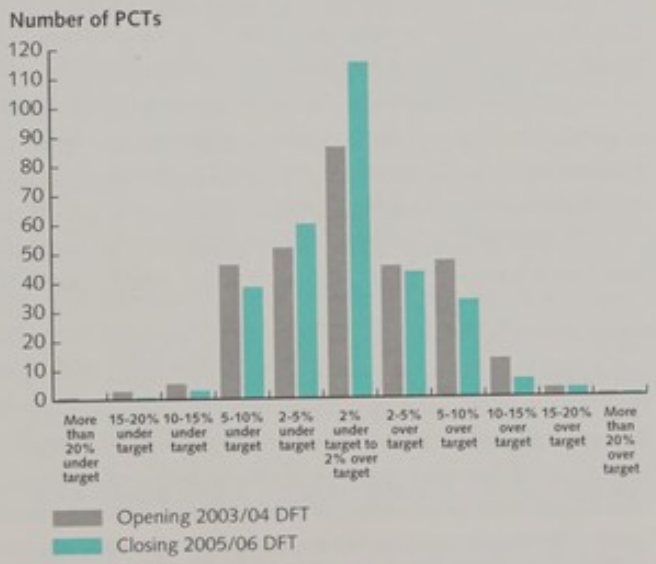
6.15 **Figure 6.7** shows the distribution of increases over the period 2003-06 by Primary Care Trust.

Figure 6.7: Unified Allocations – Distribution of Increases, 2003-06



6.16 **Figure 6.8** shows Primary Care Trusts:
Opening 2003-04 distances from unified target
Closing 2005-06 distances from unified target

Figure 6.8: Primary Care Trusts' Distances from Unified Target (DFT) 2003-04 and 2005-06



Review of Resource Allocation

6.17 A wide ranging review of the weighted capitation formula has taken place. The aim has been to produce a fairer means of allocating resources. A key criterion of the new formula has been to contribute to the reduction of avoidable health inequalities.

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

6.19 For 2003-04 onwards there are three changes to the weighted capitation formula:

- 2001 census population estimates have been used;
- a new need element for the HCHS and prescribing components of the formula; and,
- The existing staff Market Forces Factor (MFF) has been extended by undamping it and applying the MFF to medical and dental staff.

Family Health Services (FHS)

6.20 Family Health Services are services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department of Health following consultation with representatives of the relevant professions, and administered locally by Primary Care Trusts (PCTs). Funding of the FHS is demand led and not subject to in year cash limits at PCT level, though FHS expenditure has to be managed within overall NHS resources. The exceptions to this are certain reimbursements of GMS GPs' practice staff, premises, out of hours and IM&T expenses payable to doctors in general practice (GMS discretionary spending), the costs of administration, and expenditure on drugs and appliances by GPs. Funding for these items is included in PCTs' (HCHS) discretionary allocations.

FHS Gross Expenditure

6.21 **Figure 6.9** shows the gross cash FHS expenditure by services in England, the real terms increase and the year on year growth of discretionary and non-discretionary expenditure. Gross expenditure means that figures are **not** net of PPRS receipts and dental and prescription charge income.

Figure 6.9: Family Health Services Gross Expenditure (Cash), 1991-92 to 2001-02, England

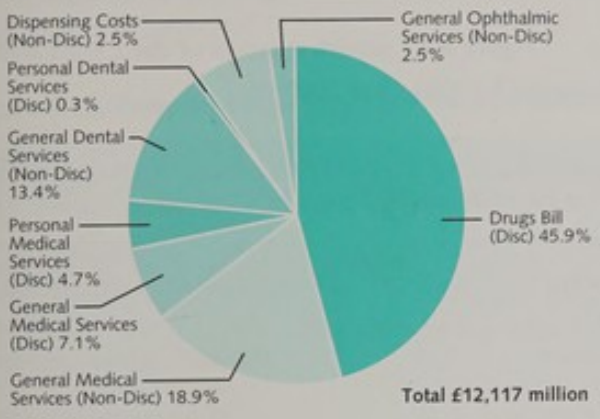
	Cash £ million												
	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	% real terms growth 1991-92 to 2001-2002[9]	% growth 2000-01 to 2001-02
Total Drugs[1][2]	**2,335**	**2,651**	**2,980**	**3,252**	**3,506**	**3,808**	**4,107**	**4,356**	**4,852**	**5,168**	**5,559**	**84.1%**	**7.6**
GMS Non-Discretionary[5]	1,656	1,768	1,840	1,902	1,965	2,073	2,198	2,243	2,451	2,510	2,288	6.8%	-8.8
GMS Discretionary	600	686	715	723	754	800	835	878	885	940	857	10.4%	-8.8
PMS (Discretionary)[3][4]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	37	84	174	569	n/a	227.0
Total GMS & PMS	**2,256**	**2,454**	**2,555**	**2,625**	**2,719**	**2,873**	**3,033**	**3,158**	**3,420**	**3,623**	**3,714**	**27.3%**	**2.5**
GDS[6]	1,248	1,308	1,223	1,281	1,292	1,325	1,349	1,439	1,479	1,556	1,629	0.9%	4.7
PDS (Discretionary)[3]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	12	21	36	n/a	70.2
GOS[7]	141	172	192	213	223	237	241	240	281	292	302	65.2%	3.3
Dispensing Costs[8]	603	658	677	679	706	746	768	781	808	856	877	12.5%	2.5
Total FHS	**6,583**	**7,243**	**7,627**	**8,050**	**8,446**	**8,989**	**9,498**	**9,978**	**10,852**	**11,516**	**12,117**	**42.3%**	**5.2**

1 Since 1999-2000 the Drugs budget has been part of the Unified Allocation. Figures reported are gross and do not include PPRS savings.
2 Drugs bill cash figures include amounts paid from April to March to contractors for drugs, medicines and appliances which have been prescribed by a GP/Nurse (relates to February to January prescriptions).
3 Personal Medical Services (PMS) and Personal Dental Services (PDS) schemes are Primary Care Act pilots designed to test locally managed approaches to the delivery of primary care. PMS and PDS expenditure figures are drawn from HAs' income and expenditure accounts.
4 PMS cash expenditure totals are intended to cover all PMS contract costs for waves 1, 2a, 2b 3a and 3b only.
5 GMS non-discretionary figures are the FIMS (FIS) returns.
6 The Gross GDS costs include the cost of refunds to patients who incorrectly paid dental charges.
7 Expenditure on GOS increased in 1999-00 as a result of the Government's decision to extend eligibility for free NHS sight tests to everyone aged 60 and over from April 1999.
8 Dispensing costs is the remuneration paid to contractors for dispensing prescriptions written by GPs. This includes payments to pharmacists and appliance contractors, dispensing doctors and non dispensing doctors in respect of personally administered items.
9 Figures have been converted into real terms using the April 2002 GDP deflator.

Family Health and Personal Medical and Dental Services Resource

6.22 **Figure 6.9a** shows the distribution of gross cash expenditure for FHS of £12,117m in 2001-02 among the constituent Family Health Services, England.

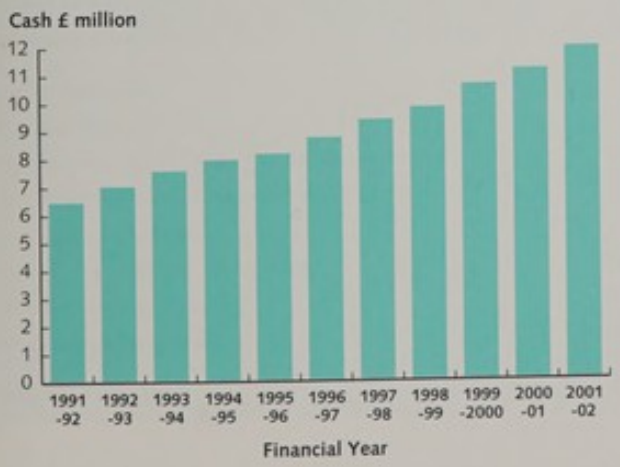
Figure 6.9a: Family Health and Personal Medical and Dental Services Gross Expenditure, 2001-2002



6.23 In 2000-01, 1.4 per cent of the gross FHS spend was attributed to PMS discretionary. In 2001-02 this has increased to 4.7 per cent and a decrease in the GMS distribution proportions has arisen. The decrease in GMS non-discretionary and discretionary spend is caused by the significant transfer of GMS GPs into PMS. PMS Pilots at 2001-02 account for some 18 per cent of GMS GPs having transferred into PMS.

6.24 **Figure 6.9b** charts the total FHS gross cash expenditure for 1991-92 to 2001-02.

Figure 6.9b: Total FHS Gross Expenditure



- The real term growth between 1991-92 and 2001-02 is 42 per cent.

**Please see Chapter 7 for more information on GMS, PMS, GDS, PDS, GOS and PhS and the Glossary for definitions of these Family Health Service areas.*

Drugs Bill

6.25 Drugs bill gross expenditure is the cash amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs medicines and certain listed appliances which have been prescribed by NHS practitioners. Net drugs bill expenditure is less Pharmaceutical Price Regulation Scheme (PPRS) receipts.

6.26 The 2001-02 FHS drugs bill out-turn for England was £5,559m in cash terms, this represents a 7.6 per cent increase on the previous year. The average increase in the drugs bill over the previous 5 years was 8 per cent per annum.

6.27 In resource terms, 2001-02 growth in the FHS drugs bill in England over the preceding year was 10.7 per cent and largely reflects the implementation of Government priorities set out in National Service Frameworks (NSFs). In 2001-02 prescribing spend showed a sharp contrast between general drug inflation at 7 per cent, and a 25 per cent rise in some areas linked to NSFs – such as statins and diabetes, and National Institute for Clinical Excellence (NICE) guidance – such as on drugs for psychoses. Of the 2001-02 growth in the drugs bill, 52 per cent was due to volume increases and 48 per cent costs increases.

6.28 The difference between cash and resource growths are due to Prescription Pricing Authority (PPA) processing and payment calculation delays. Cash expenditure represents the amounts paid between April to March to contractors for drugs, medicines and appliances which have been prescribed by a GP/Nurse and therefore due to the delays relate to February to January prescribing. Resource expenditure represents the actual cost of the prescriptions for drugs, medicines and appliances prescribed by a GP/Nurse in the period April to March.

6.29 The maximum price scheme was introduced in August 2000 to restrain the drugs bill after the instability of the generic drugs market in 1999. The maximum price scheme was rolled forward unchanged in October 2001 and as a result is saving the NHS around £330 million a year on generic medicines compared to expenditure that would have been incurred if prices had remained at March 2000 levels. Negotiations on new longer-term arrangements for the supply and reimbursement of generic medicines for the NHS are continuing with interested parties.

6.30 The 4.5 per cent price cut achieved through the 1999 Pharmaceutical Price Regulation Scheme is delivering savings to the NHS drugs bill in excess of £230 million a year.

Figure 6.10: Family Health Services Drugs Bill (Cash), 1991-92 to 2001-02

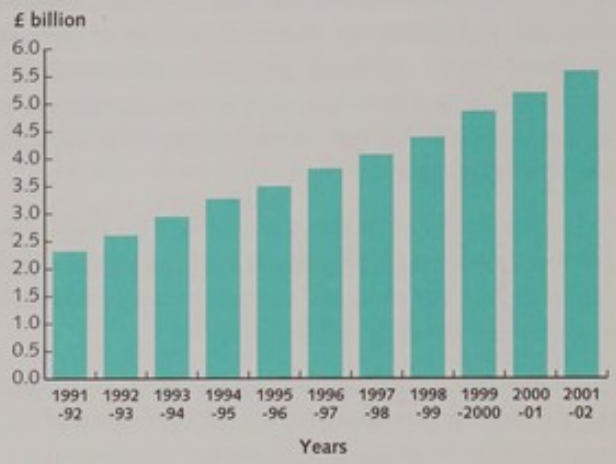
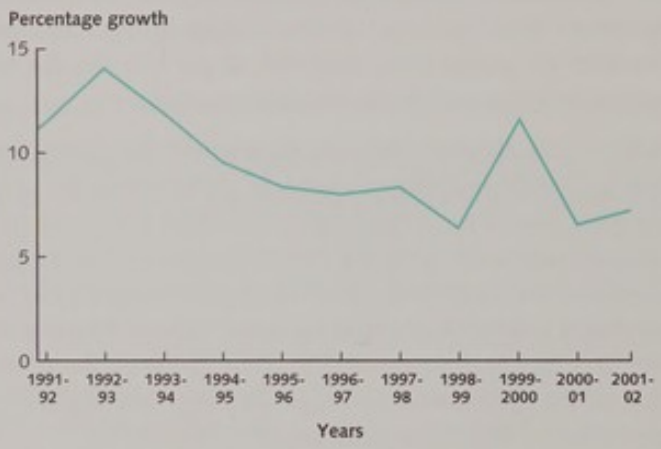


Figure 6.11: Family Health Services Drugs Bill – Percentage Growth (Cash), 1991-92 to 2001-02



Hospital Medicines

6.31 We have invested £4m this year in modernising hospital manufacturing of medicines. An Implementation Board, chaired by Professor Sir Ronald de Witt has been established to oversee the modernisation. The key objectives are to rationalise the unlicensed medicines produced, and develop a cohesive national service and ensure financial underpinning.

Central Health and Miscellaneous Services (CHMS)

6.32 The CHMS revenue budget programme includes:

- The Welfare Food Scheme;
- EEA medical costs for treatment given to United Kingdom nationals by other member states;
- Funding for medical, scientific and technical services, virtually all of which is for the National Biological Standards Board, the National Radiological Protection Board and the Health Protection Agency (a new national agency for infection control and health protection being established from April 2003); and,
- Grants to voluntary organisations, mainly at a national level, across the spectrum of health and social services activity.

6.33 **Figure 6.12** provides details of the CHMS budget programme for 2003-04 to 2005-06.

Figure 6.12: Central Health and Miscellaneous Services Gross Expenditure, 2003-04 to 2005-06

Budgets	2003-04	2004-05	£000s 2005-06
Improving Services & Outcomes in:			
• Cancer	39,000	43,692	58,000
• Mental Health	1,000	4,000	4,000
• Children	525	487	450
Reducing Health Inequalities	47,101	46,744	51,061
Contributing to a reduction in Drug Misuse	3,331	3,308	3,331
Other CHMS budgets: Central Payments made on behalf of DH (e.g EEA Medical costs)	334,893	353,726	375,893
Public Health (e.g Welfare Foods)	127,915	127,839	127,887
Statutory Bodies (e.g. Health Protection Agency)	94,451	97,501	101,311
R&D	37,794	37,529	37,794
Residual CHMS budgets (eg Communications, grants to voluntary organisations)	61,758	62,306	63,579
Non Cash CHMS budgets (including Capital Charges, Provisions etc)	27,713	29,611	31,359
TOTAL	**775,481**	**806,743**	**854,665**

Personal Social Services

Personal Social Services Revenue Provision

6.34 In 2003-04, revenue funding of £13,021 million will be available for social services, which after taking account of changes in functions, is 9.1 per cent more than in 2002-03. The vast majority of this will be distributed to authorities through formula spending, while the remainder will be distributed as either a specific formula grant or ring-fenced grants. **Figure 6.14** below sets out the resources available for social services in 2003-04.

Figure 6.13: Personal Social Services Provision 2003-04

	£ million
Total Formula Spending	11,171.0
Preserved Rights Specific Formula Grant	508.5
Delayed Discharges	50.0
Total Unhypothecated Resources	**11,729.5**
Ringfenced Revenue Grants	
Access and Systems Capacity	170.0
Carers	100.0
Deferred Payments	40.0
Care Direct	4.5
Children's Services	557.0
Child and Adolescent Mental Health Services	51.0
Young People's Substance Misuse Planning	4.5
Teenage Pregnancy Local Implementation	24.0
Mental Health	133.5
AIDS Support	16.5
Performance Fund	100.0
National Training Strategy	24.9
Training Support Programme	56.5
Human Resources Development Strategy	9.5
Total Ringfenced Revenue Grants	**1,291.9**
Capital Resources	
Basic Credit Approvals	37.0
Supplementary Credit Approvals for Mental Health	19.4
Supplementary Credit Approvals for AIDS/HIV	3.1
Secure Accommodation	6.2
Improving Information Management	25.0
Children's Services Grant	9.5
Total Capital Resources	**100.3**
Total PSS Provision:	**13,121.7**

Personal Social Services Capital Resources (Credit Approvals)

6.35 The Government provides capital resources for personal social services by means of credit approvals (permission to borrow) and cash grants. Credit approvals may be used either for any local authority service (basic credit approvals – BCAs) or are targeted on particular services or projects (supplementary credit approvals – SCAs). For 2003-04 BCAs will be allocated by the Office of the Deputy Prime Minister (ODPM) through a single capital pot of which 95 per cent will be allocated on a formula basis. The remaining 5 per cent will be allocated on a discretionary basis and based on the quality of local authorities' Capital Strategies and Asset Management Plans.

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

How the resources are used

6.37 Apart from a small element funded by grants, local authorities are free to choose how much to spend on social services, what services they provide, and how to allocate resources between services. The figures below show the actual expenditure by local authorities on personal social services in 2001-2002. **Figure 6.14** shows gross expenditure by client group in 2001-2002. **Figure 6.15** displays the breakdown by type of provision.

6.38 In 2001-2002, gross expenditure in England on personal social services was £13.6 billion. Local authorities' expenditure on services for older people and children accounted for over two thirds of this spend. The largest items of expenditure were for residential care (46 per cent) and day and domiciliary care (39 per cent). Within spending on residential care, most was spent on residential and nursing home care provided by the independent sector.

Figure 6.14: Local Authority Personal Social Services Gross Expenditure by Client Group, 2001-02

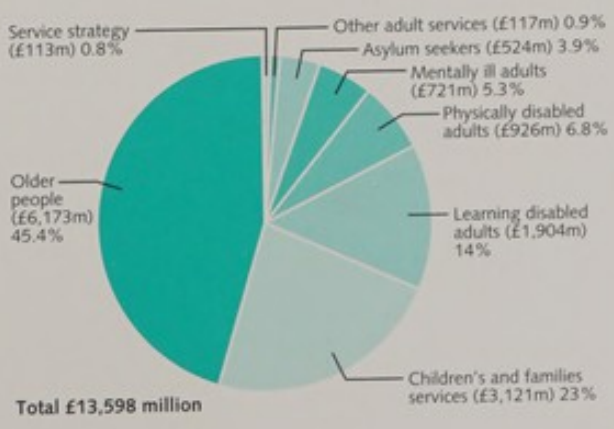
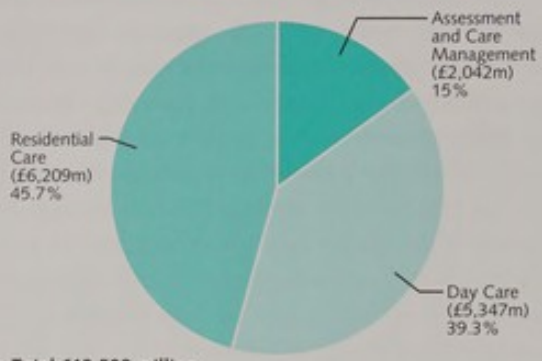


Figure 6.15: Local Authority Personal Social Services Gross Expenditure by Type of Service, 2001-02



Total £13,598 million

7. Activity, performance and efficiency

THIS CHAPTER COVERS:

7.1 NHS HOSPITAL ACTIVITY TRENDS
7.2 IN-PATIENT AND OUT-PATIENT WAITING
7.16 EMERGENCY CARE
7.27 COMMUNITY NURSING, DENTAL AND CROSS SECTOR THERAPY SERVICES ACTIVITY
7.28 ACCESS TO PRIMARY CARE
7.43 FAMILY HEALTH SERVICES (PRIMARY CARE)
7.48 MANAGEMENT COSTS
7.52 FINANCIAL PERFORMANCE
7.63 FRAUD AND CORRUPTION
7.97 EFFICIENCY
7.106 CHILDREN'S SERVICES ACTIVITY
7.108 ADULT'S SERVICES ACTIVITY
7.110 PSS PERFORMANCE AND PERFORMANCE ASSESSMENT
7.128 EFFICIENCY IN SOCIAL SERVICES

NHS Hospital Activity Trends

7.1 **Figure 7.1** gives details of hospital activity levels for each of the main sectors. Key points are that:

- The percentage increase between 2000-01 and 2001-02 for first outpatient attendances was 2.0 per cent. These figures relate to hospital outpatient attendances. The expansion of services in primary care will see GPs referring increasing numbers of outpatients to a GP with a Special Interest, rather than to a consultant outpatient clinic in hospital.
- The percentage increase between 2001-02 and 2002-03 for general and acute hospital admissions was 3.1 per cent.
- For the first time, the NHS submitted figures for 2001-02 about surgical operations and procedures carried out in outpatients and in a community setting. In 2001-02, primary care staff carried out 600,000 procedures: this figure includes minor surgery, and any procedure included in the OPCS classification of surgical operations and procedures (4th revision). In 2001-02, 1.1 million procedures were carried out in an outpatient setting, including both diagnostic and operative procedures. These figures include procedures that may formerly have taken place in an inpatient setting.

Figure 7.1: Hospital Activity Trends, 1991-92 to 2002-03

	1991-92	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	% change 2001-02 over 2000-01
General and acute[1] (thousands of episodes)								
Elective admissions	3,814	4,655	5,093	5,160	5,277	5,314	5,552	4.5%[5]
Emergency and other admissions (non-elective admissions)	3,399	3,753	3,873	3,911	3,967	3,986	4,032	1.2%[5]
Total admissions (first finished consultant episodes)	7,213	8,408	8,965	9,071	9,244	9,299	9,584	3.1%[5]
Geriatrics[2] (thousands of episodes)								
Total admissions (first finished consultant episodes)	440	401	396	380	355	347		-2.3%
Maternity[2] (thousands of episodes)								
Total admissions (first finished consultant episodes)	862	796	841	831	836	833		-0.4%
New outpatients (first attendances) (thousands)								
General and acute[3]	8,036	10,643	10,919	11,294	11,637	11,915		2.4%
Geriatrics[3]	70	107	108	113	114	117		2.6%
Maternity[3]	684	590	565	554	537	519		-3.4%
Mental Health[3]	218	290	287	282	285	273		-4.2%
Learning Disabilities[3]	3	6	6	7	7	8		14.3%
All Specialties[3]	8,942	11,529	11,778	12,136	12,466	12,714		2.0%
New A&E (first attenders) (thousands)[3]	11,035	12,794	12,811	13,167	12,953	12,853		-0.8%
Ward attenders[4]	1,008	1,034	1,068	1,073	1,078	1,089		1.0%
Average length of spell (ordinary admissions) (days)								
General and acute[2]	8.3	7.03	6.81	6.77	6.95	7.07		1.7%
Geriatrics[2]	30.7	22.7	22.2	21.7	23.4	23.4		0.0%

1 Source: 1997-2002 SaFFR. Figures are for all hospital admissions funded by the NHS in England. They include NHS patients admitted to private hospitals and exclude private patients admitted to NHS hospitals. Following the abolition of Health Authorities, figures for 2001-02 and 2002-03 are based on growth from provider-based monthly monitoring returns. A corresponding figure for 1991-92 is not available, so the figure in the table is a grossed figure from the Hospital Episode Statistics for the number of admissions to NHS hospitals in England.
2 Source: Hospital Episode Statistics. Figures are for admissions to NHS hospitals in England.
3 Source KH09.
4 Source KH05.
5 % change 2002-03 over 2001-02.

