

# A Finance Data Tables

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**Figure A.1: Department of Health CSR settlement 2007 – announced opening position**

	2008-09	2009-10	£ million 2010-11
<b>NHS<sup>(1)</sup></b>			
NHS revenue	92,642	98,499	104,833
NHS capital	4,589	5,352	6,086
Depreciation	-800	-954	-1,113
<b>Total net NHS resource</b>	<b>96,431</b>	<b>102,897</b>	<b>109,806</b>
<b>Personal social services (PSS)</b>			
PSS revenue	1,237	1,293	1,395
PSS capital	121	121	121
Depreciation	-13	-13	-13
<b>Total net PSS resource</b>	<b>1,345</b>	<b>1,401</b>	<b>1,503</b>

Source: HM Treasury Pre-Budget Report 2007

Notes:

(1) Average real terms growth of 4 per cent.

Figure A.2: Track of departmental resources from CSR settlement 2007 to current position

	2008-09	2009-10	£ million 2010-11
<b>NHS revenue – near CSR settlement 2007</b>	<b>89,476</b>	<b>95,062</b>	<b>101,150</b>
Transfer to personal social services (PSS)	-167	-272	-250
Technical changes	-200	0	0
Transfers to/from other government departments (OGDs))	26	0	-8
Value for money savings (Budget 2009)	0	0	-2,300
Forecast underspend	-1,060	0	0
<b>Current position</b>	<b>88,075</b>	<b>94,791</b>	<b>98,592</b>
<b>NHS revenue – non CSR 2007 settlement</b>	<b>3,165</b>	<b>3,437</b>	<b>3,683</b>
PSS transfers/OGD transfers/technical	-3	-11	-3
Forecast underspend	-298	0	0
<b>Current position</b>	<b>2,865</b>	<b>3,426</b>	<b>3,680</b>
<b>NHS – total revenue CSR settlement 2007</b>	<b>92,642</b>	<b>98,499</b>	<b>104,833</b>
<b>Current position</b>	<b>90,940</b>	<b>98,217</b>	<b>102,272</b>
<b>PSS revenue – near CSR settlement 2007</b>	<b>1,223</b>	<b>1,279</b>	<b>1,381</b>
Transfers from NHS	167	272	250
Technical changes	0	0	0
Transfers to/from OGDs	-25	-29	-26
Forecast underspend	0	0	0
<b>Current position</b>	<b>1,365</b>	<b>1,522</b>	<b>1,605</b>
<b>PSS revenue – non CSR settlement 2007</b>	<b>14</b>	<b>14</b>	<b>14</b>
Transfer from NHS	3	10	3
Forecast underspend	0	0	0
<b>Current position</b>	<b>17</b>	<b>24</b>	<b>17</b>
<b>PSS – total revenue CSR settlement 2007</b>	<b>1,237</b>	<b>1,293</b>	<b>1,395</b>
<b>Current position</b>	<b>1,382</b>	<b>1,546</b>	<b>1,622</b>
<b>NHS capital CSR settlement 2007</b>	<b>4,589</b>	<b>5,352</b>	<b>6,086</b>
PSS transfers/OGD transfers/technical	171	-19	-27
Fiscal stimulus and technical adjustment (Pre-Budget Report 2008) <sup>(1)</sup>	0	100	-1,385
Forecast underspend	-350	0	0
<b>Current position</b>	<b>4,410</b>	<b>5,433</b>	<b>4,674</b>
<b>PSS capital CSR settlement 2007</b>	<b>121</b>	<b>121</b>	<b>121</b>
NHS transfers/OGD transfers/technical	29	19	27
Forecast underspend	0	0	0
<b>Current position</b>	<b>150</b>	<b>140</b>	<b>148</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) Technical adjustment to bring capital allocation in line with planned level of spend.

**Figure A.3: Department of Health CSR settlement 2007 – current position**

	2008-09	2009-10	£ million 2010-11
<b>NHS<sup>(1)</sup></b>			
NHS revenue	90,940	98,217	102,272
NHS capital	4,410	5,433	4,674
Depreciation	-827	-988	-1,122
<b>Total net NHS resource</b>	<b>94,522</b>	<b>102,662</b>	<b>105,824</b>
<b>Personal social services (PSS)</b>			
PSS revenue	1,382	1,546	1,622
PSS capital	150	140	148
Depreciation	-16	-13	-15
<b>Total net PSS resource</b>	<b>1,516</b>	<b>1,673</b>	<b>1,755</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) Average real terms growth of 4.1 per cent.

Figure A.4: Department of Health public spending (core table 1)

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan	£ million
<b>Consumption of resources</b>									
NHS	61,865	66,873	74,168	78,468	86,382	90,940	98,217	102,272	
Personal social services	1,617	2,110	2,070	1,817	1,876	1,382	1,546	1,622	
NHS pensions <sup>(1)(2)</sup>	6,194	6,396	9,281	10,226	10,174	13,387	12,527	13,434	
NHS (AME)	60	30	74	139	465	364	652	577	
Credit guarantee finance (AME) <sup>(3)</sup>	40	24	54	84	84	182	355	127	
<b>Total Department of Health resource budget</b>	<b>69,776</b>	<b>75,434</b>	<b>85,647</b>	<b>90,734</b>	<b>98,982</b>	<b>106,256</b>	<b>113,297</b>	<b>118,033</b>	
<i>Of which:</i>									
Department of Health Departmental Expenditure Limit (DEL)	63,481	68,983	76,238	80,285	88,258	92,322	99,763	103,894	
<i>of which:</i>									
Near cash	61,030	68,591	74,295	77,290	83,475	89,439	96,312	100,197	
Non-cash	2,451	391	1,943	2,995	4,783	2,882	3,451	3,697	
<b>Capital spending</b>									
NHS <sup>(4)</sup>	2,602	2,624	2,151	3,069	3,597	4,410	5,433	4,674	
Personal social services	84	83	92	124	215	150	140	148	
NHS (AME)	0	229	292	0	0	0	0	0	
Credit guarantee finance (AME) <sup>(3)</sup>	0	0	357	89	37	14	0	0	
<b>Total Department of Health capital budget</b>	<b>2,686</b>	<b>2,937</b>	<b>2,893</b>	<b>3,282</b>	<b>3,849</b>	<b>4,574</b>	<b>5,573</b>	<b>4,822</b>	
<i>Of which:</i>									
Department of Health Departmental Expenditure Limit (DEL)	2,686	2,707	2,244	3,193	3,812	4,560	5,573	4,822	
<b>Total public spending in Department of Health<sup>(5)</sup></b>	<b>72,061</b>	<b>77,860</b>	<b>87,909</b>	<b>92,794</b>	<b>101,549</b>	<b>109,427</b>	<b>116,869</b>	<b>121,010</b>	
<i>Of which:</i>									
NHS (6) (7)	64,173	69,051	75,822	80,561	89,261	94,522	102,662	105,824	
Personal social services <sup>(8)</sup>	1,693	2,182	2,153	1,927	2,076	1,516	1,673	1,755	
NHS pensions	6,194	6,396	9,281	10,226	10,174	13,387	12,527	13,434	
NHS (AME) <sup>(9)</sup>	0	228	292	0	9	0	0	0	
Credit guarantee finance (AME) <sup>(3)(10)</sup>	0	3	362	80	28	2	7	-3	
<b>Spending by local authorities on functions relevant to the Department</b>									
<b>Current</b>	<b>14,705</b>	<b>16,059</b>	<b>17,243</b>	<b>17,874</b>	<b>18,505</b>	<b>19,310</b>	<b>0</b>	<b>0</b>	
<i>Of which:</i>									
Funded by grants from the Department of Health	1,816	2,148	2,141	1,772	1,795	1,207	0	0	
<b>Capital</b>	<b>164</b>	<b>209</b>	<b>300</b>	<b>278</b>	<b>306</b>	<b>312</b>	<b>0</b>	<b>0</b>	
<i>Of which:</i>									
Financed by grants from the Department of Health	132	140	122	181	159	221	0	0	

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) NHS Pensions is the resource budget of the pension scheme, and it is included in core table 1 because it is part of the Department of Health resource budget. Figures reflect the requirement specified by Financial Reporting Standard 17 – Retirement Benefits.

(2) Employers' National Insurance Contributions increased from 7% to 14% from 1 April 2004.

(3) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury. This line also includes some funding for PCT impairments.

(4) Includes funding available to NHS foundation trusts from 2004-05.

(5) Total public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £301/458/507/990/733/843/1,001/1,138 million (this excludes impairments funded in AME which is outside the DEL).

(6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £293/446/497/975/718/827/988/1,122 million (this excludes impairments funded in AME which is outside the DEL).

(7) For a more detailed breakdown of NHS expenditure in England see figures A.5 (core table 2), A.6 and A.7 (core table 3).

(8) Personal social services public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £8/12/10/14/16/16/13/15 million.

(9) Total NHS (AME) is calculated as the total of the resource budget plus the capital budget, less impairments of £60/32/74/139/456/364/652/577 million.

(10) Total credit guarantee finance is calculated as the total of the resource budget plus the capital budget, less impairments of £40/21/50/93/93/195/348/130 million.

(11) Figures are presented net of receipts £-4,173/-5,008/-6,379/-5,584/-4,746/-4,946/-4,489/-4,624 million.

(12) Figures may not sum due to rounding.

Figure A.5: Department of Health resource budget (core table 2)

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan	£ million
<b>Consumption of resources by activity</b>									
National Health Service (NHS)	61,865	66,873	74,168	78,468	86,382	90,940	98,217	102,272	
<i>Of which:</i>									
Hospital and community health services <sup>(3)</sup>	58,412	63,373	70,757	76,011	83,760	88,478	95,395	99,289	
<i>of which:</i>									
Health authorities unified budget and central allocations and grants to local authorities	58,412	63,373	70,757	76,011	83,760	88,478	95,395	99,289	
Family health services	2,141	2,129	2,131	1,021	1,022	1,108	1,182	1,263	
<i>of which:</i>									
General dental services <sup>(1)</sup>	1,283	1,246	1,038	19	0	0	0	0	
General ophthalmic services	322	341	358	381	400	443	468	571	
Pharmaceutical services	962	966	1,162	1,033	1,054	1,110	1,145	1,137	
Prescription charges income	-426	-422	-427	-412	-432	-445	-431	-445	
Central health and miscellaneous services	993	1,062	979	1,157	1,324	1,083	1,369	1,453	
<i>of which:</i>									
Welfare foods DEL	138	119	104	110	97	114	117	120	
EEA medical costs	390	429	517	598	759	441	655	818	
Other central health and miscellaneous services	465	514	359	449	468	528	597	515	
Departmental administration including agencies	320	309	300	278	276	271	272	267	
Personal social services (PSS)	1,617	2,110	2,070	1,817	1,876	1,382	1,546	1,622	
<i>Of which:</i>									
Personal social services	192	240	191	239	267	308	318	315	
Local authority personal social services grants	1,425	1,871	1,880	1,578	1,609	1,074	1,228	1,307	
<i>of which:</i>									
Training Support Programme	57	55	0	0	0	0	0	0	
Specific grants: AIDS/HIV	16	17	17	16	16	20	22	26	
Specific grants: Mentally Ill	133	131	133	132	148	0	0	0	
Carers Grant	100	125	185	185	185	0	0	0	
Performance Fund	96	0	0	0	0	0	0	0	
Deferred Payments Grant	23	0	0	0	0	0	0	0	
Care Direct	2	0	0	0	0	0	0	0	
Preserved Rights Grant	500	435	340	298	275	0	0	0	
Residential Allowance Grant	182	406	217	0	0	0	0	0	
National Training Strategy	25	29	92	108	108	0	0	0	
Delayed Discharge	51	100	100	100	100	0	0	0	
Access and Systems Capacity Grant	170	484	643	546	546	0	0	0	
Human Resources Development Strategy	10	24	63	50	50	0	0	0	
Assistive Technology	0	0	0	30	50	0	0	0	
Prevention Service	0	0	0	20	39	0	0	0	
Individual Budget Pilots	0	0	0	3	3	0	0	0	
Area Based Grant	0	0	0	0	0	943	968	979	
Learning Disabilities: closure of campuses	0	0	0	0	0	14	31	51	
Transforming Personalisation, Prevention and Well-being	0	0	0	0	0	82	192	237	
Grants for children	60	65	91	90	89	0	0	0	
Stroke Strategy	0	0	0	0	0	15	15	15	
NHS – superannuations – England and Wales	6,194	6,396	9,281	10,226	10,174	13,387	12,527	13,434	
NHS (AME)	60	30	74	139	465	364	652	577	
Credit guarantee finance <sup>(2)</sup>	40	24	54	84	84	182	355	127	
<b>Total Department of Health resource budget</b>	<b>69,776</b>	<b>75,434</b>	<b>85,647</b>	<b>90,734</b>	<b>98,982</b>	<b>106,256</b>	<b>113,297</b>	<b>118,033</b>	

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) General dental services (GDS) data represents the net cost, after taking account of patient charge income, for non-discretionary services only. Outturn trends are affected by the progressive movement of dental practices into personal dental service pilots. From April 2006, provision for GDS is included within the general HCFHS resources as dental care is now commissioned from funds devolved to PCTs. The GDS provision identified for 2006-07 represents the costs of completing payments in respect of GDS services delivered up to March 2006.

(2) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury.

(3) Further disaggregation of HCHS component of expenditure is given in figure A.6.

(4) Figures are presented net of receipts £-3,622/-4,474/-5,171/-4,417/-4,239/-4,652/-4,343/-4,594 million.

(5) Figures may not sum due to rounding.

**Figure A.6: Disaggregation of hospital and community health services (HCHS) expenditure, 2003-04 to 2007-08**

	£ million					
	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn
<b>PCT allocations</b>						
Announced allocations SR 2002	41,468	45,027	49,328	53,925		
Growth (%)		9.2%	9.6%	9.3%		
Budgets/funding transferred/managed by PCTs during SR 2002		4,015	8,114	4,967		
Announced allocations SR 2004				58,892	64,310	70,355
Growth (%)					9.2%	9.4%
Budgets/funding transferred/managed by PCTs during SR 2004				3,383	1,292	2,010
<b>PCT revenue resource limit</b>		<b>49,042</b>	<b>57,442</b>	<b>62,275</b>	<b>65,602</b>	<b>72,365</b>
<b>Strategic health authority (SHA) funding</b>						
SHA running costs		122	137	145	145	102
Budgets/funding transferred/managed by SHAs		3,721	3,923	4,220	4,796	5,867
<b>SHA revenue resource limit</b>		<b>3,843</b>	<b>4,060</b>	<b>4,366</b>	<b>4,942</b>	<b>5,969</b>
<b>Market forces factor</b>				<b>303</b>	<b>2,202</b>	<b>2,479</b>
<b>Surplus/deficit in PCTs and SHAs</b>		<b>210</b>	<b>100</b>	<b>34</b>	<b>592</b>	<b>1,295</b>
<b>Centrally managed HCHS</b>						
Central budgets, special health authority funding and technical adjustments		5,737	1,971	3,848	3,858	4,242
<b>Total HCHS expenditure</b>		<b>58,412</b>	<b>63,373</b>	<b>70,757</b>	<b>76,011</b>	<b>83,760</b>

Source: PCT and SHA consolidated accounts; HM Treasury COINS database; and Department of Health allocations records

*Notes:*

- (1) The table illustrates the transfer of funds and functions from central to locally managed within PCT and SHA revenue resource limits.
- (2) HCHS funding outside PCT and SHA resource limits in 2007-08 includes: payments direct to trusts and NHS foundation trusts of the market forces factor adjustments to payments under tariff; these funds clawed back from PCT allocations and paid direct to trusts; and funding of special health authorities, research and development and the National Programme for IT.
- (3) Key transfers into revenue resource limits include: from 2003-04, additional funds to cover commitments on free nursing care; from 2004-05, additional funds to cover pensions indexation, funding for Quality and Outcomes Framework; from 2005-06, funding for prison healthcare; from 2006-07, funding for dentistry; and from 2007-08, national specialist commissioning (funds hosted by SHA), student bursaries.
- (4) Details of PCT expenditure against its revenue resource limit is given in figure A.15.
- (5) Details of SHA expenditure against its revenue resource limit is given in figure A.16.



Figure A.7: Department of Health capital budget (core table 3)

	£ million							
	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan
<b>National Health Service (NHS)</b>	<b>2,602</b>	<b>2,624</b>	<b>2,151</b>	<b>3,069</b>	<b>3,597</b>	<b>4,410</b>	<b>5,433</b>	<b>4,674</b>
<i>Of which:</i>								
<b>Hospital and community health services(1)</b>	<b>2,566</b>	<b>2,592</b>	<b>2,111</b>	<b>3,033</b>	<b>3,554</b>	<b>4,327</b>	<b>5,360</b>	<b>4,632</b>
<i>of which:</i>								
Health authorities unified budget and central allocations and grants to local authorities	2,566	2,592	2,111	3,033	3,554	4,327	5,360	4,632
<b>Central health and miscellaneous services</b>	<b>13</b>	<b>16</b>	<b>22</b>	<b>20</b>	<b>22</b>	<b>61</b>	<b>51</b>	<b>20</b>
<b>Departmental administration including agencies</b>	<b>23</b>	<b>16</b>	<b>19</b>	<b>17</b>	<b>21</b>	<b>21</b>	<b>22</b>	<b>23</b>
<b>Personal social services (PSS)</b>	<b>84</b>	<b>83</b>	<b>92</b>	<b>124</b>	<b>215</b>	<b>150</b>	<b>140</b>	<b>148</b>
<i>Of which:</i>								
<b>Personal social services (including Credit Approvals)</b>	<b>59</b>	<b>58</b>	<b>67</b>	<b>77</b>	<b>149</b>	<b>31</b>	<b>19</b>	<b>26</b>
<b>Local authority PSS grants</b>	<b>25</b>	<b>25</b>	<b>25</b>	<b>47</b>	<b>66</b>	<b>119</b>	<b>120</b>	<b>121</b>
<i>of which:</i>								
AIDS/HIV capital grants	0	0	0	2	3	3	3	3
Improving Information Management	25	25	25	25	25	0	0	0
Learning Disabilities	0	0	0	0	0	11	11	11
Transforming Personalisation, Prevention and Well-being	0	0	0	0	0	15	16	17
Mental Health Capital Grant	0	0	0	0	0	23	23	23
Social Care Capital Grant	0	0	0	0	0	28	28	28
Extra Care Housing Grant	0	0	0	20	38	40	40	40
<b>NHS (AME)</b>	<b>0</b>	<b>229</b>	<b>292</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Credit guarantee finance (AME)<sup>(2)</sup></b>	<b>0</b>	<b>0</b>	<b>357</b>	<b>89</b>	<b>37</b>	<b>14</b>	<b>0</b>	<b>0</b>
<b>Total Department of Health capital budget</b>	<b>2,686</b>	<b>2,937</b>	<b>2,893</b>	<b>3,282</b>	<b>3,849</b>	<b>4,574</b>	<b>5,573</b>	<b>4,822</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) Includes funding available to NHS foundation trusts from 2004-05.

(2) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury.

(3) Figures are presented net of receipts £-551/-533/-1,208/-1,167/-507/-294/-146/-30 million.

(4) Figures may not sum due to rounding.

**Figure A.8: Comparison of 2008-09 outturn with 2008-09 planned expenditure in departmental report 2008**

2008-09			<b>£ million</b>
	Departmental report 2008 plan	Departmental report 2009 estimated outturn	Difference
<b>NHS revenue</b>	92,475	90,940	-1,535
<i>Of which:</i>			
Departmental administration	219	222	3
<b>NHS capital</b>	4,567	4,410	-157
<i>Of which:</i>			
Departmental administration	21	22	1
<b>PSS current</b>	1,384	1,382	-2
<b>PSS capital</b>	143	150	7
<b>Total</b>	97,725	96,038	-1,687

Source: Financial Planning and Allocations Division, DH

Notes:

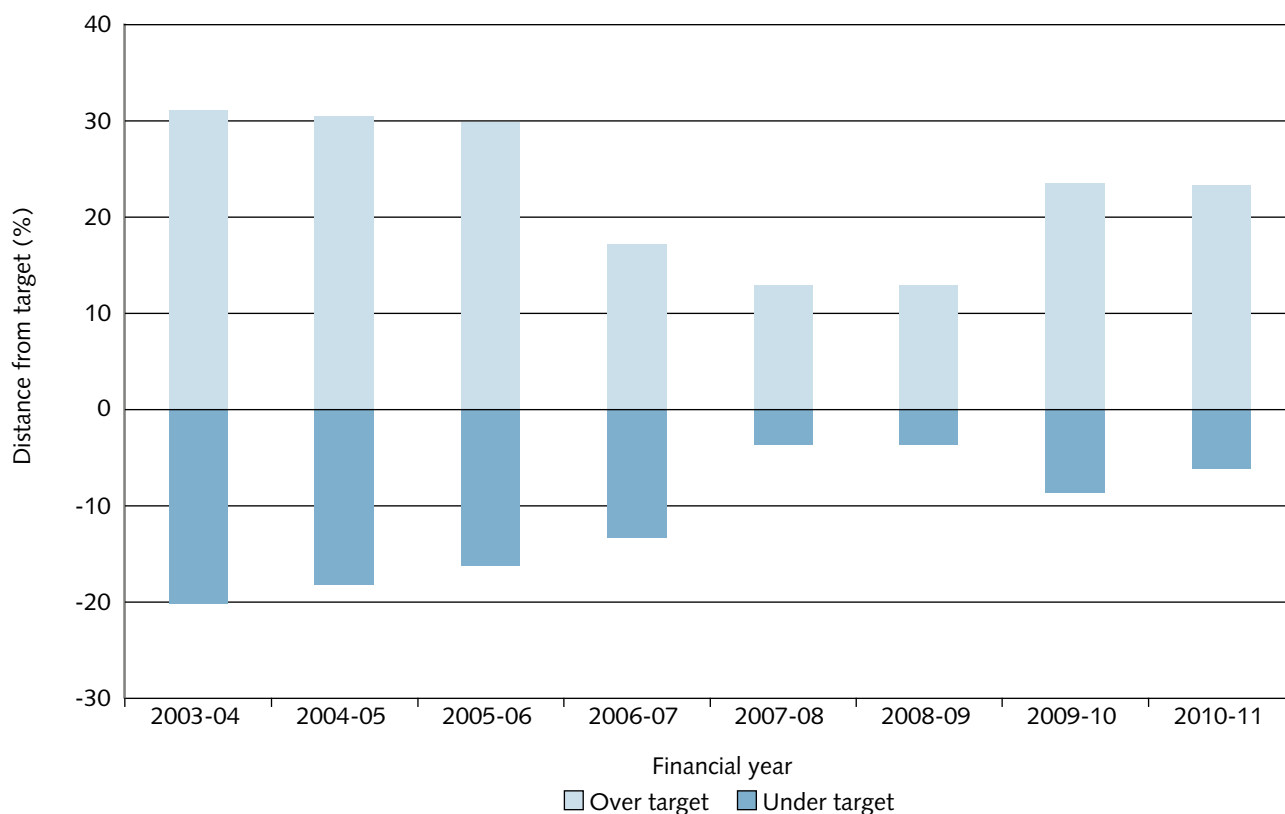
(1) Totals may not sum due to rounding.

