Modernising Social Services

Promoting independence
Improving protection
Raising standards

Presented to Parliament by
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comments

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Foreword by the Secretary of State

This White Paper spells out what the Government proposes to do to modernise social services, in line with our proposals for the NHS and for improving public health and reducing health inequalities which we have already published. We are determined to have a system of health and social care which is convenient to use, can respond quickly to emergencies and provides top quality services. We haven't got that at present. Despite the efforts of a lot of very dedicated staff many services are not provided sufficiently conveniently, promptly or to a good enough standard.

Yet these services are very important. They range from meals on wheels for elderly people, to help at home for people suffering from mental or physical ill health, to placing in residential care children who may be in danger at home. The help comes in many forms, at home, in day centres or by way of residential or nursing home care. It is provided by local councils and by voluntary and private organisations.

One big trouble social services have suffered from is that up to now no Government has spelled out exactly what people can expect or what the staff are expected to do. Nor have any clear standards of performance been laid down. This Government is to change all that.

We propose to set new standards of performance and will publish annual reports on all councils' performance. We will introduce a Commission for Care Standards for each region to regulate residential and domiciliary care, whoever provides it. We will strengthen the role of the Social Services Inspectorate, and the Joint Reviews that they do with the Audit Commission, with tough new powers for the Secretary of State to step in when standards are not met. We will raise professional and training standards through a General Social Care Council whose job will be to ensure the proper regulation and training of social services staff.

Doing things properly doesn't necessarily cost more than doing things badly. Sometimes it can even be cheaper. But we recognise that extra funds are required and over the next three years nearly 3 billion extra will be found. 1.3 billion will form a Social Services Modernisation Fund to lead the major changes that are necessary across the whole social services programme.

Social services provide vital services to some of the most deprived people in all parts of our country, inner cities, suburbs, small towns and rural areas. Many of the most needy also require help from the health service and other agencies. In future they must work together in partnership for the benefit of local people. And we will change the law to promote such partnership. These and the dozens of other proposals in the White Paper will promote independent and fulfilling lives, improve protections for vulnerable people, and raise standards across the board. They will give us modern and dependable social services to match the modern and dependable NHS we are creating. That's why I am confident they will command the support of users and carers, the staff and everyone else of good will.

The Rt Hon Frank Dobson MP
Secretary of State for Health

What are social services?

Social services provide a wide range of care and support for:

- elderly people, through residential care homes, nursing homes, home carers, meals on wheels, day centres, lunch clubs
- people with physical disabilities or learning disabilities
- people with mental health problems, ranging from support for those with mild mental illness, up to exercising legal powers for compulsory admission to psychiatric hospitals of potentially dangerous people
- people with drug or alcohol abuse problems, and ex-offenders who need help with resettlement
- families, particularly where children have special needs such as a disability
- child protection, including monitoring of children at risk
- children in care, through fostering, accommodation in children's homes and adoption
- young offenders.

They are also responsible for the inspection and registration of care homes and other services, to ensure adequate standards and safeguards for users.

Social services are the responsibility of 150 English local authorities. Those authorities work with the voluntary sector and private social care organisations, as well as with other state agencies, to provide local people with the care they need.

1 Introduction

towards modern social services

Key themes
- the need for modernisation
- the third way for social care
- the Social Services Modernisation Fund

1.1 Social services are for all of us. At any one time up to one and a half million people in England rely on their help. And all of us are likely at some point in our lives to need to turn to social services for support, whether on our own behalf or for a family member. Often this will be at a time of personal and family crisis - the onset of mental illness, the birth of a disabled child, a family break-up, a death which leaves someone without the carer they had come to rely on.

1.2 We all depend on good social services to be there at such times of crisis, to help in making the right decisions and working out what needs to be done. And more widely, we all benefit if social services are providing good, effective services to those who need them. Any decent society must make provision for those who need support and are unable to look after themselves. Breakdowns in services for young offenders, homeless people, or people with mental health problems can have damaging consequences for other people as well as the individuals themselves. Factors such as demographic changes, and changes in the patterns of family life, are likely to mean that the need for social services will increase in the coming years. With recent advances in health care, more people, including those with profound disabilities, are able to live longer, and they rely on effective social services to achieve more fulfilling lives.

' any decent society must make provision for those who need support and are unable to look after themselves'

1.3 Social services, therefore, do not just support a small number of "social casualties"; they are an important part of the fabric of a caring society. It is a concern for everyone that social services should be providing the best possible service.

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1.4 That objective is not being met. Despite some excellent services in many places, and a generally high appreciation of services by users, social services are often failing to provide the support that people should expect.

All too often children and vulnerable adults have been exposed to neglect and abuse by the very people who were supposed to care for them. There have not been effective safeguards, and the ones that did exist were frequently ignored. The Utting Report on children's safeguards highlighted significant failings; and the House of Commons Health Select Committee recently reinforced those findings. Recent inspections by the Social Services Inspectorate (SSI) have found examples where protection systems have failed. This does not just include instances of abuse but also children identified as at risk not being monitored by social services. Equally worrying are cases where people with learning disabilities or elderly people are neglected or mistreated, or live in conditions which nobody would want to call their home. Any decent society owes to every child a safe and secure upbringing, and to every elderly or disabled man or woman the right to live in dignity, free from fear of abuse. These duties must be given greater effect in future.

Co-ordination

Sometimes various agencies put more effort into arguing with one another than into looking after people in need. Frail elderly people can be sent home from hospital, and do not get the support which was promised; or they are forced to stay in hospital while agencies argue about arranging the services they need. Recent Audit Commission findings have also shown poor coordination between housing and social services. Everyone deserves to be treated as an individual, and to have the system geared to their needs, not vice versa.

Inflexibility

Although social services help many people to live fuller and more active lives, they sometimes provide what suits the service rather than what suits the person needing care. Groups with specific needs, such as people from ethnic minorities, can be poorly served. Often services are not planned and provided in a way that would best help service users and carers to get on with their own lives. If this happens it can increase dependency and exclusion instead of alleviating them.

' lack of clarity of objectives and standards'

Clarity of role

Up to now, neither users, carers, the public, nor social services staff and managers have had a clear idea which services are or should be provided, or what standards can reasonably be expected. There is no definition of what users can expect, nor any yard-stick for judging how effective or successful social services are. Individuals do not know what services are available, in what circumstances they might get them, or whether they will have to pay. This lack of clarity of objectives and standards means that on the one hand social services cannot be easily held to account, and on the other hand they can get blamed for anything that goes wrong.

Eligibility criteria

Authorities should have clear rules about who can get help - for instance, in what sorts of circumstances someone would get help with dressing or washing at home. These rules (usually known as eligibility criteria) should mean that everyone in that area gets treated fairly. Eligibility criteria should also cover charging issues, so that people can know if they will have to pay for services, and how much.

Consistency

Social services are a local service, and vary from one part of the country to another in response to differing local needs and circumstances. This is inevitable - an inner city area such as Tower Hamlets will not have the same mix of social services needs as a rural area like Devon, and it would be pointless to try to impose uniform services everywhere. However, there must be national standards so that we can avoid some people not getting the level of quality of service that Parliament has said should be available everywhere. For instance, in some authorities one in five children in care are moved three times or more in one year, while the best authorities manage to keep this down to one in fifty. There is also often inconsistency within one area, with

different people getting different services according to what day it is and who they speak to. Eligibility criteria are not clear, and this creates a strong feeling of unfairness. Differences in how charging works from one area to another can also seem unfair.

Joint Reviews

Joint Reviews of social services are carried out by the Social Services Inspectorate (SSI) and the Audit Commission. They are a new type of review, and combine for the first time the service expertise of the SSI with the Audit Commission's understanding of value for money and effectiveness. They look at the performance of each authority across the whole of its social services responsibilities, and produce a published report. The Joint Reviews cover 20 authorities each year, and have so far published reports on 27 of the 150 councils responsible for social services in England.

Inefficiency

An important finding of the Joint Reviews so far is that there is scope for many authorities to get more for what they spend on social services. The costs of services differ substantially from one authority to another, with often a 30 per cent difference in unit costs for the same service between similar authorities in the same part of the country. By running services more efficiently, some councils could save as much as 10 million, which could be used for better services.

1.5 There are various reasons for these and other failings in the system, and the Government must take its share of the responsibility for tackling them. People who work in social services have to deal with some very difficult people and many very difficult circumstances. They often find themselves the target for criticism, and their sense of vocation is often underestimated. The Joint Reviews and SSI inspections show that criticism of the service is justified, but the Government has no wish to add further to the criticism of those who work in social services. We recognise that the law and the central framework within which social services operate is also at fault. They need to be changed so that they help those working in the services rather than hindering them.

1.6 That is why there is an agenda for modernisation which will need action at national as well as local level. The problems cannot be resolved overnight, and will take time and effort to put right. But the Government is determined to tackle the failures it has identified, and intends to undertake a series of reforms that will lead to a radical improvement of social services. This White Paper explains the new approach.

' the Government is determined to tackle the failures'

1.7 The proposals in the White Paper look to the future, to the creation of modern social services. The last Government's devotion to privatisation of care provision put dogma before users' interests, and threatened a fragmentation of vital services. But it is also true that the near-monopoly local authority provision that used to be a feature of social care led to a "one size fits all" approach where users were expected to accommodate themselves to the services that existed. Our third way for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families.

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1.8 This third way for social care is based on key principles which should underlie high quality effective services. These principles are at the heart of our modernisation programme set out in this White Paper:

- care should be provided to people in a way that supports their independence and respects their dignity. People should be able to receive the care they need without their life having to be taken over by the social services system.

- services should meet each individual's specific needs, pulling together social services, health, housing, education or any others needed. And people should have a say in what services they get and how they are delivered.

- care services should be organised, accessed, provided and financed in a fair, open and consistent way in every part of the country.

- children who for whatever reason need to be looked after by local authorities should get a decent start in life, with the same opportunities to make a success of their lives as any child. In particular they should be assured of a decent education.

- every person - child or adult - should be safeguarded against abuse, neglect or poor treatment whilst receiving care. Where abuse does take place, the system should take firm action to put a stop to it.

- people who receive social services should have an assurance that the staff they deal with are sufficiently trained and skilled for the work they are doing. And staff themselves should feel included within a framework which recognises their commitment, assures high quality training standards and oversees standards of practice

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- and people should be able to have confidence in their local social services, knowing that they work to clear and acceptable standards, and that if those standards are not met, action can be taken to improve things.

1.9 In this White Paper, the Government commits itself to these principles, and spells out how it intends to deliver the necessary improvements by action at both national and local level. The proposals will support welfare reform and social inclusion by promoting people's independence. They will improve the protection of vulnerable people. And they will raise standards so that everyone can be assured of high quality social services.

Priorities in services for adults and children

1.10 Chapter 2 sets out proposals for change in services for adults, under three priority areas: **promoting independence, improving consistency**, and providing **convenient, user-centred services**. Chapter 3 sets out the priority areas in children's services: **protection, quality of care and improving life chances**. Each chapter spells out specific initiatives and actions designed to deliver the necessary improvements.

1.11 The rest of the White Paper sets out our modernisation proposals affecting all social services:

' this White Paper sets out our modernisation proposals'

Improving protection

Chapter 4 describes radical changes to the arrangements for protecting people through better regulation of care services. This will strengthen the safeguards for children and vulnerable adults, and establish a tough new independent system for regulation.

Improving standards in the workforce

Chapter 5 sets out proposals for developing and investing in the social care workforce, including the establishment of a General Social Care Council to set practice and ethical standards for staff, give the public greater protection, and give the staff a framework which recognises their commitment and responsibilities.

Improving partnerships

Chapter 6 explains our proposals for better and clearer relationships between social services and other agencies, particularly the NHS; the plans set out will make for integrated care services which give people what they need without delays and red tape. Social services also need to work in partnership with non-statutory agencies, particularly the voluntary sector and independent care providers.

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Improving delivery and efficiency

Chapter 7 sets out our new framework for raising standards and ensuring that every local authority provides good quality, best value social services delivering positive outcomes. There will be clearer responsibilities for local government, and a clearer role for central government to take action where standards are not being met. This new performance framework will also ensure that central and local government, working together, deliver the programme of change set out in the White Paper.

1.12 These proposals form part of the Government's wider programme to modernise public services. They tie in closely with a range of other Government initiatives and programmes. They are linked with the radical steps to modernise and strengthen democracy in local government; and the new emphasis on best value and accountability. They also give effect to our commitment to improve inter-agency working between social services and the NHS. And they contribute to our efforts to strengthen family life, reduce social exclusion, tackle youth crime, and reform the welfare state.

1.13 We are also delivering the resources needed for change. A lot of money is already invested in social services. Spending in England is around 9 billion, and the average social services authority spends 60 million to provide services for local people.

' we are also delivering the resources needed for change'

1.14 In the White Paper Modern Public Services: Investing in Reform, the Government set out firm three year plans for each area of public spending. The funding for social services will be increased by an annual average of 3.1 per cent above inflation over the next three years, which is a clear signal of the priority the Government is giving to this area. Over this three year period, this amounts to nearly 3 billion extra funding for social services.

1.15 But this is not more money to provide more of the same. It is money for change and modernisation. In return for the extra public investment there must be real improvements in the services given to the public.

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1.16 As part of the extra funding, we have therefore created a Social Services Modernisation Fund. This fund will deliver over 1.3 billion of new money targeted at the key areas identified in this White Paper as needing reform.

Social Services Modernisation Fund	**1999/00**	**2000/01**	**2001/02**	**Total**
Promoting independence:partnership grant	253m	216m	178m	647m
Promoting independence:prevention grant	20m	30m	50m	100m
Children's services grant	75m	120m	180m	375m
Mental health grant*	46.4m	59.4m	79.4m	185.2m
Training support grant*	3.6m	7.1m	9m	19.7m
Total Modernisation Fund*	398m	432.5m	496.4m	1326.9m

** This represents the extra money in these areas, and is in addition to the current grant levels.*

1.17 This funding will be a lever for modernisation throughout all social services activity and spending. Through the Modernisation Fund, and through the wider increases in social services funding, we are providing the resources to match the plans set out in this White Paper.

1.18 Social services are too important to be neglected. This Government will give them the attention they deserve. In partnership with local government and other stakeholders, we will work to ensure that we can all benefit from services fit for the next century.

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2

Key themes
- helping people to live independently
- creating fairer, more consistent services for all
- making sure services fit individual needs

Services for adults

independence, consistency, meeting people's needs

Introduction

2.1 Social services for adults are right at the heart of the welfare state. They carry out essential tasks working with a wide range of people - home care services, day centres, residential care schemes, rehabilitation of blind or partially-sighted people, provision of equipment to aid independent living, help to parents with disabilities to carry out their parenting tasks, support for families who have caring responsibilities, work with people with mental health problems, and support to learning disabled people and their families. Over the years, innovative services have been developed in many places to ensure that people get the help they need.

2.2 However the system can be frustrating for anyone who tries to use these services, whether for themselves, or on behalf of friends or relatives. There have been significant changes in adult services since the community care reforms earlier in the decade. But these have concentrated largely on structure and on process, rather than on outcomes. Serious problems remain.

'serious problems remain'

The Community Care reforms

In April 1993, social services' responsibilities for people needing long term care expanded significantly. Until that time,

people who lived in independent residential or nursing homes were funded through DSS benefits. The Community Care reforms gave social services the responsibility not only to fund this type of care placement (subject, as before, to a means test) but also to carry out an assessment of care needs for the individual concerned, and ensure that the care being given was what that person needed. This focus on individual care management, focused towards helping more people to live in their own homes, was the key change to the system.