In-Patient and Out-Patient Waiting

7.2 In line with the NHS Plan, inpatient waiting times will fall on a staged basis each year from 12 months now **[April 2003]** through to 9 and eventually 6 months by 2005. The maximum waiting time for a first outpatient appointment will also fall each year from 5 months, down to 4 and finally 3 months by 2005. The Government's eventual objective is to reduce the maximum wait for *any* stage of treatment to 3 months. Provided that the Government can recruit the extra staff, and the NHS makes the necessary reforms, the Government hopes to achieve this objective by the end of 2008.

ON THE GROUND:

In Leeds, an intranet-based electronic system was set up to help manage its 3,270 inpatient beds. The system provides live data on bed occupancy at any one time. This replaces the onerous and time-consuming system of telephone calls.
This has led to optimum use of all beds.

ON THE GROUND:

There was a 20-week wait for a routine orthopaedic consultant appointment.
A back triage clinic in Winchester has been set up to see patients with back pain rather than having to wait for a full orthopaedic outpatient appointment. The service is run by two physiotherapists and an orthopaedic physician. The team can also fast track patients to rheumatology, the pain clinic, physiotherapy, the surgical spine clinic and the chronic pain management group. The service assessed about 500 patients during its first year and provided follow-up treatment including spinal injections, mobilisations and manipulations, rehabilitation programmes and spinal stabilisation exercises.
Patients now wait no longer than three weeks to be seen in the back triage clinic and see urgent cases within two days

7.3 From 1 April 2003, the maximum waiting time for an inpatient appointment was cut from 15 months to 12 months and a maximum waiting time of 21 weeks for a first outpatient appointment has been put in place. The end of March 2003 waiting times figures show that around 7 out of 10 inpatients are admitted within 3 months of going on an inpatient waiting list and the average wait to be seen for an outpatient appointment is around 7 weeks.

7.4 We have reduced the time patients wait for treatment and virtually eliminated waits of over 12 month inpatient and 21 week outpatient waits. March 2003 inpatient waiting time figures show only 73 patients waiting over 12 months for an inpatient admission, a fall of around 21,800 compared with March 2002. March 2003 outpatient waiting time figures show only 64 patients waiting over 21 weeks for an outpatient appointment, a fall of around 40,000 compared with March 2002.

7.5 Although there is a very small number of patients not being seen within the inpatient and outpatient targets, this should not detract from the very real and significant achievement that the vast majority of Trusts have eliminated waiting times of over 12 month inpatient and 21 week outpatient waits and are now concentrating on eliminating waits to meet the March 2004 targets.

Booked Admissions

7.6 The National Booking Programme was launched in 1998 as part of the Government's strategy for Modernising the NHS. Booking is the key means of delivering 'choice' for patients.

7.7 All NHS inpatient and outpatient appointments should be pre-booked by 2005, with two-thirds of all first outpatient appointments and inpatient elective admissions pre-booked by March 2004. This will give all patients a choice of a convenient date and time within a guaranteed period and help to reduce waiting times.

7.8 By the end of March 2002, more than five million patients had booked their appointment at a date and time of their choice. The NHS Modernisation Agency is working with health communities all over the country to achieve booking targets.

ON THE GROUND:

Mobile phone text-messaging services have been launched to remind patients of their appointments and prevent unnecessary cancellations. Patients will get a reminder two days before their appointment as well as the standard letter that goes out. Patients are prompted to call back on a freephone number if they cannot make the appointment. This is the first pilot in the country.

7.9 The programme achieved its first target in March 2001 when every acute NHS Trust was able to offer booking for patients in at least two specialties or high volume procedures, and by March 2002 all Trusts had introduced partial booking in two 'long-wait' outpatient specialties or procedures.

7.10 The fourth stage of the programme – *Moving to Mainstream* – which began in September 2001 ended in March 2003. *Moving to Mainstream* is the key implementation strategy for achieving booking targets and is central to shifting booking from the earlier pilots to mainstream NHS activity, placing booking into the day to day operational activity of the NHS. All health communities in England are involved in taking forward the National Booking Programme.

7.11 More than 1,000 staff are involved in the redesign and improvement of healthcare systems in the booking programme alone. Health communities have been redesigning their services to facilitate improved access for patients incorporating booking of appointments and admissions to enable certainty and choice. A variety of models have been developed reflecting local needs and circumstances, including the increasing use of *electronic booking* systems.

7.12 Implementing electronic booking systems is key to delivering the vision of patient choice for 2005. There are now over 40 health communities in England actively taking forward electronic booking in the National Booking Programme – that is at least one electronic booking community in every Strategic Health Authority.

7.13 Electronic booking is a core element of the National Programme for IT in the NHS and will form part of the Integrated Care Records Service (ICRS). A national procurement exercise is underway to establish a National Applications Service Provider (NASP) with overall responsibility for electronic booking. The NASP will implement the requirements for national products and services that will provide an Electronic Booking Service for the NHS to support the development and implementation of redesigned services.

7.14 From April 2003 all health communities via Strategic Health Authorities will be responsible for developing and managing booking programmes through Local Delivery Plans which will support the achievement of national milestones and targets for booking in the run up to 2005 and beyond.

7.15 To read more about the national booking programme visit:**www.doh.gov.uk/nhsplanbookingsystems**
www.modern.nhs.uk/booking

Emergency Care

7.16 Improving access to emergency care is one of the Department's top priorities. The Department aims to deliver a whole system of fast, responsive and effective emergency care services for the benefit of patients and staff.

7.17 The NHS Plan set a new target for Accident and Emergency (A&E), to reduce the maximum wait in A&E from arrival to admission, transfer or discharge to four hours by 2004.

7.18 The target included the interim national milestone that 90 per cent of patients attending A&E should spend four hours or less from arrival to admission, transfer or discharge by March 2003. Preliminary information suggests the NHS met this milestone with 92.9% of people in England spending four hours or less in A&E in the week ending 30th March. A final national figure will be available in June.

7.19 Quarterly statistics on waiting times in A&E are available at: **www.doh.gov.uk/hospitalactivity**

ON THE GROUND:

Before, patients arriving in Kettering Hospital A&E were booked in, assessed and asked to wait. Patients with a relatively simple problem might wait more than an hour.
Now, patients are booked in and directed to an assessment/ treatment room where they are seen, assessed and treated by a doctor or an emergency nurse practitioner. Simply wound dressings and procedures are done immediately and patients discharged. Three out of four patients now attending A&E (not just those with minor injuries) are seen and treated within one hour compared to 52% before. 57% are seen and treated within 30 minutes compared with 28% before.

7.20 There is more still to be done to eliminate remaining long waits and improve the general patient experience of A&E to reach the 2004 target. In September 2002 a new clinical director for emergency care was appointed. Sir George Alberti will lead the roll out of the *Reforming Emergency Care Strategy*.[7.1] The strategy was launched in October 2001 supported by £118 million investment. It is a long term programme of reform, investment and new capacity to help meet the NHS Plan target.

7.21 All hospitals with A&Es will be benefiting over the next 2 years from Modernisation Agency support. The new Emergency Services Collaborative will work with 30-35 hospitals at a time to raise performance and help hospitals adopt new techniques to speed up care and improve the patient experience, this will be completed by August 2004.

7.22 New techniques to cut waiting times for patients with minor needs while protecting the care of the more seriously ill/injured continue to be rolled out in the NHS.

7.23 *See and Treat* is a system of care designed to reduce waits and improve the patient's experience in A&E. It has been introduced by some A&E departments and is now being disseminated as part of the Modernisation Agency's Emergency Services Collaborative. It involves assessing and treating patients with relatively minor problems as soon as they arrive in A&E rather than asking them to wait.

7.24 Intensive Support Teams are being sent into hospitals with particularly poor performance on A&E waits from the Modernisation Agency. They will work on the ground with local staff to improve standards for patients over the next few months.

7.25 We are tackling the demarcation of working practices, more nurse practitioners are seeing patients with minor injuries and assessing medical emergencies.

7.26 The improvement of A&E services is being supported by the A&E Modernisation Programme which aims to modernise, upgrade and refurbish all A&E departments that need modernising. A total of £150 million has been invested in this programme and has enabled 180 A&E departments to be modernised. 175 of these (97 per cent) have been completed.

ON THE GROUND:

A new 11-bed surgical assessment unit(SAU) at East Sussex NHS Hospital trust is helping to speed up the time it takes for doctors to see and assess emergency surgical patients. £350,000 required for the new unit came from a successful bid for funding from the Government.

Some of the benefits include a 35 per cent reduction in the number of emergency patients treated on main wards; virtually no cancelled elective operations due to the lack of surgical beds and almost no trolley waits for general surgery or urology patients in the emergency unit (they are all moved to the SAU).

ON THE GROUND:

The "See and Treat" scheme at the North Tees and Hartlepool NHS Trust was introduced in December 2002. From Monday to Friday (9 am until 5 pm) a senior doctor is dedicated to seeing and treating minor injuries patients straight away as opposed to triaging. 80% of patients are now seen within an hour. In November 2002, the average waiting time for patients with sprains and strains was 121 minutes. However by January 2003 this had dropped to 71 minutes.

Community Nursing, Dental and Cross Sector Therapy Services Activity

7.27 Statistics on community nursing services and on cross sector therapy services over the period 1991-92 to 2001-02 are

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

Number of episodes [1] [2]	1996-97	1997-98	1998-99	1999-2000	2000-01	Thousands 2001-02
Health visiting	3,700	3,600	3,600	3,400	3,300	3,100
Community nursing services (total)	3,000	2,900	3,000	2,900	2,800	2,700
District nursing	2,300	2,200	2,300	2,200	2,100	2,000
Community psychiatric nursing	380	370	360	350	330	320
Community learning disability nursing	26	26	29	26	26	25
Specialist care nursing	280	310	320	330	320	320
Chiropody services	980	940	900	860	830	840
Clinical psychology	200	200	190	190	190	180
Occupational therapy	1,130	1,150	1,160	1,190	1,200	1,200
Physiotherapy	4,100	4,100	4,200	4,200	4,200	4,200
Speech and language therapy	320	330	330	330	330	330
Community dental services[4]	1,132	1,096	967	869	747	609

1 Number of new episodes commenced in the year except health visiting (number of different persons seen at least once in a year) and community dental services (number of episodes of care commenced in year).
2 Estimated national totals based on those NHS Trusts supplying data.
3 The range of staff groups included under specialist care nursing changed in 1994-95.
4 Includes a small number of discontinued episodes of care.

shown in **Figure 7.2**. The highest increase in 2001-02 was for chiropody services with 2 per cent more new episodes of care commenced in the year; about 60 per cent of these contacts were with patients over 65. 75 per cent of the new episodes of care for occupational therapy and 63 per cent for physiotherapy were referrals from hospital (compared to GP or other referrals). For speech and language therapy, 41 per cent of the new episodes were with children aged 3 or 4. Community Dental Service episodes of care have been reduced by the transfer of some CDS work to the Personal Dental Service which began in October 1998.

Access to Primary Care

7.28 Primary care is the shop window of the NHS. There are over 250 million consultations with general practice each year and contact with primary care accounts for some 90 per cent of NHS activity. Alongside consistently high levels of satisfaction with the services provided in primary care patients have expressed some dissatisfaction about access to those services.

7.29 The NHS Plan sets a target for *"Guaranteed access to a primary care professional within 24 hours and to a GP within 48 hours, to be achieved nationally by 2004"*. This target is informed by:

- The 1998 National Patient Survey reported that patients in work were put off going to a GP because of inconvenient surgery times and that around 25 per cent of patients waited four days or more for an appointment.
- Consultation which preceded the NHS Plan showed that 20 per cent of respondents identified cutting waiting to see a GP as one of their three priorities.

7.30 The NHS Plan primary care access target is a key patient focused target, delivery of which will affect every citizen. On average, we each see the GP five times a year. The target is also a key component of the Waiting, Booking and Choice programme and the major primary care target for delivery in 2004. Progress on it is an important indicator of wider progress on the overall reform of the NHS.

7.31 The target is about faster, more convenient access to services for those people who want it. As such it provides for better access to a GP or primary care professional but not necessarily the patient's own GP. This is a crucial distinction. Research shows that patients with chronic disease or older people may prefer to wait a little longer to secure continuity of care. This is one of the key strengths of UK general practice which it is important to sustain.

7.32 To support progress towards delivery, the PCT Primary Care Access Fund for 2002-03 was increased by an earmarked £83.5m to a total of £168 million in 2002-03. This funding is recurrent and is included in PCT's three-year allocations for 2003-06. In addition, during 2002-03 the quarterly monitoring surveys have been stepped up to monthly.

7.33 The most recent survey, in February 2003 showed that:

- 86 per cent of patients were able to be offered a GP appointment within 2 working days; and,
- 89 per cent were able to be offered a primary care professional appointment within 1 working day.

both against the 90 per cent milestone for March 2003.

7.34 This result shows significant progress through 2002-03 towards the 90 per cent milestone.

Approach to Delivery

7.35 The delivery strategy has four underpinning key principles:

- Access is a function of the system and therefore requires a whole systems approach;
- Needs are variable. All PCTs must be incentivised; support must be targeted to those who need most support;
- Delivery can and must improve working lives of GPs and primary care teams as well as access for patients; and,
- PCTs are responsible for ensuring provision of better access and need to work in partnership with practices and make best and sometimes innovative use of all existing resources, including development of alternative service delivery mechanisms such as walk-in centres.

7.36 The strategy has two components:

- **Effective management by PCTs.** A managed approach through PCTs which requires PCTs to ensure that the target is delivered across their area. This ties in with the provision of additional identified monies for all PCTs to help practices that need additional resources to deliver the access target. PCTs can use these funds to develop local incentive schemes and to invest in new services.
- **Sustainable modernisation at practice level.** This bottom-up approach is led by the National Primary Care Development Team (NPDT), which promotes primary care modernisation with individual practices. Through this Advanced Access Programme, GPs' peers provide working examples that help persuade doctors that quick and convenient patient access can be delivered largely within existing resources through changed working practices. It also shows that this approach can go a long way towards improving the working lives of GPs and practice staff.

National Primary Care Development Team (NPDT)

7.37 At February 2003 the Advanced Access Programme covered practices responsible for around 20 million patients. It has succeeded in delivering shorter waits and improved working lives for participating GP's and primary care teams. The spread of the Collaborative approach could see 37 million patients covered by 2004.

7.38 Successes include:

- At February 2003, 2000 practices serving around 20 million patients were engaged in access improvement work through the Collaborative;
- Over 70 per cent reduction in waits for a GP – with faster improvements with each wave;
- Average 50 per cent reduction in waits to see a nurse – with faster improvements with each wave;

Figure 7.3: Key Statistics on General and Personal Medical Services (GPMS), England

	1991-92	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	% Change 1991-92 to 2001-02	% Change 2000-01 to 2001-02
Staffing											
Number of General Medical Practitioners (UPEs) [1]	25,686	26,567	26,702	26,855	27,099	27,392	27,591	27,704	27,843	8.4%	0.5%
of which GMS UPs	25,686	26,567	26,702	26,855	27,099	27,031	26,710	26,436	24,039	-6.4%	-9.1%
of which PMS UPs	–	–	–	–	–	361	881	1,268	3,804	–	200.0%
Number of GP practice staff (WTE) [1]	48,731	51,833	59,255	59,318	60,579	61,331	63,087	62,583	64,998	33.4%	3.9%
Number of practice nurses (WTE) [1] (included in practice staff)	8,776	9,099	9,745	9,821	10,082	10,358	10,689	10,711	11,163	27.2%	4.2%
Organisation											
Number of practices [1]	9,129	9,100	9,062	8,999	9,003	8,994	8,944	8,878	8,817	-3.4%	-0.7%
Average list size at 1 October each year [1] [2]	1,947	1,900	1,887	1,885	1,878	1,866	1,845	1,853	1,841	-5.4%	-0.6%
Consultations											
Total number of consultations (millions) [3] [4]	214	224	235	254	–	217	–	220	217	n/a	n/a
Total number of practice nurse consultations (millions) [3]	–	–	–	–	–	–	–	63	81	n/a	n/a
Cash [5]											
Expenditure											
Total General Medical Service (£m)	2,256	2,625	2,719	2,873	3,033	3,121	3,336	3,449	3,145	39.4%	-8.8%
GMS Discretionary (Cash limited) (£m)	600	723	754	800	835	878	885	940	857	42.8%	-8.8%
GMS Non-discretionary (Non-cash limited) (£m)	1,656	1,902	1,965	2,073	2,198	2,243	2,451	2,510	2,288	38.2%	-8.8%
Total personal medical services (Discretionary) [6] (£m)	n/a	n/a	n/a	n/a	n/a	37	84	174	569	n/a	227.0%
Total GMS expenditure per GMS UP (£)	87,830	98,807	101,828	106,982	111,923	115,460	124,897	130,474	130,829	49.0%	0.3%
Total GMS expenditure per GMS UP at real terms 2001-2002 prices [7] (£)	113,608	119,230	119,474	121,660	123,473	123,958	130,930	133,736	130,829	15.2%	-2.2%
GMS Discretionary expenditure per GMS UP (£)	23,359	27,214	28,238	29,790	30,813	32,481	33,134	35,543	35,650	52.6%	0.3%
GMS Discretionary expenditure per GMS UP at real terms 2001-2002 prices [7] (£)	30,215	32,839	33,131	33,877	33,993	34,872	34,734	36,432	35,650	18.0%	-2.1%
Real terms total GMS and PMS expenditure per consultation (2001-2002 prices) [7] (£)	13.51	14.02	13.46	12.76	n/a	15.41	n/a	16.58	17.12	26.7%	3.3%

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

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

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

4 The method of calculating estimates of GP consultations has been revised to produce more reliable estimates and historic figures have been revised this year. There may be further revision in the future following ONS work on amending previous population estimates in the light of the 2001 Census.

5 All cash information taken from Appropriation Accounts up to 2000-01 and from FIMS FHS 4 returns for 2001-02.

6 PMS expenditure totals are intended to cover all PMS contract costs for waves 1,2a,2b 3a and 3b only.

7 Figures have been converted into real terms using the April 2003 GDP deflator.

- Average 50 per cent reduction in 'did not attend' (DNAs);
- 15 to 30 per cent reduction in face to face consultations through telephone calls.

NHS Walk–in Centres

7.39 Forty-two NHS Walk-in Centres are now established as a convenient service which is complementary to general practice. NHS Walk-in Centres were developed as centrally funded three-year pilots with the Department contributing some 80 per cent of the running costs of each centre.

7.40 The independent National Evaluation report published in July 2002 by Bristol University shows that NHS Walk-in Centres are a safe and popular addition to the NHS family with high levels of patient satisfaction, e.g. it reported in August 2001 41 per cent of people who attended the NHS WiC would have contacted their GP if the centre had not been available; 18 per cent would have gone to their local A&E. They also improve access and reach a different population from traditional general practice and help relieve pressure on other NHS services.

7.41 NHS WiCs should now be seen as a permanent feature of the NHS. To reinforce this, the former central funding has now been fully devolved to host PCTs as part of their 3-year allocations for 2003-04 to 2005-06. This is consistent with *Shifting the Balance of Power*[7.2], and the challenge now is to persuade PCTs to recognise the contribution which walk-in services can make to securing local delivery of key national targets – particularly primary care access but also for accident and emergency care and primary care out of hours services.

7.42 Joint working is underway with the Office for Public Service Reform (OPSR) and the Modernisation Agency on the future development of NHS Walk-in Centres.

Family Health Services (Primary Care)

7.43 See glossary for definitions of the FHS areas.

General and Personal Medical Services (GMS and PMS)

7.44 **Figure 7.3** provides key information on General and Personal Medical Services in England.

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

		1991-92	1997-98	1998-99	1999-2000	2000-01	2001-02	% Change 1991-92 to 2001-02	% Change 2000-01 to 2001-02
Pharmaceutical Services[1]									
Prescriptions (millions)[2]		415.4	510.3	524.7	542.6	570.2	603.5	45.3	5.8
Number of contracting pharmacies[3,4]		9,765	9,785	9,782	9,767	9,765	9,756	-0.1	-0.1
Average number of prescriptions dispensed by pharmacy and appliance contractors		37,782	46,297	47,759	49,641	52,066	55,238	46.2	6.1
Cost of pharmaceutical services per prescription in real terms (2001-02 prices) (£)[2,5]	*Gross*	9.14	10.52	10.50	10.92	10.82	10.66	16.6	–1.5
	Drug	7.26	8.87	8.90	9.36	9.28	9.21	26.9	–0.8
	Remuneration	1.88	1.65	1.60	1.56	1.54	1.45	–22.9	–5.8
Net cost of drugs and appliances in real terms (2001-02 prices) (£m)[2,6,8]		2,994	4,501	4,653	5,060	5,283	5,552	85.4	5.1
Percentage of all prescription items which attracted a charge[7]		20.0	14.6	14.6	14.9	14.9	14.7		

1 *Pharmaceutical services are mainly the supply of drugs, medicines and appliances prescribed by NHS practitioners.*

2 *Numbers relate to prescription fees; figures relate to the annual period February to January (eg 2001-02 relates to the period Feb 2001 to Jan 2002) and include prescriptions dispensed by community pharmacists and appliance contractors, and dispensed or personally administered by GPs.*

3 *Excludes appliance contractors and dispensing doctors.*

4 *Figures refer to 31 March (eg. 2001-02 is number as at 31 March 2002).*

5 *Gross pharmaceutical expenditure is total payments (drug costs and dispensing fees) to contractors less recoveries from HAs and the Ministry of Defence (in respect of hospital and armed forces prescriptions dispensed in the community) and excluding refunds of prescription charges.*

6 *Includes receipts under the Pharmaceutical Price Regulation Scheme.*

7 *Prescriptions dispensed to patients who pay prescription charges or hold prescription pre-payment certificates. The analysis is based on a 1 in 20 sample of all prescriptions submitted to the PPA in the calendar year by community pharmacists and appliance contractors.*

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

	1991-92	1997-98	1998-99[2]	1999-2000[2]	2000-01[2]	2001-02[2]	% Change 1991-92 to 2001-02	% Change 2000-01 to 2001-02
General Dental Services[1,2]								
Number of general dental practitioners[3]	15,451	16,728	17,247	17,721	18,049	18,354	19	2
Adult courses of treatment (thousands)	24,273	25,268	26,171	25,915	26,353	26,318	8	0
Adults registered into continuing care (thousands)[4,5]	15,744	19,383	16,721	16,649	16,813	16,793	7	0
Children registered into capitation (thousands)[4,5]	5,826	7,367	6,775	6,821	6,845	6,784	16	–1
Average gross cost of an adult course of treatment (2001-2002 prices) (£)[6]	51	41	40	41	41	41	–20	0
Personal Dental Services[2]								
Number of personal dental practitioners[7]	n/a	n/a	n/a	148	326	707	n/a	117
Number of personal dental practitioners not working in the general dental service[7]	n/a	n/a	n/a	89	192	467	n/a	143
Courses of Treatment (thousands)	n/a	n/a	73	217	312	480	n/a	54
Total Dental Services								
Number of general and personal dental practitioners	15,451	16,728	17,247	17,810	18,241	18,821	22	3

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

2 *The introduction of the Personal Dental Service in October 1998 has affected some General Dental Service activity.*

3 *Principals, assistants and vocational trainees at 30 September.*

4 *Number of patients registered as at 30 September. Registrations began with the introduction of the new dental contract from 1 October 1990 and registration numbers in 1991-92 had not yet reached their peak. From September 1996, new registrations were reduced to 15 month periods unless renewed, affecting registration numbers from December 1997 onwards.*

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

6 *Based on item of service fees and adult continuing care payments. Average gross costs are converted to 2001-02 prices using the GDP deflator. Changes in the average cost are affected by changes in the dental work carried out in a course of treatment.*

7 *Number of Personal Dental Service practitioners at 30 September.*

Key Points:

- The total number of GMP UPEs continues to rise, however, the number of GMS GPs decreased by 9 per cent in 2001-02. A significant transfer of GMS GPs into PMS has caused this.
- The decrease in GMS GPs has caused a year on year decrease in total GMS non-discretionary and discretionary spend in 2001-02 (-8.8 per cent). Real terms GMS non-discretionary and discretionary expenditure per GMS GPs has also fallen slightly in 2001-02.
- The estimated number of GP consultations per year has stabilised since the mid 1990s to around 220 million per year. This may be due to the effective utilisation of all the resources within practices.
- The total estimated GPMS expenditure per consultation has risen to £17.12 (3.4 per cent year on year increase).
- PMS Pilots are a key element in the modernisation programme of the NHS, improving patient access to the NHS by opening up new, more flexible ways of offering Primary Care services.
- Up to 2001-02, 1,346 PMS pilots have been established since the introduction of PMS in April 1998 (i.e. waves 1 to 3b).
- PMS discretionary spend has grown by 227 per cent between 2000-01 and 2001-02.
- PMS Pilots at 2001-02 account for some 18 per cent of GMS GPs having transferred into PMS. This trend is set to continue increasing with the NHS Plan targets of 33 per cent coverage by 2004.