**Figure A.9: Main areas of change to the headline spending plans presented in last year's Departmental report**

2008-09	Difference	Reason	<b>£ million</b>
NHS revenue	-1,535	Forecast underspend	-1,358
		Transfer to capital	-200
		OGD transfers	26
		Technical changes	-3
NHS capital	-157	Forecast underspend	-350
		Transfer from revenue	200
		Transfer to PSS	-7

Source: Financial Planning and Allocations Division, DH

Figure A.10: Range of PCT DFTs between 2003-04 and 2010-11



Source: PCT revenue resource limit exposition book

Figure A.11: Total capital employed by the Department of Health (core table 4)

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 estimated outturn	2009-10 plan	2010-11 plan	£ million
Within the Departmental account <sup>(1)(2)</sup>	11,597	14,333	14,551	14,948	15,394	15,894	16,132	16,576	
Investment outside accounting boundary <sup>(3)(4)(5)(6)</sup>	27,468	32,692	33,596	35,502	38,671	39,928	40,527	41,641	
<b>Total capital employed</b>	<b>39,065</b>	<b>47,026</b>	<b>48,147</b>	<b>50,450</b>	<b>54,065</b>	<b>55,822</b>	<b>56,659</b>	<b>58,217</b>	

Source: Department of Health

Notes:

(1) This includes all entities within the DH resource accounting boundary, such as the central DH, SHAs and PCTs.

(2) Source: DH consolidated resource accounts.

(3) Includes the NHS Litigation Authority which moved inside the accounting boundary in 2000-01.

(4) Includes the Health Development Agency which moved inside the accounting boundary in 2002-03.

(5) This includes, for example, NHS trusts and the National Blood Authority.

(6) In 2000-01, part of NHS supplies (the Purchasing and Supply Agency) moved inside the boundary and, from 2001-02, Rampton, Broadmoor and Ashworth Special Health Authorities moved outside the accounting boundary.

**Figure A.12: Department of Health identifiable expenditure on services, by country and region (core table 7)**

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 plan	2009-10 plan	2010-11 plan	£ million
North East	3,181	3,580	3,907	4,138	4,472	4,999	5,266	5,581	
North West	8,737	9,523	10,342	10,918	11,923	13,181	13,878	14,697	
Yorkshire and the Humber	5,909	6,647	7,306	7,602	8,209	9,319	9,610	10,194	
East Midlands	4,411	4,972	5,453	5,799	6,426	7,047	7,528	8,009	
West Midlands	5,970	6,707	7,272	7,923	8,582	9,345	10,010	10,608	
Eastern	5,701	6,433	6,909	7,350	7,828	8,836	9,554	10,156	
London	10,169	11,467	12,128	12,213	13,723	15,060	15,654	16,540	
South East	8,607	9,635	10,146	11,018	11,829	12,846	14,139	14,964	
South West	5,383	6,087	6,686	6,923	7,620	8,357	8,948	9,493	
<b>Total England</b>	<b>58,068</b>	<b>65,050</b>	<b>70,149</b>	<b>73,884</b>	<b>80,610</b>	<b>88,990</b>	<b>94,587</b>	<b>100,240</b>	
Scotland	26	28	30	34	39	45	46	48	
Wales	-159	-174	-194	-193	-169	-144	-158	-168	
Northern Ireland	4	4	4	4	5	6	6	6	
<b>Total UK identifiable expenditure</b>	<b>57,939</b>	<b>64,907</b>	<b>69,990</b>	<b>73,730</b>	<b>80,485</b>	<b>88,897</b>	<b>94,482</b>	<b>100,126</b>	
Outside UK	379	561	473	669	908	786	913	996	
<b>Total identifiable expenditure</b>	<b>58,318</b>	<b>65,469</b>	<b>70,463</b>	<b>74,398</b>	<b>81,393</b>	<b>89,682</b>	<b>95,394</b>	<b>101,122</b>	
Non-identifiable expenditure	0	0	0	0	0	709	1,074	453	
<b>Total expenditure on services</b>	<b>58,318</b>	<b>65,469</b>	<b>70,463</b>	<b>74,398</b>	<b>81,393</b>	<b>90,392</b>	<b>96,468</b>	<b>101,575</b>	

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in Departmental budgets. They do include pay, procurement, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.

(2) The figures are estimates.

**Figure A.13: Department of Health identifiable expenditure on services, by country and region, per head (core table 8)**

	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 plan	2009-10 plan	2010-11 plan	£ per head
North East	1,252	1,408	1,533	1,619	1,744	1,946	2,044	2,159	
North West	1,285	1,396	1,512	1,593	1,737	1,907	1,999	2,106	
Yorkshire and the Humber	1,175	1,313	1,431	1,478	1,586	1,781	1,820	1,913	
East Midlands	1,037	1,159	1,260	1,329	1,461	1,583	1,674	1,762	
West Midlands	1,124	1,259	1,359	1,476	1,595	1,725	1,838	1,937	
Eastern	1,041	1,167	1,242	1,311	1,383	1,546	1,655	1,742	
London	1,381	1,552	1,627	1,626	1,816	1,976	2,037	2,134	
South East	1,064	1,186	1,240	1,338	1,424	1,538	1,679	1,764	
South West	1,076	1,207	1,314	1,351	1,472	1,602	1,699	1,785	
<b>Total England</b>	<b>1,164</b>	<b>1,298</b>	<b>1,390</b>	<b>1,455</b>	<b>1,578</b>	<b>1,728</b>	<b>1,823</b>	<b>1,917</b>	
Scotland	5	5	6	7	8	9	9	9	
Wales	-54	-59	-66	-65	-57	-48	-52	-56	
Northern Ireland	2	2	3	2	3	3	3	3	
<b>Total UK identifiable expenditure</b>	<b>973</b>	<b>1,085</b>	<b>1,162</b>	<b>1,217</b>	<b>1,320</b>	<b>1,448</b>	<b>1,527</b>	<b>1,607</b>	

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(1) The tables do not include depreciation, cost of capital charges or movements in provisions that are in Departmental budgets. They do include pay, procurement, capital expenditure and grants and subsidies paid to individuals and private sector enterprises.

(2) The figures are estimates.

**Figure A.14: Department of Health identifiable expenditure on services by function, by country and region, 2007-08 (core table 9)**

	<b>£ million</b>							
	Health			Social protection				Grand total
	Central and other health services	Medical services	Total health	Incapacity, disability and injury benefits	Old age	Survivors	Total social protection	
North East	47	4,523	4,571	19	-130	12	-99	4,472
North West	125	12,067	12,192	50	-353	33	-270	11,923
Yorkshire and the Humber	87	8,312	8,399	35	-248	23	-190	8,209
East Midlands	67	6,507	6,574	27	-192	18	-147	6,426
West Midlands	89	8,673	8,762	36	-238	22	-180	8,582
Eastern	82	7,947	8,029	33	-258	24	-201	7,828
London	142	13,813	13,955	57	-320	30	-233	13,723
South East	122	12,051	12,174	49	-435	41	-345	11,829
South West	80	7,774	7,854	32	-293	28	-234	7,620
<b>Total England</b>	<b>841</b>	<b>81,669</b>	<b>82,509</b>	<b>337</b>	<b>-2,467</b>	<b>232</b>	<b>-1,899</b>	<b>80,610</b>
Scotland	0	0	0	0	37	2	39	39
Wales	0	0	0	0	-186	17	-169	-169
Northern Ireland	0	0	0	0	5	0	5	5
<b>UK identifiable expenditure</b>	<b>841</b>	<b>81,669</b>	<b>82,509</b>	<b>337</b>	<b>-2,612</b>	<b>251</b>	<b>-2,025</b>	<b>80,485</b>
Outside UK	762	0	762	0	139	8	147	908
<b>Total identifiable expenditure</b>	<b>1,602</b>	<b>81,669</b>	<b>83,271</b>	<b>337</b>	<b>-2,473</b>	<b>259</b>	<b>-1,878</b>	<b>81,393</b>
Not identifiable	0	0	0	0	0	0	0	0
<b>Total</b>	<b>1,602</b>	<b>81,669</b>	<b>83,271</b>	<b>337</b>	<b>-2,473</b>	<b>259</b>	<b>-1,878</b>	<b>81,393</b>

Source: HM Treasury public expenditure statistical analyses (PESA)

Notes:

(1) The functional categories used are the standard United Nations Classifications of the Functions of Government (COFOG) categories. This is not the same as the strategic priorities used elsewhere in the report.

**Figure A.15: Primary care trust expenditure**

	<b>£ million</b>	
	2006-07	2007-08
<b>Revenue resource limit</b>	<b>65,602</b>	<b>72,365</b>
(Under)/over spend against revenue resource limit	370	-391
Adjustment for non-discretionary expenditure	1,056	1,026
<b>Net operating costs</b>	<b>67,027</b>	<b>73,000</b>
Other income	2,872	2,880
<b>Gross operating costs</b>	<b>69,899</b>	<b>75,880</b>
<i>Of which:</i>		
Secondary care	36,583	39,950
Primary drugs	7,590	7,663
Primary new general medical services	6,938	7,067
Contractor-led general and personal dental services	2,131	2,312
Pharmaceutical services	1,141	1,175
General ophthalmic services	381	405
Purchase of healthcare from non-NHS bodies	4,685	5,717
Other	10,449	11,591
<b>Total</b>	<b>69,899</b>	<b>75,880</b>

Source: Audited PCT consolidated accounts 2007-08

**Figure A.16: Strategic health authority expenditure**

	<b>£ million</b>	
	2006-07	2007-08
<b>Revenue resource limit</b>	4,942	5,969
(Under)/over spend against revenue resource limit	-962	-903
<b>Net operating costs</b>	<b>3,980</b>	<b>5,066</b>
Other income	147	60
<b>Gross operating costs</b>	<b>4,127</b>	<b>5,125</b>
<i>Of which:</i>		
Training	3,381	4,129
Staff costs	229	150
NHS Direct funding	123	138
Other	393	709
<b>Total</b>	<b>4,127</b>	<b>5,125</b>

Source: Audited SHA consolidated accounts 2007-08

**Figure A.17: Expected cost of implementing the new GMS contract**

Financial year	<b>£ billion</b>
	Cost
2003-04	5.8
2004-05	6.9
2005-06	7.7
2006-07	7.8
2007-08 <sup>(1)</sup>	7.8

Source: Primary Care Division, DH

Notes:

(1) Estimated cost subject to validation and agreement with GPC.

(2) No forecast figures are currently available for 2008-09.

(3) Figures are not consistent with those reported in figure A.15 as they include dispensing doctor drugs expenditure.

**Figure A.18: Family health services – general ophthalmic services, 2003-04 to 2007-08, England**

	<b>£ million</b>				
	2003-04 resource	2004-05 resource	2005-06 resource	2006-07 resource	2007-08 resource
General ophthalmic services	322	340	359	381	405

Source: PCT accounts

Figure A.19: Family health services – primary dental care services, 2003-04 to 2007-08, England

	2003-04 resource	2004-05 resource	2005-06 resource	2006-07 resource	2007-08 resource
GDS <sup>(1)</sup>	1,767	1,671	1,448	N/a	N/a
PDS (discretionary) <sup>(2)</sup>	48	280	757	N/a	N/a
<b>Total primary dental care<sup>(3)</sup></b>	<b>1,815</b>	<b>1,951</b>	<b>2,205</b>	<b>2,212</b>	<b>2,386</b>

Source: Dental Practice Board and PCT accounts data

Notes:

(1) General dental services (GDS) costs are gross of patient charge income.

(2) Personal dental services (PDS) schemes were Primary Care Act pilots designed to test locally-managed approaches to the delivery of primary care and were mainly based on dental practices which converted from GDS to PDS terms of service. PDS expenditure figures were drawn from health authorities income and expenditure accounts, with the exception of the 2004-05 figure for gross PDS which is an estimate based on payments data obtained from the Dental Practice Board. All PDS expenditure figures are gross of patient charge income, and exclude any related capital investment by NHS trusts.

(3) Under the new service framework introduced from 1 April 2006 for local commissioning of primary dental care services, PCTs may commission general dental or specialist personal dental services according to local needs but only report aggregate primary dental care expenditure in central financial returns.

(4) Expenditure in 2005-06 was enhanced by an accounting adjustment to correct an historic under-estimate of GDS creditor payments outstanding at the year end.

Figure A.20: Family health services – community pharmacy contractual framework expenditure, 2005-06 to 2007-08, England

	2005-06 resource	2006-07 resource	2007-08 resource
Community Pharmacy Contractual Framework <sup>(1)</sup>	1,175	1,247	1,306

Source: Prescription Pricing Division of the NHS Business Services Authority, England.

Notes:

(1) Introduced in April 2005.

(2) The above represent expenditures against the funding made available through the central global sum and money released in PCT budgets by lower generic medicine prices. In addition to these two funding sources, pharmacies also have access to funding of around £500 million from the margin retained on medicine purchases.

Figure A.21: Primary care gross drugs bill, 1996-97 to 2007-08, England

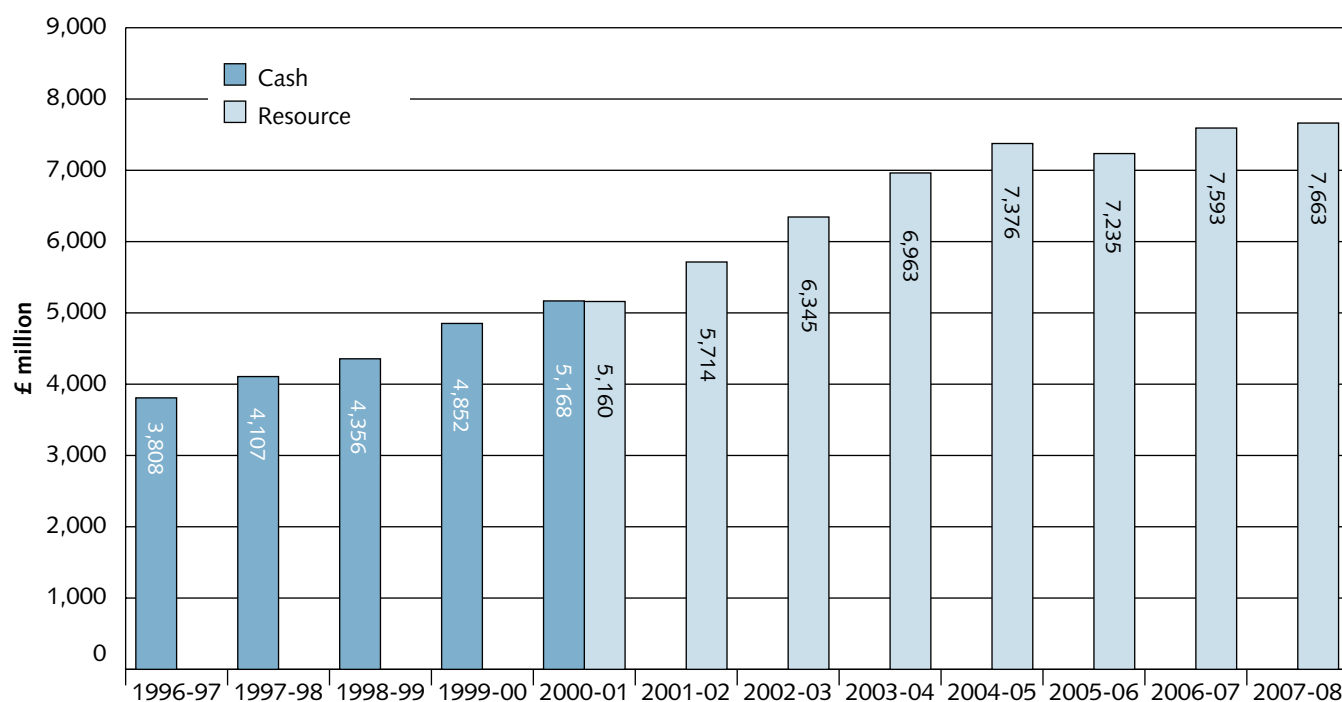


Figure A.22: Secondary care gross drugs bill, 1996-97 to 2007-08, England

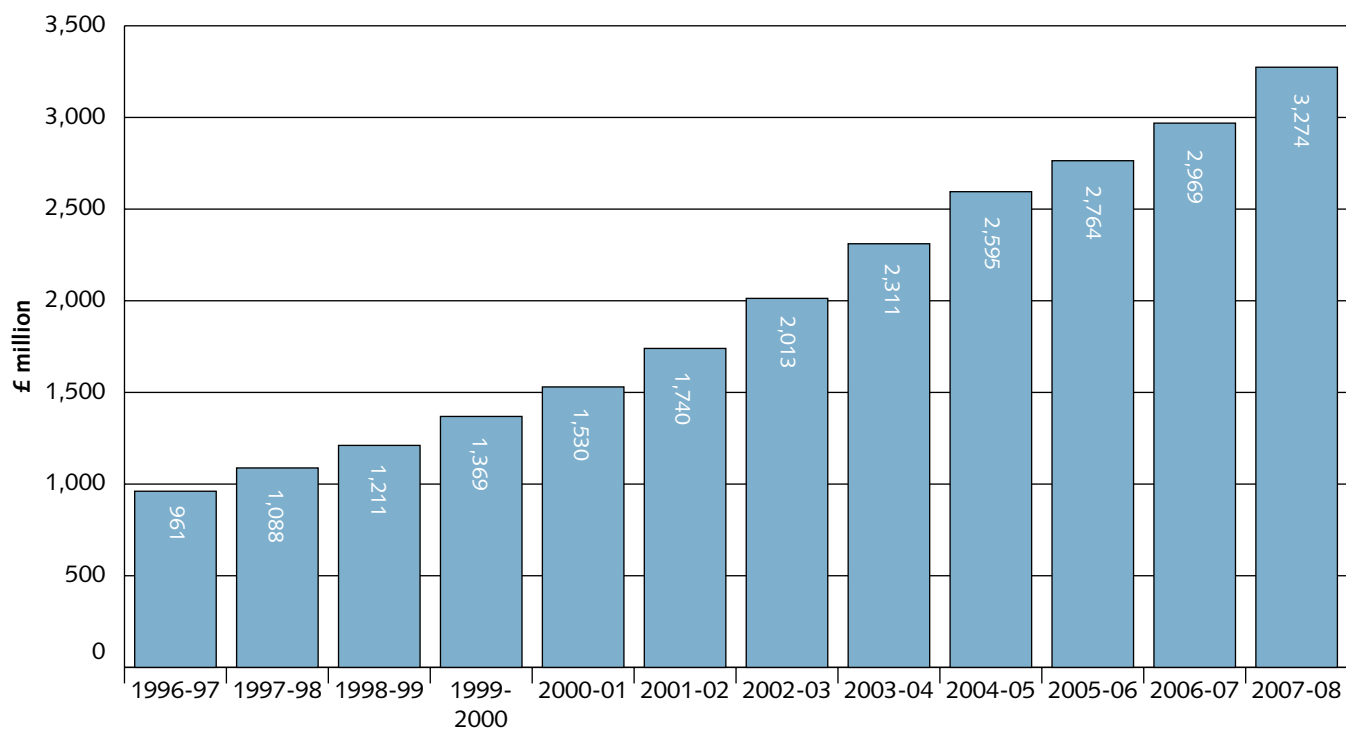


Figure A.23: Expenditure by NHS bodies on the purchase of healthcare from non-NHS bodies

				£ thousands
Year	Health authorities/strategic health authorities	Primary care trusts	NHS trusts	Total expenditure
1997-98	985,746	N/a	122,436	1,108,182
1998-99	1,108,471	N/a	121,954	1,230,425
1999-2000	1,166,412	N/a	134,784	1,301,196
2000-01	1,328,208	33,774	187,190	1,549,172
2001-02	1,136,793	409,936	246,238	1,792,967
2002-03	27,234	1,873,925	338,172	2,239,331
2003-04	3,329	2,903,763	408,801	3,315,893
2004-05	0	3,353,036	312,988	3,666,024
2005-06	0	4,096,300	319,231	4,415,531
2006-07	0	4,685,111	297,440	4,982,551
2007-08	0	5,717,489	295,079	6,012,568

Sources:

Annual Financial Returns of Health Authorities, 1997-98 to 2001-02  
 Annual Financial Returns of Strategic Health Authorities, 2002-03 to 2007-08  
 Annual Financial Returns of NHS Trusts, 1997-98 to 2005-06  
 Audited NHS Trust summarisation schedules 2006-07 and 2007-08  
 Annual Financial Returns of Primary Care Trusts, 2000-01 to 2005-06  
 Audited PCT summarisation schedules 2006-07 and 2007-08

Notes:

(1) 2004-05, 2005-06, 2006-07 and 2007-08 NHS trusts data do not include NHS foundation trusts.  
 (2) 2006-07 PCT spend has been restated following further validation.



Figure A.24: Expenditure by local authorities on Personal Social Services

	1999-2000 outturn	2000-01 outturn	2001-02 outturn	2002-03 outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	£ million
<b>Current expenditure<sup>(1)</sup></b>										
gross <sup>(2)</sup>	12,050	12,850	13,600	15,200	16,840	12,830	13,727	14,314	14,696	
charges <sup>(2)</sup>	2,000	2,150	2,230	2,310	2,080	1,955	2,009	2,068	2,126	
net <sup>(3)</sup>										
cash	10,050	10,700	11,370	12,890	14,190	10,873	11,718	12,246	12,570	
real terms <sup>(4)</sup>	12,232	12,855	13,362	14,675	15,707	11,717	12,374	12,587	12,570	
<b>Capital expenditure<sup>(2)</sup></b>										
gross	134	156	158	199	260	285	387	364	411	
income	51	63	70	75	74	75	84	85	100	
net	83	93	88	124	186	210	303	279	311	

Source: Social Care Finance, DH (PSS EX1, RO, RA LAs returns and Capital Outturn)

Notes:

(1) Figures up to and including 2003-04 include adults and children's services. Figures from 2004-05 relate to adults personal social services only, due to the transfer of responsibilities for children's social services from the Department of Health. Adults are all those aged 18 and over.