2.3 Decisions about who gets services and who does not are often unclear, and vary from place to place. Eligibility criteria are getting ever tighter and are excluding more and more people who would benefit from help but who do not come into the most dependent categories. Decisions about care can still be service driven, and concentrate on doing things for people according to what is available, rather than tailoring services to the needs of individuals and encouraging those who are helped to do what they can for themselves. Overall, people feel ill-informed about how they should find out about services, what they may be asked to contribute themselves, who will be providing the care, and how they can influence it. This is particularly true for certain groups such as older people from ethnic minorities.

2.4 Social services need direction if they are to serve adults better. In particular, they need to:

- seek to promote people's independence while treating them with dignity and respect at all times, and protecting their safety
- provide services more consistently across the country
- make the system more centred on service users and their families, and as convenient and straightforward as possible for people to use.

' social services need direction if they are to serve adults better'

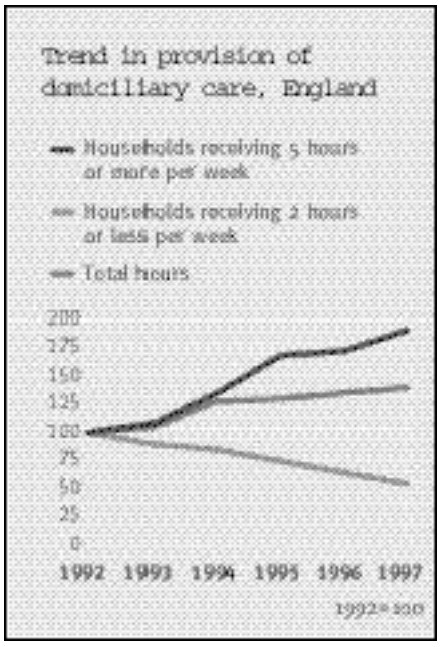
Promoting independence

The problem

2.5 We believe that the guiding principle of adult social services should be that they provide the support needed by someone to make most use of their own capacity and potential. All too often, the reverse is true, and they are regarded as services which do things for and to dependent people.

' the guiding principle of adult social services should be that they provide the support needed by someone to make most use of their own capacity and potential'

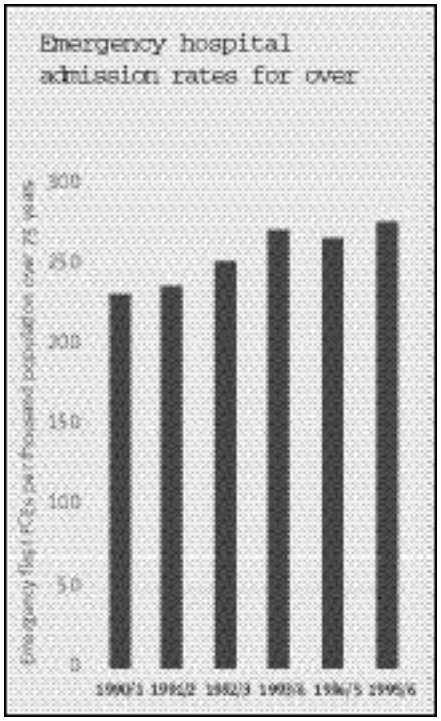
2.6 Because of resource pressures, councils are tending to focus more and more on those most dependent people living in their community. For example, although there has been an increase in the overall level of domiciliary care supporting people in their own homes, that increase has been concentrated on those getting more intensive support, and the number of people receiving lower levels of support has actually dropped (see graph). This means that some people who would benefit from purposeful interventions at a lower level of service, such as the occasional visit from a home help, or over a shorter period, such as training in mobility and daily living skills to help them cope with visual impairment, are not receiving any support. This increases the risk that they in turn become more likely to need much more complicated levels of support as their independence is compromised. That is good neither for the individual nor, ultimately, for the social services, the NHS and the taxpayer.



2.7 People generally want to live in their own homes if they can, and admission to institutional care (whether in hospital or in residential care or nursing homes) can lead to lower self-confidence and a decline in activity. Yet the evidence is that many authorities are setting a financial ceiling on their domiciliary care packages, particularly in services for older people, which can lead to premature admissions to care homes when care at home would have been more suitable.

Trend in provision of domiciliary care, England

2.8 The number of emergency admissions to hospital of people over 75 has been rising steadily. These admissions, which may well lead to permanent institutionalisation, are avoidable in many cases. People are also being admitted directly to permanent residential or nursing home care on discharge from hospital, even though in a sizeable minority of cases, better rehabilitation or recuperation services could have helped them return to their own homes.



2.9 Once services are being provided, they are often not reviewed. This again contributes to a culture of dependency rather than one of enablement. A great deal of effort is put into initial assessment of care needs, but after that there may be very

little review of progress (particularly in residential and nursing home placements) to see whether the user's needs have changed or whether the services are providing the best outcomes. Joint Reviews and SSI inspections of various aspects of adult services in recent years have consistently shown this.

2.10 And finally, the care system does not adequately recognise the enormous contribution that informal carers make to maintaining the independence of people with care needs. Carers are the most important providers of social care: according to the 1995 General Household Survey of Great Britain, they number 5.7 million, with 1.7 million of them providing care for 20 hours or more each week. The Carers (Recognition and Services) Act 1995 provided greater rights for carers, but implementation of it remains patchy. Greater efforts need to be made to recognise and cater for carers' needs.

The 1998 Annual Report of the Joint Reviews notes that in most councils cases are not reviewed unless required by law. The finding is underpinned by users' and carers' experience. Many report that they have not been asked how things are going. Many users and carers have valuable knowledge about services, but many councils are not asking them to share this knowledge.

Action

2.11 The Government will take action to reverse these trends, and to put greater independence at the heart of social services for adults. Our programme of action includes:

- better preventive services and a stronger focus on rehabilitation
- extension of direct payments schemes
- better support for service users who are able to work
- improved review and follow-up to take account of people's changing needs
- improved support for people with mental health problems
- more support for carers.

' social services must aim wherever possibleto help people get better, to improve their health and social functioning rather than just "keeping them going"'

Prevention and rehabilitation

2.12 We want to put a new emphasis on helping people achieve and maintain independence wherever possible. And when someone does need care, social services must aim wherever possible to help them get better, to improve their health and social functioning rather than just "keeping them going". We have set in train a number of specific measures to ensure that this approach is taken:

- "Promoting Independence" has been identified as one of the priorities for both health and social services in the National Priorities Guidance issued on 30 September this year (see Chapter 7). Authorities are required to implement jointly agreed plans for improving rehabilitation services, as set out in the Better Services for Vulnerable People initiative launched in October 1997
- the Social Services Modernisation Fund will deliver substantial extra funding to help shift the emphasis of service provision to promoting independence. Two new grants will be introduced, totalling nearly 750 million over three years. This grant funding will come with conditions that will ensure that the improvements we want to see are delivered.

Better services for vulnerable people

This initiative was launched in October 1997. It requires all health and local authorities to draw up Joint Investment Plans

for developing services to help people get the care they need while avoiding unnecessary hospital or care home admissions. This may include developing specialist rehabilitation services to help people to go back home after a hospital stay, or other initiatives such as dedicated hospital discharge teams.

Promoting independence: partnership grant

- a new grant, providing nearly 650 million over three years, to foster partnership between health and social services in promoting independence as an objective of adult services
- particular emphasis on improving rehabilitation services; avoiding unnecessary admissions to hospital and other institutional care; improving discharge arrangements; and fostering good joint contingency planning to deal with emergency pressures
- conditions attached to the grant will ensure that local authorities' spending plans are clearly stated in Joint Investment Plans, agreed with the NHS who will set out how their own spending plans contribute to the objectives and complement the new grant.

Promoting independence: prevention grant

- a new grant totalling 100 million over three years, for stimulating the development by local authorities of preventive strategies and effective risk assessment, so as to target some low level support for people most at risk of losing their independence
- encouraging an approach which helps people do things for themselves for as long as possible, in their own home; and helps people of working age take up, remain in or return to work for as long as possible
- authorities will be required by the grant conditions to draw up an action plan (jointly agreed with the NHS) during 1999/2000 setting out their proposals for a preventive strategy.

2.13 We have already seen many excellent examples of joint health and social care services to help promote independence, in response to the extra funding we have made available for winter pressures (see Chapter 6). We are now making this approach a priority in services for all adult client groups, backed up by substantial extra funding. We expect authorities to deliver on this programme, and will monitor progress closely through both the NHS and social services performance frameworks.

Direct payments

2.14 One way to give people greater control over their lives is to give them the money and let them make their own decisions about how their care is delivered. This was made possible for physically disabled people and people with learning disabilities aged under 65, through legislation which came into force last year. Local authorities are now able to offer cash to such people whom they had assessed as eligible for home care, day care or occasional short stays in residential or nursing homes. At the start of this year, around 1,000 people were participating in schemes, in 31 authorities. More authorities are bringing in schemes this year.

2.15 Direct payments are giving service users new freedom and independence in running their own lives and we want more people to benefit from them. We have decided, therefore, to remove the age limit and to make people aged 65 and over eligible for direct payments.

2.16 We will also be seeking to ensure that more authorities are offering this opportunity to service users in their areas. We will be conducting a further survey to see where direct payments schemes are being offered, and to find out from those

councils who have no plans for a scheme where the obstacles lie. If the case is strong enough, we will consider making it mandatory for all authorities to operate schemes, to ensure equity of opportunity across the whole country.

2.17 Other changes to direct payments are being considered as part of a review of the scheme to learn lessons from its first year of operation. The review is also looking at how direct payments support independent living by working in conjunction with the other help available, including the Independent Living Fund, a social security fund which provides benefit support on the basis of a social services assessment to very severely disabled people to help them to live independently in the community. When the review is completed early next year, we will consult local authorities and other interested groups on our plans for strengthening and extending the scheme.

Promoting independence: independent living

In Southampton, the Extended Community Care Scheme, or Companion Service, helps older people with dementia who live alone to continue to live safely in their own homes for as long as possible. The service is run by Southampton MIND who provide a companion to befriend and support service users.

Companions provide emotional and social support. But they also give the practical support needed to cope with memory loss, which other services sometimes overlook. For example, confused people can need help understanding what to do with the packages they receive from meals on wheels; they may need someone to collect prescriptions left by a doctor; and they may need accompanying to out-patients so they don't get lost between the ambulance and clinic.

Promoting independence: helping people return home

Outlands is a former home for older people run by City of Plymouth Council. For the last 5 years it has offered 6 weeks rehabilitation to older people leaving the local acute hospital. Between 70% and 80% of people who use this unit have been successfully rehabilitated to their own homes where previously they would have entered long-term residential care. People are able to go home with little if any ongoing support from social services. 5 years on, studies show few have entered long-term care.

Employment

2.18 Employment is one of the most powerful pathways to independence, and our National Priorities Guidance reminds councils of their responsibility to help service users and carers of working age work where possible. Councils are already participating in the Government's New Deal for Disabled People. For example, the innovative schemes for which funding was announced in September 1998 include a project to provide work experience for deaf people in which Lincolnshire social services are involved. Social services also have a role to play in the Single Gateway which we plan to establish for all benefit claimants of working age, including those claiming incapacity benefits. As described in A New Contract for Welfare: Principles into Practice, the Gateway will act as a single point of access to welfare, providing personal advisers to help those who can and want to work to gain access to the various services available to them.

' employment is one of the most powerful pathways to independence'

Promoting independence: a job

In Kensington and Chelsea, social services provide a service, Kensington Recruitment, which works with employers and people with sensory impairment, physical disabilities and learning disabilities to place service users in regular paid employment. Key features of the scheme are:

- one to one support from a professional job consultant
- searching out vacancies

- help in finding the right job
- on site support
- increasing the employability and skills profile of disabled people by making employers aware that disability does not mean inability.

Richmond upon Thames operates a similar scheme where social services operate an employment resource centre for mental health service users.

Review and follow-up

2.19 People should not be "signed off " once they have had their initial assessment and are receiving services. Good care management should ensure that people's needs are monitored and reviewed. When people are admitted to a care home, or begin to receive care in their own home, case reviews should be carried out within three months. Thereafter, reviews should be carried out at least annually, and should wherever possible be carried out face to face. The frequency of these subsequent reviews will depend on the type of case, and factors such as the uncertain nature of future needs and the complexity and costs of the care package. Councils should be explicit about who is to carry out the review in individual cases - sometimes the provider can play a role here - what it comprises, and how often. Whichever approach is used, it is expected that users and carers will play a full part.

'people should not be "signed off " once they have had their initial assessment and are receiving services'

2.20 We will set out our expectations on authorities' review activity as part of our Fair Access to Care initiative (described in paragraph 2.36 below); and we will monitor how well authorities are performing as part of the new arrangements for monitoring performance in social services (see Chapter 7).

Improving support for people with mental health problems

2.21 Promoting independence should not, of course, be at the expense of effective and safe services. In particular, in mental health services people have suffered in the past as a result of being left too much to look after themselves. The mental health care in the community system, while helping many people, has failed others. The Government's strategy for developing safe, sound and supportive mental health services, to be published shortly, will aim to promote the health, well being and safety of individuals and the well being and safety of the wider community. The services should be provided to people as close to home as is practicable. More detail on the forthcoming strategy is at paragraph 2.34.

3

Key themes

- new, stronger systems for protecting children
- "Quality Protects" - improving quality across all children's services
- better health and education for children in care homes, and more help for young people leaving care

Services for children

protection, quality of care, improving life chances

Introduction

3.1 All local authority services have an impact on children's lives - whether to ensure a high standard of education, or a safe and healthy environment for them to live in, or to provide safe places to play. The whole local authority has a contribution to make to children's services. But those children and families who need the help of social services are likely to be amongst the most vulnerable and excluded in our society - children in need, disabled children, children who need protection, children in trouble with the law, children who need to be cared for away from home.

3.2 Local authorities have very particular responsibilities towards these children and their families. Nowhere is the challenge of social services work better illustrated. The decisions are hard, and the consequences of misjudgment serious - whether this means removing a child from their family without good cause or leaving a child too long in a dangerous setting. Many authorities have the right intentions in their approach to this difficult field; and many people working in it bring skill and dedication to what they do. But there is ample evidence, from recent SSI and Joint Review reports, from the Children's Safeguards Review, and from the recent report on Looked After Children by the Health Select Committee, that standards of delivery and achievement are unreliable, and that though many children benefit from social services, too many are let down.

> **' standards of delivery and achievement are unreliable, and though many children benefit from social services, too many are let down'**

3.3 Working in partnership with local authorities and the voluntary sector, the Government is determined to raise standards for children who need the active support of social services. The Government is providing the necessary leadership, guidance and funding for local authorities to implement our demanding agenda for action. For their part, local authorities will be required to draw up and follow individual action plans to achieve a range of targets. The Government will closely monitor developments and, as necessary, pursue authorities where standards are not acceptable.

' the Government is determined to tackle these serious shortcomings, and has already begun the process of addressing the priority areas for improvement'

" ... concerns have been highlighted graphically in recent inspection work on planning and decision making both for children in need and children looked after. We found it was unusual for families to be assessed systematically taking account of their strengths and weaknesses. Departments more often simply responded to the problem that was presented. As a result some families who needed support were inappropriately caught up in the child protection system, whilst in other situations obvious risks to children were overlooked. Poor planning meant that many children looked after experienced unacceptably long delays before placement was made. Too many children who were the responsibility of the local authority did not have a social worker assigned to them or a proper care plan. Record keeping ranged from very good to abysmal. It was often not possible to see why social services had intervened, what they hoped to achieve and how they would know whether the situation had improved or deteriorated. This is unacceptable"

Social Services Facing the Future, the 1997/98 annual report of the Chief Inspector, Social Services Inspectorate.