Pharmaceutical Services (PHS)

7.45 **Figure 7.4** provides key information on Pharmaceutical Services in England.

Key Points:

- The volume of prescriptions and the average number of prescriptions dispensed by pharmacy and appliance contractors continue to increase. The year on year growth in the number of prescriptions in 2001-02 was 5.8 per cent, compared to a growth of 5.1 per cent in the previous year.
- The gross cost per prescription fell again in 2001-02 by 1.5 per cent. This is a continued affect of the August 2000 maximum price scheme.
- The drugs bill continues to rise - see chapter 6 for more information.
- The percentage of prescriptions that attract a charge has remained constant at between 14.6 per cent to 14.9 per cent over the past 5 years.

General and Personal Dental Services (GDS and PDS)

7.46 **Figure 7.5** provides key information on General and Personal Dental Services in England.

Key Points:

- The overall volume of activity was broadly stable in 2001-02.
- The number of general dental practitioners continues to increase, by 2 per cent in the year to September 2001 and by 19 per cent in the last 10 years but dentists on average are doing less GDS work.
- Patient registrations have been stable since 1998, following the reduction caused by the shortening of the registration period to 15 months from September 1996.
- There were over 26 million courses of treatment for adults during 2001-02, similar to the number in 2000-01 and 8 per cent higher than in 1991-92.
- The average cost of an adult course of treatment was £41 in 2001-02, the same in real terms as in the previous year. The reduction of 20 per cent since 1991-92 reflects a reduction in the amount of complex or advanced treatments.
- The introduction of the Personal Dental Service in October 1998 has replaced some GDS activity.
- At 30 September 2001, 707 dentists were working in the PDS, 467 of whom were not also working in the General Dental Service. PDS dentists include both salaried dentists working mainly in Dental Access Centres and also contractor-led services from GDS type dental surgeries.

General Ophthalmic Services (GOS)

7.47 **Figure 7.6** provides key information on General Ophthalmic Services in England.

Key Points:

- The number of sight tests increased by 3 per cent in 2001-02 over the previous year. There was a large increase (about 34

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

General Ophthalmic Services	1991-92	1997-98	1998-99	1999-2000	2000-01	2001-02	% Change 1991-92 to 2001-02	% Change 2000-01 to 2001-02
NHS sight tests (thousands)[1]	4,979	6,991	6,992	9,399	9,567	9,807	97	3
Optical vouchers (thousands)[2]	2,844	3,935	3,777	3,662	3,575	3,607	27	1
Number of opticians[3]	6,502	7,091	7,305	7,517	7,824	8,103	25	4

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

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

3 Optometrists and Ophthalmic Medical Practitioners at 31 December of each financial year.

per cent) between 1998-99 and 1999-2000 as a result of the Government's decision to extend eligibility for free NHS tests to everyone aged 60 and over from 1 April 1999.

- Between 1997-98 and 2000-01, the number of NHS optical vouchers reimbursed by HAs fell by 2 per cent to 4 per cent each year, as a result of a decrease in the number of adults claiming income support and Job Seeker's Allowance, who form the main category of people who qualify for vouchers. The number of vouchers dispensed grew by 1 per cent between 2000-01 and 2001-02. This possibly reflected the fact that the number of income support and JSA claimants stabilised in that year, combined with an increase in the take up of sight tests and vouchers.

PERFORMANCE

Management Costs

7.48 The Government made a commitment in 1997 to achieve £1 billion saving in bureaucracy over five years. The audited financial returns for 2001-02 demonstrated that this target had been achieved.

7.49 As a result of structural changes to the NHS £100 million has been identified from spending on NHS and Regional Office running costs. In 2002-03 and 2003-04 this funding supports the transition of organisational restructuring.

7.50 From April 2002 PCTs and three-star NHS Trusts (and in the future NHS Foundation Trusts) had their caps for management costs lifted, in line with *Shifting the Balance of Power*[7.3] principles, devolving responsibility to those respective organisations to set their own limits. These limits will need to be set taking advice from the Professional Executive Committees (PEC), Clinical Boards or local equivalents of those organisations, to test that increases are justifiable and to ensure clinical ownership of any proposed changes.

7.51 The cap has not been lifted on zero, one and two-star NHS Trusts. Investment decisions should not exceed the NHS Plan target, i.e. less than the annual rate of increase in NHS Gross Expenditure. Strategic Health Authorities (SHAs) will manage local arrangements to monitor NHS management costs, which will be lighter touch than previously. SHAs can challenge rises which appear excessive.

Financial Performance

Health Authorities

7.52 In 2001-02 there were 95 Health Authorities responsible for assessing the health needs of their local population and commissioning health services in line with national and locally agreed priorities. Health services are commissioned from NHS trusts, primary care trusts and other providers of healthcare.

7.52 Health authorities were responsible for spending £29.7 billion on patient care in 2001-02 (the comparable figure for 2000-01 being £38.6 billion). The significant decrease in expenditure is a result of the increasing number of PCTs and the movement of patient care expenditure from health authorities to PCTs.

7.54 Health authorities are subject to both cash and "resource" limit controls. It requires health authorities to contain their annual expenditure (measured on an accruals basis) for both revenue and capital within an approved limit set by the Department. Health authorities must also achieve financial balance without the need of unplanned financial support (not a statutory duty but an important performance management measure).

Revenue: In 2001-02 all health authorities achieved their statutory financial duty to remain within revenue resource and cash limits. With the exception of two health authorities, all others achieved the financial balance performance measure.

Capital: Four health authorities failed to remain within the capital resource limit after the application of a de minimus adjustment.

Primary Care Trusts

7.55 Primary Care Trusts first came into existence in April 2000. They are responsible for the commissioning of health care on behalf of their resident population and some PCTs are also responsible for providing community services to their population. In 2001-02 there were 164 PCTs.

7.56 PCTs were responsible for spending £15.4 billion on patient care in 2001-02 (the comparable figure for 2000-01 being £2.1 billion). The significant increase in expenditure is a result of the increasing number of PCTs and the movement of patient care expenditure from health authorities to PCTs.

7.57 PCTs are accountable to Strategic Health Authorities, who are responsible for their performance management.

7.58 In the same way as health authorities, PCTs are subject to revenue and capital resource and cash limit control and have a financial duty to achieve financial balance without the need of unplanned financial support.

Revenue: In 2001-02 all PCTs achieved their statutory financial duties to remain within revenue resource and cash limits. With the exception of four PCTs, all PCTs achieved the financial balance performance measure.

Capital: All PCTs remained within the capital resource limit after the application of a de minimus adjustment.

NHS Trusts

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

7.60 There were 318 operational NHS trusts in 2001-02. NHS trusts have four main financial duties, which are:

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

  This is the prime financial duty for NHS trusts and is known as the break-even duty. NHS trusts normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. The interpretation of the statutory financial duty for the NHS trusts to break-even was clarified in 1997-98. A run of three years is normally used to test the break-even duty, but in exceptional cases the Department of Health may agree to a five-year timetable. This recognises that although NHS trusts are expected to achieve a balanced position on their income and expenditure account each and every year, there may be reasons for NHS Trusts' to report deficits in one year which are off-set by surpluses achieved in another year(s).
- To absorb the cost of capital at a rate of 6 per cent of average relevant net assets;
- To meet, or come within agreed limits of flexibility, the external financing limit set by the Department of Health; and
- To remain within the Capital Resource Limit (CRL) set for each NHS Trust by the Department of Health.

Revenue: In 2001-02 NHS trusts reported an income and expenditure deficit, on an accruals basis, of £40 million, compared to a £56 million surplus in 2000-01. Whilst a number of NHS trusts did report a deficit in 2001-02, none breached their statutory financial duty to break-even "taking one financial year with another" (see previous paragraph).

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

Capital: After applying the de-minimus limits, five NHS Trusts exceeded the external financing limit whilst three exceeded the capital resource limit.

Payment of Bills by NHS

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

7.62 NHS performance in paying its bills has improved over the years, and a large number of NHS trusts, PCTs and health authorities are prompt payers. The national average is around 84 per cent of bills paid on time. However, further improvement is still required before the current target of 95 per cent is attained.

Fraud and Corruption

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

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

The Strategy

7.65 The Department has adopted a comprehensive, integrated and professional approach to deal with these problems, as set out in the strategic document *Countering Fraud in the NHS*[7.4] published in December 1998. The Counter Fraud and Security Management Service (CFSMS) is the specialist organisation set up to implement this strategy by following the counter fraud business process model: identifying the nature and scale of the problem; developing a clear counter fraud strategy; creating an effective structure to implement the strategy; and taking action in key areas of NHS spending.

Identifying the problem

7.66 The CFSMS programme of fraud measurement exercises has provided the first ever robust estimates of losses to fraud in all primary service areas of NHS spending, through an innovative and rigorous measurement methodology. The National Audit Office have pronounced themselves satisfied that the methodology provides a sound basis for estimating the likely levels of fraud and incorrectness. This methodology is now being used to determine levels of fraud and incorrectness in primary services in Wales.

Creating an effective structure

7.67 The CFSMS has created an effective structure to implement the strategy which encompasses policy and operational work for counter fraud and corruption in the NHS. The operational element of the CFSMS has eight regional teams, one national proactive team, a specialist pharmaceutical fraud team and a dental fraud team. Almost 500 Local Counter Fraud Specialists (LCFS) cover every NHS health body. All staff are required to be fully trained at the CFSMS Training Centre and undergo specialist, professional training accredited by the Institute of Criminal Justice Studies at the University of Portsmouth.

Taking action in all key areas

7.68 Much progress has been made towards achievement of CFSMS objectives. Work has been carried out in the following generic areas:

Creation of an anti-fraud culture

7.69 The development and implementation of Counter Fraud Charter agreements with NHS stakeholders has continued to show our joint commitment to tackle fraud and corruption through partnerships with other key organisations. The *Counter*

Fraud Charter[7.5] originally published in December 1999, has now been signed by representative organisations covering over 400,000 NHS staff and contractors. In addition, a further agreement will shortly be signed with UNISON covering several hundred thousand more NHS staff.

7.70 Meetings have been held with key staff and managers of every Health Authority (HA), NHS Trust and Primary Care Trust to explain the counter fraud strategy and their role within it. Similar meetings have also been held with local professional committees. Altogether nearly 800 fraud awareness presentations have been delivered since the NHS Counter Fraud Service was established.

7.71 Following the Secretary of State Directions issued to all HAs and NHS Trusts in December 1999, Directions were issued in December 2000 to all PCTs to set out their role in the strategy and requiring them each to appoint a LCFS. Since this time, the NHS has seen significant change, including Shifting the Balance of Power. This has led to major structural and organisational change, including the devolution of commissioning functions from HAs to PCTs. As a result, revised and updated Directions were re-issued to PCTs in September 2002, requiring all PCTs to nominate, or re-nominate, a LCFS. In early 2003, CFS will carry out a review to ensure that the nomination process has been completed.

Maximum deterrence of fraud

7.72 There has been extensive publicity of every counter fraud initiative undertaken to implement the strategy, all of which helps to maximise the deterrent effect of these measures. Since the creation of the NHS counter fraud service in 1999, there has been a steady increase in the number of positive articles and reports in the media in relation to countering fraud, with a total of 645 positive articles up to the end of March 2003.

Successful prevention of fraud

7.73 The policy unit of the CFSMS is specifically oriented to revising policies and processes to ensure that weaknesses that have allowed fraud to take place are removed so that fraud does not recur. For example, claims by contractors in the dental services concerning Recalled Attendance fell from £14.2 million in 1999-2000 to £12.3 million in 2000-01 and £9.1 million in 2001-02. Similar reductions for claims for Domiciliary Visits from £10.6 million in 1999-2000 to £8.1 million in 2001-02. Both these reductions follow the introduction of changes to legislation and procedures to prevent and deter fraud.

7.74 The CFSMS Central Unit is also actively involved in working with colleagues to ensure that new NHS initiatives being taken forward under the NHS Plan, such as the Electronic Transmission of Prescription pilots and dental "Options for Change" are designed and implemented in ways that minimise opportunities and risks of fraud.

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

Prompt detection of fraud

7.76 A confidential Fraud and Corruption Reporting Line, the first of its type to exist within the NHS, became operational in 2001. This allows practitioners, contractors, patients and others who come into contact with the NHS to report any suspicion of fraud knowing that their call will be dealt with expertly and confidentially.

7.77 A new Central Intelligence Unit (CIU) has been established in order to gather, collate and analyse information from which intelligence can be developed. The CIU are setting up a National Fraud Database to provide details of suspected and proven fraud cases, throughout the NHS, at both Local and Regional levels. This information will be key to the role of the CIU and will maximise the sharing of information throughout the service.

Professional investigation of all fraud that is detected

7.78 All those working to counter fraud within the NHS undergo specialist training accredited by the University of Portsmouth, to ensure that all investigations are carried out to a professional standard in a fair and objective manner. This training has been supplemented by a series of one day workshops to ensure that staff can be pro-active in all the areas of generic action.

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

Consistent use of appropriate legal action, sanctions and redress

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

7.81 Action has so far resulted (as at the end of March 2003) in 160 successful prosecutions (a 98 per cent success record), with a further 30 cases awaiting court hearings. A further 215 civil and disciplinary cases had been successfully completed by this time. There are also 430 ongoing investigations.

7.82 In 1999, legislation provided for a civil penalty charge to be imposed where a person wrongly fails to pay any amount in respect of NHS charges or obtains goods or services to which they are not entitled.

7.83 The primary purpose of the penalty charge is to deter incorrectness and fraud and to sanction it when it is detected. As at 31 March 2003, 88,263 Penalty Notices had been issued by the CFSMS Compliance Unit to patients incorrectly claiming exemption and remission from prescription charges. Payments to date of £1.36 million have been made.

7.84 On the 1 November 2002 the Dental Practice Board began to undertake verification checks in respect of patients who

incorrectly claim exemptions and remission from NHS dental charges. The first penalty notices are now being issued.

7.85 The legislation also introduced a specific criminal offence for trial in the Magistrates Court, which provides an appropriate sanction for serious cases of repeated or persistent fraud. On conviction the offence attracts a fine of up to £2,500.

7.86 A key aspect of the CFSMSs work has been to ensure that fraud losses are recovered so that the resources can be spent on patient care. At the end of March 2003, £14.07 million had been recovered.

Meeting targets and making savings

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

7.88 The first two measurement exercises on patient prescription charge fraud, comparing figures from 1998-99 and 1999-2000, indicate that since the introduction of the strategy, losses in this area have already been reduced by £48 million or around 41 per cent, from £117 million to £69 million. This represents good progress towards the PSA target of 'a 50 per cent reduction in prescription charge evasion (compared to 1998 levels) by the end of 2002-2003.' A review is being carried out in May 2003 which should show that this target has been met.

7.89 The results of the optical patient fraud measurement exercises indicate a reduction in losses from £13.25 million in the 1999-2000 exercise to £10.17 million in the 2001-02 exercise. This represents a 23.35 per cent reduction in losses to NHS funds.

7.90 The dental patient fraud measurement exercises have also been completed. Losses to NHS funds has shown a reducton from £40.3 million pounds using data supplied in 2000-2001 to £30 million in 2001-2002. This represents a 25 per cent reduction in losses to NHS funds. Therefore, total patient fraud losses have been reduced from £171 million to £109 million, a 36 per cent reduction in four years.

7.91 The second PSA target concerned *'£15 million savings from action on contractor fraud (representing £6 million in cash recoveries and £9 million in prevention savings) over the period 1999-2000 to 2001-2002.'* This target was achieved and to date £7.47 million has been recovered from action on contractor fraud together with £9.3 million in prevention savings.

Inspections

7.92 CFS quality inspectors ensure that all aspects of the counter fraud strategy and structure are functioning effectively through a programme of visits and inspections throughout the NHS. So far 26 inspections have been carried out, with anomalies being identified and corrected and the wider lessons learnt and disseminated.

Conclusion

7.95 2002-03 has seen major progress in countering fraud and corruption in the NHS. A structure now exists, covering every part of the NHS, which can take appropriate action. Significant results have already been achieved in reduced losses, a developing anti-fraud culture, many prosecutions, and a big increase in recoveries.

7.96 More work still needs to be done, particularly in light of NHS modernisation and associated increased spending plans but 2003-04 should see further progress.

Efficiency

Reference Costs

7.97 The Reference Costs 2002 publication details the national average unit costs across the NHS for a range of treatments and procedures for the 2001-02 financial year. As the composition of the NHS has changed, service delivery has done likewise. In addition, the cost of services has also changed, with the development of more local based health services through Primary Care Trusts. The 2002 publication includes the cost of services provided by Primary Care Trusts.

7.98 The publication covers over £25 billion of NHS expenditure, compared with approximately £21 billion in 2000-01. This accounts for almost 89 per cent of hospital and community health services expenditure. The unit costs cover services ranging from straightforward x-rays to complex treatments such as transplant surgery, and from a midwife's visit to a new baby to the cost of physiotherapy treatments.

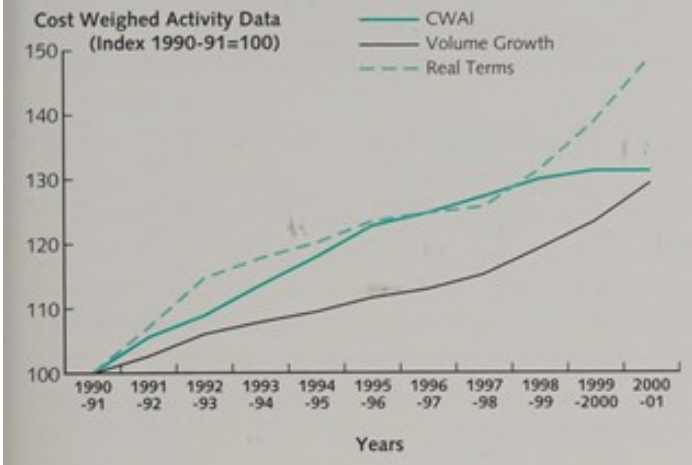
7.99 The range of coverage allows reference costs to be used as the basis of a number of other initiatives. These include efficiency targets, and the setting of guidelines for a national tariff for NHS services, as part of the new Payment by Results Initiative.

HCHS Cost Weighted Activity Index

7.100 The index provides a broad measure of the overall growth in HCHS activity, in which the contributions of the individual components are weighted by their costs. Following changes in accounting practice within the NHS it has been difficult to gauge the increase in expenditure in both volume and real terms. However, estimates have been made using broadly comparable data and are shown in **Figure 7.7**. Over the 10 years since 1990-91 overall activity levels increased by just over 30 per cent. Over the same period, the volume of inputs – that is expenditure after allowing for increases in HCHS pay and other input unit prices – increased by 28 per cent, suggesting an increase in efficiency of around 2 per cent.

7.101 The Cost Weighted Activity Index is the traditional method for assessing NHS activity, which feeds into the measure of efficiency produced by the Department. However, changes in the way healthcare is delivered by the NHS now mean that the CWAI measure gives an increasingly incomplete picture. The Department is currently working on a new measure of efficiency which will take better account of the diverse ways services are now delivered in the NHS e.g. procedures carried out in a primary care setting that previously would have been hospital episodes. In addition to accounting for these growing areas of activity the new efficiency measure will take account of investment in quality improvements and changes in case mix.

Figure 7.7: HCHS Cost Weighted Activity Index



Unit Costs

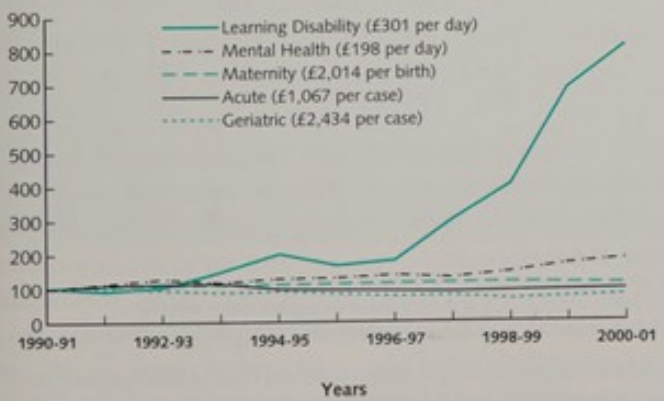
7.102 Overall unit costs in the hospital sector have tended to rise in real terms in the last ten years, to 2000-01, most markedly in Learning Disabilities. However, the position varies depending on the category of care being delivered.

7.103 In the Learning Disabilities sector, unit costs of inpatient care have risen since 1995-96, due to the changing use of NHS facilities. Although the NHS does still provide some social care for people with learning disabilities, the specialist NHS services are increasingly concerned with those with complex needs such as multiple disabilities, mental health problems or challenging behaviour. Increasingly people with learning disabilities rely on generic health services for their day to day health needs and use specialist services for assessment and treatment of needs which can only be met by the specialist learning disability services.

7.104 Due to estimations used to produce the 1999-2000 HCHS Programme Budget, the figures shown for 1999-2000 should not be used in comparison with other years.

7.105 **Figure 7.8** shows how unit costs have moved in real terms across the five major categories of hospital inpatient care.