(2) Gross current expenditure, income from charges and capital figures are not available for 2008-09.

(3) Net expenditure figures exclude the Supporting People Grant, which began in April 2003.

(4) At 2007-08 prices using the GDP deflator (as at 23 April 2009).

(5) Total expenditure on Supporting People was £570 million. This is not reported in the gross current expenditure on adults.

Figure A.25: Local authority adult personal social services gross expenditure by client group, 2007-08 (excluding Supporting People)

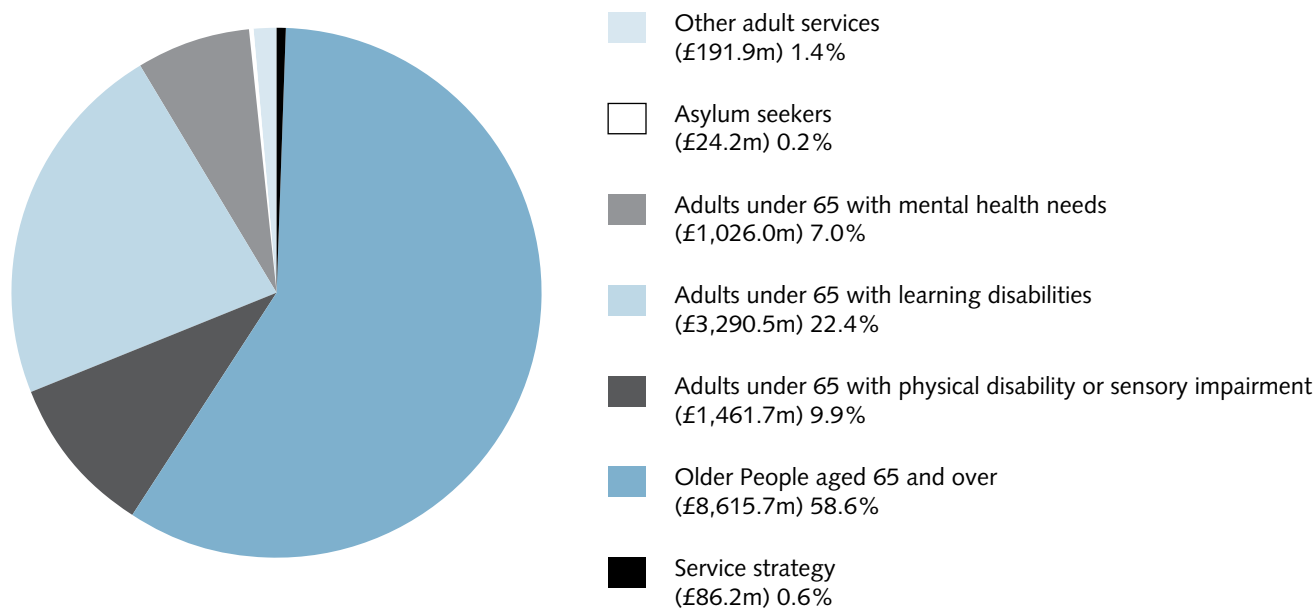
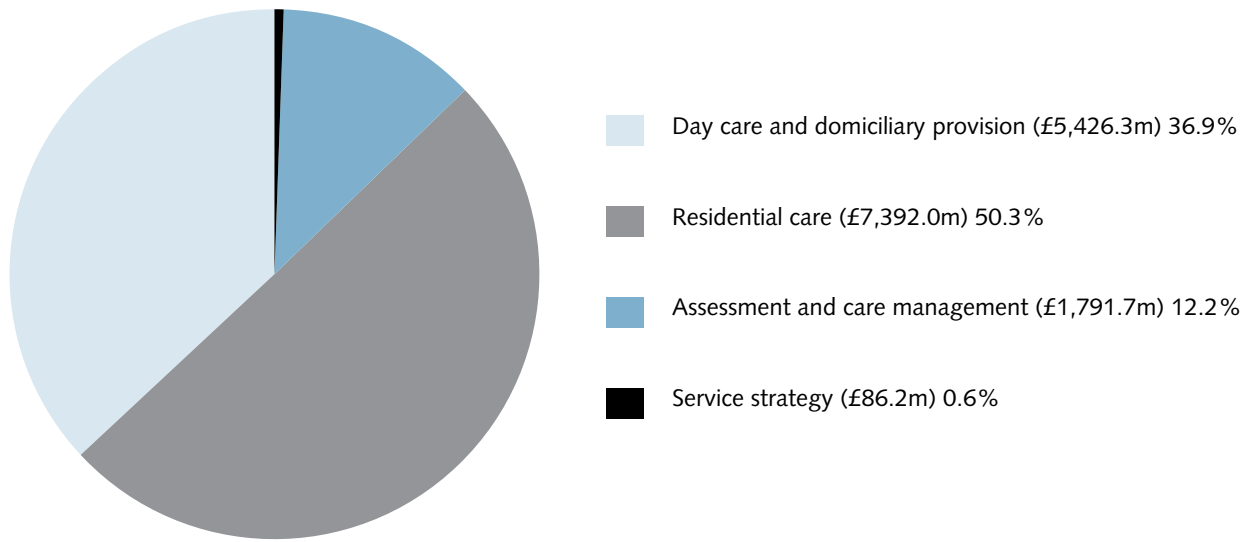


Figure A.26: Local authority adult personal social services gross expenditure by type of service, 2007-08 (excluding Supporting People)



## B Departmental Data Tables

Figure B.1: Salaries of Senior Civil Service staff in post in the Department of Health at 1 April 2008

Figure B.2: Recruitment into the Department of Health in 2008 – by gender, ethnicity and disability

Figure B.3: Department of Health administration costs (core table 5)

Figure B.4: Department of Health staff numbers (core table 6)

Figure B.5: Expenditure on professional services, 2008-09

Figure B.6: Department of Health accident statistics for 2008

Figure B.7: Public appointments sponsored by the Department – members in post at 1 January 2009

Figure B.8: Public appointments – diversity of those appointed at 1 January 2009

Figure B.9: Correspondence from the public – achievement against performance targets

Figure B.10: Parliamentary complaints, 2007-08

**Figure B.1: Salaries of Senior Civil Service staff in post in the Department of Health at 1 April 2008**

Payband (per annum)	Number of staff
£55,000–£59,999	3
£60,000–£64,999	25
£65,000–£69,999	30
£70,000–£74,999	37
£75,000–£79,999	45
£80,000–£84,999	18
£85,000–£89,999	24
£90,000–£94,999	15
£95,000–£99,999	11
£100,000–£104,999	10
£105,000–£109,999	6
£110,000–£114,999	5
£115,000–£119,999	6
£120,000–£124,999	3
£125,000–£129,999	8
£130,000–£134,999	7
£135,000–£139,999	5
£140,000–£144,999	3
£145,000–£149,999	1
Over £150,000	17
<b>Total</b>	<b>279</b>

Source: Payroll system, DH

Notes:

(1) Figures include staff on secondment out of the Department and exclude staff on secondment into the Department.

(2) Salaries include all pay-related allowances.

**Figure B.2: Recruitment into the Department of Health in 2008 – by gender, ethnicity and disability**

	By gender:		By ethnicity:			By disability:			Total
	Male	Female	White	BME <sup>(1)</sup>	Unknown	Not disabled	Disabled	Unknown	
<b>Permanent staff joining in 2008 who were still employed by the Department on 31 March 2009</b>									
Senior Civil Service	12	6	6	0	12	7	0	11	18
Fast Stream	7	13	19	0	1	14	5	1	20
Posts at former UG6 and below	75	116	149	27	15	169	11	11	191
<b>Total</b>	<b>94</b>	<b>135</b>	<b>174</b>	<b>27</b>	<b>28</b>	<b>190</b>	<b>16</b>	<b>23</b>	<b>229</b>
<b>Permanent staff joining in 2008 who were no longer employed by the Department on 31 March 2009</b>									
<b>Total</b>	<b>12</b>	<b>10</b>	<b>10</b>	<b>8</b>	<b>4</b>	<b>19</b>	<b>0</b>	<b>3</b>	<b>22</b>
<b>All permanent staff joining in 2008</b>									
Senior Civil Service	12	6	6	0	12	7	0	11	18
Fast Stream	7	13	19	0	1	14	5	1	20
Posts at former UG6 and below	87	126	159	35	19	188	11	14	213
<b>Total</b>	<b>106</b>	<b>145</b>	<b>184</b>	<b>35</b>	<b>32</b>	<b>209</b>	<b>16</b>	<b>26</b>	<b>251</b>

Source: Business Management System (BMS), DH

Notes:

(1) Black and minority ethnic.

Figure B.3: Department of Health administration costs (core table 5)

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
	outturn	outturn	outturn	outturn	outturn	estimated	plan <sup>(1)</sup>	plan <sup>(1)</sup>
<b>£ million</b>								
<b>Administration expenditure</b>								
Paybill	140	113	114	118	117	117	N/a	N/a
Other	156	163	140	116	114	109	N/a	N/a
<b>Total administration expenditure</b>	<b>296</b>	<b>277</b>	<b>254</b>	<b>234</b>	<b>231</b>	<b>225</b>	<b>218</b>	<b>212</b>
Administration income	-11	-9	-9	-5	-5	-4	-4	-4
<b>Total administration budget</b>	<b>285</b>	<b>268</b>	<b>246</b>	<b>229</b>	<b>226</b>	<b>221</b>	<b>214</b>	<b>209</b>
<b>Analysis by activity</b>								
Central Department	285	268	246	229	226	221	214	209
Other	0	0	0	0	0	0	0	0
<b>Total administration budget</b>	<b>285</b>	<b>268</b>	<b>246</b>	<b>229</b>	<b>226</b>	<b>221</b>	<b>214</b>	<b>209</b>

Source: HM Treasury public expenditure database (COINS)

Notes:

(1) A breakdown between paybill and other for years 2009-10 to 2010-11 is not available.

(2) Figures may not sum due to rounding.

Figure B.4: Department of Health staff numbers (core table 6)

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2008-09	2009-10	2010-11
	actual	actual	actual	actual	actual	plan	estimated	plan	plan
<b>Financial year average</b>									
<b>Department of Health (gross control area)<sup>(1)(2)</sup></b>									
Core Department of Health (full-time equivalents)	2,964	2,050	2,245	2,250	2,178	2,221	2,222	2,245	2,245
Other	0	0	0	0	0	0	0	0	0
Designated to transfer from the Department (full-time equivalents)	0	139	119	65	50	24	34	0	0
<b>Agencies</b>									
NHS Pensions Agency (full-time equivalents) <sup>(3)</sup>	258	0	0	0	0	0	0	0	0
Medicines and Healthcare products Regulatory Agency (full-time equivalents) <sup>(4)</sup>	747	781	819	831	875	959	923	977	995
NHS Purchasing and Supply Agency (PASA) (full time equivalents) <sup>(5)</sup>	318	332	350	321	283	290	289	314	314
NHS Estates <sup>(6)</sup>	375	314	0	0	0	0	0	0	0
<b>Total Department of Health</b>	<b>4,662</b>	<b>3,616</b>	<b>3,533</b>	<b>3,467</b>	<b>3,386</b>	<b>3,494</b>	<b>3,468</b>	<b>3,536</b>	<b>3,554</b>

Source: Department of Health (core) – Business Management System (BMS); executive agencies – HR systems.

Notes:

(1) Actual figures are an average across the financial year and are compiled on the same basis as in Departmental resource accounts. In particular they include ministers and special advisers. From 2008-09 they do not include Connecting for Health civil servants.

(2) The Department announced a major change programme in March 2003, under which it committed to reduce its workforce from 3,645 full-time equivalent posts to 2,245. The reduction of 1,400 was to consist of 680 transfers to other organisations and the removal of 720 posts. This change programme predated the 2004 Spending Review, but it was agreed that the Department could adopt the change programme target reduction as its Spending Review (Gershon) target. By the end of December 2007, the Department's full-time equivalent staffing was 2,189 (excluding ministers and special advisers), representing a reduction of 1,456 from March 2003. This consisted of 637 transfers and 819 posts removed.

(3) The NHS Pensions Agency became a special health authority (part of the NHS) in April 2004.

(4) The Medicines Control Agency and the Medical Devices Agency merged with effect from 1 April 2003 to become the Medicines and Healthcare products Regulatory Agency (MHRA).

(5) The Procurement Policy and Advisory Unit and the Centre for Evidence-based Purchasing joined PASA from the core Department from 2004-05 following an organisational review. During 2006-07, some PASA activities and associated staffing were outsourced to DHL/NHS Supply Chain.

(6) NHS Estates became a trading fund on 1 April 1999. Figures from 2003-04 include staff in Inventures. NHS Estates was abolished on 31 March 2005.

(7) Future planned staff numbers are subject to change.

**Figure B.5: Expenditure on professional services, 2008-09**

Organisation	£ million Spend
Department of Health professional services expenditure (including consultancy, temporary agency staff and interim personnel)	262.0
Executive agency professional services expenditure (including consultancy, temporary agency staff and interim personnel)	9.0
<b>Total</b>	<b>271.0</b>

Source: NHS Purchasing and Supply Agency

Notes:

(1) Expenditure is reported against the Office of Government Commerce definition of professional services.

(2) NHS consultancy spend is not included in the above table.

(3) Figures exclude NHS Connecting for Health.

(4) The expenditure figures are from 1 April 2008 to 31 March 2009. The figures are estimated from month 11 actual year to date general ledger data due to actual spend not being available for the whole year.

**Figure B.6: Department of Health accident statistics for 2008**

	Number
Total reported accidents	48
<i>Of which:</i>	
Resulting in absence	0
Total reported near misses <sup>(1)</sup>	13

Source: Health and Safety Unit, DH

Notes:

(1) A near miss is any unplanned occurrence that does not lead to injury of personnel or damage to property, plant or equipment, but may have done in different circumstances.

**Figure B.7: Public appointments sponsored by the Department – members in post at 1 January 2009**

Type of body	Chairs	Members	Total
Strategic health authorities	10	49	59
NHS trusts	124	664	788
Primary care trusts	146	911	1,057
Special health authorities	11	170	181
Advisory non-departmental public bodies	29	431	460
Executive non-departmental public bodies	10	111	121
Other bodies	1	20	21
<b>Total</b>	<b>331</b>	<b>2,356</b>	<b>2,687</b>

Source: The Appointments Commission

**Figure B.8: Public appointments – diversity of those appointed at 1 January 2009**

Total number of appointments	2,687
Percentage of non-executive board members (including chairs) who are women	35.4
Percentage of non-executive board members (including chairs) from black and minority ethnic communities	11.9
Percentage of non-executive board members (including chairs) who are disabled	4.4

Source: The Appointments Commission

**Figure B.9: Correspondence from the public – achievement against performance targets**

Type of correspondence						Percentage
	2003	2004	2005	2006	2007	2008
Private office case <sup>(1)</sup>	54.0	80.9	90.1	88.9	92.0	95.4
Treat official case <sup>(2)</sup>	67.2	88.0	97.3	92.3	99.0	97.3
Departmental e-mail <sup>(3)</sup>	87.1	95.4	96.6	95.8	99.0	98.4
Calls <sup>(4)</sup>	N/a	42.0	76.1	88.1	84.0	87.0

*Source:*

*Correspondence: From 2004, all private office, treat official and Departmental e-mail cases from Department of Health (DH) Correspondence Database. Figures include all cases with a Whitehall Standard target date and exclude cases where no reply is required. Figures do not include cases for other government departments, or agencies which are reported separately.*

*Calls: Department of Health (DH) Callscan System. Figures include all calls taken during the period. Data are not available before 2004.*

*Notes:*

*(1) Letters signed by ministers.*

*(2) Letters signed by officials on behalf of ministers.*

*(3) E-mails received through the Department's website.*

*(4) Telephone calls received in the call centre.*

**Figure B.10: Parliamentary complaints, 2007-08**

Area	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
Department of Health	0	0	2	0	2	50%	0%	50%	0
Commission for Social Care Inspection	1	0	1	0	2	0%	100%	0%	0
General Social Care Council	1	0	0	0	1	0%	0%	100%	0
Healthcare Commission	0	0	1	0	1	0%	0%	100%	0

*Source: Parliamentary and Health Service Ombudsman Annual Report 2007-08*





# C Public Service Agreement and Departmental Strategic Objective Indicators (CSR 2007) Analysis

The Government articulated its highest priorities and outcomes for the CSR 2007 period (from 2008-09 to 2010-11) through the introduction of 30 cross-government Public Service Agreements (PSAs) and a set of Departmental Strategic Objectives (DSOs), published in December 2008.

The Department leads on two PSAs:

- PSA Delivery Agreement 18 – Promote better health and well-being for all; and
- PSA Delivery Agreement 19 – Ensure better care for all.

These are also the Department’s DSO1 and DSO2 respectively. DSO3 is:

- To provide better value for all.

The Department has a set of 44 DSO indicators – to which PSAs are a subset – underpinning its wider departmental business such as the Department’s contribution to the delivery of other government departments’ PSAs.

Following publication of initial progress in the Department’s *Autumn Performance Report 2008*, this report provides some further reporting of progress on the CSR 2007 commitments.

The data systems underpinning PSA and DSO indicators are subject to validation by the National Audit Office (NAO). It has published its reports on the two PSAs that the Department leads ([www.nao.gov.uk](http://www.nao.gov.uk)) and the ratings on the data systems for each indicator (refer to **figure C.1**) are captured here. The NAO has not rated the data systems for the DSO indicators. The data systems for indicators that the Department lead on that contributes to the delivery of PSAs led by other government departments have not yet been reported on by the NAO, and are not included in this report. The Department accepts that there are some areas where data collection needs to improve, and work is in place to ensure that this is happening.

**Figure C.1: National Audit Office ratings on data systems**

Rating	Definition
Green (fit for purpose)	The data system is fit for the purpose of measuring and reporting performance against the indicator.
Green (disclosure)	The data system is appropriate for the indicator and the Department has fully explained the implications of limitations that cannot be cost-effectively controlled.
Amber (systems)	Broadly appropriate, but needs strengthening to ensure that remaining risks are adequately controlled.
Amber (disclosure)	Broadly appropriate, but includes limitations that cannot be cost-effectively controlled; the Department should explain the implications of these.
Red (systems)	The data system does not permit reliable measurement and reporting of performance against the indicator.
Red (not established)	The Department has not yet put in place a system to measure performance against the indicator.

## PSA Delivery Agreement 18: Promote better health and well-being for all

### Summary assessment

PSA 18 sets out the Government's commitment to deliver the best possible health and well-being outcomes for everyone, helping people to live healthier lives, empowering them to stay independent for longer and tackling inequalities.

Five key indicators have been chosen to monitor progress against this PSA. Overall, PSA 18 is making some progress with improvement in 2 out of the 5 indicators.

#### Indicator 18.1

Vital Sign Tier 2 and Local Government National Indicator 120.

All age all cause mortality (AAACM) rate. This is a proxy measure for life expectancy – **improvement**.

This is linked to the SR 2004 commitment: By 2010, increase average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women. (The current estimate is that this is equivalent to AAACM in England decreasing to 649 deaths per 100,000 for men and 467 deaths per 100,000 for women by 2009 to 2011. Precise numbers will change as the age distribution of deaths changes; the current estimate is based on 2005 to 2007 age distribution of deaths.)

#### Progress

The 1995 to 1997 baseline figure for AAACM rates was 931.1 deaths per 100,000 population (males), 606.4 deaths per 100,000 population (females). In the period 2005 to 2007, AAACM rates have fallen to 710.1 deaths per 100,000 population (males) (24 per cent below the baseline rate), 500.2 deaths per 100,000 population (females) (18 per cent below the baseline rate). The 2005 to 2007 figures also show that life expectancy at birth in England continued to increase for both males (77.5 years) and females (81.7 years).

For more information, visit the publications and statistics section of the Department's website at: [www.dh.gov.uk](http://www.dh.gov.uk)

#### Data quality

Green (fit for purpose)

## Indicator 18.2

Vital Sign Tier 2 and Local Government National Indicator 120.

Gap in the AAACM rate between spearhead group and England average. This is a proxy measure for life expectancy – **no improvement**.

This is linked to the SR 2004 commitment: Reduce health inequalities by 10 per cent by 2010 as measured by life expectancy at birth. (The current estimate is that this is equivalent to the AAACM gap decreasing to 98 deaths per 100,000 for men and 58 deaths per 100,000 for women by 2009 to 2011. Precise numbers will change as the age distribution of deaths and England life expectancy change; the current estimate is based on 2005 to 2007 age distribution of deaths and current England life expectancy trend.)

### Progress

The 1995 to 1997 baseline figure for the gap in AAACM rates was 142.3 deaths per 100,000 population (males), 75.5 deaths per 100,000 population (females). The 2005 to 2007 gap in AAACM rates show 124.1 deaths per 100,000 population (males), 76.1 deaths per 100,000 population (females).

Life expectancy has improved significantly for both spearhead areas and England on average, but the gaps have not narrowed compared with the baseline. The baseline figure is a three-year average for the period 1995 to 1997, when the spearhead group life expectancy was 72.7 years for males and 78.3 years for females, and the relative gap in life expectancy between England and the spearhead group was 2.57 per cent for males and 1.77 per cent for females. In the period 2005 to 2007, spearhead group life expectancy has risen to 75.6 years for males and 80.2 years for females; however, the relative gap in life expectancy was 4 per cent wider than the baseline gap for males (compared with 2 per cent wider in 2004 to 2006), and was 11 per cent wider than the baseline gap for females (the same as in 2004 to 2006).

For more information, visit the publications and statistics section of the Department's website.

### Data quality

Green (fit for purpose)

### Indicator 18.3

Vital Sign Tier 2 and Local Government National Indicator 123.

Smoking prevalence is linked to the SR 2004 commitment to reduce adult smoking rates by 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less – **improvement**.

#### Progress

The rate of stop smoking service clients who successfully quit smoking at the four-week follow-up per 100,000 population is currently used as a proxy measure for this indicator. The 2004-05 to 2006-07 baseline figure for the average annual rate was 782 quitters per 100,000 population. The rate for quarters 1 to 3 of 2008-09 was 497 quitters. This shows that the services are currently on track to exceed the baseline in 2008-09.