The wider agenda

3.4 Social services for children cannot be seen in isolation from the wider range of children's services delivered by local authorities and other agencies. The Government is committed to taking action through a broad range of initiatives to strengthen family life, to reduce social exclusion and anti-social behaviour among children, and to give every child the opportunity of a healthy, happy, successful life. Examples of Government action on the wider front include the "Sure Start" programme, the Crime Reduction Programme, Early Years Development and Childcare Partnerships and the Green Paper *Supporting Families*.

3.5 Children's social services must be seen within this wider context. However, this must not mean that social services lose their focus on the most vulnerable children. Too many reports and inquiries have highlighted cases where social services have failed vulnerable children. Children in the care of local authorities have been abused and neglected by the care system that was supposed to look after them. Children placed on a child protection register have had no monitoring or checks - despite being specifically identified as being at risk. And the majority of looked after children leave care with no educational qualification at all, many of them at great risk of falling into unemployment, homelessness, crime and prostitution.

3.6 The Government is determined to tackle these serious shortcomings, and has already begun the process of addressing the priority areas for improvement.

The priorities

3.7 As with adult services, new objectives have been defined at a national level for children's social services. They are set out in Chapter 7. The Government's plans for radical improvement target three priority aims:

- to ensure that children are **protected** from sexual, physical and emotional abuse, and from neglect
- to **raise the quality of care** of children in care so that it is as close as possible to the care provided by loving and responsible parents
- to **improve the life chances** of children in care, and of others ("children in need") who need social services' support, in particular through improving their health and education and support after they leave care.

Children and families: the wider agenda

"**Sure Start**" is a new initiative to help give children the best possible start in life, particularly those in disadvantaged areas. In England, over 450m over the next three years will be targeted on the areas of greatest need, building on what is already provided in the health, education, social services and voluntary sector.

The Government's **Crime Reduction Programme**, like "Sure Start", will include work through local partnerships to tackle social exclusion and anti-social behaviour among children and young people. 250m of funding will be available over the next

three years for the programme as a whole.

Early Years Development and Childcare Plans provide a focus for planning integrated education and care services for children and their families.

The Green Paper **Supporting Families**, published on 4 November 1998, set out the wider agenda for all government action to strengthen family life and improve opportunities for children.

Protection

3.8 Nobody knows with any certainty how much serious harm and abuse is suffered by children within their own families, or in residential homes, foster care, boarding schools and other settings where children live away from home. We cannot know whether the amount of abuse suffered by children has increased or fallen over the years. For many years, abuse - particularly sexual abuse - was a taboo subject and allegations made by children and young people were not listened to. Public and professional awareness is now much greater. But children often still lack the power and opportunity to voice what is happening to them, and the adults responsible have every motive to conceal it.

3.9 But we do know that:

- the risks to children living away from home in residential homes, foster care and residential schools in the 1970s and 1980s were seriously under-estimated. The numbers of convictions of care workers, of serious investigations into allegations of crimes from this period and the testimony of adult survivors all paint a shocking picture

- too many children die or suffer serious injury at the hands of adult abusers. In 1997/98 the Department of Health received reports of 91 such cases

- most families who become caught up in the child protection system are at high risk of social exclusion. The SSI report, Child Protection: Messages From Research, shows that many have multiple problems - poverty, family breakdown, mental health problems, domestic violence, alcohol and drug misuse - which need careful assessment and targeted intervention by local authorities to ensure that children are not put at risk.

Protection of looked after children

3.10 Failures to protect children in residential settings and in foster care are only too well known. The case of Frank Beck in Leicestershire, and the "Pindown" practices in Staffordshire, brought the issue to the public eye in the 1980s. Other scandals that have come to light in recent years also relate to abuse carried out in the 1970s and 1980s, but we cannot be complacent that such problems have been eradicated. Last year saw the convictions of Keith Laverack, who abused children in several homes in recent years, and of Roger Saint, a foster carer convicted of sexual abuse. The Tribunal of Inquiry into cases of child abuse in North Wales is expected to report shortly.

' failures to protect children in residential settings and in foster care are only too well known'

3.11 These failures have several causes:

- there have been gaps in the **regulatory safeguards** around residential homes and schools, and in the arrangements for monitoring foster care. Some of these were addressed in the Children Act 1989 and associated regulations and guidance, but significant weaknesses remain. Small private children's homes are excluded from regulation though their number has increased. Independent boarding schools are inspected for social welfare, but maintained residential schools are not. There are no regulatory safeguards applying to independent fostering agencies.

- safeguards against the **appointment or retention of unsuitable people** in work with children have improved since the report *Choosing with Care* by Norman Warner. But the recent SSI report, *Someone Else's Children*, found that local authority practice is by no means uniformly rigorous and reliable and has not been consistently applied to foster care. The process for obtaining checks is too long and complex - employers have to make several applications to check criminal records and other sources including the Department of Health's *Consultancy Index* (see box in paragraph 3.18) to ensure that they have all the information available. There has been no exchange of information on health care workers moving into the social services who should be excluded from such work.

' safeguards against the appointment or retention of unsuitable people in work with children'

- **too many children are placed a long way away** from their homes and are not properly monitored by their care authorities. The 1997 SSI survey on the safety of children in the public care found that one-fifth of children looked after were living outside the area of their care authority. Of these, 900 were reported to be placed more than 150 miles away. The survey suggested a substantial majority of councils had given less than satisfactory thought to ensuring required procedures for placement and review in "out of authority" cases were carried out properly.

Child protection in family settings

3.12 In recent years there have been improvements in procedures for child protection and in cooperation between agencies. Area Child Protection Committees have done much to foster strong partnerships in many areas. However, *Messages From Inspection*, an overview of SSI's major child protection inspection programme between 1992 and 1996, found that while the great majority of local authorities provide some examples of good practice, only a small minority of local authorities provide good quality services across the whole range of children's work. Overall it remains the case that most children and their families are not as well served as they should be.

' while the great majority of local authorities provide some examples of good practice, only a small minority of local authorities provide good quality services across the whole range of children's work'

3.13 Some of the reasons for this failure are:

- poor assessment and case planning with a tendency identified in *Someone Else's Children* to continue attempts at rehabilitation for some children in dangerous family settings for longer than is safe to do so
- poor case recording practices
- child protection plans which are often lacking in focus and not followed up systematically. This can result in children moving on and off the child protection register without a lasting improvement in their circumstances
- failure to ensure that all children on the child protection register have an allocated social worker
- weaknesses in the supervision of staff and the monitoring of the quality of practice
- shortcomings in the training and experience of staff.

3.14 Serious professional failings such as these have resulted in tragedies. The terrible cases set out in the box below were, when investigated, found to illustrate wider failings in the local authority's and other agencies' child protection system.

Rikki Neave was killed in 1995 at the age of 6, after a long history of abuse and neglect by his family. Social services had a long history of involvement, but failed to take decisive action to protect Rikki and his siblings. At one point, Rikki's name was on the child protection register but was removed. When he died, his name was not on the register.

Leanne White, who died in 1992 at the age of three, provides an example where social services staff failed to listen to concerns of relatives. Social services were too trusting and accepted plausible accounts provided by adults at face value. Despite being told by seven different people about her plight, social services failed to take adequate action. Leanne was found to have 107 separate injuries at the time of her death.

Karl Speke came from a large and deprived family with inadequate and neglectful parents. The family moved around the country at least 11 times to avoid the attentions of the agencies involved with them. The father was aggressive and violent and succeeded in intimidating staff from all agencies. Karl was killed in 1996 at the age of two. He had not been seen by social services or by health staff for 17 months before his death. Communication between health and social services was poor.

Action

3.15 Government action to improve the protection of children includes:

- root and branch reform of the regulation system, introducing checks on the full range of children's care services, and strengthening safeguards
- an extensive range of reforms, set out in the Government's response to the Children's Safeguards Review, to improve the protection of all children living away from home
- stronger systems for preventing unsuitable people from working with children
- a thorough revision of the Government guidance on child protection.

' introducing checks on the full range of children's care services, and strengthening safeguards'

Regulation reform

3.16 The detail of these changes are set out in Chapter 4. For children's services the key points are:

- a new independent regulatory system, ending the situation where the local authority is both the purchaser and the inspector
- full powers of inspection and enforcement for all children's homes, including homes run by local authorities
- new protections in services not currently covered - small children's homes, state sector boarding schools, residential family centres and independent fostering agencies
- new national standards for regulation, replacing the inconsistencies of the current system.

'new national standards for regulation, replacing the inconsistencies of the current system'

Response to the Children's Safeguards Review

3.17 The Government's response to the Children's Safeguards Review (see opposite) covered the full range of action to be taken to improve the lives of children living away from home. Many of these are set out elsewhere in this chapter (strengthened regulation, better arrangements for stopping dangerous people from working with children, revised child protection guidance, enhanced inter-agency working, and the "Quality Protects" programme). In addition to all of these, the Government's response also made the following commitments for improving protection:

- ensure proper complaints procedures exist in all residential care settings
- provide information to protect and educate young people on unsafe practices and situations, and ensure they know how to contact outside help to raise concerns
- ensure all children statutorily entitled to independent visitors are provided with one
- promote the involvement of children in decisions on their care, local planning and national policy making
- funding for a group to provide a national voice for children in care and those formerly in care, and to promote their interests;
- publish National Standards for Foster Care in 1999
- issue statutory guidance on action to be taken when a looked after child goes missing
- remind all governing bodies of organisations responsible for the care of children that they should have procedures to enable staff to raise significant concerns outside normal line management structures

- undertake an information campaign for parents on the dangers that can be faced by children living away from home.

'provide information to protect and educate young people on unsafe practices and situations, and ensure they know how to contact outside help to raise concerns'

' procedures to enable staff to raise significant concerns outside normal line management structures'

The Children's Safeguards Review

In November 1997, the Government published the report of the Review of the Safeguards for Children Living Away from Home. This review followed reports of widespread abuse of children in care.

Although the main focus of the report was children looked after by local authorities (there are about 55,000 of them at any time), it also covers safeguards for other children living away from home, for example, in boarding schools and penal settings. In all, about 200,000 of the 12 million children under the age of 18 in England and Wales are living away from their parents' home for at least 28 days.

The report makes 20 principal recommendations, and over 130 other recommendations, the aims of which include:

- improve protection for children in foster and residential care, in schools and in the penal system
- provide more effective safeguards and checks to deter abusers from working with children
- improve outcomes and life chances of all children, particularly those looked after by local authorities
- reduce the numbers of young people leaving care early and increase the support, advice and assistance available to them
- provide more effective avenues of complaint and increase access to independent advocates
- provide more vigilant management
- provide effective disciplinary and criminal procedures
- provide effective systems of communication between agencies about known abusers.

The Government's response, setting out action on all these fronts, was published on 5 November 1998.

Stopping dangerous people from working with children

3.18 The Government will take further steps to prevent unsuitable people from working with children. We will:

- establish a new Criminal Records Agency to improve and widen access to police checks on people intending to work with children and other vulnerable groups. For those who have regular access to children, this will disclose details of all convictions of all offences (whether or not they are "spent") and details of any cautions recorded on the national records, as well as any relevant non-conviction information. This will be a first step towards a "one-stop shop" which will give employers access to police records and the separate lists kept by the Department for Education and Employment (List 99) and the Department of Health (the Consultancy Index)
- in the interim, introduce legislation when Parliamentary time allows, to place the Consultancy Index on a statutory basis; to clarify the procedure for representations against inclusion on the Index; to make inclusion on the Index a bar to employment in the relevant fields; and to extend the Index to cover child care staff working in certain areas of the NHS
- enforce full compliance by social services authorities with the recommendations of *Choosing with Care* and adopt these principles in other settings where children live away from home

- create a new statutory General Teaching Council which will have registration and disciplinary powers over teachers; and through future legislation create a General Social Care Council (see Chapter 5) which will set the conduct and practice standards for the whole social care workforce and in due course register those working with children.

' the Government will take further steps to prevent unsuitable people from working with children'

The Consultancy Index

The Department of Health Consultancy Service Index enables local authorities and private and voluntary child care organisations in England and Wales to check on the suitability of those they propose to employ. It is a list of people about whom concerns exist around their suitability for work in the child care field. It is used by child care employers when considering the employment of people to posts involving substantial, unsupervised access to children. Information is supplied by employers when staff are dismissed or resign in certain circumstances. The Index also maintains a list of child care workers whose names have been notified to the Department by the Police following certain convictions and cautions.

3.19 The Government has established an Inter-Departmental Working Group, led by the Home Office, to look at how to prevent those considered unsuitable to work with children from gaining work with them. The work will cover the public, private and voluntary sectors and will draw on measures already in existence.

New child protection guidance

3.20 The Government has made clear that it intends to strengthen its guidance on child protection procedures and the arrangements for cooperation and partnership between agencies. While the existing guidance, *Working Together Under The Children Act 1989*, has made a start, we believe that more needs to be done to break down barriers, and to promote a wider, more holistic view of the needs of vulnerable children to ensure that children are not unnecessarily drawn into child protection and court procedures. We must also strengthen the safeguards that the child protection system offers to all children, whether living with their families or away from home.

3.21 Earlier this year the Department of Health issued a consultation paper inviting views on the scope and contents of the new guidance. This has generated a lively debate about the way forward with over 650 responses. The Government intends to issue new guidance by the Spring of 1999. This will be accompanied by a new framework for undertaking needs-led assessment of children and their families.

3.22 As part of the Quality Protects programme (see paragraph 3.25), local authorities must take action to bring their child protection services up to standard. They will be required to show that they:

- carry out thorough and prompt assessments of children's needs
- have good case records
- draw up and implement child protection plans which are then reviewed regularly
- ensure that all children on the child protection register have an allocated social worker
- know what outcomes they want for children in need of protection and assess whether these are being achieved
- have a human resources strategy which identifies the skills and knowledge needed by child protection staff.

' know what outcomes they want for children in need of protection and assess whether these are being achieved'

3.23 We intend to make sure that children's services continue to receive the closest scrutiny to ensure that children are safeguarded against harm. The Government will therefore put in place new arrangements whereby from time to time it will commission from all its Chief Inspectors of services substantially involved with children (the SSI, Ofsted, and the Inspectorates for Prisons, Probation and the Police) a single joint report on children's safeguards. This will enable the Government to satisfy itself that the safeguards for children across the range of services are being properly implemented, and that the safety of children continues to be given the priority it deserves. These reports will be produced every three years, or

more often if required, and will be published. Aside from these reports, the inspectorates will work together as a matter of course on issues related to children's safeguards.

' children's services will continue to receive the closest scrutiny' Chief Inspectors' reports on children's safeguards

Introduction

4.1 There are nearly half a million vulnerable people living in residential homes, nursing homes and children's homes. There are many others, often socially isolated, who receive social care in their own homes. Effective regulation of these services, and of the staff who provide them, is essential if the people themselves and their families are to have confidence that the care they receive will be competent and safe.

4.2 The present regulatory arrangements are incomplete and patchy, and the Government will replace them with a system that is modern, independent and dependable. Taken together with the establishment of the General Social Care Council (described in Chapter 5), these reforms will put in place new systems for ensuring that when people receive care, it is safe and of high quality, that they have adequate living standards if they are in care homes, and that the staff on whom they rely have the training, skills and standards that are necessary for the work they do.

' the present regulatory arrangements are incomplete and patchy'

4.3 No regulatory system can absolutely guarantee consistently good standards everywhere, but we must make sure that the system we put in place does everything that is possible to prevent and root out the abuse and neglect of vulnerable people.

' the Government's plans are designed with the principles of good regulation in mind'

4.4 The Government's plans are designed with the principles of good regulation in mind. These principles, set out by the Better Regulation Task Force, are:

- transparency
- accountability

- targeting
- consistency
- proportionality.