Figure 7.8: Average unit costs by category of care 1990-91 to 2000-01 (Index 1990-91 = 100)



PERSONAL SOCIAL SERVICES

Children's Services Activity

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

7.107 Key points are that:

- the number of children looked after by local authorities at any time during the year rose from 1997-98 to 1999-2000 by 4 per cent, since when it has remained fairly constant.
- the number of care days provided per child has steadily risen over the years 1994-95 to 2001-02, and is now 16 per cent higher than at the beginning of the period;
- the number of children looked after at 31 March has increased to 59,700. This number has risen each year since 31 March 1994, although the rate of increase in 2000-01 and 2001-02 has been markedly lower than in previous years;
- the proportion of children looked after aged under 10 has fallen each year since 1998-1999;
- there has been a further small decrease in the percentage of children looked after with three or more placements, 15 per cent in 2001-02 compared with 16 per cent in 2000-01;
- the number of children placed on the child protection register during 2001-02 has risen by 3 per cent since 2000-2001 but has fallen by 8 per cent since 1998-99; and,
- there has been further increase in the number of children adopted from care with 3,400 looked after children adopted in 2001-02, an increase of 25 per cent over 1999-2000.

Adults' Services Activity

7.108 **Figure 7.10** gives a summary of Personal Social Services provided to adults. Adult's services include all services from those who have just reached adulthood to the most elderly of the population.

7.109 Key points are that:

- the largest group of adult users of social services is people aged 65 or over, although among younger adults other groups receiving services include people with learning disabilities, people with physical or sensory disabilities and people with mental health problems;
- whilst the number of households receiving care in their own homes continues to fall, the number and proportion of households receiving intensive home care continues to increase. There is also evidence that in 2001-02 there were more people helped to live at home by means of services wider than home care. The number of older people (aged 65+) helped to live at home rose from 650,000 in Sept 2000 to 660,000 in Sept 2001. The number of younger adults (aged 18-64) helped to live at home rose from 270,000 in Sept 2000 to 290,000 in Sept 2001. This gives a rise from 920,000 in Sept 2000 to 950,000 in Sept 2001 for all adults and older people;

Figure 7.9: Children receiving Personal Social Services – a Summary

Numbers and percentages

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02[1]
Number of children looked after by local authorities at any time during the year	79,100	79,200	78,200	79,000	80,000	82,500	82,000	82,200
Average number of care days provided per child	226	230	237	240	248	252	260	263
Children looked after by local authorities at 31 March	49,500	50,600	51,200	53,300	55,500	58,100	58,900	59,700
% aged under 10	37%	38%	40%	42%	43%	43%	42%	42%
% in foster care	65%	65%	65%	66%	65%	65%	65%	66%
% in children's homes	14%	13%	13%	13%	12%	12%	11%	11%
% with 3 or more placements during year	20%	21%	20%	19%	19%	18%	17%	15%
Registrations to child protection register during year	30,400	28,300	29,200	30,000	30,100	29,300	27,000	27,800
% whose reason was sexual abuse	24%	22%	21%	20%	19%	17%	16%	10%
% that were re-registrations	16%	18%	19%	19%	15%	14%	14%	14%
All adoptions during year	5,500	5,400	4,600	4,000	4,400	4,800	4,900	5,100
adopted from care	2,000	1,900	1,900	2,100	2,200	2,700	3,100	3,400

1 Provisional.

Figure 7.10: Adults receiving Personal Social Services – a Summary

Numbers, percentages and rates

	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01[4]	2001-02[4]
All adults aged 18 or over									
Households receiving fairly intensive home care home care[1]	61,800	86,800	107,900	107,100	117,600	133,800	143,500	151,700	156,800
Households receiving intensive home care[1a]						60,700	68,700	72,300	77,400
People supported in residential care	119,200	137,500	153,200	170,300	176,500	181,200	185,800[R]	184,400[R]	186,800
People supported in nursing care	25,200	43,200	57,200	66,100	72,900	73,500	73,900[R]	71,800	72,700
People aged 18-64									
with physical/sensory disabilities									
helped to live at home per 1000 pop[2]				2.2	2.3	2.0			
helped to live at home per 1000 pop[3]						3.5	3.7[R]	3.8[R]	3.8
supported in residential care	6,300	7,100	6,700	7,200	5,900	5,900	6,300[R]	6,100	6,000
supported in nursing care	1,500	2,300	2,700	3,200	2,800	3,200	3,400	3,400	3,700
with mental health problems									
helped to live at home per 1000 pop[2]				1.2	1.2	1.2			
helped to live at home per 1000 pop[3]						1.7	2.2[R]	2.7[R]	3.2
supported in residential care	4,200	5,200	6,500	6,800	7,900	8,700	8,900[R]	9,300[R]	9,500
supported in nursing care	270	600	850	1,130	1,370	1,500	1,620	1,720	1,800
with learning disabilities									
helped to live at home per 1000 pop[2]				2.3	2.2	2.2			
helped to live at home per 1000 pop[3]						2.3	2.3[R]	2.5[R]	2.6
supported in residential care	17,500	20,300	22,200	24,800	25,100	26,900	28,500[R]	28,700[R]	29,300
supported in nursing care	190	300	640	690	930	930	1,010	990	1,090
in other groups									
supported in residential care	1,400	1,800	1,700	2,100	2,300	2,000	1,800	1,700	1,500
supported in nursing care	140	190	230	280	340	300	260	270	200
People aged 65 or over									
helped to live at home per 1000 pop[2]				83	81	71			
helped to live at home per 1000 pop[3]						82	85[R]	84[R]	84
number helped to live at home[5]					729,600	637,600	662,000	649,700	660,200
supported in residential care	89,800	103,100	116,100	129,400	135,300	137,800	140,400[R]	138,600[R]	140,500
supported in nursing care	23,100	39,900	52,800	60,800	67,500	67,500	67,600[R]	65,500	65,900

Care in own homes comes from a survey week, care in residential/nursing homes is at 31 March.
1 Intensive is defined here as receiving more than 5 hours of home care and 6 or more visits during a survey week in September/October.
1a Intensive is defined here as receiving more than 10 hours of home care and 6 or more visits during a survey week in September/October.
2 Helped to live at home by means of home care, day care and meals services. This is an Audit Commission indicator. For 1997-98 and earlier years England figures are based on an unweighted average of authority figures.
3 Helped to live at home by means of any service recorded on Referrals, Assessments and Packages of Care (RAP) return P2s. This includes planned short term breaks, direct payments, professional support, transport and equipment and adaptations as well as home care, day care and meals services. Data for 1998-99 on this basis are estimated as are data for 1999-2000 for around a quarter of the 150 local authorities.
4 The total number of households is calculated differently for 2000-01 and onwards than in previous years.
5 Data as at March each year.
R Figure has been revised.

- around 76,400 households (20 per cent of households) received intensive home help/home care in 2001 defined as more than 10 contact hours and 6 or more visits during the week. This represents a 6 per cent increase of the 2000 figure of 72,100; and,
- except for a slight fall in 2000 the number of people supported by councils in residential or nursing care has continued to increase following the implementation of Community Care in 1993, when councils took over responsibility which had previously been shared with the Department for Social Security. In particular, councils had not previously been able to support people in nursing care. The number of residents supported in local authority homes continues to fall whilst those supported in independent homes has risen.
- progress on the PSA target, to increase by March 2006 the number of those supported intensively to live at home to 30 per cent of all those being supported by social services at home or in residential care, is encouraging. The PSA has risen just over 1 per cent from 26.1 per cent to 27.2 per cent in 2001-02.

PSS Performance and Performance Assessment

7.110 Performance assessment is designed to bring together all the information about the performance of each council with social services responsibilities. The system improves the services people receive by:

- helping councils to develop their own performance management arrangements, compare their performance with others and make a contribution to the Government's objectives and priorities by improving their own performance;
- ensuring that councils work effectively with the NHS to address joint health and social care policy and service delivery issues;
- ensuring that councils work effectively with other local government departments and external agencies;
- assessing councils' progress in implementing the Government's policies for social care, in meeting national targets and in achieving Best Value;
- identifying and promoting good practice;
- identifying councils that are performing poorly and ensuring that they take action to improve; and,
- providing service users and the general public with readily understandable information about the performance of their council.

7.111 Performance assessment pulls together evidence from several sources which together are intended to provide a comprehensive overview of the performance of each council: the evidence is used by the Social Services Inspectorate (SSI) to form judgements about performance, which are reflected in the performance "star ratings". Social services star ratings, introduced in 2002, are similar to those introduced in the NHS the previous year, in that councils are rated on a scale of zero to three stars so that people can see how well their local organisations are performing, and high performing councils can receive a package of "freedoms" giving them an incentive to improve.

7.112 These evidence sources may be categorised as:

- **Performance Data** – the 50 indicators associated with the PSS Performance Assessment Framework (PAF) provide a statistical overview of performance at the year-end. Performance indicators permit direct comparisons between councils and over time and allow targets to be set and monitored. A subset of indicators are also Best Value performance indicators. However, these are only indicators and for a complete representation of performance further information is required. This is obtained from the following sources;
- **Evaluation** – SSI inspections and SSI/Audit Commission Joint Reviews of Social Services provide in-depth evaluation of all the council's social services responsibilities. For most councils SSI will carry out at least three inspections of every council in each five-year period (one on child care, one on services for older people or on mental health services, and another on a priority policy area). The Joint Review Team will visit each council once every five years. However, high performing councils receive less inspection as a freedom related to their performance.
- **Monitoring** – SSI regions are in frequent contact with councils and monitor progress in achieving national objectives and targets twice a year. They also follow up concerns arising from performance indicators, inspections and joint reviews.

7.113 The five PSS PAF performance domains (which are also the Best Value domains) are used as an organising framework for all this information (see diagram). SSI regions use this evidence to carry out annual review meetings with councils where priorities for improvement are discussed and actions agreed, and to advise external auditors on the signing off of Best Value Performance Plans. SSI's assessment process culminates in the annual publication of the social services star ratings.

7.114 Every autumn each council with social services responsibilities receives a performance star rating, ranging from zero stars for the worst performance to three stars for the best. Supporting this, separate judgements for services for children and services for adults are published. This presentation is easy to understand for service users and the general public, with the additional supporting evidence available for anyone wanting to find out more detail about their council's performance.

7.115 In addition, to provide an incentive for councils to improve a set of freedoms have been introduced, which are related directly to a council's star rating. The best performing authorities will have an increased level of freedom in the way they use centrally provided grant funds. They will also have a proportionate programme of inspection and monitoring, and reduced requirements for planning information. For further information see **www.doh.gov.uk/scg/pssperform/index.htm**

7.116 Those councils identified as having poor performance and without the capacity to improve by themselves will receive support and assistance. This approach has already been introduced in 2002, with a number of councils receiving Performance Action Teams.

7.117 A new Comprehensive Performance Assessment (CPA) for all local government services was also introduced in 2002. This fulfils the same function as the social services stars, but for all local government services. The social services star rating feeds directly into the local government CPA. The social services star rating also appears in the CPA report card, alongside assessments of other council services. A council must receive a good star rating for their social services in order to receive the highest comprehensive performance assessment rating. The CPA is also linked to a series of 'freedoms' which work in parallel with the social services freedoms. Further information can be found at **www.local-regions.odpm.gov.uk/cpa/index.htm**

Recent Performance

7.118 The first set of star ratings were published in May 2002. In November 2002 a second refreshed version of the social services performance star ratings were published. The Social Service's Inspectorate came to a judgement for each council as to current performance on children's services and adult services, and also on their prospects for improvement for each of these. The ratings were updated so that they could contribute the most recent social care evidence available to the CPA.

7.119 In the refreshed star ratings eleven councils received three stars, the best rating, and a further 52 received two stars also showing good performance. These councils were spread across the country, showing that councils of all types are able to achieve good performance. Some 75 councils received one star, and twelve received zero stars. These twelve are therefore on 'special measures', meaning that the Social Services Inspectorate monitors their performance intensively and agree with the council a performance improvement plan.

7.120 The refreshed star ratings show an overall improvement in performance and out of the 18 councils to receive a changed rating 12 have gone up and 6 have gone down (see box). Among the changes are the awarding of three stars to Kent, Kingston upon Thames and North Lincolnshire and two stars to Bath and North East Somerset, Camden, Herefordshire, Leeds, Medway Towns, Rochdale, Stockton-on-Tees and Tower Hamlets. The London Borough of Merton has also been removed from special measures and awarded one star as a result of sustained improvements over the past 18 months.

How the Star Ratings Changed from May to November 2002

7.121 The ratings show that performance is likely to improve further. More than seven in ten (76 per cent) were judged to have good or excellent prospects for improvement. Even at one star level more than half of councils had good or excellent prospects.

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

- various inspections, for the most part summarised (alongside other performance information) in the Chief Inspector's annual report *Modern Social Services – a commitment to reform (August 2002)*[7.6];
- the performance indicators published to November 2002 in *Social Services Performance Assessment Framework Indicators 2001-2002*[7.7]; and,
- monitoring information from Autumn 2001

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

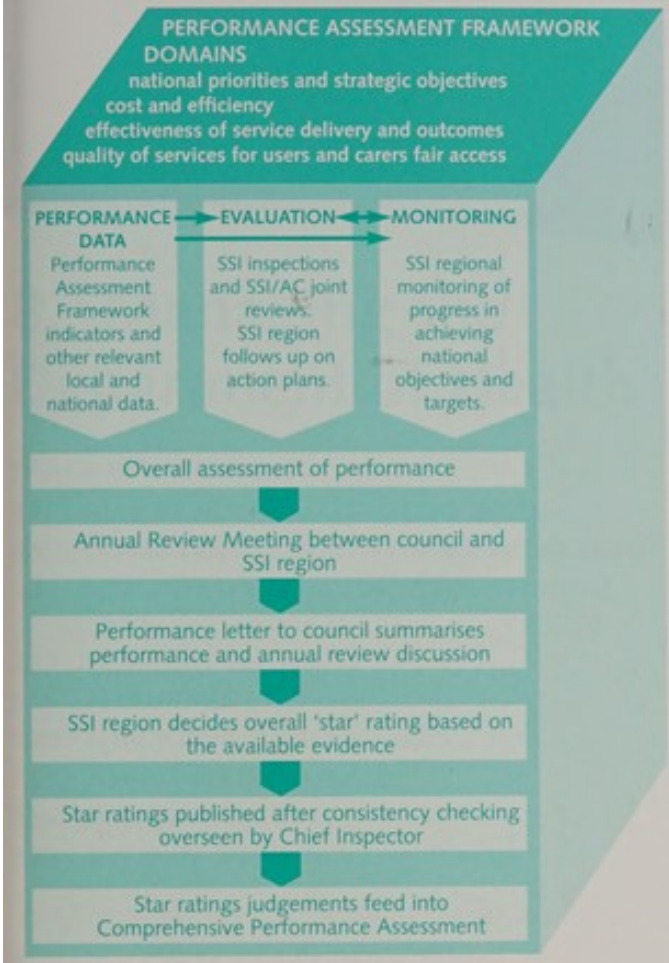
- recruitment and retention of staff is a continuing problem across all sectors of social care;
- budget pressures, particularly in children's services are evident in most councils. Councils need to reconsider how they commission children's services to get best value from the resources available;
- councils are developing new services both for children and older people – these services need to move to the mainstream of activity if reform is to make a difference to all service user groups; and,
- relationships across health and social care, which have been disrupted by recent structural changes, are now being re-established locally.

7.124 The performance indicators, published since the Chief Inspector's report, paint a picture of progress, however, it is not consistent across the country:

- for England as a whole there has been an improvement in performance for the third year running (of the indicators that can be compared, 25 showed an improvement between 2000-01 and 2001-02 and 11 remained at a similar level or worsened slightly);
- performance still varies between councils for many of the indicators but the variation reduced for the third successive year; and,
- data quality improved over the last year but there is still room for further improvement.

7.125 The messages from the Autumn 2002 monitoring round are consistent with the above, in that improvements are happening but often slowly:

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



Children's services – detailed performance messages

- Steady progress has been made towards a number of objectives including the stability of placements for children looked after, and child protection indicators.
- The educational attainment of children leaving care increased to 41 per cent in 2001-02 from 37 per cent in 2000-01 but this is still well below the target of 50 per cent. Significant improvements are required if the 2002-03 target of 75 per cent is to be achieved. Moreover, one in eight were absent from school for at least 25 days during the year. Looked after children are still three times more likely to receive a final warning, reprimand, caution or conviction.
- The timeliness of reviews of child protection cases improved significantly for the second year running but further improvement is required, as only 37 per cent of councils reviewed all their cases and seven per cent of reviews did not take place when they should have done. Nine per cent of councils reviewed less than 85 per cent of cases, but this figure is a significant improvement on 2000-01 (26 per cent).
- Duration on the child protection register reduced, signifying a continuing improvement in performance. However, 21 per cent of councils had more than 15 per cent of de-registrations relating to children who had been on the register continuously for two years or more.
- There was an increase in the percentage of looked after children adopted for the fourth successive year (from 5.2 per cent in 2000-01 to 5.7 per cent in 2001-02, representing an increase of some 350 children). In 2001-02, 6.8 per cent of children looked after for six months or more were adopted.

7.127 Further information can be found at **www.doh.gov.uk/pssratings/index.htm**

Adult services – detailed performance messages

- Progress appears to have continued in delivering services to promote the independence of adults and older people, with an increase in the number of households receiving intensive home care. Admissions of supported residents to residential nursing care fell for those aged 18 to 64 and remained the same for those aged 65 or over.
- The percentage of users who received a statement of their needs and how they will be met increased to 84 per cent.
- As in 2000-01, more than four out of five users (83 per cent) said they got help quickly, with the figure reaching over 90 per cent in one in eight councils.
- Performance at the interface, for which health and social care are jointly accountable, is mixed; the target for emergency admissions was met but the 12 per cent target for emergency psychiatric re-admissions was missed by 0.4 percentage points. However, the percentage of discharges of older people that were delayed recorded the third successive fall.
- One in ten single adults and older people are not allocated single rooms when they go into permanent residential and nursing care; seven councils reported less than 80 per cent of such people were allocated a single room but this was an improvement on 2000-01.

Efficiency in Social Services

7.128 The targets for social services efficiency for the years 1999-2000 to 2002-03 were 2 per cent, 2 per cent, 3 per cent and 2.5 per cent. The available evidence shows that the national efficiency target was missed but only by a very small margin. The estimated efficiency gains for each of these four years was 2.1 per cent, 2.3 per cent, 2.5 per cent and 2.1 per cent. The cumulative efficiency gain for these four years was therefore 9.3 per cent against a cumulative target of 9.8 per cent.

7.129 Efficiency gains are achieved where:

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

7.130 For the next three years (2003-04 to 2005-06) the efficiency target is in two parts, reflecting the above sources of efficiency gain. There is a target of 1 per cent per annum cost efficiency improvement, which will be measured by changes in unit costs, and a target of 1 per cent per annum cost effectiveness improvement, which will be measured by changes in quality indicators. These targets are the same as those for the NHS.

8. Managing the Department of Health

THIS CHAPTER COVERS:

8.1 RUNNING COSTS AND STAFFING TABLES
8.5 DEPARTMENT OF HEALTH CHANGE PROGRAMME
8.7 NON-DEPARTMENTAL PUBLIC BODIES (NDPBs), NHS BODIES AND AGENCIES
8.13 PUBLIC APPOINTMENTS
8.18 RECRUITMENT
8.20 SENIOR CIVIL SERVICE SALARIES
8.21 A HEALTHIER WORKPLACE
8.26 ACCOMMODATION
8.27 THE ENVIRONMENT

Running Costs and Staffing Tables

8.1 The Department comprises 14 directorates dealing with various aspects of the organisation's work (e.g. NHS Human Resources, Public Health & Clinical Quality, and Communications) and includes four regionally based Directorates of Health and Social Care. Directors report to the Chief Executive/Permanent Secretary. There are also four Executive Agencies.

8.2 The provisions for the administration of the Department appear, for past years, in Annex A of the 2002-03 *Departmental Report*[8.1] and, for 2003-04, they form part of the Request for Resources 2 in the 2003-04 *Main Estimates*.[8.2] Detailed information on Departmental administration costs is given in **Figure 8.1**. Information on Staffing levels is provided in **Figure 8.2**.

8.3 As part of the 2000 Spending Review, the Department agreed with Treasury a profile of administration costs over the period 2001-02 to 2003-04 which was level in real terms compared to 2000-01. The profile of administration costs agreed in the 2002 Spending Review reflects the reduction in size of the Department as functions transfer to strategic health authorities but also the one-off costs of achieving that change. Since the 2002 Spending Review, the Chief Executive has announced a major change programme for the Department of Health. These changes will support the ongoing transformation of the whole NHS and social care system and the drive for decentralisation within a framework of national standards. As a result, the Department (excluding its agencies) will be significantly smaller with planned reductions in staffing of at least a third by October 2004. The full implications of the change programme are currently being considered and are not reflected in the numbers provided in **Figure 8.1**. However in **Table 8.2** the planned outturn figure for 2004-05 and 2005-06 show provisional reductions of one third.

8.4 No maladministration payments were made in 2002.

Department of Health Change Programme – The New Vision for Health and Social Care

8.5 The health and social care system is being reformed to deliver a faster, more modern responsive service. The Department must do the same. Over the next 18 months the Department will become a smaller, more strategic organisation. It will work through the 28 Strategic Health Authorities as the local Headquarters of the NHS and devolve responsibility through the system. Ministers and the Department are leading a radical transformation of the whole of the NHS and social care system. This means that we need to rethink the core purpose of the Department of Health and we need to work differently to support this transformation.

8.6 The new system will place patients and users at the forefront offering them choice, information and control. There will be a clear framework of values and national standards combined with independent inspection and regulation. Clinical teams and front-line staff are increasingly being involved in decision making and planning. The Department of Health will set the direction, provide resources, lead the transformation and oversee the whole system, but it will not attempt to manage service delivery. This is a radical change: far greater devolution than we have at present, taking functions away from the centre, turning around the way we develop and implement policy. The acid test will be whether patients and users experience of getting the services and support they need improves. This is a radical change programme for the Department. It includes work over an 18-month period on changes in the way the Department delivers its core business working in partnership with external stakeholders. It will result in new internal structures, new relationships with external stakeholders, a clear definition of the role of the Department and significant reduction in the size of the Department.

Figure 8.1: Department of Health Administration Costs

£ million

	1998-1999 outturn	1999-2000 outturn	2000-2001 outturn	2001-02 estimated	2002-03 estimated outturn	2003-04 Plans outturn	2004-05 Plans	2005-06 Plans
Gross Administration costs								
Paybill	130	134	144	151	144			
Other	137	143	123	128	161			
Total gross administration costs	**267**	**277**	**267**	**279**	**305**	**325**	**292**	**299**
Related administration costs receipts	-7	-5	-4	-9	-21	-12	-12	-12
Total net administration costs	**260**	**272**	**263**	**270**	**285**	**313**	**280**	**287**
Total Net Administration Costs by activity								
Central Department	256	268	258	270	285	313	280	287
Youth Treatment Service	4	4	5	0	0	0	0	0
Total Net Administration Costs	**260**	**272**	**263**	**270**	**285**	**313**	**280**	**287**
Controls and Limits								
Central Department	256	268	258	270	285	313	280	287
Youth Treatment Service	4	4	5	0	0	0	0	0
Total administration Costs limits for gross controlled areas	**260**	**272**	**263**	**270**	**285**	**313**	**280**	**287**
Note: changes in definitions of administration cost limits, on net basis, since last year's Departmental Report								
Total net administration costs limits on Stage 1 * resource accounting and Budgeting (RAB)	278	280	293	305	325	338		
plus additional non cash items from move to full RAB, as part of 2002 Spending review	13	18	14	11	16	19		
less removal of some administration costs ** associated with frontline service provision	-23	-22	-41	-44	-45	-43		
less additional allowable receipts	-7	-4	-2	-2	-11	-1		
Administration Costs	**260**	**272**	**263**	**270**	**285**	**313**		

* The net administration costs limit excludes Medical Devices Agency which merged with the Medicines Control Agency from 1/4/03.
** Includes the NHS Pensions Agency, NHS Purchase and Supply Agency, and some central departmental services.