In 2007 the percentage of the overall population aged 16 or over who smoked was 21 per cent, and in the routine and manual occupations was 26 per cent.

For more information on stop smoking services visit the website of the NHS Information Centre ([www.ic.nhs.uk](http://www.ic.nhs.uk)), and for smoking prevalence figures visit the UK National Statistics website ([www.statistics.gov.uk](http://www.statistics.gov.uk))

#### Data quality

Green (disclosure)

### Indicator 18.4

Vital Sign Tier 3 and Local Government National Indicator 136.

Number of adults (aged 18 or over) per 100,000 population supported to live independently at home either directly through social care or via organisations that receive social services grants – **not yet assessed**.

#### Progress

This is a new indicator. First-time data are available for 2007-08, in which year 3,143 people per 100,000 population were helped to live independently at home (refer to **figure C.2**).

For more information, visit the website of the Information Centre.

#### Data quality

Amber (systems)

**Figure C.2: Number of adults per 100,000 helped to live at home**

Period	Number of adults aged 18+ per 100,000 population helped to live at home
2001-02	2,475
2002-03	2,531
2003-04	2,564
Definition restated	
2004-05	2,512
2005-06	2,560
2006-07	2,572
Definition restated	
2007-08	3,143

Source: Copyright © 2009 Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

*Notes:*

(1) Clients helped to live at home include Referrals, Assessments and Packages of Care (RAP) data from 2000-01 to 2006-07 and include RAP and Government Finance Statistics (GFS) data fro 2007-08.

(2) The figure for 2007-08 includes GFS data but there is some double counting between RAP and GFS data where a person receives services arranged by their council following an assessment and services from a grant-funded voluntary organisation. This is estimated at around 20 per cent of the GFS data. There is also double counting within the GFS data where a person receives services from more than one grant-funded scheme or organisation, but it is difficult to estimate how large this is due to data sharing issues.

### Indicator 18.5

#### Vital Sign Tier 3

Improving access to psychological therapies (IAPT) through the proportion of people with depression and/or anxiety disorders who are offered psychological therapies – **not yet assessed**.

#### Progress

This is a new indicator and IAPT services have been rolled out across 35 PCTs in year 1 (2008-09) of the IAPT Programme. In year 2 (2009-10), IAPT services will be rolled out across a further 81 sites, bringing the total to 116 PCTs by April 2010. A baseline will be established from quarter 4 key performance indicator data returns in May 2009.

For more information, visit [www.iapt.nhs.uk](http://www.iapt.nhs.uk)

#### Data quality

Amber (disclosure)

## PSA Delivery Agreement 19: Ensure better care for all

### Summary assessment

PSA 19 sets out the Government's commitment to ensure that people have high-quality, safe and accessible care that is sensitive to their individual health and adult social care needs, and their particular lifestyles and aspirations. Eight key indicators have been chosen to monitor progress against this PSA.

Overall, PSA 19 is making strong progress with improvement in 6 out of the 8 indicators.

#### Indicator 19.1

Vital Sign Tier 2 and Local Government National Indicator 127.

Self-reported experience of patients and users – **improvement**.

#### Progress

The baseline is drawn from the 2007-08 survey programme, and results for 2008-09 will be drawn from the accident and emergency services survey, adult in-patient survey, ambulance services (category C) survey, and mental health in-patient survey. Baseline results for 2007-08 were published on the Department's website in November 2008 and the next update will be published in June 2009.

For more information, visit the publications and statistics section of the Department's website.

#### Data quality

Green (disclosure)

## Indicators 19.2 (admitted) and 19.3 (non-admitted)

Vital Sign Tier 1.

This is linked to the SR 2004 commitment: To ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment (for clinically appropriate patients who choose to start their treatment within 18 weeks). The minimum operational standards that the NHS is expected to deliver against are 90 per cent for admitted patients and 95 per cent for non-admitted patients – **improvement**.

### Progress

From 1 January 2009, 90 per cent of patients who require admission to hospital and 95 per cent of patients who do not require admission to hospital can expect to start their consultant-led treatment within a maximum of 18 weeks from referral, unless it is clinically appropriate to do so or they choose to wait longer. As set out in *The Operating Framework 2009-10*, delivering treatment within a maximum of 18 weeks continues to be a priority for the NHS. Every PCT and trust needs to achieve this standard across all services and specialties, monitoring waits over of 18 weeks so that patients do not wait for reasons other than choice or clinical exception.

The baseline figure for admitted patients was 48 per cent in March 2007, and for non-admitted patients it was 75.5 per cent in August 2007. In February 2009, the NHS delivered the operational standards for 18 weeks for the seventh month since August 2008. Some 92.7 per cent of admitted patients and 97.3 per cent of non-admitted patients began treatment within 18 weeks of referral. The median time waited for admitted patients was 8.7 weeks, and for non-admitted patients it was 3.7 weeks (refer to **figure C.3**.)

Reducing waiting times for diagnostic tests has been pivotal in delivering treatment within a maximum of 18 weeks from referral. Stage of treatment waiting time data for the 15 key diagnostics tests show that the number of waits over 6 weeks at the end of February was 3,500 – which is 0.8 per cent of the total number of waits. This compares with 276,800 in February 2007. Patients can expect to wait around 2 weeks for one of the 15 key diagnostic tests, compared with 6.1 weeks in April 2006 when data were first published (refer to **figure C.4**.)

For more information, visit the publications and statistics section of the Department's website.

### Data quality

Green (disclosure)

**Figure C.3: Percentage of patients waiting less than 18 weeks**

Month	Percentage within 18 weeks:	
	admitted <sup>(1)</sup>	non-admitted
March 2007	48%	
April 2007	51%	
May 2007	53%	
June 2007	54%	
July 2007	54%	
August 2007	56%	76%
September 2007	57%	76%
October 2007	60%	77%
November 2007	63%	77%
December 2007	69%	79%
January 2008	69%	82%
February 2008	75%	86%
March 2008	87%	93%
April 2008	87%	93%
May 2008	89%	94%
June 2008	89%	94%
July 2008	90%	95%
August 2008	90%	95%
September 2008	90%	96%
October 2008	91%	96%
November 2008	91%	96%
December 2008	93%	97%
January 2009	93%	97%
February 2009	93%	97%

Source: NHS Finance, Performance and Operations, DH

Notes:

(1) Admitted figures unadjusted (to account for clock pauses) up to February 2008, adjusted for March 2008 onwards.

**Figure C.4: Diagnostic over 6 week waiters (patient numbers)**

Month	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	September 2007	October 2007	November 2007	December 2007
15 monthly tests	350,822	276,824	243,190	249,481	224,972	211,004	186,154	174,066	140,052	114,296	89,905	86,185
All other diagnostic tests (quarterly census)	186,580	186,580	101,489	101,489	101,489	87,630	87,630	87,630	69,160	69,160	69,160	44,400
Month	January 2008	February 2008	March 2008	April 2008	May 2008	June 2008	July 2008	August 2008	September 2008	October 2008	November 2008	December 2008
15 monthly tests	67,473	33,121	12,904	12,021	11,751	10,083	11,088	10,494	6,616	6,115	4,839	5,703
All other diagnostic tests (quarterly census)	44,400	44,400	12,600	12,600	12,600	7,069	7,069	7,069	7,457	7,457	7,457	6,279
Month	January 2009	February 2009										
15 monthly tests	5,686	3,470										
All other diagnostic tests (quarterly census)	6,279	6,279										

Source: NHS Finance, Performance and Operations, DH



## Indicator 19.4

### Vital Sign Tier 2 and Local Government Indicator 126

The percentage of women who have seen a midwife or maternity healthcare professional for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy – **not yet assessed**.

### Progress

This is a new indicator in 2008-09. The proxy, unvalidated data for quarter 3 2008-09 shows that nationally around 78 per cent of women in England are seen by the 12th completed week of pregnancy, although wide variation exists between SHAs. The first full assessment of performance improvement will be made in quarter 2 2009-10, when quarter 4 2008-09 12-week assessment data are compared with quarter 2 2009-10 birth data and performance in quarter 3 and quarter 4 2008-09 can be compared.

### Data quality

Amber (disclosure).

Figure C.5: Access for women to maternity services

Strategic health authority	% of maternities assessed by 12th completed week of pregnancy (quarter 3, 2008-09)
North East	85.2%
North West	75.1%
Yorkshire and the Humber	76.5%
East Midlands	89.0%
West Midlands	83.3%
East of England	75.3%
London	66.4%
South East Coast	85.7%
South Central	87.8%
South West	84.4%
<b>England</b>	<b>78.5%</b>

Source: PCT Vital Signs monitoring returns

Notes:

(1) The definitions for the numerator and denominator for quarter 1 and quarter 3 were revised for quarter 3 based on the variation in PCT returns due to varying interpretations of the original definitions.

(2) Quarter 3, 2008-09 shows significant improvement in number of data returns by PCTs.

### Indicator 19.5

Vital Sign Tier 3 and Local Government National Indicator 124

Percentage of people with a long-term condition (LTC) supported to be independent and in control of their condition(s) – **not yet assessed**.

#### Progress

Change in the number of emergency bed days is used as a proxy measure for this indicator during 2008-09. In 2007-08, there were 28.2 million emergency bed days and 74 per cent of people with an LTC reported feeling either fully (45 per cent) or partially (29 per cent) supported to manage their condition. Updated results for the proportion of people with LTCs feeling supported will be published by February 2010.

#### Data quality

Green (disclosure)

### Indicator 19.6

Vital Sign Tier 1.

Patient-reported experience of access to GP services, as measured by an average of five indicators in the GP Patient Survey (GPPS) covering telephone access, 48-hour access, advanced booking, seeing a specific GP and opening hours – **improvement**.

#### Progress

The GPPS showed that overall satisfaction aggregated from the five indicators was 84 per cent in 2006-07 and 85 per cent in 2007-08 (refer to **figure C.6**).

The 2008-09 GPPS will cover a broader range of questions covering overall patient experience of GP practice, and a new baseline will be established using new survey questions in the 2008-09 survey prior to publishing the latest data in July 2009.

For more information, visit the publications and statistics section of the Department's website.

#### Data quality

Green (disclosure)

Figure C.6: GP Patient Survey results

Area	Score
Reported that they were satisfied with their ability to get through to their doctor's surgery on the telephone	87.0%
Reported that they were able to get a quick appointment within 48 hours with a GP	87.0%
Reported that they were able to book ahead for an appointment with a doctor	77.0%
Reported that they were able to see a specific GP when they wanted to do so	88.0%
Reported that they were satisfied with the current opening hours in their practice	82.0%

Source: GP Patient Survey, 2007-08

### Indicator 19.7

Vital Sign Tier 1.

Healthcare-associated infection (HCAI) figures – MRSA – **improvement**.

#### Progress

Baseline figures for 2003-04 show that there were 7,700 cases. For quarter 2 in 2008-09 there were 725 MRSA cases reported and by quarter 3, 676 MRSA cases had been reported. These data bring the total of MRSA cases for quarter 1 to quarter 3 in 2008-09 to 2,239. Data for quarter 4 in 2008-09 will not be published until June 2009; however, indications are that MRSA cases continue to fall.

For more information, visit the Health Protection Agency website ([www.hpa.org.uk](http://www.hpa.org.uk)).

#### Data quality

Green (fit for purpose)

### Indicator 19.8

Vital Sign Tier 1.

Healthcare-associated infection (HCAI) figures – *Clostridium difficile* – **improvement**.

#### Progress

Baseline figures show that in 2007-08 there were 55,499 *C. difficile* cases. For quarter 2 in 2008-09 there were 8,948 cases (all cases for age 2 and over) reported, and by quarter 3, 7,906 cases had been reported. These data bring the total of *C. difficile* cases for quarter 1 to quarter 3 in 2008-09 to 27,737. Data for quarter 4 in 2008-09 will not be published until June 2009; however, indications are that *C. difficile* cases continue to fall.

For more information, visit the Health Protection Agency website.

#### Data quality

Green (fit for purpose)

### **Jointly shared indicator DWP 17.5**

Local Government National Indicator 139.

The extent to which people over 65 receive the support they need to live independently at home – **not yet assessed**.

#### **Progress**

This is a new perception-based measure. Data is now taken from the ONS Omnibus Survey that provides monthly monitoring data. The rationale for using the ONS Omnibus rather than the Natcen Omnibus (as originally intended) or Place Survey, is based on frequency of data. The Department's will continue to jointly work with CLG and DWP to ensure data quality. A baseline will be set using the ONS data in June 2009.

## **DSO 1: Promote better health and well-being for all (including the Department's contribution to OGD PSAs)**

### **Summary assessment**

The Department's DSO 1 aims to deliver the best possible health and well-being outcomes for everyone. PSA Delivery Agreement 18 is closely linked with this DSO, as the five PSA indicators are also DSO indicators. Progress against this DSO is measured by 19 of the Department's full set of 44 indicators, as set out in the Department Strategic Framework published in July 2008. Where DSO indicators contribute to the delivery of cross-government PSAs led by other government departments, this is shown in the heading of the indicator.

Overall, DSO 1 is making some progress with some indicators while others require more work which the Department is putting in place – improvement in 7 out of 19 indicators:

### **Indicator DSO 1.3**

Vital Sign Tier 2.

Reduce mortality rates from suicide and injury of undetermined intent mortality rate by at least 20 per cent by 2010.

#### **Progress**

This is an SR 2004 commitment. The baseline figure is a three-year average rate for the period 1995 to 1997, which showed 9.2 deaths per 100,000 population. In the period 2005 to 2007, the figure was 7.9 per 100,000 population (a decrease of 13.9 per cent).

For more information, visit the publications and statistics section of the Department's website.

### Indicator DSO 1.4 and DCSF PSA 12.4

Vital Sign Tier 2 and Local Government National Indicators 50 and 51.

Emotional health and well-being, and child and adolescent mental health services (CAMHS) are the two sub-measures monitoring progress against this indicator – **not yet assessed** (emotional health and well-being) and **improvement** (CAMHS)

#### Progress

Emotional health and well-being: The baseline for this sub-measure was established at December 2008 as 63.3 per cent of school-aged children reporting good emotional health. New data will be collected through the DCSF Tell Us surveys due in autumn 2009 and autumn 2010.

CAMHS: The baseline for this sub-measure was established at December 2008 as 15 per cent for PCTs and 20 per cent (provisionally) for local authorities on reporting maximum scores on their CAMHS self-assessments. There are four sub-measures in the CAMHS self-assessment which require PCTs to declare if they provide (1) a full range of CAMHS, (2) access for 16- to 17-year-olds, (3) 24-hour cover, and (4) a full range of universal services by local authority/PCT (note: this measure was introduced in April 2008). In quarter 3 2008-09, the number of PCTs in England fully compliant with the four sub-measures were as follows: (1) 68, (2) 88, (3) 97, and (4) 42. This showed that 22 per cent of PCTs were compliant with all measures.

### Indicator DSO 1.6

Vital Sign Tier 2 and Local Government National Indicator 121.

Reduce mortality rates by 2010 from heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a 40 per cent reduction in the inequalities gap between the fifth of areas with worst health and deprivation indicators (the spearhead group) and the population as a whole.

#### Progress

This is an SR 2004 commitment and is measured in three-year averages. The baseline figures for the period 1995 to 1997 showed that the England rate was 141.3 deaths per 100,000 population and the inequalities gap was 36.7 deaths per 100,000 population. For the period 2005 to 2007, the England rate was 79.1 deaths per 100,000 population (a decrease of 44.0 per cent) and the inequalities gap was 23.5 deaths per 100,000 population (a decrease of 35.9 per cent).

For more information, visit the publications and statistics section of the Department's website.

### **Indicator DSO 1.7**

Vital Sign Tier 2 and Local Government National Indicator 122.

Reduce mortality rates from cancer by 2010 by at least 20 per cent in people under 75, with a reduction in the inequalities gap of at least 6 per cent between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

#### **Progress**

This is an SR 2004 commitment and is measured in three-year averages. The baseline figures for the period 1995 to 1997 showed that the England rate was 141.2 deaths per 100,000 population and the inequalities gap was 20.7 deaths per 100,000 population. For the period 2005 to 2007, the England rate was 115.5 deaths per 100,000 population (a decrease of 18.2 per cent) and the inequalities gap was 18.0 deaths per 100,000 population (a decrease of 13.2 per cent).

For more information, visit the publications and statistics section of the Department's website.

### **Indicator DSO 1.8**

NHS Operating Framework national priority, 2008-09 to 2010-11.

Preparedness against pandemic influenza is measured by the requirement for all NHS organisations to have robust plans in place to respond to a flu pandemic by December 2008.

#### **Progress**

NHS organisations are reviewing the pandemic influenza plans put in place by December 2008 via a self-assessment, with results due in spring 2009. Procurement of antivirals had commenced and the stockpile should be increased to provide treatment to half of the population, in the event of an influenza pandemic. Procurement of the antibiotic stockpile is scheduled to commence during 2009 and a National Pandemic Flu Line Service will be established to operate during a pandemic with the first release due to take place by summer 2009.

### **Indicator DSO 1.9 and DWP PSA 17.3**

Vital Sign Tier 3 and Local Government National Indicator 137.

Healthy life expectancy (HLE) at age 65. This is a composite measure of actual life expectancy mortality data and the self-reported health question in the General Household Survey (which the Office for National Statistics will run as the Integrated Household Survey in the future) – **not yet assessed**.

#### **Progress**

The HLE indicator is measured over a three-year average. The latest data (reflecting the period 2004 to 2006) put healthy life expectancy at 12.9 years for men and 14.7 years for women and reflects a trend of sustained improvement over the last 20 years. This means that approximately 75 per cent of life after 65 is spent in good or fairly good health. The baseline data for this indicator (2005 to 2007) are expected in February 2010.

For more information, visit the UK National Statistics website ([www.statistics.gov.uk](http://www.statistics.gov.uk)).

### **Indicator DSO 1.11**

Vital Sign Tier 3 and Local Government National Indicator 125.

Proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation who are at home or in extra care housing or an adult placement scheme three months after the date of their discharge from hospital.

#### **Progress**

This is a new indicator and work is under way to finalise the data collection so that the baseline will be available in autumn 2009.

### **Indicator DSO 1.1**

Vital Sign Tier 3 and Local Government National Indicator 119.

Self-reported measure of people's overall health.

#### **Progress**

This is a new self-reported measure in the Department for Communities and Local Government's Places Survey; the baseline will be established in spring 2009 when the new data is published.

### Indicator DSO 1.13 and DCSF PSA 12.3

Vital Sign Tier 2 and Local Government National Indicator 55.

Levels of childhood obesity: To hold the rate of obesity among children under 11 to a maximum of 18.1 per cent by 2011, with the aim of reducing the proportion of overweight and obese children to 2000 levels by 2020. This indicator supersedes the SR 2004 commitment – **not yet assessed**.

#### Progress

In 2008, the HSE showed that the estimated prevalence of obesity among 2- to 10-year-olds has increased very slightly to 15.4 per cent in 2007, from 15.2 per cent in 2006. This change on its own is not considered statistically significant and, taken with the fall from 16.8 per cent in 2005, suggests that, as the HSE reports from its own data, “there are indications that the trend in obesity prevalence may have begun to flatten out over the last two to three years” (NHS Information Centre). Confirmation of this change will require at least one more year’s data. HSE 2008 will report around the end of 2009 and early 2010.

For more information, visit the website of the NHS Information Centre.

### Indicator DSO 1.14 and HO PSA 25.2

Vital Sign Tier 3 and Local Government National Indicator 39.

Rate of hospital admissions per 100,000 for alcohol-related harm – **improvement**.

#### Progress

The baseline rate for 2006-07 is, 1,384 admissions per 100,000 with a baseline rate of increase, based on data for 2002-03 to 2006-07, of 119 admissions per 100,000 per annum. The figures for 2002-03 to 2006-07, of 119 admissions per 100,000 per annum. The figures for 2002-03 to 2006-07 have been revised since publication of the *Autumn Performance Report 2008* to bring the indicator in line with published research on alcohol attributable conditions and with standard practice regarding the production of hospital episode statistics.

The rate for 2007-08 is 1,473 admissions per 100,000 – an increase of 89 admissions per 100,000 from 2006-07, showing an improvement on the baseline rate of increase.

For more information, visit the website of North West Public Health at [www.nwph.net](http://www.nwph.net)



### **Indicator DSO 1.15 and HO PSA 25.1**

Vital Sign Tier 2 and Local Government National indicator 40.

Percentage change in the numbers of drug users recorded as being in effective treatment – **improvement**.

#### **Progress**

The baseline figure in 2007-08 recorded 156,387 drug users in effective treatment. For the period July 2007 to July 2008 158,595 persons were recorded as being in effective treatment, a 1.4 per cent increase on the baseline.

### **Indicator DSO 1.16 and DCSF PSA 12.1**

Vital Sign Tier 2 and Local Government National Indicator 53.

Prevalence of breastfeeding at 6 to 8 weeks – **not yet assessed**.

#### **Progress**

Initiation of breastfeeding is used a proxy measure and shows a steady increase from 66.2 per cent in 2005-06 to 69.9 per cent in 2007-08. The Department has been collecting 6-8 week breastfeeding centrally for three quarters in 2008-09. During the first year of collection, the emphasis is on getting PCT systems up-and-running and getting data coverage up to a high level. At quarter 3 2008-09, the data show that among PCTs breastfeeding prevalence ranged from 78 per cent to 13 per cent.

The Department published a report on 6–8 week breastfeeding by PCT each quarter. For more information, visit [www.dh.gov.uk/infantfeeding](http://www.dh.gov.uk/infantfeeding)

### Indicator DSO 1.17 and DCSF PSA 13.3

Vital Sign Tier 3 and Local Government National Indicator 70.

Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people aged 0 to 17 years (per 10,000 population) – **improvement**.

#### Progress

The baseline figure for 2006-07 was 123.1 admissions per 10,000 and the latest 2007-08 data show 121.5 admissions per 10,000 population aged 0-17, in England a decrease of 1.3 per cent in the admission rate. Refer to **figure C.7**.

**Figure C.7: Emergency hospital admissions resulting from deliberate and unintentional injury**

Year	Admissions per 10,000	% change in admission rate
2003-04	116.1	
2004-05	116.2	0.11%
2005-06	120.6	3.80%
2006-07	123.1	2.07%
2007-08	121.5	-1.30%

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Notes:

(1) Age 0-17 years per 10,000 population aged 0-17, excluding patients not resident in England and patients of unknown residence

### Indicator DSO 1.18 and DCSF PSA 14.4

Vital Sign Tier 2 and Local Government National Indicator 112.