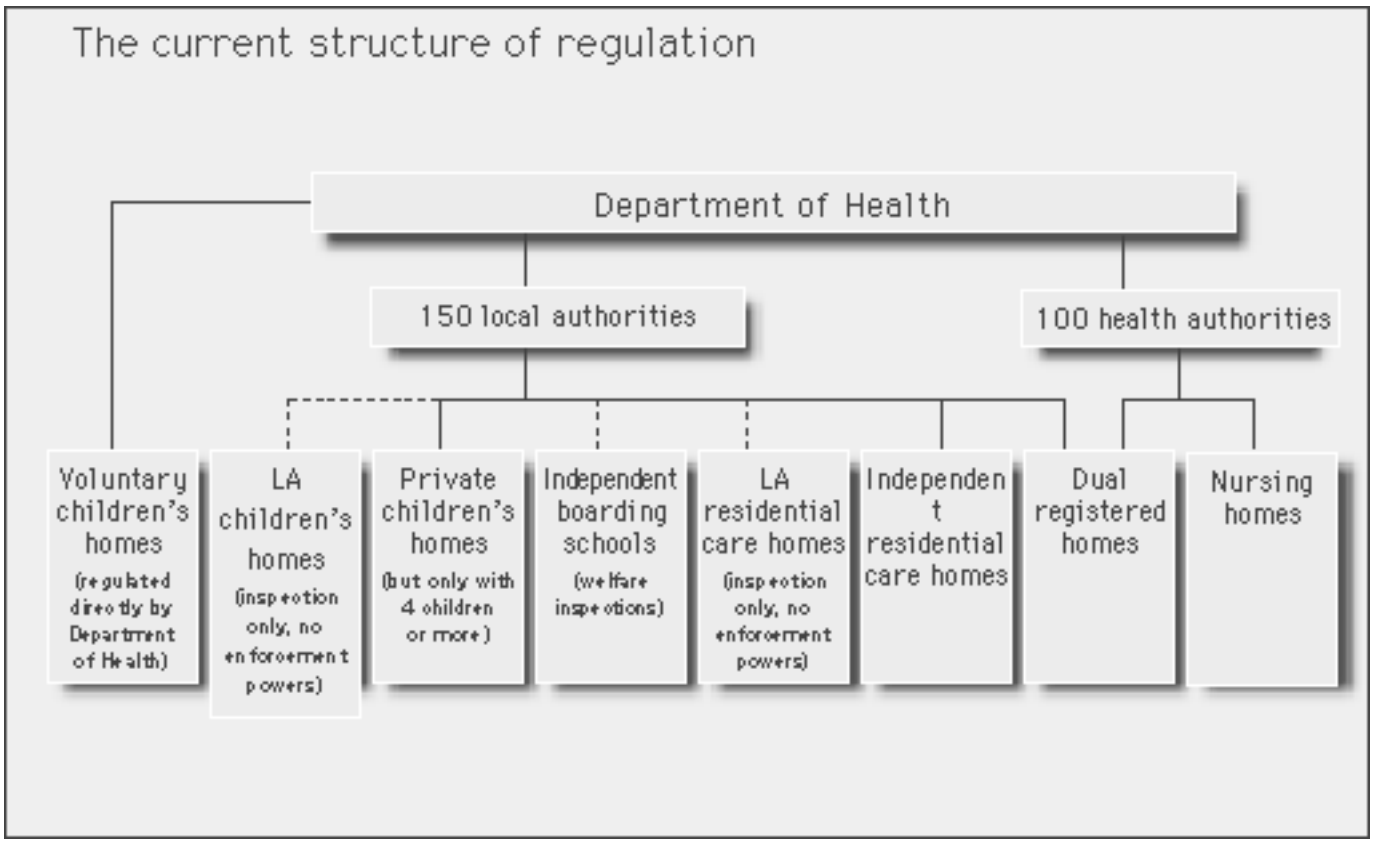
4.5 The Better Regulation Task Force's own review of long-term care regulation, published earlier this year, concluded that the existing regulation arrangements fail on all these principles.

Problems with the current system

4.6 The existing arrangements for regulating care services have developed in a piecemeal fashion. Responsibilities for regulating the various services for adults and children are divided between local authorities, health authorities and the Department of Health centrally (see chart overleaf). Other services - notably councils' own care homes, small children's homes and domiciliary care (care given to people in their own homes) - are not subject to any regulation.

4.7 This situation leads to a number of problems:

- **lack of independence** - local and health authorities have to combine responsibilities for purchasing, providing and regulating care services. As well as the conflict of interest that this causes, this means that people in local authority care homes do not benefit from independent regulation.
- **lack of coherence** - responsibilities are split between different authorities and different professional disciplines (social services professionals on the one hand, and mostly professional nurses on the other). This means that there is not effective scrutiny of nursing care in residential homes and social care in nursing homes, for example.
- l**ack of consistency** - there are 150 local authorities and 100 health authorities in England. Standards vary from one area to another, creating uncertainty for both providers and service users. For instance, different approaches are taken to room sizes, numbers and training of staff, and the maximum number of places allowed in a home. The Social Services Inspectorate has done valuable work in assessing local authorities' regulatory work, but a clear national approach has been lacking.



Our plans for reform

4.8 The Government's plans to reform the system of regulation will:

- create Commissions for Care Standards, independent regional authorities responsible solely for the regulation of care services
- introduce new statutory regulation for services not currently covered, including domiciliary care and small children's homes
- improve the way in which registration and inspection are carried out.

4.9 The result should be:

- stronger protection for vulnerable adults and children
- new safeguards for those receiving care at home
- greater assurances that high standards will be met everywhere, and greater clarity and consistency for providers as to what standards they will be required to meet.

' stronger protection for vulnerable adults and children'

4.10 Our proposals in this Chapter build on Tom Burgner's report, published in 1996, which followed extensive consultation with all interested parties, and which set out a strong consensus for change. They also reflect the recommendations of the Better Regulation Task Force's report mentioned above.

The Regional Commissions for Care Standards

4.11 To create the new independent structure, we will establish Commissions for Care Standards (CCSs) at regional level to carry out the regulation of care services. These will be based on the boundaries of the NHS and Social Care Regions (see map on next page), so there will be eight authorities in England.

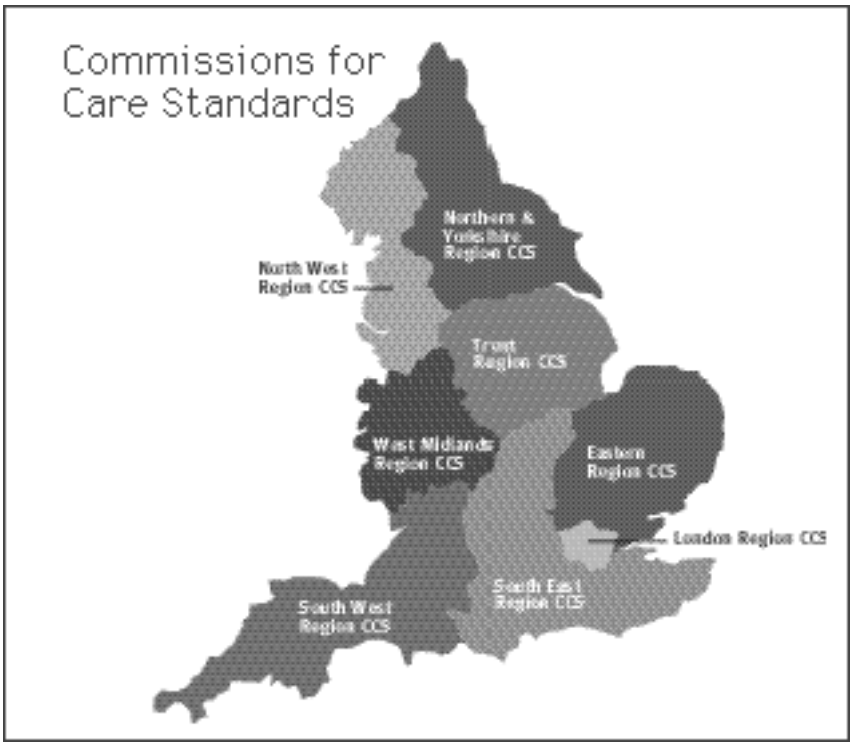
' new independent Commissions for Care Standards at regional level to carry out the regulation of care services'

4.12 The CCSs will be independent statutory bodies, each with their own Chair and management board. The boards will include representatives from local authorities and health authorities, plus user and provider representatives. The Chairs will be appointed by the Secretary of State.

4.13 The CCSs will have responsibility for regulating the following services:

- residential care homes for adults
- nursing homes
- children's homes
- domiciliary social care providers
- independent fostering agencies
- residential family centres
- boarding schools.

4.14 The CCSs will act in their own right as independent statutory bodies, but will be accountable ultimately to the Secretary of State and to Parliament. There will be arrangements for monitoring the performance of the CCSs and consistency between them from the Department of Health, and the Secretary of State will have powers of direction and guidance over them. There will be recourse to an Ombudsman for complaints against a CCS's exercise of its duties, as well as rights of appeal against deregistration to a Registered Care Tribunal (see paragraph 4.58).



4.15 There will be provision for central funding to be granted to the CCSs, but this will not normally need to be used as they will be self-financing through fee income paid by regulated providers. Fee levels will be set by central government for all regulated services.

4.16 Each CCS will have its own workforce of inspectors, and will decide how that workforce should best be deployed, for instance using area offices or teams. The workforce will consist of people with skills and qualifications from both social care and health care, including nurses. The benefits of combining these two sets of skills and backgrounds will best be realised if there is true integrated working, allowing - for instance - nurses to be involved in inspections of children's homes, and social care professionals to be involved in inspecting social aspects of nursing homes. The CCSs will also need good liaison and joint working with other regulatory agencies such as the Health and Safety Executive, fire authorities and environmental health departments.

4.17 It will be important that inspectors should have, and maintain, knowledge of the services that they are inspecting. For many inspectors, the role may be temporary, and it is expected that a spell as an inspector should form part of a professional career path that might also cover working in the commissioning or provision of health or care services. The CCSs will be able to use secondment or other methods such as fixed term or part-time contracts to achieve this.

> **' providers will be registered by the CCS in their area if they demonstrate that they meet the required criteria and standards'**

4.18 The CCSs will also need to have suitable training arrangements for inspectors, and work will be done on developing more uniform methodologies for registration, inspection and enforcement, so that there is greater consistency of practice than at present.

Scope of regulation

Care homes

4.19 Regulation will apply, as now, to residential care homes and nursing homes, although there will be improvements to the way this operates (see paragraph 4.51). In addition, all residential care homes owned by local authorities themselves will be required to register, and will be subject to inspection and enforcement procedures in the same way as will voluntary and private care homes. We will also remove the current exemption for care homes run by organisations established by Royal Charter or Act of Parliament. This is not to say that homes run by such organisations are the subject of particular concern, but the specific exemption for these homes is anomalous, and this is generally accepted among the organisations concerned.

' we promised in our election manifesto that we would introduce a regulation system for domiciliary care'

Domiciliary care

4.20 Domiciliary social care is an essential part of good community care. As Chapter 2 makes clear, we want to encourage this as part of our wider aim to promote independence and social inclusion. However, there has never been any statutory system of regulation in domiciliary care, despite the fact that in recent years an increasing proportion of it has been provided by voluntary and private agencies rather than by direct local authority providers.

4.21 We promised in our election manifesto that we would introduce a regulation system for domiciliary care. Our proposed scheme will offer an assurance of protection to vulnerable users while maintaining the principles of choice and independence that are important to those receiving care.

4.22 The regulation scheme will be based on registering the organisations providing domiciliary care, rather than the individual carers who work in the organisations. The scheme will apply to those organisations who provide personal social care to people living in their own homes. It is not, therefore, intended to cover organisations who provide services of a purely non-care nature, for instance cleaning agencies or gardeners.

' providers will be registered by the CCS in their area if they demonstrate that they meet the required criteria and standards'

4.23 Providers will be registered by the CCS in their area if they demonstrate that they meet the required criteria and standards. These will need to be developed, but they are likely to cover areas such as:

- fitness of owner and manager
- personnel issues (including recruitment/vetting procedures, personnel records, policies on training, health and safety, equal opportunities etc.)
- information to users (e.g. on charges, service withdrawals, how to complain etc.)
- quality procedures (including complaints procedures, systems for monitoring user satisfaction, supervision of care staff etc.)
- operational policies (e.g. administration of medicines, confidentiality, health and safety, promotion of choice, access to users' homes etc.)
- financial viability and insurance.

4.24 The standards will be developed in consultation with interested parties, and will be set at national level in the same way as for other services (see paragraph 4.46 below).

' registration requirements will be uniform, regardless of whether the organisation is private, voluntary or statutory, and whether it is a "principal" organisation or an agency'

4.25 As with care homes, local authority home care services will be registered, inspected and subject to enforcement action in the same way as independent providers. Registration requirements will be uniform, regardless of whether the organisation is private, voluntary or statutory, and whether it is a "principal" organisation or an agency. Arrangements will be made to ensure

that there is no unnecessary duplication, for example when several branches of the same organisation are to be registered.

4.26 Once a provider organisation is registered, it will be subject to annual review by the CCS, and may also be inspected at any time. Inspection may involve a variety of methods, such as scrutiny of records, interviews with staff and sample interviews with users, in order to check whether registration standards continue to be met.

4.27 If a registered provider is in breach of one or more of the registration requirements, the CCS will have powers to serve enforcement notices, and ultimately to deregister. In cases of deregistration, the provider will have right of appeal to the Registered Care Tribunal (see paragraph 4.58).

4.28 Registration will not be compulsory for all providers, although it is expected that the great majority will wish to be registered. However, local authorities will be required, when making arrangements for domiciliary care under their community care responsibilities, to place contracts only with registered domiciliary care providers.

' the Government's intention is not to remove all responsibility from individuals in making choices about their own care, but to offer the assurance of protection to everyone who wishes to take advantage of it'

4.29 The CCSs will be able to provide published lists of registered providers to any individuals who wish to make their own privately-purchased care arrangements. We will not, however, prohibit private individuals from making their own care arrangements with relatives, friends or others who are not registered care providers, if they choose to do so. The Government's intention is not to remove all responsibility from individuals in making choices about their own care, but to offer the assurance of protection to everyone who wishes to take advantage of it. It will be important for the CCSs to publicise widely the fact that a domiciliary care registration scheme exists, to ensure that everyone who wishes to use a registered provider can do so.

4.30 We believe that this scheme of regulation will provide a real assurance of protection to users, and will be workable. The introduction of the scheme will represent a substantial amount of work for the CCSs in their first few years. Once the system has bedded down, we intend that there should be a review of the operation of the scheme to see whether further improvements need to be made.

Children's services

4.31 The Government has recently published its response to the Children's Safeguards Review (see Chapter 3). That response included commitments to improve the regulatory arrangements for children living away from home. These regulatory responsibilities will fall to the new CCSs when established.

' in future, all children's homes will be registered and inspected by the CCSs'

4.32 There are currently different regulation arrangements for different types of children's homes (see chart after 4.7). In future, all children's homes will be registered and inspected by the CCSs. The additional Secretary of State approval that is required for homes used as secure accommodation will remain.

4.33 The regulation of children's day care is not covered in this Chapter. The Government published a consultation document in March 1998 on the future arrangements for the regulation of under-eights services, including day care, and of early education providers. This is in line with the Government's manifesto commitment to review the currently separate regulatory systems in these two sectors. The Government will be considering the options in the light of the responses to consultation and the plans set out in this White Paper.