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

8.7 The Department's arm's length bodies (NDPBs, executive agencies and special health authorities) operate under measures introduced by the Government in 1998[8.3] designed to increase public accountability and confidence in them. The Department's executive NDPBs have members' codes, published registers of members' interests and Internet sites. Where practicable and appropriate they also hold open meetings and summary reports of meetings are published on Internet sites, in annual reports or press releases where possible.

8.8 The Cabinet Office's report, *Better Government Services – Executive Agencies in the 21st Century,*[8.4] published in July 2002, made twelve recommendations designed to support the development of the agency model in Government and improve working between executive agencies and their parent departments, whilst reinforcing the need for agency autonomy and empowerment to deliver front-line services. Ministers have accepted the report's recommendations and the Department will work with the Cabinet Office to put the recommendations into effect in a way which reinforces the modernisation of the Department as a whole. It is already clear that some of the recommendations can also be used to improve the performance management of the Department's larger executive NDPBs. For example, the report will give the Department greater flexibility in when and how it conducts reviews not only of agencies but of executive NDPBs too.

8.9 The Department continues to develop its own guidance on the performance management of its arm's length bodies, and this guidance is now being fully revised. The intention is that each body should have a comprehensive performance management framework in place. The guidance also aims to promote sound management techniques by requiring these bodies to consider their work programme from the perspective of contributing to the achievement of the NHS Plan and other major Departmental initiatives. The Department's own recent internal corporate developments have further strengthened these moves.

8.10 A number of new arm's length bodies are now being set up (further details are in Chapter 5). They include:

- **Commission for Health Audit & Inspection (CHAI):** will encompass all of the current and proposed work of the Commission for Health Improvement (CHI) and the Mental Health Act Commission (MHAC) with the national NHS value for money work of the Audit Commission and the independent healthcare work of the National Care Standards Commission (NCSC);
- **Commission for Patient and Public Involvement in Health (CPPIH):** set up from 1 January 2003, CPPIH will champion and promote the involvement of the public in decisions that affect their health, putting them at the heart of decision making in

Figure 8.2: Staff Numbers

	Staff-years							
	1998-99 actual	1999-00 actual	2000-01 actual	2001-02 actual	2002-03 actual	2003-04 plans	2004-05 plans	2005-06 plans
Department of Health (Gross Control Area) *(2)								
CORE DH (Full Time Equivalents)	3,611	3,753	3,632	3,809*(1)	3,390*(2)	3,390*(2)	2,272*(2)	2,272
NHS Pensions Agency (Full Time Equivalents)	464	444	452	466	268	268	268	268
Medical Devices Agency (Full Time Equivalents)*(3)	144	143	141	149	156	156	156	156
NHS Purchasing and Supplies Agency (Full Time Equivalents)			285	291	309	309	309	309
Subtotal	**4,219**	**4,341**	**4,511**	**4,715**	**4,123**	**4,123**	**3,005**	**3,005**
NHS ESTATES (Full Time Equivalents)*(4)	242	270	326	435	390	167	167	167
Medicines Control Agency (Full Time Equivalents)*(3)	492	490	436	574	519	519	519	519
Subtotal	**734**	**760**	**762**	**1,009**	**909**	**686**	**686**	**686**
TOTAL DEPARTMENT OF HEALTH	**4,953**	**5,101**	**5,273**	**5,724**	**5,032**	**4,809**	**3,691**	**3,691**

*(1) Includes 35 FTE Departmental staff in the Modernisation Agency which will become a Next Steps Agency in 2003/4.

*(2) The Chief Executive has recently initiated a major change programme with an expectation that the number of posts in the Department – excluding its Agencies – will reduce by at least a third by October 2004. The impact on the out-turn figures for the Department for 2003-04 will become clearer as the programme develops. The planned out-turn figures for 04/05 and 05/06 show provisional reductions of one third on the 02/03 out-turn, excluding posts now in the Modernisation Agency.

*(3) The Medicines Control Agency became a trading fund on 1 April 1993. The MCA and MDA merged with effect from 1 April 2003 to become the Medicines & Healthcare Products Regulatory Agency (MHRA). Plan Staffing figures are therefore provisional and illustrative only.

*(4) NHS Estates Agency became a trading fund on 1 April 1999.

local NHS services. It is responsible for overseeing the new system of patient and public involvement in health;

- **Council for Regulation of HealthCare Professionals (CRHCP):** will come into being on 1 April 2003. Under powers given to it by the NHS Reform and Health Care Professionals Act 2002, CRHCP will co-ordinate the work of the regulators of all doctors, nurses and other health care professionals. It will be a guardian of the public interest, totally independent from Government and directly answerable to Parliament.
- **Commission for Social Care Inspections (CSCI):** will encompass all of the work of the Department's Social Services Inspectorate (SSI) and the Joint Review team of the SSI/Audit Commission and the functions of the NCSC in relation to social care;
- **Health Protection Agency (HPA):** the aim is to establish the HPA in two stages: (i) first as a special health authority which from 1 April 2003 will take on functions under the NHS Act (including functions currently performed by the Public Health Laboratory Service, the Centre for Applied Microbiology as well as by other key health protection professionals); (ii) subsequently as an executive non-Departmental public body which will be able to perform a wider range of functions, including functions currently held by the National Radiological Protection Board. HPA's establishment will provide for an integrated approach to protecting the public against infectious diseases and chemical and radiological hazards; and
- **National Health Service University (NHSU):** will contribute to the transformation of the NHS and help secure radical and tangible improvements in healthcare by providing personal learning and development for everyone working in Health and Social Care as it develops the NHS University concept.

8.11 The Department has five executive agencies: the Medical Devices Agency (MDA); the Medicines Control Agency (MCA); NHS Pensions Agency (NHSPA); NHS Purchasing and Supply Agency (NHSP&SA) and NHS Estates (NHSE). NHSE continues its strategic focus on delivering its part in the NHS Plan. The Agency will shortly be completing a PPP to dispose of surplus estate and its trading arm, Inventures. The Department has announced the merger of the MCA and the MDA from 1 April 2003 to form the Medicines and Healthcare products Regulatory Agency (MHRA). This decision reflects the increasing convergence, as technology develops, of pharmaceuticals and medical devices; and potential synergies between organisations with a similar role and purpose in protecting public health. The USA and nearly all of Europe have already gone this way.

8.12 The relationship between the Department and its Agencies is set out in published framework documents which are available from the Agencies direct. Further details about the management of the Agencies can be found in **Annex B.**

Public Appointments

8.13 The Department is responsible for public appointments to a wide range of bodies, as detailed below.

Figure 8.3: Public Appointments Sponsored by the Department (members in post) at 1 January 2003

Type of Body	Chairs	Members	Total
Health Authorities	28	196	224
NHS Trusts	275	1,425	1,700
Primary Care Trusts	303	1,823	2,126
Special Health Authorities	18	319	337
Advisory Non-Departmental Public Bodies	26	431	457
Executive Non-Departmental Public Bodies	6	98	104
Other Bodies	2	15	17
Total	**658**	**4,307**	**4,965**

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

Department of Health
Public Appointments Unit
HRD-HRB 2N35A
Quarry House
Quarry Hill
Leeds
LS2 7UE

Tel: 0113 254 5613
Email: jerry.bird@doh.gsi.gov.uk

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

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

8.17 As at 1 January 2003 the gender and ethnic balance and proportion of non-executive board members who were disabled on the boards of public bodies for which the Department is responsible was as follows:

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

	NHS Trusts, Health Authorities and Primary Care Trusts	Special Health Authorities and Non-Departmental Public Bodies
% board members who are women	47.8	40.7
% chairs who are women	40.6	31.4*
% board members from ethnic minorities	10.4	23.5
% board members who are disabled	3.4	2.3

** Also includes vice chairs.*

Recruitment

8.18 This was the first full year for external recruitment for jobs outside the Senior Civil Service to be devolved to Directorates. The well-established systems continued to be applied to the devolved structure to ensure that all external recruitment is carried out on the basis of fair and open competition and is in accordance with the provisions of the *Civil Service Commissioners' Recruitment Code*.[8.5] The recruitment controls introduced in December 2001 remained in place for the whole of 2002. This

Figure 8.5: Recruitment into the Department of Health, 2002

	Total	Male	Female	Ethnic Minorities*	Disabled
Permanent Staff joining during 2002 who are still employed by the Department of Health					
Senior Civil Service	27	15	12	0	0
Fast Stream	20	8	12	0	0
Posts at former UG6 and below	359	132	227	5	0
Total	**406**	**155**	**251**	**5**	**0**
Permanent Staff joining during 2002 who are no longer employed by the Department of Health					
Senior Civil Service	1	0	1	0	0
Fast Stream	0	0	0	0	0
Posts at former UG6 and below	37	11	26	0	0
Total	**38**	**11**	**27**	**0**	**0**
All Permanent Staff joining during 2002					
Senior Civil Service	28	15	13	0	0
Fast Stream	20	8	12	0	0
Posts at former UG6 and below	396	143	253	5	0
Total	**444**	**166**	**278**	**5***	**0**

** The information on ethnicity and disability is incomplete and a data cleansing exercise will be undertaken in spring 2003.*

involved the introduction of a revised procedure for filling posts and was designed to support financial control of administrative expenditure, and critically to support colleagues whose posts may be displaced by organisational change. Further organisational change means that controls which were due to remain in place until 31 March 2003 will now extend beyond that date.

8.19 The number of successful candidates in external competitions is shown in **Figure 8.5** and, as required by the Code, gives the number of women, ethnic minorities and disabled people successful at each level. The figures include the following permitted exceptions:

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

Senior Civil Service Salaries

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

Figure 8.6: Salaries in the Department of Health for Senior Civil Service staff in post as at 1 April 2002

Payband (per annum)	Number of Staff
£50000 – £54999	25
£55000 – £59999	47
£60000 – £64999	66
£65000 – £69999	59
£70000 – £74999	55
£75000 – £79999	22
£80000 – £84999	18
£85000 – £89999	24
£90000 – £94999	17
£95000 – £99999	11
Over £100,000	39
Total	**383**

A Healthier Workplace

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

8.22 The Department is about to introduce comprehensive guidance for managers on staff on how to manage both intermittent and long-term sickness absence including support for disabled staff who are sick and advice on rehabilitation.

8.23 The Department continues to meet its legal obligations to safeguard the health and safety of its staff and, in response to the 'Revitalising Health and Safety' initiative, will be introducing revised policy guidance setting out the roles of managers and staff. In addition the Department is about to introduce an electronic system for reporting sickness absence, followed by a similar system for reporting accidents and other health and safety incidents. This will improve the quality of the data available for monitoring and planning.

8.24 Future initiatives include the development of a protocol for Directorate responsibilities for health and safety, to be integrated into new corporate governance arrangements, and the development of a proforma for annual health and safety reporting and related information gathering arrangements.

8.25 The Department has also provided a healthier workplace by closing all the smoking rooms in its own buildings.

Statistics for 2002

Reported accidents	
Not resulting in absence	78
Resulting in absence	21
Resulting in absence and requiring a RIDDOR report	2
Total	**101**
Reported near misses	4

Accommodation

8.26 There has been no significant change to the Department's HQ buildings in London and Leeds during the year, which continue to operate at or near capacity. The Department will progressively take over space coming available in another government building in London over the next 2-3 years allowing the release of three of our existing older buildings at lease end. This will complete the Department's long term strategy to concentrate its London base into a small number of buildings giving good quality long term accommodation, mainly south of the river where rent and rates are lower. The closure of the Department's Regional Office structure under the *Shifting the Balance of Power*[8.6] initiative has significantly reduced the requirement for accommodation outside London and Leeds with nearly all the surplus property reused elsewhere within government or the NHS.

The Environment

8.27 The Department continues to develop its sustainable development strategy in line with Government policy [see Chapter 2, paragraph 2.22]. This strategy is wide-ranging, encompassing sustainable development, environmental appraisal and operational environmental management, building on work undertaken to identify significant environmental impacts and the development of strategies to improve the Department's environmental performance.

8.28 The Government's new *Framework for Sustainable Development on the Government Estate*[8.7] was launched in July 2002 and will eventually cover all key environmental and social impacts of the running of departments. The *Framework* provides

a structured approach to identifying and reporting the key sustainable development impacts of Departments through the management of their estates, employment of staff and external relations with communities in which they operate. It identifies a common agenda and shared priorities for Departments in contributing to sustainable development. Information on the Department's sustainable development impacts is contained on the Department's new sustainable development web page at **http://www.doh.gov.uk/sustainabledevelopment**.

8.29 The Department has completed a comprehensive review of its existing Environmental Management System (EMS) under the auspices of its Facilities Management supplier. The EMS has been adopted and refined and data collection processes are in place. The Department is actively considering the BT envoy electronic system to record and monitor the achievements of the EMS. A rollout programme to introduce the EMS to the other buildings on the estate will be completed by April 2004.

8.30 The Department is purchasing renewable energy for its London administrative buildings. This effectively reduces the release of carbon emissions to the air by 39 per cent.

8.31 The Department's official environmental contacts are Martin Chaplin, Head of Contract Management (operational), 020 7972 5749, and Marjorie Thorburn, Sustainable Development Team (policy), 020 7972 5158

List of Annexes

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ANNEX A1

Total Capital Employed by the Department

£ million

	1998-99 outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 estimated outturn	2003-04 plan
Within the Departmental Account[1][2]	17,896	15,813	15,146	15,006	15,381	15,727
Investment outside Accounting Boundary[3][4][5][6]	15,853	22,529	23,011	23,112	23,693	24,229
Total Capital Employed	33,749	38,342	38,157	38,117	39,074	39,956

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

2 Source: DH consolidated resource accounts. For 2002-03 and beyond figures are based on projected growth.

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

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

5 Source: NHS Trusts summarisation schedules, and accounts of other organisations. For 2002-03 and beyond figures are based on projected growth.

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

ANNEX A2

Department of Health – Resource Budget

£ million

	1998-99[1] outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 estimated outturn	2003-04 plan	2004-05 plan	2005-06 plan
Consumption of Resources by activity								
National Health Service (NHS)	**39,233**	**40,769**	**44,109**	**50,906**	**55,097**	**60,787**	**66,536**	**72,673**
of which								
Hospital and Community Health Services[2]	**34,326**	**35,703**	**38,797**	**45,732**	**50,066**	**56,212**	**59,191**	**64,605**
of which								
Health Authorities unified budget and central allocations and grants to local authorities	34,326	35,703	38,797	45,732	50,066	56,212	59,191	64,605
Family Health Services[2]	**4,223**	**4,269**	**4,382**	**4,215**	**3,955**	**3,297**	**6,070**	**6,738**
of which:								
General dental services	1,004	1,071	1,109	1,165	1,213	1,042	1,183	1,183
General medical services[3]	2,212	2,473	2,507	2,276	1,946	1,441	4,103	4,771
General ophthalmic services	236	288	290	302	310	329	307	307
Pharmaceutical services	1,113	808	869	884	916	931	911	911
Prescription charges income	–343	–371	–393	–412	–430	–446	–434	–434
Central Health and Miscellaneous Services	**396**	**500**	**521**	**626**	**712**	**890**	**921**	**969**
of which								
Welfare Foods DEL	295	101	102	105	103	120	120	120
EEA Medical Costs	–62	141	187	202	268	244	244	244
Other Central Health and Miscellaneous Services	163	258	233	320	341	527	557	605
Departmental Administration including agencies[4]	**289**	**297**	**319**	**333**	**365**	**387**	**353**	**362**
Personal Social Services (PSS)[3]	**711**	**631**	**650**	**1,049**	**2,127**	**2,102**	**1,994**	**2,046**
of which								
Personal Social Services	32	34	40	57	204	125	199	226
Local Authority personal social services grants	679	597	610	991	1,922	1,977	1,794	1,820
of which								
Training Support programme for social services staff	35	39	43	47	58	57	53	
Grants for adults	618	436	445	556	1,170	1,199	1,589	1,564
Grants for children	26	122	121	386	645	613	129	194
Grants funded from the invest to save fund			2	1	2			
Performance fund					48	100		
Pensions								
of which								
NHS – Superannuations – England and Wales	**5,403**	**7,170**	**4,803**	**13,769**	**7,503**	6,188	6,559	6,952
Total Department of Health Resource Budget	45,347	48,570	49,472	65,723	64,727	69,077	75,088	81,672

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

2 *Figures for FHS non-discretionary expenditure between 1999-00 and 2005-06 are not comparable because of transfer to FHS Discretionary principally to fund successive waves of Personal Medical and Dental services. For a consistent run of FHS figures, please see Figure 3.3a and 3.3b.*

3 *Figures for 2004-05 and 2005-06 include funding for Personal Medical Services pilots which will be transferred to FHS Discretionary.*

4 *Figures may not sum due to rounding.*

ANNEX A3

Department of Health Capital Budget

£ million

	1998-99[1] outturn	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 estimated outturn	2003-04[2] plan	2004-05 plan	2005-06 plan
National Health Service (NHS)	**700**	**850**	**1,173**	**1,676**	**1,953**	**2,892**	**3,383**	**4,363**
of which								
Hospital and Community Health Services	**700**	**819**	**1,154**	**1,650**	**1,929**	**2,856**	**3,351**	**4,332**
of which								
Health Authorities unified budget and central allocations and grants to local authorities	700	819	1,154	1,650	1,929	2,856	3,351	4,332
Central Health and Miscellaneous Services	**0**	**15**	**9**	**13**	**15**	**11**	**11**	**11**
Departmental Administration including agencies	**–0**	**16**	**9**	**13**	**9**	**25**	**20**	**20**
Personal Social Services (PSS)	**60**	**61**	**58**	**92**	**94**	**107**	**107**	**117**
of which								
Personal Social Services	55	57	56	91	81	91	91	90
Local Authority Personal Social Services Grants	5	4	2	1	13	16	16	26
of which								
Grants for Children	5	4	1	1	12	16	16	26
Grants funded from the Invest to Save Fund	0	0	1	0	1	0	0	0
Total Department of Health Capital Budget	**760**	**911**	**1,231**	**1,768**	**2,047**	**2,999**	**3,490**	**4,479**
of which								
Departmental Expenditure Limit (DEL)	760	911	1,231	1,768	2,047	2,999	3,490	4,479

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

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

3 Figures may not sum due to rounding.

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

ANNEX B

Executive Agencies of the Department of Health

NHS Estates Agency

NHS Estates was established as an Executive Agency in April 1999. The Agency's task is to support Ministers, the Department of Health and the NHS in the management of the estate and patient environment. It employs approximately 150 staff and its turnover is in excess of £20 million. The main objective of the Agency is to help the NHS to improve patient care through better use of NHS estates and enhancing the patient environment by taking a responsive approach to providing healthcare services. NHS Estates is supporting Ministers and the NHS through policy development and implementation on estates, facilities and capital management issues including:

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

The Agency is currently putting full efforts into the implementation and delivery of Chapter 4 of the NHS Plan. It offers expert advice and guidance to the service, and encourages the development of estates and facilities management personnel to equip them for the future. In particular, the Agency is developing benchmarks, tools, analysis and professional support for performance management together with estate and facilities management leadership in the NHS. Expertise and advice is offered for different NHS needs including: support for the development of primary, secondary and tertiary care services; Strategic Health Authorities aims for the estate in Health Improvement Programmes and Health Action Zones; and for property and facilities management in primary care groups and trusts.

Details of the Agency's key tasks and targets and more information about the Agency's activities can be found on the website at **www.nhsestates.gov.uk** or by calling 0113 254 7000.

Medicines Control Agency (*)

The Medicines Control Agency (MCA) was launched as an Executive Agency in July 1991 and became a trading fund in 1993. It safeguards public health by ensuring that all medicines on the UK market meet appropriate standards of safety, quality and efficacy. This is achieved through a system of licensing, inspection, enforcement, post-marketing surveillance and information provision. The Agency employs over 500 staff and has gross running costs of £37 million derived from fees charged to the pharmaceutical industry and other users of its services. These fees wholly cover the Agency's costs.

An independent review conducted in 1999 found that the MCA is performing very effectively and efficiently and is regarded as a world leader in its field. A recent report from the National Audit Office concluded that the MCA ensures a high standard of medicines safety and quality in the UK, and is a source of good practice for many nations in medicines regulation. The MCA continues to contribute to the NHS Plan and to building a safer NHS for patients. The Agency's forward plans and targets are set out in the Annual Report which can be purchased from the Stationery Office, price £16.60 and the Business Plan, which can be obtained by writing to the office of the Chief Executive, Room 16-208, Market Towers, 1 Nine Elms Lane, London SW8 5NQ, or from the MCA website at **www.mca.gov.uk**.

Medical Devices Agency (*)

The Medical Devices Agency (MDA) was launched in September 1994 to safeguard public health by ensuring that medical devices and equipment for sale or use in the UK meet appropriate standards of safety, quality and performance. With some 150 staff and net expenditure of around £7 million, it has fulfilled its aim principally by:

- investigating reports about adverse incidents involving medical devices, issuing safety warnings to the NHS and other healthcare providers, and offering them advice;
- negotiating and implementing a series of European Directives and enforcing the UK Regulations which support the Directives; and
- publishing evaluations of new medical devices to provide independent findings on their comparative performance and ease of use.

The achievements and work of the Agency in 2002-03 included:

- dealing with ever-more reports of adverse incidents; there has been a sustained increase of around 10% a year;
- planning joint approaches with the National Patient Safety Agency to have common focal points in the NHS for reporting adverse events, and shared feedback on the impact of safety warnings;
- initiatives to enhance the safe and effective use of medical devices throughout the health service;
- a significant contribution to two new Directives, one to reclassify breast implants to afford them the highest degree of regulatory control, the other to impose additional controls on devices incorporating animal material to minimise any risks associated with TSE;
- the consolidation of existing legislation into the Medical Devices Regulation 2002;

- the European Commission's report following the UK-inspired review of the operation of the Medical Devices Directive, which supported virtually all the UK's concerns, and proposed remedies;
- an active and influential role in working groups set up by the European Commission following the review – to improve the performance of Notified Bodies and co-operation amongst Member States in enforcement activities, and to increase public transparency in the way the Directives operate; and
- a major international role in the Global Harmonisation Task Force and close collaboration with the US FDA.

The Committee on the Safety of Devices has continued to meet and has addressed a number of important issues such as the safety of high strength MRI and the development of guidelines for patients.

Further details can be found in the Agency's Annual Report, available by phoning 020 7972 8000.