Reduce the under-18 conception rate by 50 per cent by 2010 – **no improvement**.

#### Progress

The baseline figure for 1998 showed there were 46.6 conceptions per 1,000 females aged 15 to 17-years-old. In 2007, there were 41.7 conceptions per 1,000 females aged 15 to 17 years old showing that England's rate fell overall by 10.7 per cent between 1998 and 2007. Within the overall reduction in conceptions, there has been a steeper decline of 23.3 per cent of conceptions leading to births. However, the latest annual data shows a reversal in trend as the 2007 under-18 conception rate was 2.6 per cent higher than the 2006 rate. The 2008 abortion data shows a 4.5 per cent reduction in the abortion rate for under-18s. As the increase in 2007 was as a result of all conceptions leading to abortion, the reduction in abortion rate may suggest that the rate of conceptions is returning to a downward trend. Nonetheless, meeting the 2010 target remains a significant challenge, but work is underway to support PCTs to successfully reduce teenage pregnancy rates.

### **Indicator DSO 1.19**

Vital Sign Tier 2 and Local Government National Indicator 113.

Prevalence of chlamydia in under-25-year-olds is measured by a proxy of the percentage of the population aged 15 to 24 accepting a test/screen for chlamydia.

#### **Progress**

The baseline figure screened in 2007-08 was 4.9 per cent of the target population. Work is under way with PCTs to increase the numbers screened in order to establish the prevalence baseline.

### **Indicator DSO 1.20 and CO PSA 16.4**

Vital Sign Tier 3 and Local Government National Indicator 145.

Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation – **not yet assessed**.

#### **Progress**

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. The Department has identified resources in 2009-10 for the regional level to help deliver accommodation outcomes for the learning disability client group.

### **Indicator DSO 1.21 and CO PSA 16.7**

Vital Sign Tier 3 and Local Government National Indicator 150.

Proportion of adults in contact with secondary mental health services in employment – **not yet assessed**.

#### **Progress**

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. Work is under way on an employment strategy for the mental health client group, developed by cross-government teams including input from the Social Exclusion Taskforce at the Cabinet Office and DWP, among others. The employment strategy will be completed by summer 2009. In addition, the Department has identified resources in 2009-10 for the regional level to help deliver employment outcomes for the mental health client group.

### Indicator DSO 1.22 and CO PSA 16.3

Vital Sign Tier 3 and Local Government National Indicator 149.

Proportion of adults in contact with secondary mental health services in settled accommodation – **not yet assessed**.

#### Progress

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. The Department has identified resources in 2009-10 for the regional level to help deliver accommodation outcomes for the mental health client group.

### Indicator DSO 1.23 and CO PSA 16.8

Vital Sign Tier 3 and Local Government National Indicator 146.

Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment – **not yet assessed**.

#### Progress

This is a new indicator and the baseline will be established in 2008-09 with the aim to report data covering 2008-09 in July 2009. Work is under way on an employment strategy for the learning disability client group, developed by cross-government teams including input from the Social Exclusion Taskforce at the Cabinet Office and DWP, among others. The employment strategy will be completed by summer 2009. In addition, the Department has identified resources in 2009-10 for the regional level to help deliver employment outcomes for the learning disability client group.

## DSO 2: Ensure better care for all (including the Department's contribution to OGD PSAs)

### Summary assessment

The Department's DSO 2 aims to deliver high-quality, safe and accessible care for everyone. PSA Delivery Agreement 19 is closely linked with this DSO, where the eight PSA indicators are also DSO indicators. Progress against this DSO is measured by 8 of the Department's full set of 44 indicators, as set out in the Department's *Strategic Framework* published in July 2008. Where DSO indicators contribute to the delivery of cross-government PSAs led by other government departments, this is shown in the heading of the indicator.

Overall, DSO 2 is making some progress with some indicators while others require more work which the Department is putting in place – improvement in 6 out of 8 indicators.

### **Indicator DSO 2.26**

Vital Sign Tier 3 and Local Government National Indicator 131.

Number of delayed transfers of care from all NHS hospitals, both acute and non-acute, per 100,000 population (aged 18 and over).

#### **Progress**

The baseline figure in 2006-07 showed 14.9 per 100,000 population, and in 2007-08, this decreased to 13.8 per 100,000 population.

### **Indicator DSO 2.31**

Vital Sign Tier 3 and Local Government National Indicator 132.

Timeliness of social care assessment is measured through the percentage of new clients (aged 18 and over) where the time from first contact to completion of assessment is less than or equal to four weeks.

#### **Progress**

The baseline figure in 2006-07 was 76 per cent, and data for 2007-08 show an increase to 79.5 per cent.

For more information, visit the website of the NHS Information Centre.

### **Indicator DSO 2.32**

Vital Sign Tier 3 and Local Government National Indicator 133.

Timeliness of social care packages is measured through the percentage of new clients (aged 18 and over) where the time from completion of assessment to provision of all services in the care packages is less than or equal to four weeks.

#### **Progress**

The baseline figure in 2006-07 was 89.3 per cent, and in 2007-08, this increased to 90.9 per cent.

For more information, visit the website of the NHS Information Centre.

### **Indicator DSO 2.33**

Vital Sign Tier 3 and Local Government National Indicator 129.

Proportion of all deaths that occur at home.

#### **Progress**

The baseline figure in 2005 was 18.4 per cent and in 2007 it was 19.5 per cent, showing a steady rise of people choosing to die at home.

### **Indicator DSO 2.34**

Vital Sign Tier 3 and Local Government National Indicator 130.

Percentage of adults (aged 18 or over), older people and carers receiving social care through a direct payment (and/or an individual budget) in the year to 31 March.

#### **Progress**

The baseline figure in 2006-07 showed that 4.5 per cent of clients received social care through a direct payment or individual budget; this figure rose to 5.6 per cent in 2007-08.

For more information, visit the website of the NHS Information Centre.

### **Indicator DSO 2.37**

Vital Sign Tier 3 and Local Government National Indicator 135.

Proportion of carers receiving a 'carer's break' or a specific service for carers, or advice and information in their role as carers as a percentage of clients receiving community-based services.

#### **Progress**

The baseline figure in 2006-07 showed that 20.7 per cent of carers received a carer's break, a specific service or advice and information; this figure rose to 21.9 per cent in 2007-08.

### **Indicator DSO 2.38**

Vital Sign Tier 3 and Local Government National Indicator 128.

Patient and user-reported measure of respect and dignity in their treatment.

#### **Progress**

The baseline figure in 2002 showed that, when asked if they were always treated with respect and dignity, of 92,961 respondents, 79 per cent said 'Yes, always', 18 per cent said 'Yes, sometimes', and 3 per cent said 'No'. In 2007, of 74,873 surveyed, the figures showed 78 per cent, 19 per cent and 3 per cent respectively. The next data from the 2008 National Patients Survey will be published in May 2009.

For more information, visit the Care Quality Commission website at: [www.cqc.org.uk](http://www.cqc.org.uk)

### Indicator DSO 2.39 and DCSF PSA 12.5

Vital Sign Tier 3 and Local Government National Indicator 54.

Parents' experience of services for disabled children and the 'core offer' – **not yet assessed**.

#### Progress

This is a new indicator. The first data for England and from those local authorities who chose this indicator as a Local Area Agreement target will be published in May 2009, with further data published in September 2009 to establish the baseline.

## DSO 3: To provide better value for all

### Summary assessment

The Department's DSO 3 aims to deliver affordable, efficient and sustainable services by contributing to the wider economy and nation through providing better value for everyone. Progress against this DSO is measured by 5 of the Department's full set of 44 indicators, as set out in the Department's *Strategic Framework* published in July 2008.

Overall, DSO 3 is making some progress with some indicators while others are new and require more work, which the Department is putting in place – improvement in 3 out of 5 indicators.

### Indicator DSO 3.40

Vital Sign Tier 3 and Local Government National Indicator 134.

Reduce emergency bed days per head of weighted population by 5 per cent by 2008.

#### Progress

In 2007-08, there were 28.2 million emergency bed days (refer to **figure C.8**). This indicator is linked to the long-term conditions indicator (see PSA Delivery Agreement 19, indicator 19.5).

Figure C.8: Emergency bed days

Period	Number of emergency bed days	% change from baseline
2003-04	32,479,221	
2004-05	31,902,650	-1.8%
2005-06	30,699,595	-5.5%
2006-07	29,254,686	-9.9%
2007-08	28,193,185	-13.2%

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### **Indicator DSO 3.41**

Vital Sign Tier 1.

Financial balance (PCT).

#### **Progress**

As reported in the PCT audited financial monitoring and accounts forms in 2007-08, the NHS ended the 2007-08 year with a net surplus in PCT accounts of £391 million. At the end of 3 quarter of 2008-09, PCTs are forecasting an overall surplus of £421 million. There is only one PCT forecasting a gross operating deficit. This totals £7.5 million compared with the last quarter where there were three PCTs with a combined deficit of £27 million, and to the first quarter where no PCTs were forecasting a gross operating deficit. The Department is working through SHAs to ensure that the PCT forecasting an operating deficit develops a recovery plan to return to financial balance while maintaining and improving services to patients.

The unaudited draft annual accounts information for 2008-09 will be published during June 2009 in *The Quarter* on the Department's website.

### **Indicator DSO 3.42**

Vital Sign Tier 3.

Prescribing indicator.

#### **Progress**

A set of three better care and better value indicators has been in development in order to provide a composite measure of this new indicator; these focus on low-cost prescribing of drugs for lipid modification, low-cost proton pump inhibitor prescribing, and low-cost prescribing of drugs affecting the rennin-angiotensin system. This set was published in January 2008 and data for quarter 1 of 2008-09 indicate that, if all PCTs moved to the level of performance achieved by the top quartile of trusts, £114 million would be saved over a year.

For more information, visit: [www.productivity.nhs.uk](http://www.productivity.nhs.uk)



### Indicator DSO 3.43

Vital Sign Tier 2.

Public confidence in local NHS.

#### Progress

This is a new indicator and has been in development under three broad headings in order to provide a composite measure covering an indication that the organisation: organises services with a focus on the individual; arranges services with a focus on dignity and respect for the patient; and makes use of patient and public feedback and learns from experience. The Department is currently working with NHS performance leads to agree this set with the aim to begin data collection in 2009-10.

The baseline position as at April 2009 is shown in **figure C.9**.

**Figure C.9: Public confidence in local NHS**

Area	Score
Focus on the individual	67.8
Dignity and respect	83.3
Improving as an organisation	41.1
<b>Overall score</b>	<b>64.2</b>

Source: Various including the adult in-patient survey, the A&E patient survey, the NHS staff survey and NHS written complaints data

Notes:

(1) Scores out of 100.

### Indicator DSO 3.44

Vital Sign Tier 3.

NHS Estates energy/carbon efficiency is measured in two targets: to reduce the overall level of primary energy consumption by 15 per cent or 0.15 MtC (million tonnes carbon) from March 2000 to March 2010; and to achieve a level of 35–55 GJ/100 m<sup>3</sup> (gigajoules per 100 m<sup>3</sup>) energy performance for all new capital developments and major redevelopments/refurbishments, and 55–65 GJ/100 m<sup>3</sup> for existing facilities.

#### Progress

The baseline is the 1999-2000 Estates Related Information Collection (ERIC). Initial analysis for 2007-09 shows that energy performance has improved by 6.5 per cent since 2000 and total energy consumption has increased by 9 per cent as the size of the NHS has increased by 18 per cent; and that 55 per cent of NHS buildings meet the target for new capital development, with an additional 17 per cent meeting the existing facilities target.

The Department continues to report on the following legacy targets from previous Spending Reviews.

## SR 2004

Targets 1, 3, 4, 5 and 7 have been subsumed into CSR 2007. Targets 6 and 8 have been achieved and final reporting took place in the 2008 Departmental Report.

### Target 2

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

### Progress

Infant mortality – **slippage**.

The baseline figure is a three-year average for the period 1997 to 1999; the infant mortality rate among the routine and manual group was 13 per cent higher than in the total population. In the period 2005 to 2007, the infant mortality rate among the routine and manual group was 16 per cent higher than in the total population, a wider gap than at the baseline. However, the gap has narrowed in recent years – the rate among the routine and manual group was 19 per cent higher than in the total population in the period 2002 to 2004, 18 per cent higher in the period 2003 to 2005, and 17 per cent higher in the period 2004 to 2006.

For more information, visit the publications and statistics section of the Department's website.

Life expectancy: See under PSA Delivery Agreement 18 Indicator 18.2: Gap in the AAACM measure.

## SR 2002

Information on the one remaining target is provided below.

### Target 11

Reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth – **slippage**.

### Progress

Infant mortality: See under SR 2004 measure.

Life expectancy – **slippage**.

Note that the life expectancy target was revised as part of SR 2004 – the SR 2004 target relates to the spearhead group of local authorities, while the SR 2002 target relates to the fifth of local authorities with the lowest life expectancy. The baseline figure is a three-year average for the period 1997 to 1999; the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 2.67 per cent for males and 1.92 per cent for females. In the period 2005 to 2007, the relative gap in life expectancy was 2 per cent wider than the baseline gap for males (compared with 1 per cent wider in 2004 to 2006), and was 12 per cent wider than the baseline gap for females (compared with 11 per cent wider in 2004 to 2006).

## CSR1998

The majority of SR 1998 targets were subsumed within the SR 2002 targets and details were given in previous performance reports. Information on the remaining targets 3 and 4 are provided below.

### Target 3

Reduction in the rate of hospital admissions for serious accidental injury by at least 10 per cent by 2010 – **slippage**.

### Progress

The baseline figure for the financial year 1995-96 was 315.9 admissions per 100,000 population. In 2006-07, this had risen by 3.1 per cent to 325.8 admissions per 100,000 population, showing an increase in the number of accidents such as falls among people aged over 65.

### Target 4

Reduction in the death rate from accidents by at least 20 per cent by 2010 – **slippage**.

### Progress

The baseline figure is a three-year average for the period 1995 to 1997 and showed 15.8 deaths per 100,000 population. In the period 2005 to 2007, the figure was the same as at the baseline.

For more information, visit the publications and statistics section of the Department's website.



## D Executive Agencies of the Department of Health and Other Bodies

### Executive agencies

#### Medicines and Healthcare products

##### Regulatory Agency (MHRA)

The MHRA helps to safeguard public health through the regulation of medicines and medical devices. It does this by ensuring that they meet the required standards of safety, quality, performance and effectiveness and are used safely. Its main sources of funding are from fees from the pharmaceutical industry for the licensing of medicines, and funding from the Department for the regulation of medical devices.

The main tasks carried out by the MHRA are to assess medicines before they can be used in the UK, and to ensure compliance with statutory requirements for the manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices.

The agency also operates systems for recording, monitoring and investigating adverse reports and incidents, and for taking enforcement action in order to safeguard public health. The agency provides advice and support to the Department's ministers on policy issues, and represents the UK in European and other international areas concerning the regulation of medicines and medical devices.

The MHRA has also recently taken on the authorising and inspecting of blood establishments, monitoring compliance of hospital blood banks and the assessment of serious adverse events

and reactions associated with blood and blood components (haemovigilance).

For further information, visit the website at: [www.mhra.gov.uk](http://www.mhra.gov.uk)

##### NHS Purchasing and Supply Agency (NHS PASA)

NHS PASA was established in April 2000. It works to ensure that the NHS in England makes the most effective use of its resources by getting the best possible value for money when purchasing goods and services. Its prime target is to release money that could be better spent on patient care by achieving purchasing savings and improving supply performance across the NHS.

For further information, visit the website at: [www.pasa.nhs.uk](http://www.pasa.nhs.uk)

## **Other bodies (including executive non-departmental public bodies and special health authorities)**

### **Executive non-departmental public bodies**

Alcohol Education and Research Council (AERC)  
[www.aerc.org.uk](http://www.aerc.org.uk)

Appointments Commission (AC)  
[www.appointments.org.uk](http://www.appointments.org.uk)

Care Quality Commission (CQC)  
[www.cqc.org.uk](http://www.cqc.org.uk)

Commission for Social Care Inspection (CSCI)  
(closed on 1 April 2009 when the Care Quality Commission took over the work)  
[www.csci.org.uk](http://www.csci.org.uk)

Council for Healthcare Regulatory Excellence (CHRE)  
[www.chre.org.uk](http://www.chre.org.uk)

General Social Care Council (GSCC)  
[www.gsc.org.uk](http://www.gsc.org.uk)

Healthcare Commission (HC) (closed on 1 April 2009 when the Care Quality Commission took over the work)  
[www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

Health Protection Agency (HPA)  
[www.hpa.org.uk](http://www.hpa.org.uk)

Human Fertilisation and Embryology Authority (HFEA)  
[www.hfea.gov.uk](http://www.hfea.gov.uk)

Human Tissue Authority (HTA)  
[www.hta.gov.uk](http://www.hta.gov.uk)

Independent Regulator of NHS Foundation Trusts (Monitor)  
[www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

National Institute for Biological Standards and Control (NIBSC) (became part of the Health Protection Agency on 1 April 2009)  
[www.nibsc.ac.uk](http://www.nibsc.ac.uk)

Postgraduate Medical Education and Training Board (PMETB)  
[www.pmetb.org.uk](http://www.pmetb.org.uk)

### **Special health authorities**

Information Centre for Health and Social Care (HSCIC)  
[www.ic.nhs.uk](http://www.ic.nhs.uk)

Mental Health Act Commission (MHAC)  
(closed on 1 April 2009 when the Care Quality Commission took over the work)  
[www.mhac.org.uk](http://www.mhac.org.uk)

National Institute for Health and Clinical Excellence (NICE)  
[www.nice.org.uk](http://www.nice.org.uk)

National Patient Safety Agency (NPSA)  
[www.npsa.nhs.uk](http://www.npsa.nhs.uk)

National Treatment Agency for Substance Misuse (NTA)  
[www.nta-nhs.org.uk](http://www.nta-nhs.org.uk)

NHS Blood and Transplant (NHS BT)  
[www.nhsbt.nhs.uk](http://www.nhsbt.nhs.uk)

NHS Business Services Authority (NHS BSA)  
[www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk)

NHS Institute for Innovation and Improvement (NHSi)  
[www.institute.nhs.uk](http://www.institute.nhs.uk)

NHS Litigation Authority (NHS LA)  
[www.nhsli.com](http://www.nhsli.com)

NHS Professionals (NHS P)  
[www.nhsprofessionals.nhs.uk](http://www.nhsprofessionals.nhs.uk)

For a full listing of public bodies that exist to support the Department's business, please go to:  
[www.dh.gov.uk/en/Publicationsandstatistics/  
Publications/PublicationsPolicyAndGuidance/  
DH\\_092395](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092395)

The following advisory non-departmental public bodies were established during 2008 and do not currently appear in the above publication:

Medical Education England  
[www.mmc.nhs.uk](http://www.mmc.nhs.uk)

National Information Governance Board (NIGB)  
(please note the Patient Information Advisory Group (PIAG) was abolished and their responsibilities transferred to NIGB)  
[www.nigb.nhs.uk](http://www.nigb.nhs.uk)





## E Public Accounts Committee Recommendations

The Department's *Autumn Performance Report 2008* (DH, December 2008) set out the recommendations made by the Committee of Public Accounts (PAC) since April 2008. This can be viewed at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091854](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091854)

Since the Autumn Performance Report, the Department has responded to two PAC reports: *NHS Pay Modernisation: New Contracts for General Practice Services in England* (The Stationery Office, 2008); and *The National Programme for IT in the NHS: Progress since 2006* (The Stationery Office, 2008).

### **NHS Pay Modernisation: New Contracts for General Practice Services in England**

**Recommendation (i):** Incomplete data on the cost of services provided by GPs led the Department to underestimate expenditure in the first three years of the contract. Where practicable, major changes should be piloted before they are implemented so that costs can be determined with greater accuracy.

**Progress:** The Department has already introduced more robust systems for costing and evaluating proposals for contract changes. These comprise internal scrutiny and review by the Department's Revenue Investment Branch on all planned investments with costs over £40 million per annum. In addition, as part of the Department's

proposals for introducing an independent process for reviewing Quality and Outcomes Framework (QOF) indicators led by NICE, the Department is proposing that new QOF indicators should be piloted. This is one of the proposals made in a consultation document on the new process, *Developing the Quality and Outcomes Framework: Proposals for a new, independent process* (DH) published on 30 October 2008.

**Recommendation (ii):** The Office for National Statistics' (ONS) method for estimating productivity in primary care was not accepted by the Department as sufficiently robust. An agreed method for measuring productivity in primary care should be developed, which has the support of the NHS, the Department, the Treasury and the ONS. More specifically, the Department needs to set a clear strategy and timetable for PCTs to report to SHAs on how their GP practices have improved productivity.

**Progress:** The Department has commissioned a three-year research project from the Centre for Health Economics (CHE) to take forward work on measuring NHS productivity. As part of this work, CHE has just published a report on NHS output growth which presents separately, outputs in primary medical care. In April 2009, a similar report on inputs was published and from these two reports it should be possible to produce much better estimates of GP productivity. In addition, the Department continues to work closely with the ONS to improve its measures of output and

productivity. ONS is currently developing an alternative approach to measuring GP input to the NHS based on the volumes of service delivered by practices to PCTs under the various contractual arrangements for primary medical services. This would enable calculation of NHS productivity treating GP practices as a contracted-out service but could also facilitate estimation of GP practice productivity.

**Recommendation (iii):** Many PCTs have failed to negotiate with their GPs for the provision of enhanced services to meet specific local needs, and have not spent to the minimum level set by the Department for enhanced services. PCTs should use the standards developed as part of the Department's World Class Commissioning Programme to benchmark their commissioning performance and identify priority areas requiring improvement.

**Progress:** The world class commissioning assurance system was launched on 4 June 2008. It is a national system to hold commissioners to account, reward performance and ensure that health outcomes are improving.

The World Class Commissioning Programme has set out 11 competences – the skills, knowledge, behaviour and processes of world class commissioning organisations. These include knowledge management and data analysis skills, investment prioritisation and strategic planning skills, and the ability to commission collaboratively with clinicians, patients and the public, local authorities and other community partners. PCTs' development and performance are assessed against these competences as part of the assurance system. The system also reviews PCT governance, including financial management, strategy and board function. The third strand of commissioning assurance assesses how PCTs achieve improvement against local health outcomes, an approach which reflects the fact that world class commissioning is driven by health outcomes and focused on local priorities. In addition, because the assurance system has a

strong focus on improvement, PCTs will receive a commentary on the organisation's 'potential for improvement', which will review the PCT's status, current direction of travel and its development needs, focusing on organisational health issues. The system will provide a common basis for agreeing development by PCTs as they move towards world class performance.