Voluntary children's homes

4.34 At present, the 60 or so voluntary children's homes in England are registered and inspected by the Department of Health directly, while all other homes are registered and inspected by local authorities. In recent years, a number of inquiries and reviews have recommended that voluntary children's homes should be regulated in the same way as all other children's homes, and we support this view. The CCSs will therefore have the responsibility for registering and inspecting voluntary children's homes.

Small private children's homes

4.35 Private children's homes with fewer than four children are currently not required to be registered. The Government considers this unacceptable, and agrees with the recommendation of (among others) the Burgner Report and the Children's Safeguards Review, that these homes must be regulated. We will therefore require small private children's homes to be registered and inspected by the CCSs. 4.36 The same regulatory system will in principle apply to all children's homes, whether private, voluntary or local authority, and - as far as possible - whatever the size. Regulation should not be more burdensome than is necessary, but the first priority must be to safeguard children. All homes will be subject to mandatory inspection.

' the Government also intends to introduce regulation for residential family centres operated by local authorities or independent providers'

Residential family centres

4.37 The Government also intends to introduce regulation for residential family centres operated by local authorities or independent providers. These centres have not been subject to any regulation, because children remain in the care of their parent(s) while in the centre. The Government considers that appropriate regulation should apply to these centres. We intend that mother and baby homes - currently regulated as nursing homes - should in future be subject to the same regulation as residential family centres. The CCSs will carry out the regulation responsibilities.

' we plan to bring independent fostering agencies within the regulatory framework'

Independent fostering agencies

4.38 Most children who are looked after by foster parents are in placements provided and managed by local authority social services. However, the Children Act permits local authorities to delegate certain of their fostering duties to voluntary organisations, and over the last few years there has been a growth of these independent fostering agencies. In line with the recommendations from the Burgner Report and the Children's Safeguards Review, we plan to bring independent fostering agencies within the regulatory framework, and they too will be regulated by the CCSs. We intend to allow private as well as voluntary organisations to act as fostering agencies, as long as they meet the standards of the regulation system.

4.39 The Burgner Report also suggested that the regulation requirements for independent fostering agencies should be extended to local authority fostering services, to ensure even- handedness for such services. We plan to require local authority fostering services to meet the same standards as the independent fostering agencies.

Welfare inspection of boarding schools

4.40 Inspections of the welfare arrangements for children accommodated in boarding schools currently apply to independent schools only (under Section 87 of the Children Act). The Children's Safeguards Review recommended that the duty on independent boarding schools to safeguard and promote the welfare of children they accommodate, should be extended to all schools with boarding provision. These include all LEA maintained boarding schools, and special schools approved to take children with special educational needs. We will extend welfare inspections to these other types of schools. The responsibility for all welfare inspections of schools with boarding provision will transfer from local authorities to the CCSs.

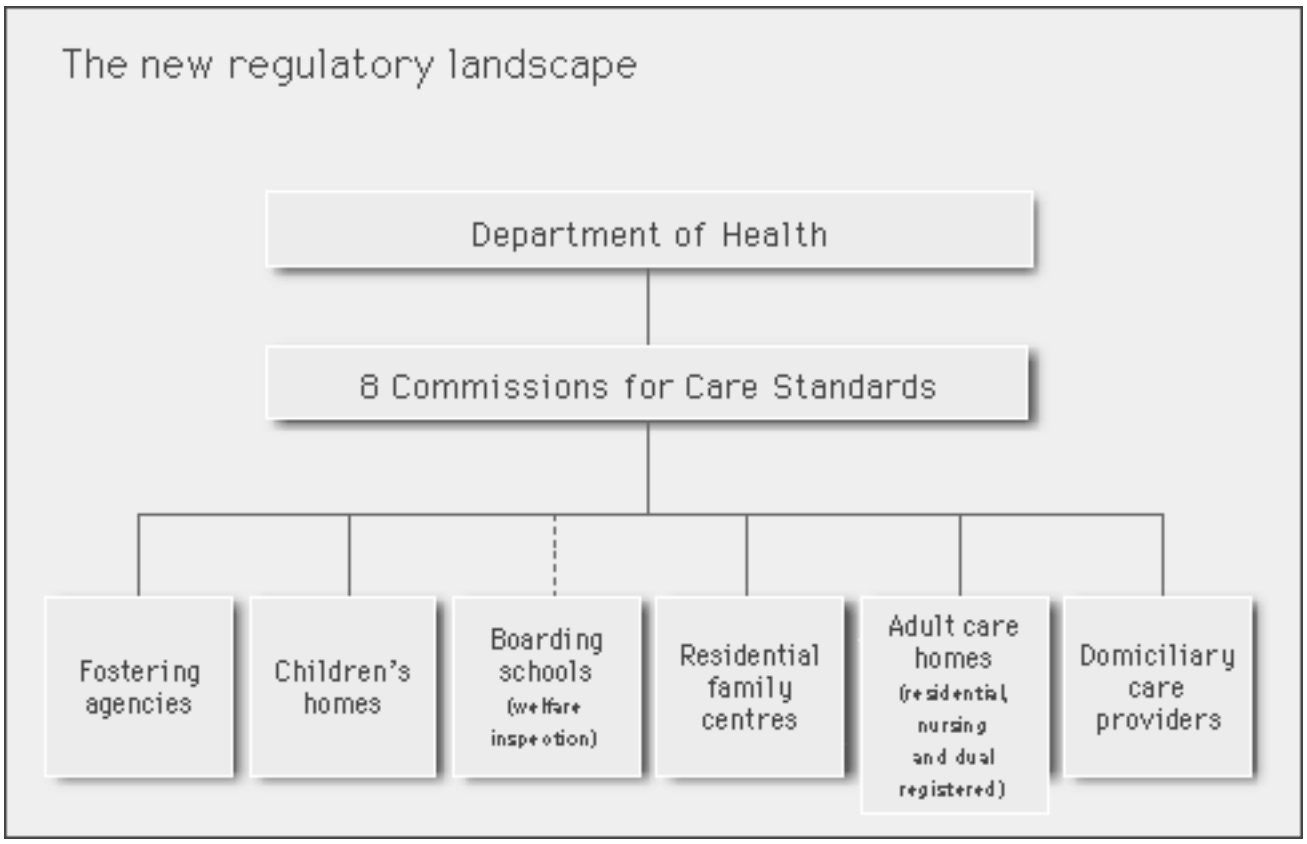
' Children's Rights Officers for each region'

Regional children's rights officers

4.41 The Government wants to ensure that children's welfare is given the highest priority by the CCSs - the regulation of children's services must not be swamped by the much larger volume of adult services that the Commissions will deal with. We intend to establish arrangements for a nominated high-level officer to take charge of the children's regulatory function in each

CCS. 4.42 The Government is anxious that this new development should also provide a channel of communication for serious concerns relating to children's safety and rights. We intend therefore to designate the senior officer referred to above as the Children's Rights Officer for the regional area covered by the CCS. The role of that officer, subject to the CCS itself and to guidance and direction that the Secretary of State may issue, will be to:

- help the CCS to give a full and effective coverage of children's services and children's rights in their statutory regulatory responsibilities and in the reports they make on the discharge of those responsibilities
- ensure that the views of children placed in the facilities and services regulated by the CCS are given proper weight in that regulatory task. This will include close liaison with the new arrangements for promoting the voice of the child in care described in Chapter 3
- report directly to the Chief Inspector of the Social Services Inspectorate any significant evidence relevant to the rights and safety of children gained from the CCS's regulation and assessment of services for children, which might help local authorities or other providers to improve the services and support they give to children.



' the legislative framework for the new regulation system should allow for flexibility and adaptation'

Other services

4.43 The Government does not intend at this stage to introduce new regulation for other service areas, such as day care for adults or field social work. The need for regulation in these and any other areas will be reviewed from time to time, but the Government's aim is that the new CCSs, once established, must concentrate on carrying out effectively the regulatory duties given to them. In due time, as patterns of services change, there may be a need for changes in the range of services subject to regulation. We intend that the legislative framework for the new regulation system should allow for flexibility and adaptation in response to such changes.

4.44 The Government is considering how best to deal with the regulation of the independent acute health sector which is currently regulated on the same basis as nursing homes. In the same context it will look at the most appropriate arrangements for regulating independent mental health hospitals. It will also be considering further the regulation of nurses' agencies, particularly in view of the introduction of regulation for domiciliary care, to see what improvements can be made to the current

system.

Other improvements to the regulation system

4.45 As well as the structural changes outlined above, we intend to improve the way in which regulation is carried out.

More consistent standards

4.46 Currently the Registered Homes Act and its regulations do not set out much detail in terms of the standards that care homes must meet. The Children Act is more prescriptive about the standards for children's homes, but essentially a great deal of discretion is left to the individual local authorities and health authorities in setting standards. Although local discretion allows flexibility, it means that there is inconsistency between authorities, leaving providers uncertain about what they need to do in order to be registered, and leaving service users unclear about what standards they can expect as a minimum in all care homes. The Government is therefore committed to introducing a greater degree of consistency in regulation standards.

4.47 The introduction of the new CCSs provides the organisational basis for more consistency in regulation, as well as reducing duplicated bureaucracy. Where there are currently 250 registering authorities, there will in future be eight. The Government will also develop national regulatory standards to be applied consistently by all eight CCSs.

' a limited range of standards to apply at national level, with a certain degree of flexibility allowed more locally'

4.48 There is always a tension between national prescription and local discretion, and too much national prescription can lead to bad regulation. The key objective must be to develop a limited range of standards to apply at national level, with a certain degree of flexibility allowed more locally. These standards will focus on the key areas that most affect the quality of life experienced by service users, as well as physical standards. The regulatory standards will need to have regard to costs and effectiveness when they are being developed.

4.49 Overall, there will be three levels at which standards are set:

- some standards will be set firmly in legislation, and these will be non-negotiable (an example in the current system is the requirement that the person in charge of a nursing home must be a registered nurse or medical practitioner)
- some standards will be spelled out at national level (for example, required procedures for the proper selection and vetting of staff)
- some of these standards will allow for interpretation by the CCSs, who will be able to define their own requirements within the limits of the national standards (for example, timescales within which specific below-standard accomodation must be upgraded).

' standards for all the various regulated services will be developed through a consultative process'

4.50 The standards for all the various regulated services will be developed through a consultative process. As a first step, the Government has commissioned the Centre for Policy on Ageing to advise on proposed national standards for the largest group of regulated services, residential and nursing home care for older people. The outcome of this project which will be the subject of consultation will provide a basis for developing standards in other areas.

Greater flexibilities in residential and nursing home care

4.51 The Registered Homes Act 1984 introduced, for the first time, the provision for a single home to be registered to provide both residential care and nursing care. In theory, this would allow much greater flexibility, with residents allowed to remain in the same home when their condition requires a greater level of care. However, it meant that homes had to register separately with two different authorities (the local authority and the health authority), who might have different standards and procedures.

In practice dual registration has proved too bureaucratic and time-consuming for many homeowners, and for the health and local authorities.

4.52 The benefits of one home being able to cater for a wide range of needs are clear, for social services, for providers, and most importantly for users, who can feel more assured of having a "home for life" if that is what they wish. The Government wishes to encourage this type of provision, although it is for homeowners themselves to decide what services they wish to offer, and many will of course wish to specialise in particular needs.

4.53 The new CCSs will bring together the currently separate regulation responsibilities for residential care homes and nursing homes. In addition, the national standards that are developed for residential and nursing home care will take an integrated approach, with common standards for all care homes, differing only in matters related to the nursing care needs of those in nursing homes. It should therefore be no more difficult for a provider to register to provide both residential and nursing care, than it is to register to provide either one or the other. In this way, we hope to introduce the greatest level of flexibility while retaining the protections that are necessary. In due course, it may be sensible to move to a single registration category for all care homes, and we intend that the legislative framework should be flexible enough to allow this possibility.

Inspection

' greater use could be made of risk assessment procedures'

4.54 As mentioned above, the new CCSs will have the responsibility to deploy staff appropriately to carry out inspection work, and there will be a more consistent approach to methodologies of inspection and related activities. Inspections - particularly unannounced inspections - are an important method for checking that vulnerable people are receiving the protection and care that they require. They will remain an essential part of regulation. The Government believes that greater use could be made of risk assessment procedures in order to ensure that greater attention is paid to providers where risks to users appear to be greater. This would mean that providers would be assessed in relation to various factors, including past history, previous concerns or complaints, and other matters. Other quality assurance mechanisms - such as independent accreditation schemes - could also be taken into account in determining the level of attention paid to a particular provider. All providers will nevertheless have a minimum frequency of inspections. For care homes this will remain at two per year.

4.55 The current lack of mandatory inspections for adult homes with fewer than four residents is no longer acceptable. Currently there is no requirement to inspect, and guidance issued under the previous administration actively discouraged authorities from inspecting such homes. The Government accepts that small homes, because of their domestic nature, should not be required to meet regulation standards that would undermine their very purpose. The national regulatory standards will take account of this. However, in order to ensure that vulnerable people receive the protection they deserve, we will introduce a requirement that all such homes should be inspected at least once per year. In addition, the definition of small homes will be tightened up to make clear that they are those which are genuinely in small-scale domestic settings.

Complaints, enforcement and appeals

4.56 Effective and easily accessible complaints procedures are an important part of ensuring that care provision continues to meet the necessary standards. The recent Office of Fair Trading inquiry into care homes found evidence of confusion and variation in what complaints procedures were available and how well they were understood. We will be undertaking further work to tackle this issue and to ensure that complaints procedures are better publicised and understood by service users and carers. We will also consider in establishing the CCSs how best to ensure complementarity and coherence between the various complaints procedures that apply to care homes and other regulated services.

4.57 All services subject to regulation will be subject to appropriate enforcement action. This will include powers to serve improvement notices, to prosecute, and where necessary to deregister, including emergency closure. We aim to achieve a greater degree of consistency in enforcement practice under the new system, so that people can be assured that action will be taken to improve standards and - where necessary - to close down services. CCSs will act in accordance with the Government's Enforcement Concordat.

' a greater degree of consistency in enforcement practice'

4.58 Providers will have rights of appeal against deregistration decisions, and formal appeals will be made to a national independent tribunal. This will in future be called the Registered Care Tribunal, and will replace the current Registered Homes Tribunal. As well as making the necessary changes to the Tribunal to allow it to consider appeals for new services (for instance, domiciliary care providers and independent fostering agencies), we will take the opportunity to make changes to improve its operations. There is a need to cut down the delays that can occur in Tribunal cases, and we will shortly be taking

steps to improve this through changes to the Tribunal's procedures. But there are other problems with the Tribunal, for instance a high percentage of appeals that are withdrawn (sometimes at the last minute), and a tendency for cases to be over-legalistic.

We will consult with interested parties, including the Council on Tribunals, when drawing up plans for establishing the Registered Care Tribunal to ensure that it provides, as originally intended, a speedy, inexpensive and simple means of resolving disputes without recourse to the Courts. This is in everyone's interest, not least the service users who can suffer most from delays in the current system.

Conclusion

4.59 Our proposals for improving the way services are regulated will provide better protection for vulnerable people, as well as giving providers a clearer and more efficient system to work with.

4.60 The majority of our plans will need primary legislation, and we intend to legislate as soon as Parliamentary time is available to implement them. We will continue to work with all interested parties as we move to making our proposals reality. As part of this, we will assess closely the costs and benefits of our proposals, as with all proposed regulatory measures. We have produced a draft regulatory impact appraisal, which will be developed as we move to legislation. The draft appraisal is available from the contact point at the end of this White Paper.