*** Merger of the MCA and the MDA**

The Department has announced the merger of the MCA and the MDA from 1 April 2003 to form the Medicines and Healthcare products Regulatory Agency (MHRA).

NHS Pensions Agency

The NHS Pensions Agency is responsible for the administration of the NHS Pension Scheme and the NHS Injury Benefit Scheme for England and Wales. The Pension Scheme has 1.9 million members and pensioners and receives pension contributions totalling £3.0 billion per annum and pays benefits of £2.96 billion per annum.

During 2001-02, the Agency undertook procurement and subsequent partial contractorisation of support and ancillary services to an on-site partner, Envision.

The Agency had an average number of employees across the year of 444, though this is weighted by the TUPE transfer of 107 staff to the partner on 1 January 2002. In administering the Scheme, the Agency incurred net expenditure of £18.85 million for 2001-2002.

The Agency is tasked to ensure that:

- The NHS Scheme and its delivery contribute actively to the wider modernisation of the NHS;
- NHS Staff receive a pension service that is comparable with the very best industry standards and conforms with the e-government strategic framework; and
- The administration costs for the scheme are commercially competitive.

More information about the Agency's activities, progress towards its objectives and associated key targets, can be found in its Annual Report and Accounts for 2001-02, which is available from the NHS Pensions Agency, Hesketh House, 200-220 Broadway, Fleetwood FY7 8LG; 01253 774774 and at the Agency's website at **www.nhspa.gov.uk**.

NHS Purchasing and Supply Agency

The NHS Purchasing and Supply Agency was launched as an executive agency on 1 April 2000. It acts as the centre of advice and expertise on matters of purchasing and supply for the NHS for the benefit of patients and the public. The Agency is an advisory and co-ordinating body and also an active participant in the ongoing modernisation of purchasing and supply in the health service. The Agency ensures that purchasing and supply issues are taken into account when determining national healthcare policies.

The Agency also provides advice to individual NHS bodies and negotiates contracts for goods and services on behalf of the NHS. The Agency employs over 300 people and its gross running costs from 1 April 2001 to 31 March 2002 were £19.5 million.

Key achievements for 2002 include:

- achieved purchasing savings of £150 million for the NHS;
- leading a fundamental re-organisation of purchasing and supply throughout the NHS. This centres on the creation of a 'middle tier' of purchasing to bridge the gap between national (NHS PASA) and local (individual trust) level purchasing. The Agency is piloting six inter-trust collaborative groups known as Supply Management Confederations.
- developing a national framework of standards for best practice procurement in the NHS.

In 2003 the Agency aims to:

- introduce a new national NHS Supplier Information Database to rationalise the management of pre-qualification data during the procurement process, reducing the administrative burden on potential suppliers to the NHS;
- continue to develop and monitor supply management confederations;
- contribute to the delivery of fast, responsive care built around the needs of patients;
- achieve purchasing savings of at least 5 per cent of contract value; and,
- continue to play a leading role in the purchasing and supply implications of more than 40 projects in the NHS Plan.

Medicines and Healthcare Products Regulatory Agency

The Medicines and Healthcare products Regulatory Agency (MHRA) will be created on 1 April 2003 as an executive agency of the Department of Health. It will be created from a merger of the existing Medicines Control Agency and the Medical Devices Agency.

The aim of the Medicines and Healthcare products Registry Agency will be to protect and promote public health and well-being by ensuring that medicines, healthcare products and medical equipment meet set standards of safety, quality, performance and effectiveness, and are used safely.

The MHRA will have some 700 staff and a total budget of around

£50 million. It will operate as a trading fund. The Agency's main sources of funding will be fees and charges from the pharmaceutical industry, and funding from the Department of Health for its operations on regulating medical devices.

The main tasks carried out by the MHRA will be licensing manufacturers of pharmaceuticals, ensuring compliance in the UK with statutory obligations relating to the manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices, operating systems for recording, monitoring and investigating adverse reports and incidents, and taking enforcement action to safeguard public health. The Agency will also provide advice and support to Department of Health Ministers on policy issues and will represent the UK in European and other international discussions concerning the regulation of medicines and medical equipment.

ANNEX C

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

Human Fertilisation and Embryology Authority

The Authority was established by the Human Fertilisation and Embryology Act 1990 and began its work in August 1991. Its main responsibilities are to license and monitor those clinics which carry out IVF and donor insemination, and to license research projects involving the creation of embryos in vitro, or the keeping or use of embryos. It also regulates the storage of gametes and embryos. It has 17 members (including the Chairman and Deputy Chairman) and has 69 staff.

The Authority's total expenditure in 2001-02 was £2,743,558. Approximately 53 per cent of the Authority's income was raised from licensing income, with the remaining 47 per cent from the Department of Health. Particular issues considered by the Authority were the use of pre-implantation genetic diagnosis, donor information, aneuploidy screening and intracytoplasmic sperm injection (ICSI). Further information about the work of the Authority and its accounts can be found in its Annual Report and Accounts, which is available on the HFEA's website **http://www.hfea.gov.uk**. Otherwise, information can be obtained from Mr Ted Webb at the Department of Health, Room 654C, Skipton House, 80 London Road, London SE1 6LH; (020 7972 5863).

The Commission for Health Improvement (CHI) – (See also CHAI)

The Commission for Health Improvement was set up under the Health Act 1999 with the aim of raising the quality of NHS care. CHI's main role is to carry out a programme of reviews of all NHS bodies in England and Wales (known as clinical governance reviews) in order to assess the standard of care being provided to patients. It also has the power to investigate local service problems and review the implementation of national standards set for specific clinical services or care groups. To date, CHI has published over 220 reviews of local NHS services, 8 investigation reports and, jointly with the Audit Commission, a report on NHS cancer care in England and Wales.

In the coming year, CHI will publish over 100 clinical governance review reports and begin a national study into the implementation of the National Service Framework for Coronary Heart Disease. CHI will also begin to use new powers under the NHS Health Reform and Health Care Professions Act 2002. This will enable CHI to carry out inspections of NHS services against published standards and recommend special measures where it identifies unacceptably poor services. CHI will also publish an independent annual report on the quality of services to NHS patients and establish an Office for Information on Health Care Performance.

CHI is currently funded by a grant from the Department and the National Assembly for Wales and its gross expenditure in 2001-02 was £27.72 million.

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

National Biological Standards Board (NBSB)

The NBSB, set up in 1976, functions through its executive arm, the National Institute for Biological Standards and Control (NIBSC). NIBSC creates standards for, and tests, the purity and potency of biological substances (e.g. vaccines, hormones, blood products) and is important to the Government's public health programme and to the pharmaceutical industry in assisting with licensing and with on-going batch testing and quality assurance of biological preparations. It has a significant research element. The Board's gross expenditure in 2001-02 was £17.1 million of which £13.9 million was funded by the Government. It employs 279 staff. NBSB's corporate aims and strategy together and its performance against key targets can be found in the Annual Report and Accounts. For more information about the NBSB contact Ed Davis, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 1644 or see the NIBSC's website at **http://www.nibsc.ac.uk**.

National Radiological Protection Board (NRPB)

The NRPB was set up in 1970. It conducts research into, and provides advice on the effects and risks of radiation (including non-ionising radiation such as ultra-violet, mobile phones and powerlines, etc.), radiation measurement and dose assessment, monitoring radon in homes, the environmental impact of nuclear discharges and waste disposal, emergency planning and the consequences of nuclear accidents. The Board also provides advice to international organisations and provides services to industrial and other radiation users. Gross expenditure in 2000-2001 was £14.6 million of which £6.65 million is provided by the Government (£6.34 million by DH and £0.31 million by The Scottish Executive). NRPB employs 311 staff.

NRPB's corporate aims and strategy together with performance against key targets can be found in their Annual Report and Accounts.

Subject to legislation, it is intended that the functions of the National Radiological Protection Board, other than those it carries out on the direction of the Scottish Executive, should transfer to the Health Protection Agency when that agency is established as a non-departmental public body. It is envisaged that this will take place on 1st April 2004.

For more information about the NRPB, contact Yemi Fagun, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5027, or NRPB's website at **http://www.nrpb.org**.

Public Health Laboratory Service (PHLS)

The PHLS was set up in 1946. Its primary function is to protect the health of the population through diagnosis, surveillance, prevention and control of infections and communicable diseases in England and Wales. It carries this out through a network of eight regional groups of laboratories (46 laboratories in total) co-ordinated through its headquarters at Colindale, London which also comprises the Central Public Health Laboratory (CPHL) and the Communicable Disease Surveillance Centre (CDSC). Gross expenditure in 2001-02 was £146.2 million of which £58.2 million was directly funded by Government. PHLS employs 3,057 staff.

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

General Social Care Council

The Care Standards Act 2000 brought into being, among other regulatory bodies, the General Social Care Council. In line with its sister councils in Scotland, Wales and Northern Ireland the GSCC has the remit to:

- establish a comprehensive and up-to-date **register of qualifying social care workers**;
- establish transparent and fair **rules for achieving and retaining registration**;
- develop and enforce **professional standards** of conduct and practice;
- ensure **high levels of training** for social workers;
- as a consequence of these actions, **promote the status** of social care workers;
- be a forward looking and pro-active public sector body with committed staff, responsive management, sound corporate governance and effective delivery of its remit.

The GSCC will have a registration function based on the completion of approved training. Before a person may be registered with the GSCC he/she will need to show that they are:

- of good character;
- physically and mentally fit to undertake the work;
- properly qualified and trained;
- satisfies any requirements of practice, conduct and competence the Council imposes.

The Care Standards Act makes very clear the Government's intention to see all social workers and social care workers registered with the appropriate Council. A social care worker is defined in the Act as a person who:

a) engages in relevant social work;

b) is employed at a children's home, care home or residential family centre or for the purposes of a domiciliary care agency, a fostering agency or a voluntary agency or a voluntary adoption agency;

c) manages an establishment, or an agency, of a description mentioned above;

d) is supplied by a domiciliary care agency to provide personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance;

e) a person employed in a day centre;

f) a person participating in a course approved by a Council under section 63 for persons wishing to become social workers.

The registration of social care workers of any other description specified by the appropriate Minister can also be ordered. A register for professionally qualified social workers will be opened in 2003. Heads of homes are a priority group after social workers.

The GSCC published Codes of Practice for social care workers and employers on 23 September 2002. These are the first codes of practice governing social care and are UK wide. They were developed in consultation with a wide range of stakeholders, including service users. They are a critical part of regulating the profession and helping to improve standards and public protection.

All staff and employers will be required to adopt these. The Code for employers includes the need to have rigorous and thorough recruitment and selection processes making sure that only people who have the appropriate knowledge and skills to enter the workforce. It is also necessary to undertake checks on relevant registers and indexes and assess whether people are capable of carrying out the job they have been selected for prior to appointment. The NCSC and SSI will take the Code of Practice for Social Care Employers into account in their enforcement of care standards.

The CSA gave each Council the right to set a fee for registration. The GSCC announced in the Autumn of 2002 a registration fee of £30 per annum for qualified social workers. This is a delegated power and not one on which the Department is consulted or required to agree. This income is taken into account when predicting future budgets.

National Care Standards Commission

The National Care Standards Commission was established under the Care Standards Act 2000 as part of the Government's reforms to modernise the regulatory system for care services and independent healthcare. The Commission became fully operational on 1 April 2002.

The Commission is an independent body, regulating statutory and independent sector care services in accordance with statutory regulations and national minimum standards to ensure consistency and improve the quality of life and level of protection of some of the most vulnerable people in society.

In addition to fulfilling its regulatory functions, the Commission is charged with other responsibilities, reflecting its position as a national body well-placed to monitor changes in the provision and quality of registered services across the country. It will provide information about registered services available to both the Government and the public. The Commission also has discretionary powers to investigate complaints which will inform its role as regulator, and it has a general duty to encourage improvements in the quality of registered services and it will be able to suggest ways in which services can be improved.

The Commission employs around 1400 staff and is funded via grant in aid from the Department of Health. The cost of setting up the NCSC was approximately £60 million. The NCSC's budget for 2002-03 is £132.5 million, which includes an indicative planning assumption of £32 million of fee income.

Special Health Authorities

Dental Vocational Training Authority

The DVTA exercises the functions of Health Authorities by allocating vocational training numbers to dentists who wish to practise unsupervised in the NHS General Dental Services to demonstrate that they satisfy the vocational training requirements. The Authority's gross expenditure in 2000-01 was £125,800. The Authority is entirely funded by Government. From October 2001 to September 2002 the DVTA issued 1,200 vocational training numbers. 68 applications for a vocational number were rejected in the same period. The Authority has two staff. For further information, contact Andrea Goring, Dental Vocational Training Authority, Master's House, Temple Grove, Compton Place, Eastbourne, East Sussex BN20 8AD; 01323 431189.

NHS Appointments Commission

The NHS Appointments Commission was established in April 2001 following the announcement in the NHS Plan and charged with ensuring that health authorities, NHS trusts and primary care trusts have the highest quality non-executive leadership. It achieves this by appointing the chairs and non-executive directors of these bodies, ensuring that annual appraisals are carried out in line with national procedures and that they are supported with appropriate training and development opportunities. In its first year of operation the Commission made over 1700 appointments. Details of the appointment process to local NHS boards adopted by the Commission were published in October 2001. A range of training initiatives was launched in January 2001, and a national appraisal process was established in March 2002. More recently, the Commission has also begun to make appointments to Department of Health national bodies on behalf of the Secretary of State. The Commission comprises the Chair, eight Regional Commissioners and the Chief Executive.

For further information, contact:
NHS Appointments Commission
Cheapside House
138 Cheapside
London
EC2V 6BB
Tel: 0207 615 9300
(for appointments to bodies in the former London, South, South West and Eastern Regions)

NHS Appointments Commission
Blenhiem House
Duncombe Street
West One
Leeds
LS2 7UE:
Tel: 0113 254 5611.
(for appointments to bodies in the former Northern and Yorkshire, North West, Trent and West Midlands Regions)

National Clinical Assessment Authority (NCAA)

The NCAA is a SHA which provides a support service to NHS Trusts, the Prison Health and Defence Medical Services when faced with concerns over the performance of an individual doctor or dentist. The NCAA's role is to support employers and clinicians and to boost patient confidence in the NHS.

In order to help doctors and dentists in difficulty, the NCAA will provide advice, take referrals and carry out targeted assessments where it is deemed necessary. Many cases are resolved locally following NCAA advice, however a small proportion of referrals progress to the assessment stage. Once an objective assessment has been carried out, the NCAA will advise on the appropriate course of action. The Authority was established as an advisory body and the employer organisations remain responsible for resolving the problem once the NCAA has produced its assessment.

The NCAA has doubled in workforce over the year and now employs around 50 people. In 2002-03 the NCAA has made progress by:

- Proving a full advice service which managed around 400 referrals.
- Undertaking a targeted number of prototype assessments to ensure that the Authority's process and procedures are fair, robust, transparent and effective.
- Further strengthening relations with stakeholders including the medical profession, NHS managers, patients' groups and other bodies leading the health service quality agenda.
- Widening its service coverage to include the NHS in Wales and the Prison Health and Defence Medical Services.
- Supporting the Chief Medical Officer in tackling the problem of unnecessary long term medical suspensions.

The NCAA's work programme for 2003 includes providing a full

assessment service to doctors and hospital dentists and taking forward its education and research and development strategies.

The NCAA's revenue expenditure was £4.3 million in the year to 31 March 2003.

For further information on the NCAA contact Simon Gregor at **sgregor@ncaa.nhs.uk**. Useful information on the role of the NCAA can also be found on the NCAA web at **www.ncaa.nhs.uk**. You can also write to the NCAA at its office which are located on the 9th Floor Market Towers, 1 Nine Elms Lane, London SW8 5NQ or phone 0207 2730850.

National Blood Authority (NBA)

The National Blood Authority is responsible for the management of the National Blood Service in England including:

- the collection of blood from voluntary donors, its processing, testing and supply to hospitals through its network of blood centres; and,
- the International Blood Group Reference Laboratory (IBGRL), which provides a reference service and issues diagnostic materials, and the Bio Products Laboratory (BPL), which makes therapeutic products from blood plasma and makes and issues diagnostic materials.

The Authority's gross expenditure in 2001-02 was £337 million which was largely recouped through blood handling charges to hospitals and through sales of BPL products. It employs around 5,560 staff. The Authority collected over 2.9 million units of blood in 2001-02 and supplied over 300 hospitals.

Further information, including summary financial statements, are included in the NBA's 2002 Annual Report which is available from the National Blood Authority, Oak House, Reeds Crescent, Watford WD1 1QA; 01923 486800. Website **http://www.blood.co.uk**.

National Treatment Agency (NTA)

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

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

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

Prescription Pricing Authority (PPA)

The PPA was established under the National Health Service Act 1977. Its purpose is to manage a range of services on behalf of the NHS that cannot be effectively undertaken by other types of health bodies. The Authority's main functions are to:

- calculate and make payments for amounts due to pharmacies and appliance contractors, and calculate amounts due to general practitioners, for supplying drugs and appliances prescribed under the NHS (over 600 million prescription items were processed in 2001-02);
- produce information for General Practitioners (GPs), Primary Care Groups/Trusts (PCGs/PCTs), Health Authorities (HAs), the Department of Health (DoH) and other NHS stakeholders about prescribing volumes, trends and costs;
- administer the NHS Low Income Scheme (LIS);
- issue Prescription Pre-payment Certificates (PPCs), and medical and maternity exemption certificates *(PPA assumed responsibility for this from 1 October 2002)*;
- produce the Drug Tariff containing the reimbursement prices of a range of prescribable items and other remuneration rules;
- deter prescription charge evasion, recovering unpaid charges and penalty charge payments from those who have incorrectly claimed exemption *(responsibility for this was transferred to the NHS Counter Fraud and Security Management Service from 13 January 2003)*;
- provide enquiry and analytical services to Health Authorities and others to inform and facilitate their monitoring role;
- administer the Pharmacy Reward Scheme *(responsibility for this was transferred to the NHS Counter Fraud and Security Management Service from 13 January 2003)*.

The Authority's gross expenditure in 2001-02 was £65.933 million of which the Department funded £62.125 million. As at 31 March 2002 the Authority employed approximately 2,300 staff (WTE) in nine locations in the North of England and the West Midlands. The Authority's corporate aims and strategy together with performance against key targets can be found in their Annual Report. For further information on the Authority contact Mr John Roberts, PPA Business Manager, Room 147, Richmond House, 79 Whitehall, London SW1A 2NS; **john.roberts@doh.gsi.gov.uk** 020 7210 5312 or visit the PPA website **www.ppa.org.uk**.

The Mental Health Act Commission (MHAC)

The Commission was set up in 1983 as an SHA with responsibility under the Mental Health Act 1983 for keeping under review the exercise of powers and discharge of duties conferred or imposed by the Act in respect of detained patients. It therefore seeks to safeguard the interests of all people detained under the Mental

Health Act 1983. Commissioners visit all hospital and mental nursing homes where patients are detained to make sure that the powers of the Act are being used properly, and to meet with detained patients to discuss their concerns. The Commission reports on its visits to hospital managers and requires follow-up action on issues of concern.

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

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

On behalf of the Secretary of State, the Commission administers the provision of Second Opinion Appointed Doctors (SOADs), whose authorisation is required for the administration of certain treatments without consent. It also receives and monitors reports on SOADs work. The Commission arranges over 8,500 SOAD visits each year.

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

The Commission is required to publish an Annual Report (September 2002) summarising the Commissions activities and expenditure, and has a statutory duty under the 1983 Act to publish and lay before Parliament a Biennial Report. The Ninth Biennial Report, covered the period 1999-2001 and was published in December 2001 detailing the Commissions functions, the discharge of that function and its findings on general issues in relation to detained patients.

The Department of Health directly funds the Commission. Its budget in 2002-03 was £3.72 million. The Commission employs 35 staff. For further information, contact Mat Kinton (Communications Manager), Mental Health Act Commission, Maid Marion House, 56 Hounds Gate, Nottingham NG1 6BG; 0115 9437106. The Commission's e-mail address is chief.executive@mhac.trent.nhs.uk and its website address is **http://www.mhac.trent.nhs.uk**.

Family Health Services Appeal Authority (Special Health Authority) (FHSAA(SHA))

The Family Health Services Appeal Authority (Special Health Authority) was established on 1 April 1995. In 2001-02, the Authority received £774,000 Government funding, and gross expenditure was £783,000. The Authority employs 14 staff (11 whole time equivalents). Its role is to perform quasi-judicial appellate and other functions, devolved to it by the Secretary of State, in connection with primary care trust decisions on family health services issues arising under the General Medical Services Regulations, General Dental Services Regulations, General Ophthalmic Services Regulations, the Pharmaceutical Regulations, family health services practitioners' terms of service with the NHS, and the NHS (Service Committee and Tribunal) Regulations. The Special Health Authority also provides support to the Family Health Services Appeal Authority which was introduced by the Health and Social Care Act 2001.

For further information contact Jenny Smith, Department of Health, Room 2N35A, Quarry House, Leeds LS2 7UE; 0113 254 5825, or from the website at **http://www.fhsaa.nhs.uk**.

Health Development Agency (HDA)

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

The Agency's gross expenditure in 2001-02 was £12.091 million of which £11.7 million was from the Department of Health. The Agency employed 123 staff in 2001-02. More information about the HDA can be obtained from Holborn Gate, 330 High Holborn, London WC1V 7BA; telephone: 020 7430 0850.

NHS Information Authority (NHSIA)

The NHS Information Authority was established as a SHA on 1 April 1999. The Authority, working in partnership with NHS professionals, suppliers, academics and others, is responsible for the provision of national products, standards and services to support the sharing and best possible use of information throughout the health service.

The Board of the NHSIA consists of a Chair, Chief Executive, three executive officers and four non-executive members. The Authority had 960 WTE staff as at 31 December 2002. Its gross operating cost in 2001-02 was £108 million of which the Department of Health funded £106 million.

Details of the Authority's key achievements are contained in its 2001-02 Annual Report. This report, together with more information about the Authority's activities, is available from the Authority's website at **http://www.nhsia.nhs.uk** or by contacting Steven Harrison, Head of Corporate Affairs, NHS Information Authority, Aqueous II, Waterlinks, Aston Cross, Rocky Lane, Birmingham B6 5RQ. Telephone 0121 333 0120, fax 0121 333 0150 or e-mail: steven.harrison@nhsia.nhs.uk.

The Retained Organs Commission

The Retained Organs Commission was established formally by the Secretary of State on 1 April 2001 as part of the progressive

implementation of 17 recommendations made by the Chief Medical Officer (CMO) in his report, *The Removal, Retention and Use of Human Organs and Tissue from Post-mortem Examination; Advice from the Chief Medical Officer.*[C2] This followed the organ retention findings from the inquiries at the Royal Liverpool Children's Hospital (Alder Hey) and at the Bristol Royal Infirmary.

As recommended by the CMO, the Commission oversees the proper return of retained organs and tissue to families who request it and to address the question of historical and archived collections obtained from post-mortem collections. The Commission:

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

The Commission provides a dedicated help-line which has handled more than 4,000 calls since April 2001. The Commission has issued comprehensive guidance to NHS Trusts on a wide range of issues relating to organ retention and has taken up over 500 cases on behalf of families where there were problems with the return of organs and tissue. It has also held 14 meetings in public in venues around the country (up to the end of January 2003). It has overseen investigations in Manchester and Birmingham and held four other public meetings in connection with these. It has prepared, or is preparing, leaflets on several areas of public interest involving organ retention. It published its first annual report in September 2002. The Commission's core budget for 2002-03 was £1 million.