**Recommendation (iv):** The Minimum Practice Income Guarantee (MPIG) has stood in the way of the needs-based funding formula reducing historic inequality of service provision. The Department should consider replacing MPIG with a redesigned global sum allocation in order to move more money into areas of greatest need.

**Progress:** The Department agrees that MPIG, which was introduced as part of the new contract to protect GP practices' historic income for essential core services, has outlived its purpose and should be phased out. Through NHS Employers, the Department has been discussing this with the British Medical Association (BMA) and on 14 October 2008 announced changes to the contract for 2009-10, which will take the first step towards abolishing MPIG, depending on the Doctors' and Dentists' Review Body (DDRB) recommendation for GPs for 2009-10 and the Government's response. The Government has now accepted, in full, the Doctor's and Dentists' Pay Review Body (DDRB) recommendation for GPs for 2009-10, that gross contract payments will be increased by 2.29 per cent to allow for an average increase in GMS practitioners net income of 1.5 per cent, after allowing for movement in their expenses.

DDRB recommendations for GPs for 2009-10 will now be applied differentially, which will now see every GMS practice receive a national minimum uplift of 0.70 per cent to their global sum equivalent. Consequently, 91 per cent of practices currently reliant on MPIG correction factor payments in 2008-09 at a cost of £285 million will, in 2009-10, be reduced to 68 per cent

at a cost of £131 million. NHS Employers and the BMA have agreed the principle that there should be a comparable process in future years to continue the phasing out of MPIG.

The formula approach (or a comparable process) is likely to make significant progress in phasing out MPIG over a five-year period (subject to the annual recommendations of the DDRB).

The contract changes agreed for 2009-10 also include moving towards a full prevalence adjustment for QOF payments by April 2010. This means that by April 2010 practices will receive the same weighting per patient with a relevant disease no matter what their practice list size. At the moment, the prevalence weighting is damped down by the QOF payment formula in order to protect practices with low prevalence such as university practices. This will be a major step forward in ensuring that QOF payments are fairly related to the relative prevalence of long-term conditions within a practice population. This will see more money going to deprived areas and create better incentives for identifying patients with conditions that need treatment.

More immediately, the Department has already initiated a programme of investment and procurement to deliver 112 new GP practices in the areas that need them most. This will begin to deliver new additional services and capacity to patients in the 50 most poorly served PCTs (in primary care) in the country during 2009-10, with additional investment increasing to £120 million by 2010-11.

**Recommendation (v):** Access to general practice services has not improved significantly since the new contract was introduced, although the Department is taking action to address this. PCTs need to commission services that are more clearly linked to local needs, underpinned by a performance management framework that enables them to monitor how well GP practices meet this and

other requirements. They must also tackle poor performance as necessary.

**Progress:** The organisational competences for world class commissioning set out the knowledge, skills, behaviours and characteristics that underpin effective commissioning. They set out how world class commissioners will be fully engaged with local people and communities, aware of their needs and addressing them in the most effective ways. The Department is also developing a range of practical support to help PCTs manage contracts with GP practices and tackle poor performance, drawing on examples of good practice in PCTs. Earlier this year the Department also consulted on proposals to bring all GP services within the scope of the new Care Quality Commission in order to assure standards of safety and quality.

Since April 2008 there have been significant improvements in access to GP services, with 72.5 per cent of them now offering extended opening hours to their patients (as of February 2009). The 2008 GP Patient Survey (carried out from January to March 2008), showed that 87 per cent of patients are able to get GP appointments within 48 hours when they want to, up from 86 per cent the previous year, and that 87 per cent of patients are satisfied with telephone access and 88 per cent with the ability to see the GP of their choice. There was relatively lower performance on advance booking, with 77 per cent of patients reporting that they were able to book appointments more than two days in advance when they wanted to. This is an area where a number of PCTs need to work with GP practices to secure further improvements.

The Department has secured additional investment to provide a new GP-led health centre in each PCT. The new health centres will be open from 8am to 8pm, 7 days a week, 365 days a year, offering both bookable appointments and walk-in services for any member of the public; patients may also choose to register at a health centre if more convenient than their existing practice. PCTs have been asked to

work with the local NHS and patients to ensure that the services provided reflect local needs. The new centres already will provide over 2.5 million extra GP appointments a year. The first centre opened in Bradford on 28 November 2008; evidence from centres already open suggest that they are being well used and are popular, especially at times when GPs are closed, eg Saturdays.

**Recommendation (vi):** The QOF links GPs' pay to the quality of patient care they deliver but requires further enhancement, with less emphasis on indicators that are easy to measure and more on improvements in population health. The Department should:

- develop the QOF so that it is better aligned to national health priorities;
- give more weight to achieving health outcomes, rather than to clinical practices which are easy to measure; and
- allow PCTs some discretion to agree the content of the framework to reflect local priorities.

**Progress:** The contract changes agreed for 2009-10 include the reallocation of 72 QOF points, worth around £80 million, to reward GP practices for delivering a range of new interventions for their patients across seven clinical areas – cardiovascular disease, contraception, depression, chronic kidney disease, diabetes, chronic lung disease and heart failure.

*Lord Darzi's High Quality Care For All: Final Report* (DH, 2008) NHS Next Stage Review acknowledged that the number of organisational or process indicators in the QOF should be reduced and resources focused instead on new or enhanced indicators to promote health and greater clinical quality. The report also gave a commitment to introduce a new, independent process to provide advice on QOF indicators.

The Department published a consultation document on 30 October 2008 to seek views from

professional groups, patient groups and other stakeholders on how the new process should work. The Government's response to the consultation was published on 19 March 2009.

The Department has asked NICE to oversee an independent, transparent and objective process for prioritising, developing and reviewing QOF clinical and health improvement indicators for England from 1 April 2009 as part of their role in providing guidance for the NHS based on evidence of clinical effectiveness and cost effectiveness.

The main elements of the new process are:

- collating information to inform the prioritisation of potential new indicators, including setting up a facility on the NICE website for interested parties to submit ideas for priority topics;
- carrying out a prioritisation process to decide on areas for indicator development and advising on candidates for new indicators in these areas based on evidence of clinical and cost effectiveness;
- ensuring that the existing clinical and health improvement indicators are regularly reviewed;
- setting up a Primary Care QOF Indicator Advisory Committee, consisting of a range of experts and representatives from the primary care field, to consider the relative priority of potential new clinical and health improvement topics;
- appointing a contractor to develop and pilot potential new indicators and review existing indicators, applying a methodology for assessing cost-effectiveness;
- carrying out a consultation on the developed indicators during the piloting phase;
- validating the final proposals for new and reviewed indicators through the Primary Care QOF Advisory Committee and publishing its conclusions via the NICE website; and
- giving advice on:
  - time limits for new indicators after which they should be reviewed;

- the potential lower and upper thresholds for new indicators based on information about baseline uptake and expected increased uptake;
- information based on the assessment of cost-effectiveness evidence to inform the financial value of indicators; and
- guidance on the application of existing indicators in the light of the latest evidence.

At national level, NHS Employers (on behalf of the Department) would then (as now) negotiate with the BMA on which indicators should be applied nationally (or, with the agreement of the devolved administrations, across the UK as a whole) and what the value of those indicators should be.

**Recommendation (vii):** While GP partners' pay has increased by an average of 58 per cent since March 2003, practice staff have tended just to get inflation pay rises and some practice nurses do not even have appropriate contracts of employment. PCTs need to require practices, as part of their GMS contracts, to have appropriate contracts of employment in place for all staff, and advise practices on appropriate pay rates. PCTs should also, as part of the contract, require GP partners to provide annual feedback on how they have used NHS funding to improve practice productivity.

**Progress:** The contractual and statutory requirements that GMS practices need to observe are set out in the standard GMS contract and in the National Health Service (General Medical Services Contracts) Regulations 2004 (SI 2004/291). In particular, this requires a GMS contractor to comply with all relevant legislation and have regard to all relevant guidance issued by the PCT, the relevant SHA or the Secretary of State for Health. Employment Equality legislation would be considered to be 'relevant legislation' for this purpose. Contractors are rewarded as part of the QOF for having a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absences.

*Delivering Investment in General Practice: Implementing the new GMS Contract* (DH, December 2003) stated that salaried staff should be supported through the introduction of Agenda for Change (AfC) principles in general practice. The guidance made clear that, while AfC was not mandatory, GMS contractors were expected to implement its principles and to work with their PCTs on this.

While practices may approach their PCT for advice on appropriate rates of pay for practice staff, it is ultimately a matter for each practice, as independent employers, to determine themselves.

PCTs have a range of potential options where a contractual term is breached. In serious cases, such as a breach that puts the safety of patients at serious risk, the contract can be terminated immediately. For less serious breaches there is a mechanism for issuing breach and remedial notices; multiple minor breaches under these procedures can also lead to termination on notice. There are also alternatives to termination such as financial penalties, where termination is disproportionate to the contractor's failures.

The GMS and PMS contracts provide that each contractor shall submit an annual return to their PCT. The content of the annual report is not centrally directed, but each PCT must require the same categories of information from each of its contractors. Consequently, PCTs can already seek information about practice productivity from each of their contractors.

On productivity improvements, the Committee has already noted (PAC conclusion (II)) that there is no agreed robust methodology for measuring productivity. As mentioned above, the Department will work with others to agree such a methodology. Until that work is concluded, the Department will keep the final part of this recommendation under review.



## The National Programme for IT in the NHS: Progress since 2006

**Recommendation (i):** Recent progress in deploying the new care records systems has been very disappointing, with just six deployments in total during the first five months of 2008–09. The completion date of 2014–15, four years later than originally planned, was forecast before the termination of Fujitsu’s contract and must now be in doubt. The arrangements for the South have still not been resolved. The Department and the NHS are working with suppliers and should update the deployment timetables. Given the level of interest in the programme, the Department should publish an annual report of progress against the timetables and revised forecasts. The report should include updates on actions to resolve the major technical problems with care records systems that are causing serious operational difficulties for trusts.

**Progress:** The Department accepts this recommendation. While many of the programme’s systems have been delivered successfully, it is regrettable that progress has been slower than anticipated with the NHS Care Record Service at a local trust level. Some progress is being made and the Department continues to work closely with suppliers to ensure that software is fit for purpose before deployment. This approach ensures that quality takes priority over target dates before go-live, and that trusts are fully involved in the testing and sign-off of products.

The Department agrees the need to revise and publish new deployment timetables. However, precise go-live dates will always depend on quality and readiness criteria being met before deployment in healthcare settings.

The Department will consider the recommendation to publish an annual report of progress against the timetables and revised forecasts. This may, from 2009-10, take the form of a single document combining the Annual Report and

the Annual Benefits Statement (see this section, recommendation (viii)).

**Recommendation (ii):** By the end of 2008 the Lorenzo care records software had still not gone live throughout a single acute trust. Given the continuing delays and history of missed deadlines, there must be grounds for serious concern as to whether or not Lorenzo can be deployed in a reasonable timescale and in a form that brings demonstrable benefits to users and patients. Even so, pushing ahead with the implementation of Lorenzo before trusts or the system are ready would only serve to damage the programme. Future plans for deployment across the North, Midlands and East should therefore only follow successful deployment and testing in the three early adopter trusts. This will mean that lessons can be learned before any decision is taken to begin a general roll-out.

**Progress:** The Department accepts this recommendation, which reflects the current approach. The plan is for Lorenzo to be deployed and tested successfully in the three early adopter sites and for lessons to be learned before any decision is made on national implementation. Although not deployed fully throughout an acute trust by the end of 2008, the Lorenzo software was being used for clinical processes in the South Birmingham PCT and University Hospitals Morecambe Bay early adopter sites as part of the process to deliver software to bring benefits for patients, clinicians and administrators. The Department is already taking the approach in the recommendation to ensure that the implementation of Lorenzo occurs only when trusts and the IT system are both ready.

**Recommendation (iii):** The planned approach to deploy elements of the clinical functionality of Lorenzo (Release 1) ahead of the patient administration system (Release 2) is untested, and therefore poses a higher risk than previous deployments under the programme. The

Department and the NHS should undertake a thorough assessment of whether or not this approach to deployment will work in practice. No trust other than the three early adopters should be invited to take the first release of Lorenzo until it is certain that Release 1 and Release 2 will work effectively together.

**Progress:** The Department's approach with the three Release 1 early adopter sites has been to ensure that the Release 1 software and the existing Patient Administration System are thoroughly tried and tested together. Release 2 contains both clinical and Patient Administration System functionality and will be a replacement system for Release 1. This will be a significant upgrade and will be tested and managed carefully.

A different approach to upgrading will be taken for Lorenzo from Release 2 onwards. Release 2 offers the capability to introduce functionality to a trust progressively. This is a tried and tested approach used regularly in the introduction of large-scale Enterprise Resource Planning systems in the private sector. The introduction of this approach will be carefully tested and reviewed with the early adopter sites prior to national roll-out.

Any specific issues for resolution will be identified as the Lorenzo releases are progressed and any new challenges are encountered. No trusts will be expected to take a Lorenzo Release until the functionality has been demonstrated to work in practice.

**Recommendation (iv):** Of the four original Local Service Providers, two have left the programme and two remain, both carrying large commitments. CSC is responsible for deploying care records systems to the whole of the North, Midlands and East after taking over Accenture's contracts. As well as deploying systems in London, BT is responsible for the N3 broadband network and the Spine. In the light of the experience of Accenture's and Fujitsu's departures from the programme, it is vitally

important that the Department assesses BT's and CSC's capacity and capability to continue to meet their substantial commitments. The assessment should consider the impact on the strength of the Department's position of having only two suppliers responsible for the programme's major components.

**Progress:** The Department accepts this recommendation. The Department recognises the need to review suppliers' performance regularly for any signs of financial difficulties and has continually assessed the capability and capacity of its suppliers to deliver the programme as part of its arrangements for supplier management. The contracts provide the Department with the right to undertake audits, including financial audits, and these have been carried out as appropriate. The contracts also permit action to be taken if a supplier's credit rating reduces. Since 2004, NHS Connecting for Health has engaged independent analysts specifically to monitor suppliers in order to identify emerging financial issues.

The programme's contracts have proved robust, and protect the taxpayer through the principle of payment only on delivery. There are still two system suppliers for the NHS Care Records Service (iSOFT and Cerner) and two system integrators (CSC and BT). As a contingency, framework contracts were awarded to a range of companies last year in order to increase the number of potential suppliers to the programme, thereby reducing the risk from supplier failure. Framework contracts were awarded to selected suppliers who can now compete for business if the need arises. These framework contracts are complementary to the existing suite of programme contracts and provide contingency. The procurement exercise demonstrated a high level of interest among suppliers in developing IT for the NHS.

**Recommendation (v):** The termination of Fujitsu's contract has caused uncertainty among trusts in the South and new deployments have stopped. One option being considered for new

deployments is for trusts to have a choice of either Lorenzo provided through CSC or the Millennium system provided through BT. However, there are, considerable problems with existing deployments of Millennium and serious concerns about the prospects for future deployments of Lorenzo. Before the new arrangements for the South are finalised, the Department should assess whether it would be wise for trusts in the South to adopt these systems. Should either of the Local Service Providers take on additional commitments relating to the South, the Department should take particular care to assess the implications of the extra workload on the quality of services to trusts in the Local Service Providers' existing areas of responsibility.

**Progress:** The Department accepts this recommendation. Assessments of capability and capacity are key features in determining the future arrangements for the provisions of services in the South, following the termination of the contract with Fujitsu. Both BT and CSC will have to demonstrate their capacity and capability to deliver across the wider area, and be subject to independent evaluation. However, the Department has not yet contracted with either of these suppliers and other options are not yet closed.

No decisions have been made on the placing of the contracts for the South beyond protecting the position of those sites that had previously deployed systems from Fujitsu.

**Recommendation (vi):** The programme is not providing value for money at present because there have been few successful deployments of the Millennium system and none of Lorenzo in any acute trust. Trusts cannot be expected to take on the burden of deploying care records systems that do not work effectively. Unless the position on care records system deployments improves appreciably in the very near future (ie within the next six months), the Department should assess the financial case for allowing trusts to put forward applications for

central funding for alternative systems compatible with the objectives of the programme.

**Progress:** The Department agrees with some of the principles behind this recommendation, in particular that trusts should not be expected to deploy care records systems that do not work effectively. However, it does not accept that the programme is not providing value for money at present. Many elements of the programme have been delivered and are working successfully, and the principle of payment on delivery has provided protection for the taxpayer for items that are late.

The Department remains confident in the potential of both Cerner's Millennium and iSOFT's Lorenzo systems to work effectively once development and testing have been completed. Trusts will not be expected to take the systems until they work effectively, and they will be involved fully in the sign-off processes that lead to the implementation going live. Lorenzo will be tested fully in the early adopter sites before national implementation begins. In London, an improvement programme for Millennium has been completed successfully in the Royal Free Hospital, resulting in the approval by the NHS of a resumption of deployments to acute trusts across London.

Although the Department does not agree the six-month timetable, it does agree that the position on the deployment of care records systems needs to improve appreciably over the coming months, and it also agrees the principle of checkpoints as part of firm contract management. In response to recommendation (i) in this section, the Department has agreed to publish an annual report on progress. As the first of these will not be available until after the end of the 2009-10 financial year, the Department proposes to provide the Committee with a note on progress of the deployment of the NHS Care Records Service by the end of 2009.

**Recommendation (vii):** Despite the Department's previous recommendation, the estimate of



£3.6 billion for the programme's local costs remains unreliable. The Department intends to collect some better data as part of the process of producing the next benefits statement for the programme. In the light of that exercise, the Department should publish a revised, more accurate estimate for local costs and, thereby, for the cost of the programme as a whole.

**Progress:** The Department accepts the need for an accurate estimate of local costs. In line with the devolved governance structure of the programme, local costs are managed by a hierarchy of local boards. Previous approaches to collate the information in an effective manner have proved unsuccessful. The Department will consult on how best to meet the Committee's recommendations in reporting local costs and benefits without introducing an overly complex procedure into the NHS (see recommendation (viii) in this section).

**Recommendation (viii):** The Department hopes that the programme will deliver benefits in the form of both financial savings and improvements in patient care and safety. In March 2008, the Department published the first benefits statement for the programme, for 2006-07, predicting total benefits over ten years of over £1 billion. There is, however, a lot of work to do within the NHS to realise and measure the benefits. Convincing NHS staff of the benefits will be key to securing their support for the programme, and the credibility of the figures in the benefits statement would be considerably enhanced if they were audited. The Department considers future benefits statements should be subject to audit by the Comptroller and Auditor General. The Department should also review achievements under the programme so that lessons can be identified and shared where products and services are working well.

**Progress:** The Department accepts this recommendation. The first Annual Statement of Costs and Benefits (for 2006-07) prompted questions about the local costs element of the

expenditure and the ability to measure benefits satisfactorily. It is acknowledged that progress in resolving these matters has been difficult, and a fresh approach will be developed for 2009-10 alongside the Annual Report – see this section, recommendation (i) to determine how best to establish a reliable base for capturing the benefits of the national programme.

**Recommendation (ix):** Little clinical functionality has been deployed to date, with the result that the expectations of clinical staff have not been met. Deploying systems that offer good clinical functionality and clear benefits is essential if the support of NHS staff is to be secured. For all care records systems offered under the programme, the Department and the NHS should set out clearly to NHS staff which elements of clinical functionality are included in existing releases of the software, which ones will be incorporated in the next planned releases and by what date, and which will be delivered over a longer timescale.

**Progress:** The Department accepts this recommendation. It is true that there is potential for greater clinical functionality to be deployed. For both Lorenzo and Millennium, full functionality is planned to be delivered over four releases. Some systems are already providing considerable clinical advantages – for example the Picture Archiving and Communications System (PACS), which make X-rays and other images readily available to clinicians and the RiO system which has brought clinical benefits to mental health and community health trusts.

The *Health Informatics Review* Report (DH, July 2008) acknowledged the 'clinical five' elements to be provided in order to deliver value to clinicians and patients:

- the Patient Administration System (PAS), with integration with other systems and sophisticated reporting;

- Order Communications and Diagnostics Reporting (including all pathology and radiology tests and tests ordered in primary care);
- letters with coding (discharge summaries, clinic and accident and emergency letters);
- scheduling (for beds, tests, theatres etc.); and
- e-prescribing (including 'To Take Out' medicines).

The Department agrees the need to ensure that staff are aware of the content and timing of forthcoming releases. Clinicians are engaged in all aspects of the programme. The Department will consider how best to ensure that clinicians and other NHS staff are aware of the content of the new systems and when they will be delivered.

**Recommendation (x):** The Department has taken action to engage clinicians and other NHS staff but there remains some way to go in securing their support for the programme. In order to assess and demonstrate the impact of its efforts to secure support for the programme, the Department should repeat its surveys of NHS staff at regular intervals (at least every year) and publish the results.

**Progress:** The Department accepts this recommendation. The Department recognises the importance of the engagement of clinicians and other NHS staff, and welcomes the Committee's acknowledgement of the work already undertaken. The Department did not conduct a survey of NHS staff in 2008 because it was conducting a review of health informatics on which it consulted widely, involving over 1,400 stakeholders including patients, the public, clinicians, and other front-line health and social care professionals from every NHS region in England. The Department intends to keep under review its work to engage clinicians and other NHS staff, and has already established a Clinical Leaders' Network, aiming to involve at least 60 senior practising clinicians within each SHA.

**Recommendation (xi):** Patients and doctors have understandable concerns about data security. However extensive the Care Record Guarantee and other security provisions being put in place are, ultimately data security and confidentiality rely on the actions of individual members of NHS staff in handling care records and other patient data. To help provide assurance, the Department and the NHS should set out clearly the disciplinary sanctions that will apply in the event that staff breach security procedures, and they should report on their enforcement of them.

**Progress:** The Department has already directed that NHS trusts should publish details of disciplinary outcomes in relation to confidentiality breaches and data losses in their annual reports. However, the Department does not accept that it would be appropriate or practicable to change the disciplinary sanctions that should be applied at a local level or to generalise on which sanctions should be applied as each case must be looked at fairly with all facts and any extenuating circumstances considered. Guidance has been issued by NHS Employers to clarify expectations that staff who breach security procedures should be disciplined appropriately.