4.61 In the meantime, local authorities and health authorities remain responsible for regulation under existing legislation. It is essential that those responsibilities are conscientiously carried out, and the Government will not tolerate any cutting back of activity or resources in this area by authorities because it is a responsibility they are about to lose. Protection of vulnerable people is essential now as well as in the future. We will be ensuring that regulation is a priority area for authorities in the period before the new system is established. The National Priorities Guidance gives effect to this by specifically identifying regulation as one of the priorities for both health and social services.

' regulation is a priority area for authorities in the period before the new system is established'

Introduction

5.1 Social care has been one of the fastest growing employment sectors in recent years, and the workforce now numbers around one million. This includes people working in a wide range of care settings, two thirds of them in the independent sector (mainly working in residential homes).

5.2 The people who work in social care are called on to respond to some of the most demanding, often distressing and intractable human problems. Yet there are few public accolades for getting it right and virulent criticism for getting it wrong. Staff can feel embattled and undervalued, and their morale suffers.

> **' people who work in social care are called on to respond to some of the most demanding, often distressing and intractable human problems'**

5.3 The Government recognises this, and has no wish to undermine or attack those who work in the social care sector. Nevertheless, there are serious problems which we will tackle:

- 80% of this large workforce which works directly with very vulnerable people have no recognised qualifications or training
- there are no national mechanisms to set and enforce standards of practice and conduct. Health care professions have had such mechanisms for many years. A General Teaching Council has just been established. Yet for social workers and other social care staff there has been no comparable body, even though they often have access to people's confidential and intimate lives
- the standards and suitability of some education and training in social care do not enjoy general confidence.

5.4 A competent and confident workforce is an essential component of the modernisation of social services. The policy agenda and explicit service objectives set out in this White Paper have profound implications for the workforce, not only the 40,000 or so professionally qualified social workers, but also the much larger number of care staff providing the bulk of the day to day care. All the staff need to play their part in moving social work away from the public perception of an association with dependence to the promotion of independence, and achieving the provision of safer services for children and modern, enabling services for adults.

5.5 To give their best, staff will need support by:

- clear definition by employers of their roles and the way they are deployed
- individual objectives related to service objectives
- better supervision and management
- improved education and training which is geared to the new agenda.

' to give those working in social care a new status which fits the work they do'

5.6 In this context the Government judges that institutional change is essential to improve standards and public confidence and to give those working in social care a new status which fits the work they do. It will therefore:

- introduce legislation when Parliamentary time allows, to create a new General Social Care Council which will replace the Central Council for Education and Training in Social Work in regulating the training of social workers; set conduct and practice standards for all social services staff; and register those in the most sensitive areas
- develop a new training strategy centred around a new National Training Organisation for social care staff.

Establishing a General Social Care Council

5.7 The Government believes that the need to improve public protection, to raise the quality of services and improve performance, and to give proper recognition to the vocational commitment of the workforce, requires the regulatory framework for social care to be strengthened by regulating social care personnel for the first time. To do this it will create a new statutory body called the General Social Care Council.

' a new statutory body called the General Social Care Council'

Governance issues

5.8 The constitution of the GSCC, its methods of operation and the arrangements for its governance will reflect a paramount general duty to secure the interests and the welfare of service users and the confidence of the public. It will be an independent statutory body with clear functions which it will be responsible for discharging efficiently and effectively. The proper discharge of the functions are however a matter of some importance to the Government and the wider public. The Council will therefore be appointed by the Secretary of State and be accountable to him for the way it performs. It will also operate generally with the approval and consent of the Secretary of State and subject to such guidance or directions as he may give. We also intend that the Secretary of State should have powers of default.

5.9 The Government intends the GSCC to be lean and effective. It will be only as big as is needed to secure the cost-effective discharge of its business and is unlikely to exceed 25 people. The Council will need to be able to employ staff for its day-to-day work, with the approval of the Secretary of State. It is intended that the directly employed staff of the Council will be as small as possible with full use made of bought-in skills.

5.10 In keeping with its objectives the Council will be composed of people representing all the key interests. It will be chaired by a lay person appointed by the Secretary of State and half the members will be appointed so that service users and lay members will be a majority of the Council. Appointments will be made after consultation with service user interests and by inviting applications from the public.

5.11 The remaining members will be drawn from employment, professional and education interests including local government, independent sector employers, and social services education and training. The various representative bodies in these fields will be invited to suggest nominations for appointment of people who can bring the necessary skills and knowledge the Council will need to do its job.

5.12 It will be necessary for the GSCC to discharge its functions through properly constituted committees. The Government will provide for powers to create such committees by approval of the Secretary of State.

5.13 Broadly, the Government intends that any start-up costs and the costs of the regulation of professional social work training will be met at an appropriate level from sums currently allocated to the Central Council for Education and Training in Social Work. The Government believes that registered staff should pay a fee to meet the registration costs and expects that this will be a sum similar to that payable by nurses to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). It therefore intends that the Council, when established, should have powers to receive central grants and to levy registration fees set with the approval of the Secretary of State. The Council will similarly have powers to raise income from charging for any services provided to employers, awarding bodies and educational institutions.

' the GSCC must meet the particular needs of modern social care and the aspirations of the public'

Objectives of the GSCC

5.14 The Government believes that the GSCC must be designed to meet the particular needs of modern social care and the aspirations of the public. The social care workforce is not a homogeneous group of professionally qualified staff. It is large, the people are employed in a diverse range of settings where expectations vary, and they are largely unqualified. Neither is there a generally accepted and widely understood set of values and ethics or standards of conduct and practice which is reflected in the attitudes of the staff as a whole.

5.15 Against this background the Government believes that the GSCC should deliver two key objectives. These are:

- to strengthen public protection by relevant and appropriate regulation of personnel which has the interests of service users and the public at its heart

- to ensure through a coherent, well developed and regulated training system that more staff are equipped to provide social care which allows and assists individuals to live their own lives, and offers practical help, based on research and other evidence of what works, and free of unnecessary ideological influences.

Setting the standards

5.16 The Government recognises that the majority of staff carry out their work safely and with humanity often in situations of great difficulty. The Government believes that consistent action must now be taken to set enforceable standards of conduct and practice for the whole workforce and that these standards should be published in codes. Codes will enable users and the public to know what standards they can expect of staff. They will also guide all staff and their employers in a common understanding of conduct and practice requirements. The Government therefore intends the GSCC to have the necessary powers to set standards and that drawing up the codes will be the first priority for the Council.

' consistent action must now be taken to set enforceable standards of conduct and practice'

5.17 Individual practitioners should be personally accountable for their own standards of conduct and practice based on the codes. They will therefore be required to sign up to the codes as a condition of their employment. However, service users and the public must have satisfactory assurance that where conduct and practice fall short of the accepted standard, effective action to enforce the codes can be taken, and where necessary, unsuitable individuals removed from the workforce. The Government intends to achieve this by reinforcing the responsibilities of employers to adopt and rigorously apply the best employment practices when recruiting people and when taking disciplinary action against unsatisfactory members of staff.

5.18 The GSCC will therefore also draw up and promulgate a code of practice for employers. This will be enforced even-handedly in the regulated services by the Commissions for Care Standards (described in the previous Chapter) through the national regulatory standards. Where necessary the code will be enforced in the statutory sector using the existing powers of

direction and guidance given to the Secretary of State.

Registration of individuals

5.19 Most regulatory bodies use registers in some form as a way of setting and maintaining standards for entry to and remaining in the professional or occupational group concerned. The Government accepts that registration of individuals has a part to play in improving the quality of the staff and in strengthening public protection. It therefore intends that the GSCC will have a registration function. However, the Government believes that existing models of regulation used in other areas are not appropriate for social care and the circumstances of the workforce described earlier. The registration function of the GSCC will be framed specifically and introduced incrementally to secure the best interests of service users and the public.

' registration of individuals has a part to play'

5.20 Registration can strengthen the regulatory framework and public protection only if it has a proper basis. The Government does not accept it is sensible to proceed at once with registration of a largely unqualified workforce on the basis of vetting procedures alone. With a workforce of a million, this would be costly and cumbersome, and would not in practice lead to better standards. The Government has therefore decided that registration by the GSCC will be based on the satisfactory completion of approved training which provides the necessary skills and knowledge for safe, effective and lawful practice in any job or at any level. The Secretary of State will approve the opening of a register where, in his opinion, a registration requirement would justify the cost by reliably adding to the safeguards to the public; and when he can accept advice from the GSCC that for the relevant section of the workforce the following conditions are met:

- a suitable form of training exists
- an education/training supply side is capable of delivering that training
- a large enough proportion of the people in the group concerned have completed the training to make the register viable.

5.21 The criteria for registration are already met in respect of qualified social work staff. The GSCC will therefore be able soon after its establishment to open a register of people who have obtained a professional social work qualification. The GSCC will however be concerned with the whole workforce, and the Government wants to see considerable improvements in the levels of training and qualifications generally. It sees the GSCC as playing a significant role in achieving that objective.

' considerable improvements in the levels of training and qualifications'

5.22 It therefore intends that another group of staff will be registered at or about the time of the professionally qualified staff. The Government has already provided 2 million for 1998/99 in its Training Support Programme to enable residential child care workers to be qualified at NVQ Level 3. The Government expects that this group of staff will be registered as well as social workers.

5.23 Taking this priority approach to training and subsequent registration, the Government has identified heads of care homes as a group in which it expects to see more progress in the next few years. Most heads of children's homes have already been qualified to Diploma in Social Work level, and will therefore be eligible for registration on that basis. However, only a relatively small percentage of heads of adult care homes are similarly qualified. The Government wishes to see more heads of homes, particularly in the adult care sector, appropriately qualified. It will be working with the sector to ensure that suitable training which can build on the considerable experience of many heads of homes is put in place. The Government can then consider whether registration of heads of homes with the GSCC would be a helpful further step.

5.24 It is common in other professions for continued registration to be linked to continuing professional education and development. The Government believes that while individual workers have a personal responsibility to ensure they are up to date, more positive steps are needed. It therefore intends to provide for periodic re-registration to be introduced when the Secretary of State considers it appropriate.

Deregistration

5.25 The GSCC will have the power to deregister individuals for breach of the codes of conduct and practice. The

Government intends that the deregistration mechanism which may provide for hearings to determine the facts and adjudicate the matter will operate so as to ensure that proper weight is given to the interests of the service users concerned. Provision will also be made for immediate suspension from the register in appropriate cases prior to the full hearing of the issues.

' the GSCC will have the power to deregister individuals for breach of the codes of conduct and practice'

5.26 As set out in Chapter 3, the Government intends to strengthen the Consultancy Index which includes the names of persons who are considered unsuitable to work with children. The Government will ensure that the GSCC and the new Consultancy Index complement each other.

Job reservation

5.27 In some professions or occupational groups it is common for restrictions to apply which allow only registered staff to carry out certain work. For instance, only a nurse registered with the UKCC may work as a nurse in the NHS. The Government does not think that such a blanket approach is possible or even desirable in social care. Social care is increasingly multi-disciplinary in nature involving the medical, nursing and other professions allied to medicine, for example. Developments in delivering social care and restructuring in local government are also continuing to break down traditional roles or functions which are in any case very difficult to define. The Government does not wish to stifle such developments by building rigidities into the regulatory system. The Government therefore sees no case for general job reservation.

5.28 But it will be considering the circumstances in which the public interest requires a statutory restriction on employment. In some areas, there are existing statutory restrictions which effectively result in job reservation. The Mental Health Act 1983 requires that certain mental health functions are carried out by Approved Social Workers (qualified social workers who have completed a further course of specialist training). In the case of registered nursing homes there is a regulatory requirement for heads of homes to be registered nurses or medical practitioners. The Government believes that for heads of other types of homes there is a case to be considered for restricting these posts to people with particular qualifications. This could be done through the statutory basis for regulation of these services at some future date when this part of the workforce can be and is trained to an appropriate level as described above.

5.29 There is also a strong case for ensuring that some areas of children's services involving highly specialised functions such as management of children's cases involving the exercise of statutory powers, child protection, and assessing families with particularly complex needs, should be restricted to individuals who are registered by the GSCC or the statutory regulatory bodies for the health professions. The Government will be considering this area further and will seek an appropriate power to introduce job reservation when the Secretary of State considers it to be right. The Government will, however, use such a power cautiously and selectively so that it does not block the involvement of a range of professional and occupational skills.

Regulation of education and training

5.30 The Government has already announced that when the GSCC is established, it will take on responsibility for the regulation of professional social work training from the Central Council for Education and Training in Social Work which will then be abolished. It will also be the statutory body responsible for advising the Secretary of State on the suitability and cost effectiveness of training across the social care workforce prior to the establishment of registers. It will, therefore, take a keen interest in the availability and "fitness for purpose" of training.

' CCETSW will be abolished'

5.31 It will be important for the GSCC to establish and maintain close links with the National Training Organisation (see paragraph 5.34), the Qualifications and Curriculum Authority and awarding bodies for NVQ level training to ensure that occupational standards, course content, assessment arrangements and programme approval mechanisms produce qualifications of a quality and consistency on which registration can be based.

5.32 The Government intends the GSCC to have the powers necessary to reshape and maintain the professional training system to ensure that it is fit for purpose. As in other professions, it is important that professionally qualified social workers base their practice on the best evidence of what works for clients and are responsive to new ideas from research. Their early education and training will play a significant part in encouraging a flexible, intelligent approach to practice in later years and assist social workers in taking personal responsibility for their continuing professional education and development. The

Government believes that the regulation of the training system must also be responsive to the changing needs of the services and their users. It will expect, facilitate and encourage all key interests - users, the public and employers - to see that this happens.

' it is important that professionally qualified social workers base their practice on the best evidence of what works for clients'

5.33 It will therefore be an early priority of the GSCC to consider and take what action is necessary to redefine the regulation of professional social work training. This is however an area to which the Government has attached such importance that it has put in place a programme of work to secure some improvements in the system in advance of and for the benefit of the new Council. Much of this work will be done in conjunction with employment and academic interests.

A training strategy

5.34 Alongside the GSCC's role in setting the standards for training in social care, the development and promotion of training at all levels will be the main responsibility of the recently licensed Training Organisation for Personal Social Services. This national training organisation (NTO), like those for other industries, is an employment-led body representing the whole sector, including service users. Its functions are:

- to maintain the occupational standards underpinning the qualifications recognised by social care staff and employers
- to carry out workforce analysis
- to identify training needs and ensure they are met.

' a new National Training Organisation'

5.35 The new NTO provides a unique opportunity to capitalise on and unite past work in the areas of training and workforce analysis. In recent years our understanding of the characteristics and dynamics of the social services workforce, and the priority areas for improvements in education and training, has increased significantly. Research funded by the Department of Health has played an important part in establishing the sound knowledge base required to underpin plans for future investment in the workforce, and we intend that high quality research shall continue to play an important role. However, more is needed than mere consolidation and further analysis. The Government believes there is a need to put in place a training strategy for social care which defines a new and more effective agenda. This does not have to wait for the establishment of the GSCC, and as a start, the Government has, jointly with the NTO, held a conference of all the major interests in social care to begin addressing: the key elements of a training strategy in social care; the need for clear agreements linking staff groups to the training and qualifications structure; targets for quantitative and qualitative improvements; the commitment of all employers to their achievement; and the key role of the NTO in delivering results.

5.36 The co-operative development of a national training strategy for social care does not diminish the continuing responsibilities of all employers for wider workforce issues and for linking these to local corporate objectives. The Government wishes to see further developments of local human resource strategies, of which training is one part, which are themselves more comprehensively connected to coherent business and training plans. With a large, diverse workforce it is essential that employers have a clear sense of their workforce, have carefully analysed the sorts of skills and people they need to achieve their business objectives, and can plan and direct the available resources for training to where they are needed.