Further information can be obtained from the Commissions' website at **www.nhs.uk/retainedorgans/** or contact the Communications and Media Manager, Janet Lewis@doh.gsi.gov.uk.

Microbiological Research Authority (MRA)

The MRA was established as a SHA in April 1994. The MRA oversees the work of the Centre for Applied Microbiology and Research (CAMR). CAMR is engaged in the investigation of highly infectious bacteria and viruses, and the production of bio-pharmaceutical products. Gross expenditure in 2001–02 was £34 million (£27 million revenue and £7 million capital) of which £11 million was funded by the Department of Health (£5 million revenue and £6 million capital). CAMR employs 387 staff. CAMR's corporate aims and strategy together with performance against key targets can be found in their Annual Report and Accounts. For more information about CAMR, contact Jan Ebdon, Department of Health, Skipton House, 80 London Road, London SE1 6LH; 020 7972 5570, or CAMR's website at **http://www.camr.org.uk**.

NHS Litigation Authority

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

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

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

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

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

The Authority's administration costs for 2001-02 amounted to £7.9 million. At 1 April 2002 it employed 145 staff. For further information on the NHSLA contact Tom Fothergill, Director of Finance, NHS Litigation Authority, Napier House, 24 High Holborn, London WC1V 6AZ; 0207 430 8705

NHS Logistics Authority

The NHS Logistics Authority was set up as a Special Health

Authority on 1 April 2000. The Authority's aim is to provide a quality range of consumable healthcare products and supply chain services for the benefit of the NHS. The Authority works in partnership with NHS trusts to help them to develop efficient supply channels; to maximise the use of NHS Logistics' consolidated supply route; to realise efficiencies and to make cost savings. The NHS Logistics Authority's gross expenditure in 2001-02 was £567 million. The Authority employs around 1,440 staff.

In 2001-02 The Authority:

- brought into operation a new distribution centre serving the South and West of England, under a Public Private Partnership arrangement with Excl Logistics;
- expanded the range of products stocked from 15,500 lines to 27,000 lines;
- developed and rolled out to trusts a new co-ordering service, Logistics OnLine;
- launched an e-billing service to trusts.

Details of the NHS Logistics Authority's other key achievements can be found in its 2001-02 Annual Report. More information about the Authority's activities, is available by visiting **http://www.logistics.nhs.uk**.

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

Dental Practice Board

The DPB is an independent statutory body supporting dentistry in England and Wales. Its main tasks are to handle payment claims and remunerate dentists providing General Dental Services and Personal Dental Services under the NHS. It provides an important check to detect and prevent potential fraud or abuse of the dental payments system. It also manages the Dental Reference Service, which provides independent professional dental patient examinations. At the end of 2001-02 the DPB employed 390 staff, and during the year approved fees amounting to almost £1.6 billion to an average 19,910 dentists, at a gross administration cost of £24.7 million. For further information contact the Chief Executive, Dental Practice Board, Compton Place Road, Eastbourne BN20 8AD; 01323 417000 or **http://www.dpb.nhs.uk**.

The National Patient Safety Agency (NPSA)

The National Patient Safety Agency (NPSA) was established as a special health authority on 2 July 2001. Its core function is to improve the safety of NHS patient care by promoting a culture of reporting and learning from adverse events, and to manage a national reporting system to support this function. The issues raised from the information received from the reporting system and from other information sources such as litigation and research will inform the choices and the development of safety solutions to reduce both the numbers of incidents that occur and the seriousness of the outcomes for patients.

The reporting and learning system was piloted in 28 hospitals and primary care units in 2001-02 and will undergo further testing and development in early 2003 prior to being implemented across the NHS from summer 2003. The NPSA issued its first Patient Safety Alert to the NHS on 23 July 2002, on preventing accidental overdose of intravenous potassium in hospitals.

The NPSA is funded by a grant from the Department and its gross expenditure during 2001-02 was £1.763 million. Sue Osborn and Susan Williams are the Joint Chief Executives of the Agency and may be contacted at 4-6 Maple Street, London W1T 5HD, telephone 020 7927 9500. Further information about the work of the NPSA is available in the Agency's annual report 2001-02, which can be obtained from its website at **www.npsa.nhs.uk**.

United Kingdom Transplant (UKT)

UK Transplant was formed on 12 July 2000 as a result of the Quinquennial Review of the former United Kingdom Transplant Support Service Authority (UKTSSA) which was established in April 1991. The results of the Review were published in February 2000 and made a number of recommendations relating to the operation of the Authority and its role in the 21st century. UKT supports organ transplantation throughout the UK and the Republic of Ireland. Its main objective is to facilitate the effective and equitable distribution of human organs for transplantation. The Department of Health funds UKT through a centrally held budget in Vote 1. Other UK countries contribute on the basis of agreed proportions. In 2001-02, the Authority employed around 110 WTE staff and its gross expenditure was £7.112 million. The Authority also operates and maintains the NHS Organ Donor Register, which is a computerised record of people who have registered their wish to be an organ donor. For further information on the Authority contact nicole.sutherland@uktransplant.nhs.uk or the Communications Directorate, UK Transplant, Fox Den Road, Stoke Gifford, Bristol BS34 8RR – Tel: 0117 975 7575.

National Institute for Clinical Excellence (NICE)

NICE is a SHA which was formally established in Febuary1999 to provide guidance for the NHS, patients and their carers on medicines, medical equipment and clinical procedures based on evidence of both clinical and cost effectiveness. NICE's initial work programme was agreed with the Department of Health and the National Assembly for Wales and was launched on 4 November 1999. This sets clear quality standards which the NHS will be expected to meet. The work programme consists of two main forms of guidance:

- guidance on the potential use of particular health interventions including new treatments such as pharmaceuticals, diagnostic procedures, health promotion activities, etc (appraisals); and
- guidance on best practice for treating particular clinical conditions (clinical guidelines and referral protocols).

NICE has an executive board consisting of four executive

members (Chief Executive, Director of Resources and Planning, Communications Director and Clinical Director) and seven non executive members. A Partners' Council of over 40 members representing the health professions, patient and carer interests, industry and academic bodies works with NICE to monitor progress against its work programme. NICE has completed 52 technology appraisals and 11 Clinical Guidelines from its inception to 31 December 2002.

NICE has two Appraisal Committees and during 2003-04 will be establishing a further committee.

NICE has six collaborating centres in Acute Care, Chronic Disease, Nursing and Supportive Care, Mental Health, Primary Care and Women and Children. Work is in progress to establish a seventh centre which will specialise in cancer. These centres enable NICE to produce clinical guidelines.

For further information contact Catriona Gregory at the Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE; 0113 254 5636 or the NICE website at **http://www.nice.org.uk**.

OTHER NHS BODIES

Tribunal Non-Departmental Public Bodies

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

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

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

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

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

Family Health Services Appeal Authority

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

The FHSAA deals with:

- appeals from practitioners against primary care trust discretionary decisions to refuse to admit them to a list, to remove them from a list, to set conditions on their admission to a list, or to contingently remove them from a list;
- applications from primary care trusts that practitioners removed from a list should be disqualified nationally from all primary care trust lists. (When considering an appeal from a practitioner the FHSAA can decide itself to disqualify nationally.);
- representations that PMS doctors seeking to exercise their preferential right of return to GMS should be prevented from so doing;
- requests from primary care trusts to extend certain suspensions beyond 6 months; and,
- requests to review its earlier decisions or earlier decisions of the NHS Tribunal.

The FHSAA hears appeals and applications from practitioners and primary care trusts in England and (from August 2002) Wales. A practitioner may appeal on a point of law to the Court against a FHSAA decision. For further information contact Jenny Smith, Department of Health, Room 2N35A, Quarry House, Leeds LS2 7UE; 0113 254 5825.

Mental Health Review Tribunals (MHRTs)

MHRTs are independent judicial bodies and their role is to review the continued compulsory detention of patients under the Mental Health Act 1983. Members of the Tribunal are appointed by the Lord Chancellor. There is a legally qualified Tribunal chairman for each of the four 'Tribunal Regions' in England. They are responsible for the members within their region. There is a Tribunal office in each of the these regions. The office of the national secretariat is in London. The MHRT employs a total of 73 Department of Health staff who arrange hearings in hospitals and units throughout England. Staff at local and national level also provide administrative support to the regional chairmen. In 2001-02 there were 20,179 applications and 11,091 hearings. Administrative running costs, including salaries were £1.84 million. The costs for the membership were £11.1 million. For more information about MHRT contact Margaret Burn, Head of the MHRT Secretariat, NHS Executive, Wellington House, 135-155 Waterloo Road, London SE1 8UG; 020 7972 4577/4503.

The Protection of Children Act Tribunal

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

Registered Homes Tribunal

This Tribunal was established under the Registered Homes Act 1984 but will cease to exist once all appeals brought under that Act have been determined. The functions of the Tribunal have now transferred to the Care Standards Tribunal and since April costs and provision of the Secretariat have been met under the CST arrangements.

The Care Standards Tribunal

The Care Standards Tribunal is an independent judicial body that became operational from 1 April 2002. Although legally it is the Tribunal established under the Protection of Children Act 1999, the functions of the tribunal provided under that Act were extended by other legislation. This includes the Care Standards Act 2000, the Children Act 1989 (as amended by the Care Standards Act and the Education Act 2002); the Criminal Justice and Court Services Act 2000 and; the Education Act 2002.

The Care Standards Tribunal hears appeals in relation to: decisions made by the National Care Standards Commission, and the National Assembly for Wales in respect of the registration of establishments and agencies and refusal to waive disqualification from running or being involved in a children's home; decisions of the Chief Inspector of Schools in England and the National Assembly for Wales in respect of the registration of child minders and day care providers for children; decisions of the Secretary of State for Health in respect of inclusion on the list of those considered unsuitable to work with children; decisions of the Secretary of State for Education and Skills in respect of prohibition or restriction of employment in Schools.

Once other underlying regulatory schemes have been commenced the Tribunal will also hear appeals against: decisions of the General Social Care Council and the Care Council for Wales in respect of the registration of social workers and social care workers; decisions of the Chief Inspector of Schools in England in relation to the registration of Early Years Child Care Inspectors and Nursery Education Inspectors; decisions of the Secretary of State for Education and Skills in respect of the registration of independent schools, decisions of the Secretary of State for Health in respect of inclusion on the list of those considered unsuitable to work with vulnerable adults and; applications for the removal from the PoCA list and revocation of Court orders barring individuals from working with children.

The Tribunal has a full time President appointed by the Lord Chancellor. The legal and lay members of the Tribunal are also appointed by the Lord Chancellor. The Department of Health provides the Secretariat for the Tribunal which is located in central London.

In the six-month period 1 April to 31 October, the Tribunal received 97 appeals (including ongoing RHT appeals – see below), 58 or which were withdrawn before the hearing. The Tribunal heard 20 appeals in this period. The costs of the Tribunal were £300k. This includes expenditure on setting up the tribunal, accommodation expenditure, training costs for members and administration costs. For further information contact Barbara Erne, Secretary to the Tribunal, Care Standards Tribunal, 18 Pocock Street, London SE1 0BW. Tel: 0207 960 0664.

National Health Service Tribunal (NHST)

The NHS Tribunal has been abolished in England and Wales.

Commission for Health Audit and Inspection – (See also CHI)

CHI, in addition to the Audit Commission and the National Care Standards Commission, plays an important and effective role in regulating and assessing healthcare performance. Whilst each has made an important contribution to improving standards, the current fragmentation in the structure of NHS inspection can lead to unnecessary bureaucracy and confusion about how well the NHS is performing.

The Government has therefore announced its intention to establish a tough, new independent healthcare inspectorate: the Commission for Healthcare Audit and Inspection (CHAI). The work of CHI will form as a strong foundation for the work of the new inspectorate body which will be formed by bringing together functions of CHI, the National Care Standards Commission and the Audit Commission. Legislation to create the new body will be introduced as soon as parliamentary time allows.

Commission for Patient and Public Involvement in Health (CPPIH)

CPPIH was set up on 1 January 2003. CPPIH is responsible for funding, supporting and managing Patients' Forums and the delivery of ICAS. Through contract with local networks of voluntary and community organisations, it will provide staff to support PCT Patients' Forums. It will be a powerful means of aggregating and promoting information picked up from the work of Patients' Forums and from the delivery of ICAS. It will use this information to advise the Secretary of State and other bodies. It also has a duty to report any issue of concern that it becomes aware of regarding patient safety or welfare to the appropriate bodies. It also has the power to conduct national reviews of issues identified by Patients' Forums as being of concern.

Its board is made up of 10 non-executive Commissioners and a Chair. It has a Chief Executive and some temporary staff and is currently recruiting permanent employees. For information about the Commission contact Laura McMurtrie (Chief Executive) at 9th Floor, Ladywood House, 45 Stephenson Street, Birmingham B2 4DY. Further information can be obtained from CPPIH's website at **www.cppih.org** or by emailing **information@cppih.nhs.uk**.

Commission for Social Care Inspections

On 19 April 2002 the Secretary of State for Health announced plans to establish two new independent inspectorates: the Commission for Social Care Inspection (CSCI) and the Commission for Healthcare Audit and Inspection (CHAI). These new bodies will further strengthen the system for inspecting health and social care,

ensure clearer public accountability and rationalise the number of bodies regulating health and social care.

The Commission for Social Care Inspection will create a single comprehensive Inspectorate for social care, bringing together the inspection functions of the Social Services Inspectorate and the National Care Standards Commission and including the regulation of social care providers. The Inspectorate will be independent of the Government. Commissioners will be appointed by an independent appointments commission, rather than Ministers. The Inspectorate will:

- carry out local inspections of all social care organisations – public, private, and voluntary – against national standards and publish reports;
- register services that meet national minimum standards;
- carry out inspections of local social service authorities;
- publish an annual report to Ministers and Parliament on national progress on social care and an analysis of where resources have been spent;
- validate all published performance assessment statistics on social care;
- publish the star ratings for social services authorities; and,
- undertake independent scrutiny of complaints.

The new Inspectorate will be staffed mainly by people currently employed by the National Care Standards Commission and the Social Services Inspectorate. They will continue their existing work until the new body goes live in 2004. The Inspectorate will be of a size that is fit for the purpose, without imposing more burdens on front-line staff or creating unnecessary bureaucracy.

Council for the Regulation of Health Care Professionals (CRHCP)

CRHCP is being established as a key part of the drive for greater co-ordination and accountability in professional self-regulation. CRHCP was established in law in June 2002 by the NHS Reform and Health Care Professions Act and will become fully operational in 2003.

Professional self-regulation in health care provides independent standards of training, conduct and competence for each profession to protect the public and to guide workers and employers.

CRHCP was proposed in the NHS Plan and its functions have been shaped by the Kennedy report into Children's Heart Surgery at the Bristol Royal infirmary. The new Council will oversee the nine regulatory bodies who regulate all health care. They are the:

- General Medical Council;
- General Dental Council;
- General Optical Council;
- Nursing and Midwifery Council;
- Health Professions Council;
- General Chiropractic Council;
- General Osteopathic Council;
- Royal Pharmaceutical Society of Great Britain; and
- The Pharmaceutical Society of Northern Ireland.

CRHCP's role is to promote the interests of patients and the public in the way that these regulators do their work. Its main functions will include formulating principles of good regulation and helping the regulators conform to them in a consistent manner. It will publish an annual report on the performance of the professional regulation system.

For further information on CRHCP contact Tim Lund (0113 254 5046) or Paul Atkinson (0113 254 5311) of the Health Regulatory Bodies Branch, or e-mail *Tim.lund@doh.gsi.gov.uk.*

Counter Fraud Service

The NHS Counter Fraud Service (CFS), a specialist directorate, was established in September 1998 with a remit to counter fraud and corruption in all areas of NHS spending and subsequently to counter fraud and corruption in the Department of Health. The strategic document Countering Fraud in the NHS, published in December 1998, sets out the comprehensive, integrated and professional approach to tackling all fraud and corruption in the NHS. The high level aims are to reduce fraud to an absolute minimum and hold it permanently at that level, releasing resources for better patient care and services. The NHS CFS also has similar responsibilities on behalf of the National Assembly for Wales.

From 1 April 2003 all these responsibilities will be transferred to a Special Health Authority, the Counter Fraud and Security Management Service, which was established on 1 January 2003.

For further information on the NHS CFS contact the Executive Office, Hannibal House, 7th Floor, Elephant & Castle, London SE1 6TE; 020 797 22505.

Health Protection Agency

The Health Protection Agency was established as a Special Health Authority on 1 April 2003. It has responsibility for a range of health protection functions provided under the NHS Act and previously carred out by other bodies. These functions were detailed in the consultation paper *Health Protection: A Consultation document on Creating a Heath Protection Agency*[C3]. In England the SHA will be responsible for the functions that were previously performed by:

- the Public Health Laboratory Service (but not in general its clinical diagnostic microbiology services, which are transferring to the NHS);
- the Microbiological Research Authority;
- the National Focus for Chemical Incidents, Regional Service Provider Units and the National Poisons Information Service;
- the health protection functions provided by consultants in

communicable disease control and other health protection staff;

- the advice and other functions provided by regional health emergency planning advisers and their staff.

It will have an estimated gross turnover of £180m; and will employ approximately 2,700 staff.

If legislative time allows, it is planned to establish the HPA as an executive non-departmental public body (NDPB). At this point it is intended that it will take on both the functions of the new SHA (which will be wound up) and the other functions detailed in the consultation paper *Health Protection: A Consultation Document on Creating a Health Protection Agency*[CD] (chiefly advice on radiological protection currently carried out by the National Radiological Protection Board). When it is established as an NDPB it will have an estimated gross turnover of approximately £200 million; and will employ about 3,000 staff. Contact: Edward Goff, Department of Health, room 601a Skipton House, 80 London Road, Elephant and Castle, London SE1 6LH.

Medicines and Healthcare Products Regulatory Agency (NHRA)

Now an Executive Agency of the DoH – see **Annex B**.

NHS University (NHSU)

NHSU is the organisation set-up by the Department of Health to establish a university for the NHS. This is a major undertaking and will help focus education, training and development within the NHS giving more people more opportunities to improve the way we provide patient care.

NHSU is currently a 'hosted service' within the Department of Health. At present NHSU has no independent legal status. The Prescription Pricing Authority provides financial and HR services for NHSU under a service level agreement. The staff of NHSU are currently employed by or seconded to the Prescription Pricing Authority.

The aim is that by October 2003, NHSU should be constituted as a Special Health Authority. A Chair and governing body, the main board, will be established to reflect the special status of the NHSU and an Academic Strategy Board will be established to ensure the quality and integrity of the curriculum operating independently of the main board.

NHSU also intends to consider establishing a company, limited by guarantee, as a trading arm, to act commercially to secure the benefits of NHSU's products and services, including intellectual property, for the NHS and the UK.

In the longer term, NHSU aims to seek university status. Governance arrangements will be put in place for NHSU that are fully consistent with this aim. The governance structures will also be designed to ensure appropriate representation of the views and opinions of major stakeholders, including those of patients and staff.

The Department of Health, Director of Human Resources, is the NHSU sponsor Director. The Human Resources Directorate is responsible for the performance management of NHSU.

For further information contact Jane Hare, Department of Health, Room 2E46, Quarry House, Leeds LS2 7UE; 0113 254 6121, or from the website at **http://www.nhsu.nhs.uk**.

Postgraduate Medical Education and Training Board (proposed)

The NHS Plan set out the Department's intention to establish a Postgraduate Medical Education and Training Board (PMETB) to oversee the supervision and certification of postgraduate medical education and training. The new body will be an independent competent authority covering the whole of the UK. It will have the general duty of supervising postgraduate medical education, ensuring that it raises standards and quality wherever possible. It will replace the Specialist Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

A public consultation took place between November 2001 and February 2002 on the paper. 'Postgraduate Medical Education and Training: The Medical Education Standards Board.' Major stakeholders were consulted. As a result, the 'Statement on Policy' was published in July 2002. This document was well received generally. The policy has been translated into a draft Order (The General Medical Practice and Specialist Medical Education, Training and Qualifications Order) which will establish PMETB as a statutory body. This was published for statutory consultation on 4 November 2002.

The closing date for the consultation period for the draft PMETB legislation was 27 January 2003. The parliamentary process is currently underway. The Order will be debated in the Houses of Commons and Lords and also by the Scottish Parliament.

Details of the draft Order establishing PMETB can be found at **www.doh.gov.uk/medicaltrainingintheuk**.

ANNEX D

Public Accounts Committee – Reports Published in 2002

Seven PAC reports have been published in the calendar year of 2002. For each report a Treasury Minute has been produced (a Treasury Minute is the Government's considered response to a PAC report).

The list of PAC reports, with date of publication, is as follows:

1. Tackling Obesity in England — 16 January 2002
2. Educating and Training the Future Health Professional Workforce in England — 8 March 2002
3. Handling Clinical Negligence Claims in England — 13 June 2002
4. NHS Direct in England — 10 July 2002
5. Inpatient and Outpatient Waiting in the NHS — 18 September 2002
6. Inappropriate Adjustments to NHS Waiting Lists — 18 September 2002
7. The Management of Surplus Property by Trusts in the NHS in England — 19 September 2002

1. Tackling Obesity in England

The Committee concluded that: it is on a worldwide epidemic scale; tackling obesity requires a twin track approach of prevention and management; a cross Government approach within the UK and with local strategies in primary care settings.

Action taken on PAC conclusions and recommendations includes:

- The Coronary Heart Disease National Standard Framework (CHD NSF) sets standards and specific milestones for action on local programmes of effective policies on reducing overweight and obesity.
- DfES, DCMS and Sport England are working to develop PE and sport in schools and the wider community and have a PSA target.
- Initiatives to improve diet and nutrition include the five-a-day programme, five-a-day local community initiatives, the National School Fruit Scheme, the National Healthy School Standard and the Food in Schools Programme. There are initiatives with the food industry to improve the overall balance of diet including salt, fat and sugar in food.
- DfES confirms that there are clear guidelines in place concerning commercial advertising and sponsorship in schools. FSA are also funding a systematic review of promotion of foods to children.
- Partnership working, between Local Authorities, PCTs and other key stakeholders, is encouraged through Local Strategic Partnerships and/or other linked partnership arrangements.
- The Department for Transport's Local Transport Plan funding will provide opportunities to make cycling more accessible.
- There is improved co-ordination across Government on issues relating to sport and physical activity, at Ministerial and official levels. Ministers for Health, Transport, Education and the Chief Executives of Sport England and the New Opportunities Fund meet monthly.

2. Educating and Training the Future Health Professional Workforce in England

The Committee concluded that the key to success to meeting the NHS Plan, for the numbers of nurses and other health professionals, was partnership working between the NHS, the higher education sector and through membership of the new Workforce Development Confederations. There was also a need to improve the value for money from the training arrangements and improve recruitment, retention and returners.