As with other employers, NHS bodies must comply with the statutory dismissal and disciplinary procedures set out in the Employment Act 2002 and should adhere to the Advisory, Conciliation and Arbitration Service's (ACAS) *Code of Practice on Disciplinary and Grievance Procedures* (ACAS, May 2009). The law on unfair dismissal requires employers to act reasonably when dealing with disciplinary issues, and the ACAS Code states that the core principles of reasonable behaviour include making sure that disciplinary action is not taken until the facts of the case have been established and that the action taken is reasonable in the circumstances.

All NHS trusts have documented disciplinary procedures in line with these legal and best practice requirements. The code outlines appropriate

sanctions including written warnings, final written warnings and dismissal.

**Recommendation (xii):** The Department does not have a full picture of data security across the NHS as trusts and SHAs are required to report only the most serious incidents to the Department. The Department's view is that it is not practical for it to collect details of all security breaches, but at present it can offer little reassurance about the nature and extent of lower-level breaches that may be taking place. Given the importance of data security to the success and reputation of the programme, the Department should consider how greater assurance might be provided through regular reporting. The Department should also report annually on the level of 'serious untoward incidents', on any penalties that have been imposed on suppliers for security breaches, and on the steps being taken to keep patient data secure.

**Progress:** The Department recognises the concerns expressed in this recommendation. The Department takes all security incidents seriously and will consider the recommendation further, including the implications of publishing annually a report of serious untoward incidents. In respect of data loss, a serious untoward incident is regarded as any event that involves the actual or potential loss of personal information that could lead to a significant impact on individuals. In the context of the assurance that the Committee has recommended, it will be important to ensure that these reports distinguish between security incidents relating to systems, and applications provided by the national programme and other systems; as one of the purposes of the programme is to provide a greater degree of security of data over and above that which exists currently in paper and local IT systems.

While the Department only receives reports of significant security incidents, details of lower-level breaches are reported to the SHAs and published in NHS trusts' annual reports. The Department accepts that SHAs must take all reasonable steps

to provide greater assurance on data security and will direct them to publish, each quarter, details of data losses in their areas, including details of any disciplinary action taken.

**Recommendation (xiii):** Confidentiality agreements that the Department made with CSC in respect of two reviews of the delivery arrangements for Lorenzo are unacceptable because they obstruct Parliamentary scrutiny of the Department's expenditure. The Department made open-ended confidentiality agreements in respect of these reviews, with the result that information will not be disclosed even after commercial confidentiality has lapsed with the passage of time. We believe that this is improper and that the Department should desist from entering into agreements of this kind.

**Progress:** The Department accepts this recommendation. The Department will aim to avoid this situation as far as possible. In this particular instance, the Department judged that the circumstances were unusual and that there were good grounds for accepting confidentiality agreements, without which it would have been impossible to complete the reviews.

The Department wished to engage independent analysts to review the work on Lorenzo, but had no contractual power to impose this measure on subcontractors of CSC. The parties agreed to the reviews provided that a binding confidentiality clause was included. This enabled an independent and objective assessment to be obtained leading to changes managed through a programme of improvements, which would otherwise not have been possible.

Since the *Autumn Performance Report 2008* was published, the Department, has been able to update progress against a number of recommendations.

## Prescribing Costs in Primary Care

**Recommendation (i):** The NHS could save more than £200 million a year, without affecting patient

care, by GPs prescribing lower-cost but equally effective medicines. Many drugs are available in both branded and generic versions, and the latter is usually much cheaper than the brand-name drug, for which the manufacturers have to recover research and development costs.

**Progress:** The National Audit Office has updated its original calculations, and has estimated that £396 million was saved in 2008 through more cost-effective prescribing practices.

**Recommendation (ii):** The proportion of prescriptions written by chemical name rather than by brand name, known as generic prescribing, rose from 51 per cent in April 1994 to 83 per cent in September 2006. However, only 59 per cent of prescription items were actually dispensed as generics in 2005, mainly because not all drugs prescribed were available in generic form. For some common conditions doctors have a choice of clinically equally effective drugs, some of which are available in generic form while others are only available as branded medicines. Where it is clinically appropriate, GPs should prescribe those available in generic form.

**Progress:** The NHS Institute for Innovation and Improvement's Better Care Better Value (BCBV) indicator on statins is already in operation and will continue. Two new BCBV indicators will be introduced shortly:

- proton pump inhibitors; and
- anti-hypertensive drugs.

**Recommendation (iii):** The proportion of lower-cost prescriptions for some common conditions varies greatly between PCTs, for example between 28 per cent and 86 per cent for statins. SHAs should work with the National Prescribing Centre to spread best practice in prescribing and to help those PCTs that have difficulty implementing switching programmes to learn from PCTs that have successfully done so.

**Progress:** The Department understands that there is considerable progress on this recommendation by PCTs and they are taking action in many areas to reflect their local circumstances. The BCBV indicators have generated a lot of publicity – PCTs are now taking action on their own account, backed up by the National Prescribing Centre.

**Recommendation (iv):** Comparing GP practices and PCTs on indicators of efficient prescribing is an effective way of influencing prescribing behaviour. The Department, in conjunction with the NHS Institute for Innovation and Improvement, should develop more BCBV prescribing indicators to measure the proportion of generics dispensed and the level of potential savings where more cost-effective prescribing would generate significant savings, such as for renin-angiotensins used to treat high blood pressure. SHAs should use these indicators to hold PCTs to account for prescribing costs.

**Progress:** See this section, progress for recommendation (ii).

**Recommendation (vii):** Hospital consultants' prescribing choices are bound by agreed 'formularies' of cost-effective drugs, but GPs are generally not subject to formularies. Although prescribing decisions must be sensitive to the needs of the individual patient, evidence on the cost and clinical effectiveness of treatments for a particular disease should apply consistently across the country. The Department should encourage PCTs to pilot joint primary/secondary care formularies. SHAs should work with the National Prescribing Centre to promote agreement and consistency of formularies across primary and secondary care, and across PCTs.

**Progress:** The National Prescribing Centre has undertaken some work, as part of the *NHS Constitution* activity, to provide advice to PCTs about local decisions on funding for drugs for which NICE guidance is not available.

The National Prescribing Centre's *supporting rational local decision-making about medicines (and treatments)*, a handbook of good practice guidance, was published in February 2009.

The Department believes that this will lead to more collaboration by PCTs on prescribing decisions, facilitated by SHAs.

**Recommendation (viii):** Some 88 per cent of prescription items are dispensed free of charge, and the remainder for a standard charge not directly linked to actual cost. The Department should do more to make patients aware of the costs of drugs, and hence the importance of not wasting them, for example by displaying on dispensed drugs information such as the cost of the specific items dispensed or an indication of the typical cost of items to the NHS.

**Progress:** The Department has commissioned a joint research team from the York Health Economics Consortium of the University of York, and the School of Pharmacy, University of London, to undertake research into the scale, causes and costs of waste medicines. The research teams have begun the preliminary work in undertaking the research and are due to report in mid-2009.

**Recommendation (ix):** Unused and wasted drugs cost the NHS at least £100 million a year. The Department does not have robust or up-to-date information on the cost of drugs wastage or a good understanding of the varied and complex reasons why patients do not always use their drugs. It should commission research to establish the extent to which medicines are not used, and establish the reasons why patients do not take their drugs.

**Progress:** See this section, recommendation (x).

**Recommendation (x):** Generic versions of drugs can vary considerably in appearance, colour and packaging. This variation can be confusing for patients, particularly elderly patients on several

medications, and can increase the risk of patients taking their drugs wrongly, or not at all. The Department should explore with the industry the scope to achieve greater consistency of appearance, labelling and/or packaging of the more common drugs supplied to the NHS.

**Progress:** No further update to the Department's response in the PAC Treasury Minute of March 2008.

## Caring for Vulnerable Babies: The Reorganisation of Neonatal Services in England

**Recommendation (i):** PAC recommendation (2). The reorganisation of neonatal services into clinical networks has had limited impact in reducing geographic variations in mortality rates. Prematurity and illness in newborn babies are associated with a complex range of factors, including social deprivation, ethnicity and maternal age. PCTs need to improve their understanding of the changing demographics of their local population and model the impact on demand for neonatal services to target intervention and prevention strategies on key high-risk groups.

**Progress:** The Department accepts the Committee's conclusion that the reorganisation of neonatal services into clinical networks has had limited impact to date in reducing geographic variations in mortality rates. It is important that PCTs improve their understanding of the changing demographics of their local population and model the impact on demand for neonatal services. This should be undertaken as part of the local strategic needs assessment and capacity planning process.

The Department's framework document, *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* (DH, April 2007), sets out the strategy for modernised maternity services, placing safety, quality and improving standards of care at the heart of its vision. It promotes the provision of



co-ordinated maternity and neonatal care delivered through networks. This will ensure that all women and their babies have equitable access to the whole range of specialist services where necessary.

*Maternity Matters* recognises that for the best health outcomes, it is important that women access maternity care at an early stage. The Department has developed a maternity indicator to increase the proportion of women who access maternity services by 12 completed weeks of pregnancy for a health and social care assessment of needs, risk and choices. This will enable women from high-risk groups to be identified at an early stage and an individualised care plan developed.

The Department also published the *Implementation Plan for Reducing Health Inequalities in Infant Mortality* (DH, December 2007). This plan featured key interventions to help reduce the infant mortality rate between disadvantaged groups and the whole of the population, and provided examples of good practice to help narrow the infant mortality gap – one of the aims of the 2010 national health inequalities target. In line with the commitment made in *Health Inequalities: Progress and Next Steps* (DH, June 2008), the Department has established a health inequalities infant mortality national support team to help deliver the recommendations of the plan.

**Recommendation (ii):** PAC recommendation (4). There are currently no formal arrangements for performance-managing neonatal networks. In return for continued funding of networks, SHAs should agree a set of performance measures and review networks' performance against these objectives. SHAs should also require the two areas without a formal managed network to establish them as a priority.

**Progress:** The Department accepts the Committee's recommendation that, in return for continued funding of networks, SHAs should agree a set of performance measures and review networks'

performance against these objectives. In order to assist in this local process, the taskforce will develop a suite of quality standards by autumn 2009, which can be used locally to create indicators covering quality, efficiency and capability, and which will allow trusts and commissioners to agree and review achievement against these indicators.

The Department is working with the NHS to ensure that both the Northern region and Essex are covered by formal managed networks. The Northern network is currently working to formalise its board, appoint a network manager, lead clinician and lead nurse, while in Essex a review has been established to assess the options for the future network arrangements. Its recommendations have gone out to public consultation from March 2009, with implementation in the 2009-10 commissioning cycle.

## Improving Services and Support for People with Dementia

**Recommendation (i):** There are over 560,000 people in the UK with dementia, costing the economy some £14 billion a year, yet dementia has not been an NHS priority. In response to a report by the Comptroller and Auditor General, the Department is now developing a National Dementia Strategy. The strategy should have a clear timetable for implementation and should include criteria for evaluation and reporting progress and addressing areas of under-performance such as poor diagnosis or availability of interventions recommended by NICE. It will also require an effective communications strategy to engage patient groups, health and social care professionals, the Royal Colleges, health and social care inspectorates, and the voluntary sector, all of whom are essential to improving care for people with dementia.

**Progress:** The Government's *National Dementia Strategy* was published on 3 February 2009. This followed wide consultation both before and during a formal consultation exercise in 2008.

Stakeholder events were held throughout the country, with representation from NHS and social care professionals, people with dementia and their carers, and many others. In preparing the final strategy, account was also taken of over 600 written responses to the draft strategy consultation document.

The published strategy contains 17 objectives, focusing on:

- raising awareness and understanding of dementia;
- early diagnosis and support;
- living well with dementia; and
- delivering the strategy.

Some £150 million is being made available for implementation of the strategy in the first two years, as part of PCTs' overall general allocations. These are increasing by 5.5 per cent in each of 2009-10 and 2010-11 – a total increase of £8.6 billion over the two years. This growth in allocations is new money going into the NHS and the £150 million is the Department's national estimate of the proportion of this required to implement the strategy.

Alongside the strategy, the Department has published an implementation plan based on a five-year programme of change. This is available at the Department's dementia website at: [www.dh.gov.uk/dementia](http://www.dh.gov.uk/dementia). The plan identifies the support that will be offered to PCTs, local authorities, care homes and others in implementing the strategy. It sets out the arrangements for local and national support for implementation of the strategy, and the Department's intention to work with a wide range of key stakeholders in delivering the changes required. The Department has established an Implementation Working Group to help deliver the strategy. The Working Group will co-ordinate the support programme that will be delivered regionally. It will also oversee the evaluation of demonstrator sites and other piloting

work, and the production of materials to support implementation.

Governance arrangements for the strategy will also include an Implementation Programme Board, responsible for strategic direction, and an Implementation Reference Group to ensure that key stakeholders play a central part in the process. Membership and terms of reference for all these groups will be published on the Department's dementia website. A communications plan for the implementation of the strategy will also be finalised shortly.

**Recommendation (ii):** Unlike cancer and coronary heart disease, there is no single individual with responsibility for improving dementia services. Without clear leadership there is a risk that dementia care will continue to lack priority. The Department should appoint a Senior Responsible Officer to drive through the dementia strategy, learning from the model used for cancer services.

**Progress:** David Behan, Director general for Social Care, Local Government and Care Partnerships, is the Senior Responsible Officer in the Department for the development of the National Dementia Strategy.

The Department is still considering whether there is a compelling case for a National Clinical Director as part of the strategy.

**Recommendation (iii):** Between one-half and two-thirds of people with dementia never receive a formal diagnosis. Diagnosis should always be made, regardless of whether or not interventions are available. The rate of diagnosis could be significantly improved by GP practices receiving greater support from mental health services; by the Royal College of Psychiatrists and the Royal College of General Practitioners developing a dementia care pathway including guidance on the importance of early diagnosis; and by the Institute of Innovation

and Improvement promulgating good diagnostic practice.

**Progress:** The Department agreed with the conclusions reached by the Committee on the need for the diagnosis of dementia to be made in all cases and the importance of that diagnosis being made as early as possible. The second objective in the strategy identifies the need for good-quality early diagnosis and intervention for all, with all people with dementia having access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support as needed following diagnosis.

**Recommendation (iv):** There is poor awareness among the public and some professionals of dementia and what can be done to help people with the disease. The Department should commission a dementia awareness campaign in order to increase understanding of the symptoms of dementia, emphasising that there are interventions and treatments which can slow the progress of the disease and help people with dementia and their carers lead independent lives for longer.

**Progress:** Objective 1 of the strategy identifies the need for public and professional awareness of dementia to be improved, and the stigma associated with it addressed. Individuals need to be informed of the benefits of timely diagnosis and care, the prevention of dementia should be promoted, and social exclusion and discrimination reduced. Individuals also need to be encouraged to seek appropriate help and support.

The Department has already commissioned the *Worried About Your Memory?* public awareness campaign being undertaken by the Alzheimer's Society. This was launched in May 2008. The Society sent a supply of leaflets to all GPs in England, to be made available to patients in surgeries. Copies were also made available in

pharmacies, libraries, community centres and other appropriate venues. The leaflet encourages people who are worried about their memory or someone else's memory to talk to their GP, call the Alzheimer's Society helpline, go to the Alzheimer's Society website, or request more detailed information in an information booklet. The leaflet and booklet are available in a range of languages and accessible versions.

The materials are intended to raise public awareness about dementia; to encourage people to seek help when appropriate; to enable the diagnosis of dementia earlier; and to signpost people to appropriate local help and support. Follow-up evaluation will survey GPs, people who requested information, helpline call volumes and booklet request volumes. Further awareness-raising will be undertaken by the Department as part of the strategy's implementation as part of the work on objective 1, with support given locally for awareness-raising by PCTs and local authorities.

**Recommendation (v):** People with dementia require support from multiple health and social care professionals but this is often difficult to manage. On diagnosis, people with dementia and their carers should be given a single health or social care professional contact point in order to improve the co-ordination of care between the various services and professionals. The contact point could be a social worker or a community psychiatric nurse, for example.

**Progress:** The Committee rightly acknowledged the difficulty in managing the course of this complex illness over the passage of time given the number of different health and social care professionals that may need to be involved as needs develop and change. The Department agreed that an identified single point of contact would be desirable for people with dementia and their carers, in order to co-ordinate care over time. This was covered in the consultation document issued in June 2008, and will be addressed explicitly in the final strategy.



As a result, objective 4 of the strategy identified the need for the appointment of ‘dementia advisers’ in order to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers. The role of dementia adviser would not be that of intensive case management. Rather, they will provide a single identifiable point of contact for people with dementia and their carers, with knowledge of access to the whole range of local services available. Their role will therefore be to identify what the problem might be, and then to signpost and facilitate engagement with the specialist services that can best provide the person with dementia and their carer with the help, care and support they need, simply and quickly. As this is a new role, there will be a need first for the development and generation of demonstrator projects, and for the piloting and evaluation of models of service prior to decisions on implementation.

**Recommendation (vi):** Between one-half and two-thirds of carer’s do not receive the carers assessment to which they are entitled. Carers often struggle to cope with caring for a relative with dementia at home, particularly if the person with dementia has challenging behaviour, leading to costly admission to a care home or hospital. The Department should emphasise to local health organisations and their social care partners that they need to develop an action plan, which gives priority to assessing and meeting the needs of carers. The Department should develop a commissioning toolkit to help demonstrate the cost and benefits of the different options for providing support, including respite and domiciliary care.

**Progress:** Objective 7 of the strategy addresses the need for the provisions of the Carer’s Strategy to be available for people with dementia, and emphasises the right of carers to have an assessment of their needs.

The Department accepts that not enough carers receive the carer’s assessment to which they are

entitled. The Carers Strategy, *Carers at the Heart of 21st-Century Families and Communities* (DH, June 2008), recognises the increasingly important role that carers play in our society and acknowledges that all carers, including carers of those diagnosed with dementia, need more help and support than has been available in the past. The Carers Strategy contains a number of commitments including information and advice, new break provision and a recognition that family carers should be involved in decisions about treatment and support.

The Department knows that carers need accessible and reliable information that enables them to access services and support for themselves and the person they care for. This may especially be the case for people caring for someone with a mental health problem who may feel particularly isolated and in need of help and advice. The Department recognise that, although caring for someone with mental health problems can be intermittent, it may be very intensive and stressful when the need arises.

The Department has therefore established Carers Direct, an information service for carers. The service provides advice and support for anyone looking after someone else – everything from benefits to local help – via a website, a single national freephone number, e-mail and post. One of the aims of the service is to ensure that carers are aware of their rights, including the right to an assessment. The website, hosted by NHS Choices, went live on 26 January 2009. The Carers Direct helpline is under development and went live in April 2009 and will reach full capacity by July 2009.

The Department’s vision is that carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.

The key to achieving greater integration of services is the use of more effective holistic assessment, which enables the person cared for and their carer

to identify their needs, what matters to them and how their own outcomes will best be met.

It will also be important that carers (who have a specific right to an assessment) have their own individual assessment, to ensure that specific needs around their own health and well-being are identified. This approach will enable individuals and their carers to design care and support which better meets their individual needs and draws in contributions from a range of people, organisations, family and friends.

Such assessment will be supported by the development of a Common Assessment Framework for Adults, in order to share relevant information between agencies and encourage close working between councils, the NHS and other statutory agencies as well as the third sector.

The Department is supporting a consortium, made up of stakeholder bodies (The Princess Royal Trust for Carers; Crossroads Caring for Carers; Carers UK; the National Black Carers and Care Workers Network; the Association of Directors of Adult Social Services; the Local Government Association; NHS Confederation; the Social Care Institute for Excellence; and the Improvement and Development Agency for local government), to gather good practice on commissioning for local health organisations and their social care partners.

Significantly, the *NHS Operating Framework*, which sets out the specific business and financial arrangement for the NHS in any given year, in 2008-09 makes specific reference for the first time to supporting carers.

There are similar references in guidance on practice-based commissioning and in the guidance covering joint strategic needs assessments. The aim of these various measures is to ensure that the new local performance framework recognises the importance the Government attaches to supporting carers. Improvements in the identification of cases

of dementia resulting from the strategy will also mean that carers can be identified and appropriate assessments completed.

**Recommendation (vii):** Some 62 per cent of care home residents are currently estimated to have dementia, but less than 28 per cent of care home places are registered to provide specialist dementia care. Few care home staff have specialist-nursing qualifications or have been trained in dementia care. There is high turnover of staff and high vacancy levels, and some staff do not have English as a first language. Poor standards of care have resulted in instances of inappropriate medicines management and complaints that people are not afforded sufficient dignity and respect. The Commission for Social Care Inspection should assess staff qualifications and training as part of its review of the quality of care for people with dementia, and local mental health services should use the findings when allocating resources to community psychiatric teams so that they can provide adequate out reach services to support care homes.

**Progress:** The issue of registration of care homes providing for people with dementia is not straightforward. Guidance issued by the Commission for Social Care Inspection makes clear that not all services that provide support for people who have a diagnosis of dementia must be registered as providing dementia care. Nor does this mean that a care home that is not so registered is unable to support a person with a diagnosis.

Most people with dementia are supported by general services in their own home, or in a non-specialist care home, and this is entirely appropriate. Specialist mental health services should be targeted at those people who have more complex needs and who require a higher level of expertise in their management and treatment. However, the Department needs to be confident that the services offered by all care homes fully meet the needs of all those residents with dementia.

Objective 11 of the strategy identifies the need for improved quality of care for people with dementia in care homes, by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services for community mental health teams, and through inspection regimes. Objective 13 also addresses the need for all health and social care staff, including staff in care homes, to have the necessary skills to provide the best quality of care for people with dementia, to be achieved by effective basic training and continuous professional and vocational development in dementia. Both these objectives will be priorities for the Department's Implementation Working Group and regional support network (as set out in the implementation plan) in implementing the strategy, engaging with and providing support for appropriate stakeholders, including third sector provider organisations, the Care Quality Commission, Skills for Care and others.

**Recommendation (viii):** Hospital care for people with dementia is often not well managed, increasing the risk of longer stays, admission to a care home and deterioration in the patient's health. Hospital staff generally focus on the physical reason for admission and can fail to identify or deal with dementia as a disease, resulting in longer stays and poorer outcomes than for people who are psychiatrically well. In order to improve the cost effectiveness of acute care, families of people with dementia should hold a copy of the person's care record so that paramedics will be able to make an informed decision about whether the person needs to be taken into hospital or can be treated at home. For older patients admitted and known or suspected to have cognitive impairment, hospitals should routinely undertake a mental health assessment.