' the Government will provide an extra 19.7 million for the Training Support Grant over the next three years'

Training support programme

5.37 The Training Support Programme (TSP) is a central programme supported by the Training Support Grant. The Government will provide from the Social Services Modernisation Fund an extra 19.7 million for the Training Support Grant over the next three years. The Government intends that in future this money will be increasingly geared towards raising qualification levels. Once the NTO has mapped the workforce and achieved some consensus in qualifications linked to particular occupational groups, it will be possible to set qualification targets for these groups. The Training Support Grant will be used to support the achievement of these targets.

5.38 Given the priority of improving services for children, the Government has already put in place a range of new child care training initiatives which will receive funding from the TSP. They include:

- 1 million rising to 6 million over three years to enable 7,000 social workers engaged in child care and child protection work to achieve a new post-qualifying award
- 2.5 million rising to 3m over three years for 9,500 residential child care workers to attain an NVQ level 3.

5.39 There will in addition be about 500,000 available for each of the next three years for training top social services managers, which will also help to implement the Quality Protects programme.

Conclusion

5.40 Good social services cannot be delivered without good staff. Work in the social care field is an important vocation through which many people give valuable service to individuals and the community. To give greater public recognition of this, the Government intends to introduce an awards scheme for outstanding individual social care staff, beginning next year. Through improvements in training arrangements, and through the work of the GSCC, we intend to ensure that the social care workforce is fit for delivering modern, high quality services, and that all the people who work in social care can feel that their work and their commitment are given the recognition that they deserve.

> **' through improvements in training arrangements, and through the work of the GSCC, we intend to ensure that the social care workforce is fit for delivering modern, high quality services'**

6

Key themes
- better joint working to help people get the services they need
- integrated health and social care
- better co-ordination of children's services

Improving partnerships

better joint working for more effective services

Introduction

6.1 An important feature of the provision of social services is that social services are rarely the only public service in contact with a family or individual service user. The main agencies who work alongside social services include:

- the National Health Service
- local housing departments
- the employment service
- the education service
- the criminal justice system.

6.2 As well as these statutory agencies, social services operate more broadly in partnerships with voluntary organisations, independent providers and with users, their carers and their representatives. This Chapter sets out action to help social services to work in effective partnerships in the best interests of service users.

6.3 Although there are often difficulties in bringing together different agencies' responsibilities, major reorganisation of service boundaries - always a tempting solution - does not provide the answer. This would simply create new boundaries and lead to instability and diversion of management effort. Instead, the Government is fostering a new spirit of flexible partnership working which moves away from sterile conflicts over boundaries to an approach where this wasted time and effort is directed positively towards working across them. The Government will play its part in helping this partnership approach by removing legal and other obstacles to joint working, and by adopting the same principles of partnership and joint

working in policy-making as we expect from those who are responsible for delivering the services at local level.

' flexible partnership working which moves away from sterile conflicts over boundaries'

6.4 The Government's reforms to modernise local government, set out in the White Paper Modern Local Government: In Touch with the People, will place on local authorities clearer duties to act corporately in the interests of their local citizens, and they will need to forge partnerships with other services to carry out those duties.

Partnership with the NHS

6.5 The National Health Service is a crucial partner in almost all social services work. This is particularly true in services for elderly people, people with mental health problems, people with physical disability or a learning disability, and some children's services. The Government has made it one of its top priorities since coming to office to bring down the "Berlin Wall" that can divide health and social services, and to create a system of integrated care that puts users at the centre of service provision. People do not fit into neat service categories, and if partner agencies are not working together it is the user who suffers.

New corporate duties of local authorities

The White Paper Modern Local Government: In Touch with the People set out a new legal duty which will be placed on local authorities to "promote the economic, environmental and social well-being of all their citizens". The intention is that authorities should stop thinking in terms of discrete, departmental functions, and start thinking more corporately about what will benefit their citizens, cutting across traditional service boundaries if need be. This will require close partnership working both within authorities (for instance, between social services and education) and with other agencies (such as the police and the NHS).

6.6 Both health and social services authorities recognise this and many have worked hard to develop means of joint working to enable users to receive the high quality, integrated services they need.

6.7 We know that there is plenty of enthusiasm among staff and managers in health and social services to work together innovatively. We saw the benefits of this in the use of the extra funding provided to cope with 1997/98 winter pressures (see box). That is why we are continuing this winter pressures money for a second year. And there have been many excellent examples of joint working in other areas, for example in child and adolescent mental health services.

6.8 But we need to translate these individual examples of good practice into routine joint working at all levels and in all parts of the country. We are determined to overcome the obstacles to effective joint working that remain.

Good practice in joint working: use of winter pressures money

An extra 159 million was made available during the 1997/98 winter period to help ease pressure on the health and social care system. Elderly people are particularly vulnerable during the winter months, and all too often, an emergency admission to hospital following a fall or other problem becomes a permanent stay either in hospital or a care home. Increased admissions of older people puts pressure on the whole hospital system, creating difficulties in dealing with other emergency cases. The extra money was used in many areas to tackle this problem, for example:

In **Lambeth, Southwark** and **Lewisham**, the local hospitals appointed discharge co-ordinators to work closely with the three local social services departments to ensure that people could return to their own homes - with support - at the earliest opportunity.

In **Bromley**, the continuing care multi-disciplinary team provided intensive medical, nursing and therapy care for patients in their own home - without this service half of the 135 patients dealt with by the team would have been referred directly to hospital for admission.

In **Greenwich**, additional funding was used to enhance the provision of community alarms. 93 new alarms were provided

during the winter of which 85% were connected within 48 hours. The average age of recipients was 78.

Additional funding of 209 million for England was announced for winter pressures in 1998/99, and this will fund further joint health and social care initiatives around the country.

6.9 Some of the Government's initiatives to improve joint working between health and social services have been mentioned in Chapter 2. They include the Better Services for Vulnerable People initiative, the new Promoting Independence grants which encourage joint working, the Long-term Care Charter, and the development of National Service Frameworks covering both health and social care.

6.10 We will also be legislating to make joint working easier. The proposals in our consultation document Partnership in action include new arrangements to allow health and social services authorities to work together better (see box). These flexible approaches will benefit services for all population groups: children, young people, working age adults and elderly people.

' legislative change to make joint working easier'

Partnership in action - the Government's proposals

The Government will legislate to make it easier for health and social services authorities to work together. The three key proposals are:

- **pooled budgets** - where health and social services put a proportion of their funds into a mutually accessible joint budget to enable more integrated care. Pooled budgets will require robust management and accountability arrangements

- **lead commissioning** - where one authority transfers funds to the other who will then take responsibility for purchasing both health and social care. The legislation will allow the local authority or health authority to delegate their functions and money

- **integrated provision** - where one organisation provides both health and social care. It is often integrated provision (for example of health and social care for learning disabled people) which brings most immediate benefit to users. This flexibility would allow NHS Trusts and Primary Care Trusts greater freedom to provide social care and would allow social services in-house providers to provide some community health services on behalf of the NHS.

These powers will be permissive, which means that it will be up to local and health authorities to decide between themselves which arrangements if any will be most helpful for their joint working. What works locally is what counts.

The new NHS

6.11 More widely, local authorities will be crucial partners in the new approaches to health and health care set out in the White Paper The new NHS and the Green Paper Our Healthier Nation. This will involve local authorities in their wider corporate role, covering for example, public health responsibilities, community safety, and housing and regeneration plans. But social services will obviously be the main local authority responsibility which will contribute to and benefit from these new arrangements.

' local authorities will be crucial partners in the new NHS'

6.12 At national level, as described in Chapter 7, we have introduced National Priorities Guidance covering both the NHS and social services. At local level, Health Improvement Programmes, to be introduced from April 1999, will bring together a range of health and local government services to work with others towards common objectives to improve the health and well-being of local communities. Social services will need to take account of that strategic framework in planning their own services. At operational level, they will need to draw up with the NHS Joint Investment Plans based on commonly agreed objectives for vulnerable groups. Social services will also be involved in the governance arrangements for Primary Care Groups and Primary Care Trusts being set up from April 1999, for which shadow arrangements are already being established

now.

' social services will be involved in the governance arrangements for Primary Care Groups and Primary Care Trusts'

The new NHS - partnership with social services

The White Paper The new NHS set out the Government's plans to modernise the NHS by replacing the internal market with a system of integrated care based on partnership and driven by performance. The White Paper described further new initiatives to continue the drive for improved working at the NHS and local government interface. These initiatives included:

- **a new statutory duty of partnership** on all local bodies in the NHS family and on local authorities to work together to promote the well-being of their local communities - this gives substance to the co-operation necessary to bring about improvements in health and social care
- provision for **local authority Chief Executives to participate in health authority meetings**
- establishment of **Primary Care Groups** to improve the health of their local population, develop primary care and community health services, and commission hospital services - these groups will work closely with social services on both planning and delivery of services; and will have social services representation on their governing bodies
- the introduction of **Health Improvement Programmes** for each health authority area to provide the local strategy for improving health and health care with involvement from partner agencies such as local government and voluntary bodies
- a key element of the Health Improvement Programme in each area will be Joint Investment Plans, drawn up between health and social services to deal particularly with groups where coordinated services are most important.

6.13 This presents a demanding and exciting agenda, which should mean that social services can do more for the people they try to help. It will require a new way of thinking, which in turn will require the investment of management and staff time both in local authority social services and in partner agencies. The Department of Health will provide support through the dissemination of good practice and local development work through the Social Care and NHS Regional Offices.

Partnerships in services for drug misusers

6.14 Drug misuse is an important area where social services work not only with the NHS, but with many other local interests, such as housing, the probation service and the police. The Government's Drugs Strategy White Paper, Tackling Drugs to Build a Better Britain, sets out a ten year plan for addressing the problems of drug misuse and identifies a central role for social services in delivering the strategy's objectives. The White Paper recommends that "funding for the purchase of community care services for drug misusers should be given adequate priority by local authorities. The Department of Health should take steps to ensure that this money is used for drugs-specific partnership work, with mechanisms put in place to ensure that current expenditure on drug misusers from community care funding is protected."

6.15 The Government has committed itself to the new strategy, and following the Comprehensive Spending Review has allocated 20.5 million of new money over three years to enable the commissioning of additional community care services for drug misusers in support of locally agreed Drug Action Team plans.

Partnership with housing

6.16 Housing is an essential element in the network of community care services. The Audit Commission estimate that around 2 billion a year is spent on housing-related community care services for around 1.3 million people. There are some 450,000 placements by local authorities and housing associations in sheltered housing with wardens on site - similar to the

total number of residential and nursing home places. Yet, a recent Audit Commission report found that collaboration between housing and social services is still often weak, and the full potential of housing departments and providers to contribute to community care is not being exploited.

" A picture emerges of inadequate identification of needs, inflexible use of stock and insufficient early intervention to prevent vulnerable people reaching crisis point."

" None of the fieldwork authorities conveyed a clear vision of the future role of sheltered housing. There is little evidence of joint working with social services and local Registered Social Landlords to include sheltered housing in a wider strategic approach to services for older people...".

" In effect, many people with mental health problems become trapped in the "revolving door" syndrome whereby tenancy crisis leads to hospitalisation and/or homelessness, and then a lack of on-going support after being rehoused means that these tenants fail to establish these tenants fail to establish a firm foothold in the community."

Home Alone, Audit Commission, 1997

6.17 The Government recognises the crucial role housing has to play in community care and the need for partnership between health, housing and social services in supporting people in the community. This partnership needs to involve not only the statutory authorities but also housing providers to ensure that housing needs are identified and strategies developed to address them. In areas with two-tier local government, social services are the responsibility of the county council while housing is the responsibility of the district councils, so there is an additional boundary to overcome in these cases.

' the Government recognises the crucial role housing has to play in community care'

6.18 The Department of Health and the Department of the Environment, Transport and the Regions have worked together to assist them with this. We have produced joint guidance to assist health, housing and social services to develop strategic plans and, more recently, the Making Partnerships Work in Community Care workbook to help frontline workers to make the connections locally. This is being backed up by joint work between the Social Care Regions and the Government Offices for the Regions to promote the messages in the workbook to local housing, social services, and health professionals working at the interface between housing and care and support services.

6.19 Examples of further work at national level are:

- the current inter-departmental review to establish a modern, practicable and sustainable arrangement for the long-term funding of supported accommodation
- changes to the building regulations to make all new homes more accessible to disabled people
- a commitment to give local authorities new powers to provide community alarms to a wider range of people.

Better housing for disabled people

On 9 March 1998 the Government announced that Part M of the Building Regulations, covering access and facilities for disabled people, is to be extended to include new dwellings. The purpose of these proposed measures is to allow people to be able to remain in their own homes longer as they get older, and to make it easier for disabled people to visit the homes of friends or relatives.

In practice this means that in future, new homes will generally include a level or gently sloping approach, a wide entrance without steps, adequate circulation, wider internal doors and a toilet on the ground floor to enable access by wheelchair users. This will result in more homes that are accessible to disabled people.

6.20 At a local level we are:

- working closely with the National Housing Federation to improve service standards in housing and support schemes

through its "Framework for Housing with Support"

- preparing guidance for local authorities on housing options for people with a mental illness or learning disability.

6.21 But the Audit Commission report makes it clear that there is more to be done. The joint DETR/DH guidance provides a firm foundation for authorities to address the Audit Commission criticisms. Development of the Long-term Care Charter, with its emphasis on housing as well as health and social services, will build on this and give increasing clarity about what users can expect and how authorities should jointly assess their respective performance.

6.22 As described in Chapter 3, the Government is taking steps to help young people leaving the care of local authorities, who often face great difficulty in finding suitable and affordable accommodation. It is essential that the relevant agencies - social services, housing authorities, other housing providers, and voluntary agencies - come together to assess and plan to meet the accommodation needs of care leavers, as well as other vulnerable young people. The Government will issue guidance to social services to accompany the forthcoming revised Housing Allocation and Homelessness Code of Guidance from the DETR. This will make it clear that when placed in mainstream or social housing, young people formerly looked after may need a great deal of personal and other support to sustain them in the community and help them meet their responsibilities as tenants. They must also receive assistance and support to develop life skills so that they can live independently in the future.

6.23 More widely, social services can make an important contribution to wider local authority-led programmes to tackle the problems of homelessness, poor housing conditions, and social exclusion in deprived neighbourhoods. These issues, and the need for co-ordinated local approaches to tackle them, have been covered in the Social Exclusion Unit's reports on rough sleepers and on Neighbourhood renewal.

Social Exclusion Unit reports

Rough sleeping

The report Rough Sleeping describes the factors that contribute to people sleeping rough, and identifies the gaps in services available to them. Only five per cent of rough sleepers do so by choice. There are not enough beds, not enough help with drug, alcohol or mental illness problems, and a job and a home can prove impossible to secure. Many cannot register with a GP and health outcomes are very poor, with the mortality rate 25 times higher than the national average.

The report sets in train a strategy, to cut the number of people sleeping rough by two thirds by 2002. This includes a major programme to prevent rough sleeping by ensuring that people leaving institutions are better equipped to live on their own and are not left to fend for themselves. A new body will be established to bring effective co-ordination and direction to services for rough sleepers in London, and outside London the Department of the Environment, Transport and the Regions and the Department of Health will co-ordinate help for rough sleepers.

The report Bringing Britain Together: A Strategy for Neighbourhood Renewal describes the effects of poverty, unemployment, poor health, crime and lack of access to services in deprived neighbourhoods. It also identifies the success stories from around the country where communities have come together to find solutions to their own local problems.

The report sets in train a national strategy to support neighbourhood renewal. Eighteen Policy Action Teams, drawn from 10 Government Departments and involving experts from outside government, will focus on a range of issues including getting people into work, improving the management and fabric of neighbourhoods, building a future for young people, improving access to services and getting Government to work better for local communities.