Action taken on PAC conclusions and recommendations includes:

- A Workforce Planning Framework and associated toolkit are being developed to ensure that workforce planning is fully integrated with local health community service and financial plans.
- The Department will also:
  - ensure by April 2004 that all NHS employers will be accredited under the Improving Working Lives standard;
  - set return to practice targets for 2002;
  - conduct further national, regional and local recruitment campaigns targeted at recruits and returners; and,
  - develop specific action plans to tackle shortages in midwifery and therapeutic radiography.
- The move to a national standard contract and the adoption of standardised prices for NHS funded education and training will free Higher Education Institutions and Workforce Development Confederations from much time wasting negotiation, and will permit the development of new co-operative partnerships to support Education and Training.
- Various measures have been taken to minimise attrition including; new, better tailored and more flexible pathways to support existing staff through education with step on and step off points; continued development of rigorous selection procedures; childcare support for all health professional students with 0-5 children by 2004; bursaries for NHS funded students, increases in basic NHS bursaries from September 2001.

3. Handling Clinical Negligence Claims in England

The Committee concluded that the NHS and the legal system had failed to deal with patients who had suffered injury with speed and compassion; that the value of claims is rising; and that there was a need to reduce the incidence of negligence in the first place.

Action taken on PAC conclusions and recommendations includes:

- The Chief Medical Officer, Professor Liam Donaldson, has reviewed a wide range of options to tackle the complex issues involved in improving the present system for handling clinical negligence claims; these are under consideration by Ministers. The Government hopes to publish proposals for reform soon.
- One way of reducing incidences of clinical negligence, in the first place, is by improving the overall quality and safety of care and services provided to patients. Some of the recent quality initiatives include:
  - national standard setting (for example, through National Service Frameworks and the National Institute of Clinical Excellence (NICE));
  - dependable local delivery (for example, through clinical governance and professional self-regulation); and
  - monitoring standards (for example, through performance management and external assessment – the Commission for Health Improvement (CHI), National Patient Safety Agency (NPSA) and National Clinical Assessment Authority (NCAA)).

4. NHS Direct in England

Overall the Committee concluded that NHS Direct had quickly established itself as the world's largest provider of healthcare advice by telephone and had a good safety record. However, the Department needed to set a clear strategic direction for the service in order to avoid it becoming a victim of its own success by trying to do to much at once. Awareness of NHS Direct remained too low for certain groups within the population and that some callers waited too long to speak to a nurse.

Action taken on PAC conclusions and recommendations includes:

- A review of the organisational structure of NHS Direct with recommendations is expected to be published in May 2003.

NHS Direct is also:

- Increasing the overall nursing workforce.
- Developing a human resources strategy.
- Introducing a telephony intelligent network, a number of data centres and queue sharing capabilities which facilitates a virtual call centre.
- Has identified and set productivity target improvements of 30 per cent by March 2003.
- Guidance on working with Black and Minority Ethnic Communities has been issued to each NHS Direct site.

5. Inpatient and Outpatient Waiting in the NHS

The Committee concluded that reduction in waiting lists and times were required and that this needed a change in culture and working practices. Patients and GPs needed accurate information to provide a real choice of where to go for examination and treatment.

Action taken on PAC conclusions and recommendations includes:

- The Department has set challenging waiting times targets which will contribute to overall reductions in waiting times for the whole patient journey. In addition, the Department has set targets for the overall waiting time for cancer.
- The Department has taken action to improve data quality and ensure correct reporting, including:
  - Showing measures of data quality in performance ratings;
  - Writing directly to chief executives, to reinforce the importance of on-going waiting list validation;
  - Publishing best practice guidance on validation;
  - Strengthening expert help and support for reporting organisations;
  - Bringing key guidance on reporting together in one place.
- The Modernisation Agency has been running the primary targeting list approach to ensure the best practice of the management of waiting lists. They have also had a considerable amount of success in the Action-On programmes where outpatient waiting times have been reduced significantly.
- The Department has introduced a new NHS resource allocation mechanism so that decisions on funding are made closer to the services provided.
- New arrangements for paying hospitals which were announced in *Delivering the NHS Plan*[D1] and set out in more detail in *Reforming NHS Financial Flows*[D2] are also designed to help PCTs and Trusts locally to tackle long wait areas.
- The Changing Workforce Programme has worked very closely with the Royal Colleges to review work roles to improve patient care and make better use of staff skills and time.
- The Government set out within the NHS Plan how, by the end of 2005, all patients and their GPs will be able to book hospital appointments for both a time and a place that is convenient to the patient. This is the aim of the 'National Booked Admissions Programme; Access, Booking and Choice'.

6. Inappropriate Adjustments to NHS Waiting Lists

The Committee concluded that in at least 10 hospitals, managers and staff made inappropriate adjustments to their waiting list data and that the Department did not know to what extent patients' health had suffered. Arrangements for identifying and disciplining those involved fell short of good practice. The Department should outlaw confidentiality clauses that prevent full disclosure of circumstances to other employers.

Action taken on PAC conclusions and recommendations includes:

- NHS trusts have been advised that clinical priority must be the main determinant of when patients are seen and that any mis-reporting of figures is treated as being very serious indeed.
- The use of confidentiality clauses in contracts of employment is not contrary to the Department's or Public Interest Disclosure Act 1998, but employers will be asked to seek legal advice regarding the need for a confidentiality clause.
- Action has been taken to improve data quality and ensure correct reporting. The Department has introduced independent spot checks on waiting list statistics by hospital. These spot checks are being undertaken by the Audit Commission.
- The establishment of the Commission for Healthcare Audit and Inspection (CHAI) is underway. CHAI will inspect all NHS and private healthcare and will review the quality of patient care and how well the NHS is using its funds. New CHAI will be independent of both government and the NHS and will produce an annual report direct to parliament. CHAI is likely to operate in shadow form during 2003 and be formally established by April 2004.
- In response to introducing a standard format for future investigation, in addition to spot checks, the Department has introduced trigger analysis aimed at exposing future cases, and a framework to be followed where there is evidence or strong suspicion of serious malpractice. The framework will support trusts in handling disciplinary cases.
- To prevent re-employment of those involved who resign, the Department has issued a Code of Conduct for Managers. Providing false information is one of several serious breaches of the Code and could lead to dismissal. On making proper and detailed checks on all prospective employees, it would be virtually impossible for an NHS employer to unknowingly employ a manager who had left for disciplinary reasons.

7. The Management of Surplus Property by Trusts in the NHS in England

The Committee concluded that estate strategies should pay particular attention to the longer term operational and accommodation needs of the NHS and the wider public sector. The Department and NHS Estates should ensure all Trusts have 'exemplar standards' strategies and that they maintain good contact with local authorities and local planners.

Action taken on PAC conclusions and recommendations includes:

- A NHS Housing Co-ordinator within NHS Estates has been appointed to ensure that the NHS Plan's targets for the provision of key worker accommodation, particularly in London, are met.
- A target of 31 December 2002 was set for all Trusts to have estate strategies to 'exemplar standard' that have been approved by the Trust board.
- An Estate and Investment Plan has been prepared for each Strategic Health Authority which will assist in deciding on the priorities for NHS spending within the wider local health economy.
- The Department's guidance on disposals, Estatecode, has been amended to emphasise when clawback (where there is potential for development at a later date) should be included in sales.

ANNEX E

Spending on Publicity and Advertising and Income from Sponsorship 2002-03 (Estimate)

The Department runs a number of publicity campaigns each year and the forecast outturn for 2002-03 is estimated to be £39 million. The main components included in this total are given below.

New activities in 2002-03 were:

- A new Adult Sexual Health campaign entitled *The Sex Lottery* aimed at 18-30 year olds warning them of the risk of contracting Sexually Transmitted Infections (STIs) through unprotected sex. This fulfils the commitment in the Sexual Health Strategy published in summer 2001;
- A six-month pilot 'contact strategy' to test the success of individually tailored programmes for smokers who want to give up. Plus a campaign targeted at families and friends of pregnant smokers to assist mothers to be in giving up smoking; and
- A revised award winning campaign to recruit social workers.

Responsibility for publicity and advertising on Organ Donation will transfer to UK Transplant on 1 April 2003.

Sponsorship

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

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

The following amounts have been received in the past financial year as sponsorship "In-kind", i.e. the provision of goods or services to support a campaign or other activity.

Sponsor	Amount received	Support received
Superdrug	£117,000	Publicising the Teenage Pregnancy campaign in-store
Durex	£105,000	Publicising the Teenage Pregnancy campaign
So Fragrance	£82,000	Provision of publicity materials to support the Teenage Pregnancy campaign in Boots and Superdrug stores
Durex	£40,000	Provision of free condoms to support the Adult Sexual Health campaign
Mates	£40,000	Provision of free condoms to support The Adult Sexual Health campaign
BBC	£40,000	Website presence for Teenage Pregnancy campaign on Radio 1 and *So* Websites
Mykindplace.co.uk	£26,500	Website presence for Teenage Pregnancy campaign
Stabilo	£23,000	Supporting the Teenage Pregnancy campaign
Sugar magazine	£10,000	Website presence for Teenage Pregnancy campaign
Guardian newspaper	£6,800	Advertising space to publicise the Health and Social Care award

Figure E1: Departmental Spending on Publicity and Advertising and Sponsorship 2002-03

Campaigns run by the Department	£ million
Smoking (Tobacco Information)	11.5
Workforce	5.2
Teenage Pregnancy	4.0
Child Immunisation	3.0
Flu Immunisation	2.5
Mental Health	1.8
Drugs	1.7
Sexual Health	1.5
Social Workers Recruitment	1.5
NHS Direct	1.4
Children's Services	1.0
Organ Donation	0.7
Health Care Abroad	0.7
Older People (inc Keep Warm, Keep Well)	0.6
Cancer Screening	0.6

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Glossary

Acute Services

Medical and surgical interventions provided in hospitals.

Accruals accounting

Accruals accounting recognises *assets* or *liabilities* when goods or services are provided or received – whether or not cash changes hands at the same time. Also known as "the matching concept", this form of accounting ensures that income and expenditure is scored in the accounting period when the "benefit" derived from services is received or when supplied goods are "consumed", rather than when payment is made.

Annually Managed Expenditure (AME)

In agreeing the longer-term *Departmental Expenditure Limit (DEL)* with the Treasury, it will be found that some areas of a government department's expenditure may be less predictable and liable to fluctuate more in the period covered by the DEL. Because a shorter-term view will be required in such areas, a separate, annual spending limit will be imposed in such areas. *Subheads* containing this sort of expenditure will be outside of the DEL and categorised separately as Annually Managed Expenditure (AME).

Block Capital

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

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

Capital

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

Capital Charges

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

Central Health and Miscellaneous Services

These are a wide range of activities funded from the Department of Health's spending programmes whose only common feature is that they receive funding direct from the Department of Health, and not via Health Authorities. Some of these services are managed directly by Departmental staff, others are run by non-Departmental public bodies, or other separate executive organisations.

Community Care

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

Consolidated Fund

The Government's general account at the Bank of England. Tax revenues and other current receipts are paid into this Fund. Parliament gives statutory authority for funds to be drawn from the Consolidated Fund to meet most expenditure by the Government.

Cost of Capital

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

Credit Approvals

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

Departmental Expenditure Limit (DEL)

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

Depreciation

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

Discretionary

Expenditure subject to cash limit controls.

Distance from target

The difference between a Health Authority's allocation and its target fair share of resources informed by the weighted capitation formula.

Drugs Bill

Drugs bill gross expenditure is the cash amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs medicines and certain listed appliances which have been prescribed by NHS practitioners. Net drugs bill expenditure is less Pharmaceutical Price Regulation Scheme (PPRS) receipts. Funding is subject to local resource limits and forms part of PCTs' HCHS discretionary allocations.

Estimated Outturn

The expected level of spending or income for a budget, which will be recorded in the Department's Accounts.

Estimates

See *Supply Estimates*.

European Economic Area

The European Community countries plus Norway, Iceland and Liechtenstein.

Executive Agencies

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

External Financing Limits (EFLs)

NHS trusts are subject to public expenditure controls on their spending. The control is an external financing limit (EFL) issued to each NHS trust by the NHS Executive. The EFL represents the difference between the resources a trust can generate internally (principally retained surpluses and depreciation) and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the internal resources are more than the capital spend then the money is used to meet any due repayments of debt principal on the trust's ordinating capital debt and Secretary of State loans, with an excess being invested.

Family Health Services (FHS)

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department of Health following consultation with representatives of the relevant professions, and administered locally by Primary Care Trusts (PCTs). Funding of the FHS is demand led and not subject to in year cash limits at Primary Care Trust level, though FHS expenditure has to be managed within overall NHS Resources. The exceptions to this are certain reimbursements of GMS GPs' practice staff, premises, out of hours and IM&T expenses payable to doctors in general practice (GMS discretionary spending), the costs of administration, and expenditure on drugs and appliances by GPs. Funding for these items is included in Primary Care Trusts' (HCHS) discretionary allocations.

General Dental Services (GDS)

The GDS offers patients personal dental care via General Dental Practitioners (GDPs), who work as independent contractors from High Street and local surgeries. Although the GDS is administered by PCTs as part of the Family Health Service, GDPs are engaged under a uniform national contract. Funding is provided from the national demand led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

General Medical Services (GMS)

These are services covered by contract arrangements agreed at national level by GPs to provide one to one medical services, for example: giving appropriate health promotion advice, offering consultations and physical examinations, offering appropriate examinations and immunisations.

Non-discretionary GMS expenditure includes all demand led item of service payments such as capitation payments, health promotion and basic practice allowance.

Funding for this is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation. Discretionary GMS expenditure includes reimbursement of GMS GPs' practice staff, premises, out of hours and IM&T expenses. Funding for this is subject to local resource limits and forms part of PCTs' discretionary allocations.

General Ophthalmic Services (GOS)

The GOS offers priority groups of patients free NHS sight tests or vouchers to help with the purchase of glasses. NHS sight tests are mainly available to children, people aged 60 or over, adults on low income, or people suffering from or predisposed to eye disease. NHS optical vouchers are mainly available for children, adults on low incomes, and those who need certain complex lenses. Services are provided by optometrists and ophthalmic medical practitioners who work as independent contractors from High Street opticians. Although the GOS is administered by PCTs as part of the Family Health Service, optical contractors are engaged under a uniform national contract. Funding is provided from the national demand led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation.

Gross Domestic Product (GDP) Deflator

The official movement of pay and prices within the economy that

is used for expressing expenditure in constant (real) terms. The series is produced by HM Treasury, and the one used in this report is that published in April 2003.

Gross/Net

Gross expenditure is the total expenditure on health services, part of which is funded from other income sources, such as charges for services, receipts from land sales and income generation schemes. **Net** expenditure (gross minus income) is the definition of "public expenditure" most commonly used in this report, since it is the part of the total expenditure funded by the Exchequer.

Health Action Zone (HAZ)

An initiative to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people.

Health Authority (HA)

The Health Authority (HA) is responsible within the resources available for identifying the health care needs of its resident population, and of securing through its contracts with providers a package of hospital and community health services to reflect those needs. The Health Authority has a responsibility for ensuring satisfactory collaboration and joint planning with the Local Authority and other agencies.

(Note: HAs were superseded by the establishment of Strategic Health Authorities (SHAs) – see separate entry.)

Health Improvement Programmes

An action programme to improve health and health care locally and led by the Health Authority. It will involve NHS trusts, Primary Care Groups, and other primary care professionals, working in partnership with the local authority and engaging other local interests.

Hospital and Community Health Services (HCHS)

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by Health Authorities and provided by NHS trusts. HCHS provision is discretionary and also includes funding for those elements of FHS spending which are discretionary (GMS discretionary expenditure). It also covers related activities such as R&D and education and training purchased centrally from central budgets.

NHS Trusts

NHS trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as represented by Health Authorities and GPs.

National Insurance Fund

The statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid, and from which expenditure on most contributory social security benefits is met. The NHS also receives an element of funding from this.

Non-Discretionary

Expenditure that is not subject to a cash limit, mainly "demand led" family health services, including the remuneration of general medical practitioners, the cost of general dental and ophthalmic services, dispensing remuneration and income from dental and prescription charges.

Outturn

The actual year end position in cash terms.

Personal Dental Services (PDS)

PDS offers patients personal dental care equivalent to that provided by General Dental Practitioners within the Family Health Services, but within a more flexible framework of local commissioning. PCTs can contract with practitioners or other providers to provide patient services but are free to negotiate and set contract terms which best suit local circumstances and priorities. Where services have converted from GDS contracts, a transfer is made on an annual basis from the General Dental Services non-discretionary budget and allocated to the individual PCT's discretionary budget. PCTs can also commit other funding from their HCHS discretionary allocations or integrate more specialised elements of former Community Dental Services into PDS schemes. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

Personal Medical Services (PMS)

A PMS contract is locally agreed between the commissioner and the provider. This means that primary care service provision is responsive to the local needs of the population. As a result PMS has been successful in reaching deprived and under-doctored areas. Many PMS pilots focus on the care of vulnerable groups, including homeless, ethnic minorities, and mentally ill patients. A transfer is made on an annual basis from the General Medical Services Non-discretionary to a PMS discretionary budget. PCTs can also commit other funding for PMS pilots, as appropriate, from their HCHS discretionary allocations.

Personal Social Services (PSS)

Personal care services for vulnerable people, including those with special needs because of old age or physical disability and children in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and

social workers who provide help and support for a wide range of people.

Pharmaceutical Services (PhS)

Pharmaceutical Services cover the supply of drugs, medicines and appliances prescribed by NHS practitioners. Gross PhS expenditure includes total drugs bill costs (see Drugs Bill definition) and dispensing costs. Dispensing costs is the remuneration paid to contractors for dispensing prescriptions written by NHS practitioners. This includes payments to pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items. Net PhS expenditure is the gross expenditure less associated income from prescription charges.

As stated in the drugs bill definition funding for the total drugs bill is subject to local resource limits and forms part of PCTs' HCHS discretionary allocations. However, funding for dispensing costs is provided from the national demand led or non-discretionary budget, and is not subject to local resource limits and does not form part of a PCT's HCHS discretionary allocation.

Primary Care

Family health services provided by family doctors, dentists, pharmacists, optometrists, and ophthalmic medical practitioners.

Primary Care Trust (PCT)

Primary Care Trusts are the new free standing, statutory bodies with new flexibilities and freedoms. They have the same overall functions as Primary Care Groups but also are able to directly provide a range of community health services, thereby creating new opportunities to integrate primary and community health services as well as health and social care provision.

Private Finance Initiative (PFI)

The use of private finance in capital projects, particularly in relation to the design, construction and operation of buildings and support services.

Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, eg estimates for clinical negligence liabilities. Provisions are included in the accounts to comply with the accounting principle of prudence. An estimate of the likely expense is charged to the *income & expenditure* account (for the Department, to the *Operating Cost Statement*) as soon as the issue comes to light, although actual cash payment may not be made for many years, or in some cases never. The expense is matched by a balance sheet provision entry showing the potential *liability* of the organisation.

Real Terms

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

Regional Offices

The eight NHS Executive Regional Offices were established on 1 April 1996. These offices are responsible for developing the commissioning function in the health service and for monitoring the financial performance of the NHS trusts. The Regional Offices took on the non-statutory functions of the Regional Health Authorities following their abolition on 1 April 1996.

Request for Resources (RfRs)

Under the Resource Budgeting system, a Department's Supply Estimate will contain one or more requests for resources (RfRs). Each request for resources will contain a number of *Subheads*. A request for resource specifies the combined cash and non-cash financing requirement of the Department in order to provide the range of services contained in its *Subheads*.

Resource Accounting and Budgeting (RAB)

Finally introduced in full on 1 April 2001, Resource Accounting and Budgeting (RAB) is a Whitehall-wide programme to improve the management of resources across Government. The concept deals with the wider issue of the resources available to government departments and includes consideration of all of their assets and liabilities and not just the level of cash financing which was the principal measure used historically.

Resource Accounting comprises:

- accruals accounting to report the expenditure, income and assets of a department;
- matching expenditure, income and assets (resource consumption) to the aims and objectives of a department of the appropriate financial year determined by accruals accounting; and
- reporting on outputs and performance.

Resource Budgeting is the extension of Resource Accounting principles and represents the spending plans of the department's programmes and operations measured in resource terms (resource consumed in the financial year rather than just cash spent/received) to reflect the full costs of its activities.

Revenue

Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.

Secondary Care

Care provided in hospitals.

Special Health Authority (SHA)

SHAs are health authorities which have been set up to take on a delegated responsibility for providing a national service to the NHS

or the public. They can only carry out functions already conferred on SofS. They originate under Section 11 of the NHS Act 1977, which gives SofS the power to establish a special body for the purpose of performing certain specified functions on his behalf.

Specific Grants

Grants (usually for current expenditure) allocated by Central Government to Local Authorities for expenditure on specified services, reflecting Ministerial priorities.

Strategic Health Authority

Twenty-eight new health authorities, covering the whole of England, were established in April 2002. They were renamed Strategic Health Authorities (SHA) by Section 1 of the NHS Reform and Health Care Professions Act 2002, which came into force on 1 October 2002. SHAs serve populations of between 1.2 million and 2.7 million people and have boundaries, which are aligned with the boundaries of one or more local authorities and, which broadly reflect clinical networks. As the headquarters of the local NHS, the Strategic Health Authorities are the main link between the Department of Health and the NHS and are responsible for ensuring that all NHS organisations work together to deliver the NHS Plan for modernised patient-centred services. Their main functions include creating a strategic framework for the delivery of the NHS Plan locally; drawing together local delivery plans, and performance management, of local NHS bodies; and building capacity and supporting performance improvement.

Supply Estimate

The term is loosely used for the Main Estimates, a request by the Executive to Parliament for funds required in the coming financial year. There are also Supplementary Estimates. Supply Estimates are sub-divided into groups (Classes) which contain provision (usually by a single department) covering services of a broadly similar nature. A sub-division of a Class is known as a "Vote" and covers a narrower range of services. The Department of Health has three Votes which form Class II. Vote 1 covers the Department of Health and contains two Requests for Resources (RfRs) – the first covering expenditure on the NHS, the second other Departmental services and programmes. A Supply Estimate does not of itself authorise expenditure of the sums requested. This comes through an Appropriation Act passed by Parliament.

Trading Fund

Trading funds are Government Departments or accountable units within Government Departments set up under the Government Trading Funds Act 1973, as amended by the Government Trading Act 1990. The Acts enable the responsible Minister to set up as a trading fund a body which is performing a statutory and monopoly service whose fees are fixed by or under statute. A trading fund provides a financing framework within which outgoings can be met without detailed cash flows passing through Vote accounting arrangements.

Unified Allocation

Before April 1999, Health Authorities (HAs) received separate revenue funding streams for: hospital and community health services (HCHS); discretionary funding for general practice staff, premises and computers (GMSCL); and family health services prescribing. The White Paper, *The new NHS: Modern, Dependable* proposed unifying these funding streams. Since April 1999, there has been a single stream of discretionary funds flowing through Health Authorities to PCGs.

Vote

See *Supply Estimate*.

Walk-In Centre

Walk-in Centres are part of a tranche of initiatives to modernise the NHS by providing quick and convenient access to basic primary care services without the need for an appointment.

Weighted Capitation Formula

A formula which uses population projections for resident population which are then weighted as appropriate for the cost of care by age group, for relative need over and above that accounted for by age and to take account of unavoidable geographical variations in the cost of providing services. They are used to determine Health Authorities target share of available resources.

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