**Progress:** The strategy addresses the need for better leadership on and knowledge of dementia care in general hospitals. Objective 8s set out the need for a senior clinician to be identified in general hospitals to provide leadership on improving the

quality of dementia care; to be responsible for the development of an explicit care pathway for the management of care; and to commission specialist liaison older people's mental health teams to work in general hospitals. Objective 3 of the strategy sets out the need for good-quality information to be given to family and carers throughout the course of the illness. This should include advice on the progression of the illness, and the care and medication required for people with dementia.



# F Spending on Publicity and Advertising and Income from Sponsorship, 2008-09

## Sponsorship guidelines

Under guidelines published by the Cabinet Office in July 2000, government departments are required to disclose sponsorship amounts of more than £5,000 in their departmental annual reports. For these purposes, 'sponsorship' is defined as: "The payment of a fee or payment in kind by a company in return for the rights to a public association with an activity, item, person or property for mutual commercial benefit."

**Figure F.1: Departmental spending on publicity, advertising and sponsorship, 2008-09**

Campaign title	£ million Amount
Tobacco control	25.5
Change4Life	8.6
Alcohol (Department of Health contribution to cross-government initiative)	5.9
Stroke	4.3
Sexual health (including the Department of Health's contribution to cross-government initiative)	3.0
Human papillomavirus (HPV) vaccination	3.0
Social care recruitment	2.5
NHS Choices	2.0
Respiratory and hand hygiene	1.7
Flu immunisation	1.6
Hepatitis C	1.4
Antibiotics	1.3
Frank (Department of Health contribution to cross-government initiative)	0.6
Patient choice	0.6
Other	0.6
<b>Total</b>	<b>62.6</b>

Source: Communications Directorate, DH

Notes:

(1) These figures represent projected totals for advertising-led campaigns delivered in the course of 2008-09. They should not be considered the total for all communications expenditure in the course of the year, which would incorporate a wider range of activity (eg stakeholder events).

**Figure F.2: Sponsorship paid by the Department of Health to other organisations, 2008-09**

Recipient	Amount sponsored	Support donated
None	0	None

Source: Communications Directorate, DH

**Figure F.3: Sponsorship received by the Department of Health from other organisations, 2008-09**

Campaign	Sponsor/Partner	Value (£s)	Reach	Support received
Tobacco control	Northern Foods	972	11,000 employees	Poster space in staff areas, space in staff newsletter and staff intranet.
Tobacco control	Tragus restaurants	N/a	5,000 employees	Poster space in staff areas across 270 sites.
Tobacco control	ARAMARK	1,872	13,000 employees	Poster space in staff areas and distribution of resource items.
Tobacco control	Uniq Prepared Foods	72	5,000 employees	Poster space and distribution of resource items.
Tobacco control	Arla Foods	N/a	5,000 employees	Poster space in all sites.
Tobacco control	First Group	N/a	38,000 employees	Poster space across all sites, article in staff newsletter.
Tobacco control	Premier Foods	3,708	22,000 employees	Poster space across all sites, quit kits distributed, articles on intranet and in staff newsletter, link up with NHS local stop smoking services.
Tobacco control	ASDA	100,800	175,000 employees	Poster space in staff areas of all stores, space in newsletters, intranet and link up with NHS local stop smoking services.
Tobacco control	Anchor Trust	54	10,000 employees	Activity with Bradford Local Stop Smoking Service.
Tobacco control	Rentokil Pest Control	691	1,000 employees	Distribution of Smoke-free materials.
Tobacco control	United Biscuits	1,008	7,000 employees	Distribution of Smoke-free materials.
Tobacco control	Lafarge Cement	54	1,500 employees	Work with NHS local stop smoking services.
Tobacco control	Pickfords	36	1,300 employees	Poster space and distribution of Smoke-free materials.
Tobacco control	Netto	N/a	3,000 employees	Poster space and Smoke-free collateral items distributed across all sites.
Tobacco control	Iceland	N/a	32,200 employees	Poster space in staff areas.
Tobacco control	Stagecoach	14,400	25,000 employees	Poster space in staff areas and Smoke-free items distributed.
Tobacco control	Robert McBride	162	2,000 employees	Distribution of Smoke-free materials.
Tobacco control	Greggs	864	22,000 employees	Distribution of Smoke-free materials.
Tobacco control	Tesco	5,320	240 pharmacy stores	Materials distributed in pharmacies.
Tobacco control	Morrisons	27,501	94 pharmacy stores	Materials distributed in pharmacies, in-store campaign planned for March 2009.
Tobacco control	Superdrug	22,712	260 pharmacy stores	Materials distributed in pharmacies, in-store point of sale in January 2009.
Tobacco control	ASDA	5,275	150 pharmacy stores	Materials distributed in pharmacies, in store campaign planned for March 2009.
Sexual health	Club 18-30	166,424	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	Escapades	124,337	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	Freestyle	123,497	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	2wentys	103,021	N/a	'Jonny' campaign advocating condom use on holiday promoted through pre-holiday communications, and collateral, posters and condoms distributed in-resort.
Sexual health	Morrisons	4,455	N/a	A3 in-store poster in 99 stores, visited by an average of 5.5 million customers a week.
Sexual health	Cosy Camper/Mates	52,170	N/a	30,000 festival kits distributed for free.
Sexual health	Company Time (now Yellow Hammer Bars)	97,366	N/a	Collateral sampling, and messaging on toilet roll holders, standees, cue cards and plasma screens. SMS and e-mail messaging sent out to database, and dedicated page on club website.
Sexual health	The Body Shop	32,420	N/a	In-store point of sale, 300,000 leaflets distributed, and branded condom cases inserted in the Student Guide which sold 8,000 copies.
Keep warm, keep well	Lidl	N/a	400 stores	Posters, leaflets and thermometers distributed to 400 stores in England.
Keep warm, keep well	The Co-operative	35,937	N/a	In-store DJ and till screen advertising.
Change4Life	ASDA	N/a	N/a	E-media, point of sale, staff and customer magazine activity.
Change4Life	Tesco	N/a	N/a	E-media, point of sale and customer magazine activity.
Change4Life	The Co-operative	N/a	N/a	Point of sale and in-store radio activity.
Change4Life	Convenience stores	N/a	N/a	Point of sale activity.
Change4Life	Wright Foundation	N/a	N/a	Point of sale activity.
Change4Life	Kellogg's	N/a	N/a	Direct mail, e-media, point of sale and staff activity.
Change4Life	Fitness Industry Association	N/a	N/a	Direct mail, e-media and staff activity.
Change4Life	PepsiCo	N/a	N/a	E-media activity.
Change4Life	Fit For Sport	N/a	N/a	E-media activity.

Source: Communications Directorate, DH

Notes:

(1) When attributing an advertising equivalent value on activity, the Central Office of Information only put values on activity that could be purchased. The opportunities within the employer campaigns are 'money can't buy' and therefore cannot be valued. Instead, 'reach' information has been included. Media partnerships are not included in the above. At the time of publication it was too early to report further figures for Change4Life.

## G Glossary

### **A&E (Accident & Emergency)**

The emergency department of and hospital that deals with people who need emergency treatment because of sudden illness or injury. Sometimes called the casualty department.

### **Acute services**

Medical and surgical interventions usually provided in hospital. Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

### **Annually Managed Expenditure (AME)**

Totally Managed Expenditure (TME) is divided into Annually Managed Expenditure (AME) and Departmental Expenditure Limits (DEL). AME is public expenditure for which multi-year spending limits are not seen as appropriate, and which is instead subject to annual review.

### **Arm's length bodies (ALBs)**

Government-funded organisations which work closely with local services, and other ALBs. In the Department they regulate the system, improve standards, protect public welfare and support local services. The Department has three main types of ALB: executive agencies, executive non-departmental public bodies, and special health authorities.

### **Atkinson Review**

Review of the measurement of government output and productivity.

### **Capital**

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

### **Capital charges**

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

### **Central health and miscellaneous services**

These are a wide range of activities funded from the Department spending programmes whose only common feature is that they receive funding direct from the Department, and not via primary care trusts. Some of these services are managed directly by departmental staff; others are run by executive non-departmental public bodies, or other separate executive organisations.

### **Commissioning for Quality and Innovation (CQUIN)**

The key aim of the CQUIN framework is to support a shift towards the vision set out in *High Quality Care for All* of an NHS where quality is the organising principle. The framework helps to make quality part of the commissioner/provider discussion everywhere.

### **Community care**

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

### **Corporate governance**

The system by which organisations are directed and controlled.

### **Cost of capital**

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



## Credit approvals

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

## Departmental Expenditure Limit (DEL)

Totally Managed Expenditure (TME) is divided into Annually Managed Expenditure (AME) and Departmental Expenditure Limits (DELs). The DEL is made up of departmental budgets for which there are multi-year spending limits. Almost all the Department budget, including allocations to the NHS, is within the DEL.

## Departmental Strategic Objectives (DSOs)

The core purpose of the Department – what it is here for – is enshrined in the Departmental Strategic Objectives so that its individual and team objectives and its departmental targets can all connect directly to them.

## Depreciation

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

## Derogation

The partial revocation of a law.

## Distance from target

The difference between a primary care trust's allocation and its target fair share of resources informed by the weighted capitation formula.

## Drugs bill

Drugs bill gross expenditure is the amount paid to contractors (i.e. pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for drugs, medicines and certain listed appliances which have been prescribed by NHS practitioners. Net drugs bill expenditure is less Pharmaceutical Price Regulation Scheme receipts. Funding is subject to local resource limits and forms part of primary care trusts' revenue allocations.

## Estimated outturn

The expected level of spending or income for a budget, which will be recorded in the Department's accounts.

## Estimates

See 'Supply Estimate'.

## European Economic Area (EEA)

The European Union countries plus Norway, Iceland and Liechtenstein.

## Executive agencies

A discrete unit set up to undertake an executive function of government. The Department has two executive agencies; the Medicines and Healthcare products Regulatory Agency and the NHS Purchasing and Supply Agency.

## Family health services (FHS)

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, most of whom are independent contractors.

## General dental services (GDS)

The GDS scheme offers patients personal dental care via general dental practitioners (GDPs), most of whom work as independent contractors from high street and local surgeries. Since April 2006, PCTs have been responsible for the local commissioning of GDS and other primary dental care services. Formerly GDPs claimed item of service fees for each individual treatment provided, but remuneration is now based on PCTs agreeing with each dental practice an annual contract sum for a specified level of dental services. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

## General medical services (GMS)

These are services covered by contract arrangements agreed at national level by GPs to provide one-to-one medical services: for example, giving appropriate health promotion advice, offering consultations and physical examinations, or offering appropriate examinations and immunisations.

The introduction of the new General Medical Services (nGMS) contract represents a fundamental change in the way in which practices are incentivised to deliver patient care. While it retains the independent contractor status for GPs, it moves away from remunerating individual doctors to a practice-based contract funded within primary care trusts' discretionary allocations.



The new contract provides a range of new mechanisms allowing practices greater flexibility in determining the range of services they wish to provide, including rewards for delivering clinical and organisational quality, modernisation of GP infrastructure including premises and IT, and unprecedented levels of investment through the Gross Investment Guarantee. All these mechanisms are designed to deliver a wider range of quality services for patients and to empower patients to make best use of primary care services.

### **General ophthalmic services (GOS)**

The GOS scheme offers priority groups of patients free NHS sight tests and, where necessary, optical vouchers to help with the purchase of glasses. NHS sight tests are mainly available to children, people aged 60 or over, adults on low incomes, or people suffering from, or who are predisposed to, eye disease. Entitlement to NHS optical vouchers is mainly restricted to children, adults on low incomes and those who need certain complex lenses. Services are provided by optometrists and ophthalmic medical practitioners who work as independent contractors from high street opticians. Although services are administered by PCTs, terms of service are set nationally and funding is provided from a national demand-led, or non-discretionary, budget.

### **Gershon Programme**

An independent efficiency review of Whitehall departments looking at common core functions.

### **Green Paper**

Green Papers are consultation documents produced by the Government. Often when a government department is considering introducing a new law or other major policy change, it will put together a discussion document called a Green Paper. The aim of this document is to allow people both inside and outside Parliament to debate the subject and give feedback on the proposals.

### **Gross Domestic Product (GDP) deflator**

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms. The series of GDP deflators is produced by HM Treasury.

### **Gross/net**

Gross expenditure is the total expenditure on health services, part of which is funded from other income sources, such as charges for services, receipts from land sales and income generation schemes. Net expenditure (gross minus income) is the definition of 'public expenditure' most commonly used in this report, since it is the part of the total expenditure funded by the Exchequer.

### **Healthcare Resource Groups (HRGs)**

Groupings of similar clinical procedures that require approximately similar levels of resource input. They provide a way of categorising the treatment of patients in order to monitor and evaluate the use of resources.

### **Health Improvement Programmes**

An action programme to improve health and healthcare locally and led by the PCT. It will involve NHS trusts and other primary care professionals, working in partnership with the local authority and engaging other local interests.

### **Hospital and community health services (HCHS)**

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by primary care trusts and provided by NHS trusts or NHS foundation trusts. HCHS provision is discretionary and also includes funding for those elements of family health services spending that are discretionary (GMS discretionary expenditure). It also covers related activities such as research and development, and education and training purchased centrally from central budgets.

### **Independent sector treatment centre (ISTC)**

Private sector treatment centres that offer pre-booked day and short-stay surgery, and diagnostic procedures.

### **In-patient**

A person admitted on to a hospital ward for treatment.

### **MRSA**

MRSA (sometimes referred to as the superbug) stands for methicillin-resistant *Staphylococcus aureus*. It is a bacterium from the *S. aureus* family.

### **Near cash**

Transactions that have an impact on cash flow in the short term, e.g. pay and pension costs, revenue expenditure on goods and services, or cash payments for the release of provisions.

## **National Service Framework (NSF)**

NSFs are long-term strategies for improving specific areas of care. They set measurable goals within set timeframes. Each NSF is developed with the assistance of external stakeholders in groups that usually contain health professionals, service users and carers, health service managers, partner agencies and other advocates, adopting an inclusive process to engage the full range of views.

## **NHS foundation trusts**

NHS hospitals that are run as independent, public benefit corporations, which are both controlled and run locally.

## **NHS LIFT**

NHS LIFT stands for NHS Local Improvement Finance Trust. A local LIFT will build and refurbish primary care premises which it will then own. It will rent accommodation to GPs on a lease basis (as well as other parties such as chemists, opticians dentists).

## **NHS trusts**

NHS trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as represented by primary care trusts and GPs.

## **Non-cash**

Items that will either never require a cash payment (e.g. the cost of using capital assets, depreciation, bad debts) or other items classified as non-cash that may require cash payments but in the longer term (e.g. provisions).

## **Non-discretionary**

Expenditure that is not subject to a cash limit, mainly applying to certain 'demand-led' family health services, such as the general ophthalmic services, dispensing remuneration for pharmacists and income from prescription charges.

## **Outpatient**

A person treated in a hospital but not admitted on to a ward.

## **Outturn**

The actual year end position in cash terms.

## **Overage**

Overage (also called 'clawback') is a term to describe a sum of money in addition to the original sale price which a seller of land may be entitled to receive following completion if and when the buyer complies with agreed conditions.

## **Payment by results**

A transparent rules-based system that sets fixed prices (a tariff) for clinical procedures and activity in the NHS, enabling all trusts to be paid the same for equivalent work.

## **Performance indicator**

Measures of achievement in particular areas used to assess the performance of an organisation.

## **Personal dental services (PDS)**

PDS schemes initially started as pilots where dentists offered patients personal dental care equivalent to that provided within the general dental services (GDS) scheme, but within a more flexible framework of local commissioning arrangements and alternative payment systems to item of service fees. From April 2006 most former PDS pilots switched to the new GDS contract terms. PDS agreements are now generally reserved for the commissioning of specialist care within the community, for example from practices offering orthodontic services only. Gross expenditure represents the total cost of the service; net expenditure represents the proportion of total costs met by the NHS after taking into account the income from dental charges collected from patients.

## **Personal medical services (PMS)**

A PMS contract is a system of locally agreed contracts between practices and PCTs for delivering primary medical services and is seen as a local alternative to GMS. This means that primary care service provision is responsive to the local needs of the population. As a result, PMS has been successful in reaching deprived and under-doctored areas. Many PMS pilots focus on the care of vulnerable groups, including the homeless, ethnic minorities and mentally ill patients. Funding for PMS contracts is within primary care trusts' discretionary allocations.

## **Personal social services (PSS)**

These are care and support services for people who may require them as a result of old age, mental or other ill health, substance misuse, physical or learning disability, and children being in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and social workers who provide help and support for a wide range of people.

## Pharmaceutical services (PhS)

NHS pharmaceutical services cover the supply of drugs, medicines and appliances prescribed by NHS practitioners. Gross PhS expenditure includes total drugs bill costs (see 'Drugs bill') and dispensing costs which are the remuneration paid to contractors (community pharmacists and appliance contractors, dispensing doctors and non-dispensing doctors in respect of personally administered items) for dispensing NHS prescriptions. Net PhS expenditure is the gross expenditure less income from prescription charges.

Funding for the total drugs bill is subject to local resource limits and forms part of primary care trusts' (PCTs') hospital and community health services discretionary allocations. However, funding for dispensing costs is currently provided from the national demand-led or non-discretionary budget, and is not subject to local resource limits and is not included in a PCT's discretionary allocation.

## Primary care

The initial contact for many people when they develop a health problem is a member of the primary care team. The term covers family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners. NHS Direct and NHS walk-in centres are also primary care services.

## Primary care trust (PCT)

Primary care trusts are responsible for identifying the healthcare needs of their relevant population from within their available resources, and for securing through their contracts with providers a package of hospital and community health services to reflect those needs. PCTs have a responsibility to ensure satisfactory collaboration and joint planning with local authorities and other agencies.

## Private finance initiative (PFI)

An initiative aimed at securing private sector money and management expertise for the provision of services which have traditionally been undertaken by the public sector. It was introduced as a means by which private funds can be used to supplement public investment in capital projects such as hospitals. The aim is to transfer risks of cost overruns, design faults, servicing and maintaining over the lifetime of the contract onto the private sector.

## Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, eg estimates for clinical negligence liabilities. Provisions are included in the accounts to comply with the accounting principle of prudence. An estimate of the likely expense is charged to the income and expenditure account (for the Department, to the Operating Cost Statement) as soon as the issue comes to light, although actual cash payment may not be made for many years, or in some cases never. The expense is matched by a balance sheet provision entry showing the potential liability of the organisation.

## Public Accounts Committee (PAC)

The PAC is a Committee of the House of Commons that examines the regularity and propriety of government expenditure and how it is accounted for. It also examines the economy, efficiency and effectiveness of public expenditure.

## Public Service Agreement (PSA)

PSAs accompany the Spending Review and set out output targets agreed with HM Treasury detailing the exact outcomes departments have committed to deliver with the money provided.

## Real terms

Cash figures adjusted for the effect of general inflation as measured by the Gross Domestic Product deflator.

## Reference costs

Reference costs are the average cost to the NHS of providing a defined service in a given financial year. Reference cost data allow NHS trusts to compare their costs with the NHS average and therefore benchmark their relative efficiency.

## Revenue

Revenue is expenditure other than capital, for example staff salaries and drug budgets. It is also known as current expenditure.

## Secondary care

Specialised medical services and commonplace hospital care, including outpatient and in-patient services. Access is often via referral from primary care services.

## **SNOMED**

Systematised Nomenclature of Medicine. It is a common computerised language that will be used by all computers in the NHS to facilitate communications between healthcare professionals in clear and unambiguous terms.

## **Social Services**

These are local authority departments that provide direct services in the community to clients.

## **Special health authority**

Independent health authorities that provide a service to the public and/or the NHS. They generally provide a service to the whole population of England and not just to a particular local community. Examples include NHS Direct and the National Patient Safety Agency.

## **Specific grants**

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

## **Spending Review**

HM Treasury-led review of public funding across all government departments, leading to the publication of Public Service Agreements and the budgets departments will receive to fulfil those agreements.

## **Strategic health authority (SHA)**

The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans, and that primary care trusts are performing well. There are ten in England, largely coterminous with Government Offices of the Regions.

## **Supply Estimate**

The term is loosely used for the Main Estimates, a request by the Department to Parliament for funds required in the coming financial year. There are also Supplementary Estimates. Supply Estimates are subdivided into groups (Classes) which contain provision (usually by a single department) covering services of a broadly similar nature. A subdivision of a Class is known as a Vote and covers a narrower range of services. The Department has three Votes which form Class II. Vote 1 covers the Department and contains two requests for resources – the first covering expenditure on the NHS, the second other departmental services and programmes. A Supply Estimate does not of itself authorise expenditure of the sums requested. This comes through an Appropriation Act passed by Parliament.

## **Telecare**

The use of information and communications technology systems to provide diagnosis, advice, treatment and monitoring to patients remotely. It is being used in both primary and secondary care settings.

## **Third sector**

Non-governmental organisations that are run on a not-for-profit basis and are not part of the public sector. They are motivated primarily by a desire to further social, environmental or cultural objectives rather than to make a profit for their own sake, and any surpluses they make are reinvested to further these objectives. This includes the voluntary and community sector as well as co-operatives and social enterprises, trade unions, not-for-profit trade associations etc.

## **Trading fund**

Trading funds are government departments or accountable units within government departments set up under the Government Trading Funds Act 1973, as amended by the Government Trading Act 1990. The Acts enable the responsible minister to set up as a trading fund a body which is performing a statutory monopoly service and whose fees are fixed by or under statute. A trading fund provides a financing framework within which outgoings can be met without detailed cash flows passing through Vote accounting arrangements.

## **TUPE – Transfer of Undertakings (Protection of Employment) Regulations**

This is an important part of UK labour law, protecting employees whose business is being transferred to another employer.

## **Voluntary and community sector (VCS)**

Groups set up for public or community benefit such as registered charities, and non-charitable non-profit organisations and associations.

## **Vote**

See ‘Supply Estimate’.

## **Walk-in centre**

Centres staffed by nurses that offer patients fast and convenient access to treatment and information without an appointment.

## **Weighted capitation formula**

This determines PCTs' target share of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare needs. It is a formula that uses PCT populations, which are then weighted for (i) the cost of care by age group; (ii) relative need over and above that accounted for by age; and (iii) unavoidable geographical variations in the cost of providing services (the market forces factor).

## **White Paper**

A document produced by the Government setting out details of future policy on a particular subject. A White Paper will often be the basis for a Bill to be put before Parliament. The White Paper allows the Government an opportunity to gather feedback before it formally presents the policies as a Bill.



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