The New Deal for Communities will support this work by providing 800 million funding over the next three years for the intensive regeneration of neighbourhoods.

Partnership with the employment service

6.24 As mentioned in Chapter 2, social services also have a part to play in achieving our aim of work for those who can. They have a key role in working with disabled people, in partnership with other agencies, to ensure appropriate, timely, cost effective and consistent support. Such partnerships and joint working benefit the individual through helping them to an independent life in the community; and the employer through enabling them to recruit employees that are motivated. Effective social services will help disabled people to get and stay in work where they need help, for example before leaving for work; and will work closely with local employment services at an early stage to provide integrated support for someone facing the onset of a disability so as to maintain maximum independence. Social services will need to work closely with the Single Gateway we have proposed to enable it to act as a single point of access to welfare.

Education and other children's services

6.25 In children's social services, partnership with the education service are at least as important as those with the health service. Since both social services and education are the responsibility of the same authorities in every part of the country, there are no organisational excuses for poor co-ordination. However, joint working is frequently poor, and in general, children's social services often suffer a high degree of isolation from the rest of the local authority.

' the welfare of children must be seen as a corporate responsibility of the entire local authority'

6.26 Chapter 3 makes clear that the welfare of children must be seen as a corporate responsibility of the entire local authority, and social services for children must be seen as an element of that wider responsibility. Some authorities are tackling this through using their management arrangements to bring together a range of services affecting children. Whatever the management arrangements in place, every authority must bring the resources of all its departments to bear to improve children's social services. The objectives for children's social services identified in Chapter 3 require inter-agency co-operation and will, in turn, deliver benefits to other services. And the Quality Protects initiative, also mentioned in Chapter 3, is directed at each local authority as a whole, not just at social services functions for children.

6.27 We will reinforce this council-wide responsibility by redefining the requirements for children's services planning. We will place the duty to plan on the local authority as a whole, and require them to include specific proposals, for example, to:

- improve the health and education of looked after children
- determine priorities for improving support for children in need, including disabled children and those with emotional and behavioural difficulties, and set out how those priorities will be given effect
- address housing needs of families with children in need
- summarise the outcomes intended in youth justice, behaviour support, and early years plans, and thus bring together action on behalf of the main groups of children at risk of social exclusion.

6.28 These children's services plans will need to be agreed with all interested agencies, and arrangements established to monitor the outcomes. Social services will need to work with interested parties to ensure they recognise that effective expenditure and action in these areas could reduce the resources needed in other areas and in the future; to obtain the necessary commitment and ownership from them to ensure that agreed plans can be achieved; and to ensure that outcomes are effectively monitored.

6.29 This change to the status of children's services plans will need legislation which we intend to introduce when Parliamentary time allows. Current guidance encourages, but cannot require, authorities to cover all services for children and families. In addition, although legislation requires social services to consult with other departments and organisations there is no requirement that those consulted respond or participate in planning. In future all interested parties will be required by statute to participate in and take responsibility for their role in children's services planning. In the meantime, we will rely on inter-departmentally issued guidance.

Partnership with the voluntary sector

Voluntary organisations make an enormous contribution to social care, working alongside and in co-operation with social services. Social services should have good relationships with voluntary organisations, both in service provision partnerships

and also in order to help understand the needs and views of users. Local authorities should ensure that they know which voluntary organisations are in their area; what the voluntary sector can contribute to meeting the needs of the local population; and where the authority's support for the sector can be used to best effect.

In November 1998 the Home Office and a voluntary sector representative group jointly launched a Compact on Relations between Government and the Voluntary and Community Sector in England, setting out agreed principles for effective working relationships. Authorities are encouraged to adopt these principles and to establish their own versions of the Compact.

Criminal justice agencies - youth justice

6.30 The Government has undertaken a comprehensive review of youth justice issues. New structures for work with young offenders are to be set up under the Crime and Disorder Act. Multi-agency youth offending teams are to be established by local authorities with social services and education responsibilities, in partnership with health authorities, the police and the probation service. A draft inter-departmental circular *Establishing Youth Offending Teams* explained the important role that social services and health authorities will have within these teams. This is linked with their broader work on the welfare and health of young offenders and children and young people at risk of offending. Pilots of the teams began on 30 September 1998 in selected areas and will run for a total of eighteen months, with a view to implementing them nationally by April 2000. A new national body - the Youth Justice Board for England and Wales - has been established to advise Ministers on setting standards for service delivery and to monitor performance across the youth justice system, including youth offending teams.

Other partnerships

6.31 As well as these partnerships between social services and other public agencies, there are important partnerships with the voluntary sector, with independent social care providers, and indeed with users, carers, and their representatives. A partnership approach should underlie the relationships that social services have with all these groups.

Introduction

7.1 The delivery of social care to the people of this country is a substantial task, costing 9 billion. It involves dealing with a huge variety of people in need in practically every part of the country, from rural villages to densely-populated inner city areas. Managing such an operation is a complex and demanding job. High quality and good value services can only be achieved if there are sound management, information and performance systems in place. Checks are needed both locally and nationally to make sure that people are getting the modern and dependable social services that they deserve.

' the delivery of social care to the people of this country is a substantial task, costing 9 billion'

7.2 The SSI/Audit Commission Joint Reviews are providing invaluable information on how social services are being delivered throughout the country, in terms of quality of services, effectiveness of delivery, and value for money. It is the first time that such a comprehensive picture of social services performance has been available, and it is instructive. With the number of reviews completed now more than 30, the Joint Reviews have found many examples of good practice, including some authorities who are delivering good quality social services across the board. However, they have also found too many examples of poor services, widespread inefficiency, and a worryingly high number of authorities with serious and deep-rooted problems.

7.3 This situation must change. Improvements are needed in the quality and value for money of social services and to ensure that local people are receiving the services that, as taxpayers, they should expect. There is much that local authorities can do to improve their services, and to drive up their standards to match those of the best. But local authorities cannot deliver all the necessary improvements on their own. The Government accepts that it has responsibilities for ensuring the effective delivery of social services, and will work in partnership with local authorities to achieve continuous improvement.

' drive up standards to match those of the best'

Getting the framework right

7.4 Whilst social services are locally-managed services meeting local needs they operate within the framework of legislation and policy set by Government. In the past Government has not done all that it could to support the local delivery of social services or to assist local authorities in improving their performance. The proposals in this White Paper address this, and enable the Government to promote better management of social services. At a national level the Government will provide the proper context for social services by:

- establishing clear objectives for social services, creating a clear expectation of the outcomes social services are required to deliver
- publishing National Priorities Guidance, setting out the key targets for social services to achieve in the medium term
- providing the resources to support the achievement of demonstrable change
- putting in place effective systems to monitor and manage performance.

Clear objectives

7.5 Social services need direction if they are to serve people better. The new national objectives for social services arising from the Comprehensive Spending Review and set out below provide this direction. The action set out for adult and children's services in Chapters 2 and 3 of this White Paper address the areas where improvement is most needed. This is the first time that any Government has laid out explicitly its expectations of social services. This clarity will allow local authorities to focus their efforts, and provide them with the guidance they need to carry through the programme of change necessary to modernise social services. The monitoring arrangements described in this Chapter will allow progress against the national objectives as a whole, and of the action identified for adult and children's services, to be assessed both locally and nationally.

' social services need direction if they are to serve people better'

National priorities guidance

7.6 The agenda embodied in the new objectives for social services is a challenging and significant one. Over time we wish to see improvements in performance against each of the objectives. But we recognise that this will take time and that there is a need to prioritise. *Modernising Health and Social Services*, the National Priorities Guidance (NPG) sets out the key priorities for 1999/00 - 2001/02 at national level for both health and social services:

National priorities for health and social care 1999/2000 - 2001/02

Social services lead	Shared lead	NHS lead
• Children's welfare	• Cutting health inequalities	• Waiting lists/times
• Inter-agency working	• Mental health	• Primary care
• Regulation	• Promoting independence	• Coronary heart disease
		• Cancer

National objectives for social services

Children's services

Adult services

- to ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood
- to ensure that children are protected from emotional, physical, sexual abuse and neglect (significant harm)
- to ensure that children in need gain maximum life chance benefits from educational opportunities, health care and social care
- to ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care
- to ensure that young people leaving care, as they enter adulthood, are not isolated and participate socially and economically as citizens
- to ensure that children with specific social needs arising out of disability or a health condition are living in families or other appropriate settings in the community where their assessed needs are adequately met and reviewed
- to ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response.
- to promote the independence of adults assessed as needing social care support arranged by the local authority, respecting their dignity and furthering their social and economic participation
- to enable adults assessed as needing social care support to live as safe, full and as normal a life as possible, in their own home wherever feasible
- to ensure that people of working age who have been assessed as requiring community care services, are provided with these services in ways which take account of and, as far as possible, maximise their and their carers' capacity to take up, remain in or return to employment
- to work with the NHS, users, carers and other agencies to avoid unnecessary admission to hospital, and inappropriate placement on leaving hospital; and to maximise the health status and thus independence of those they support
- to enable informal carers to care or continue to care for as long as they and the service user wish
- to plan, commission, purchase and monitor an adequate supply of appropriate, cost-effective and safe social care provision for those eligible for local authority support
- to identify individuals with social care needs who are eligible for public support, to assess those needs accurately and consistently, and to review care packages as necessary to ensure that they continue to be appropriate and effective.

Common objectives

- to actively involve users and carers in planning services and in tailoring individual packages of care; and to ensure effective mechanisms are in place to handle complaints
- to ensure through regulatory powers and duties that adults and children in regulated services are protected from harm and poor care standards
- to ensure that social care workers are appropriately skilled, trained and qualified, and to promote the uptake of training at all levels
- to maximise the benefit to service users for the resources available, and to demonstrate the effectiveness and value for money of the care and support provided, and allow for choice and different responses for different needs and circumstances. For adult services, to operate a charging regime which is transparent, consistent and equitable; and which maximises revenue while not providing distortions or disincentives which would affect the outcomes of care for individuals.

7.7 These national priorities have been drawn from the whole of the Government's modernisation programme, both the vision for social care articulated in this White Paper and that for the NHS and public health as set out in *The new NHS and Our Healthier Nation*. Delivering the objectives set in each of the priority areas will be an important first step in the Government's programme to modernise health and social care.

7.8 Although the NHS has had similar guidance in the past, this is a new departure for social services and reflects the Government's determination to provide a clear lead to social services. The fact that it is joint guidance makes clear the extent to which health and social services are interdependent. *Modernising Health and Social Services* was published on 30 September 1998.

The resources to deliver change

7.9 The Government is providing new resources to support the programme of modernisation. This is investment for reform and the Government expects to see improvements in quality and efficiency in return for the increased funding.

> **' this is investment for reform and the Government expects to see improvements in quality and efficiency in return for the increased investment'**

7.10 In the White Paper *Modern Public Services: Investing in Reform*, the Government set out firm three-year plans for each major spending programme. The total funding for social services will be increased by an annual average of 3.1 per cent above inflation over the next three years - a clear signal of the priority the Government is giving to this area of spending. Knowledge of the Government's future financial intentions should help authorities to plan the delivery of services with greater confidence and enable them to look beyond a single year horizon.

7.11 To support the delivery of reform we are introducing a new Social Services Modernisation Fund which will target grant funding on priority areas. Whilst the Modernisation Fund will provide significant resources, success in modernising social services will be dependent on the effective use of all resources, and the Modernisation Fund will be used as a lever for delivering reform across all social services activity and expenditure.

7.12 The Modernisation Fund will deliver over 1.3 billion of additional resources over the three years 1999/2000 - 2001/2002. Taking this together with the increase in funding delivered through Standard Spending Assessments (SSAs), and the increases in the existing grants for specialist services such as HIV/AIDS and drug and alcohol services, there will be in total nearly 3 billion extra resources for social services over the next three years.

Delivering improved performance

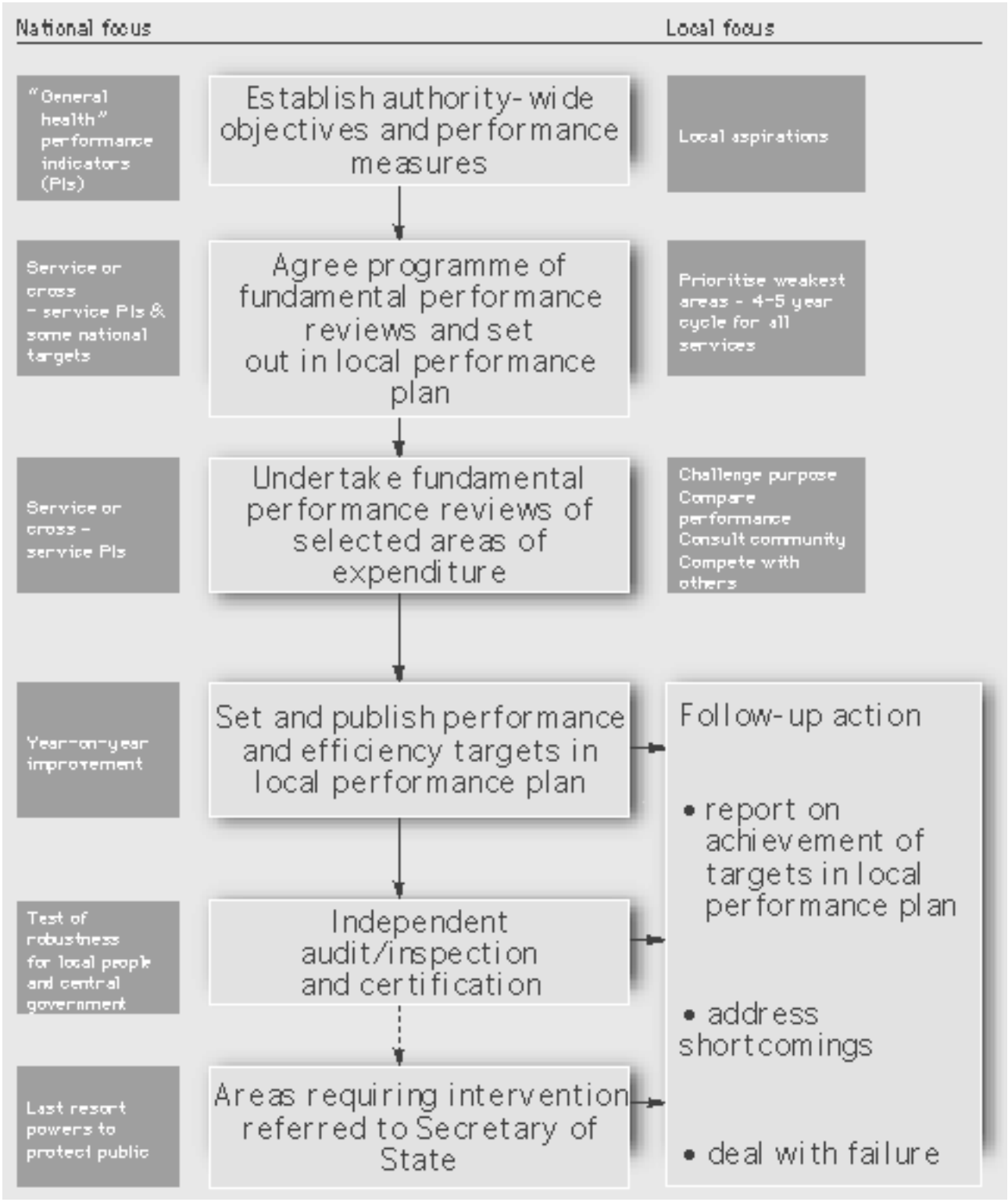
7.13 The Government's White Paper, *Modern Local Government: In Touch with the People*, sets out the Government's proposals for Best Value, a rigorous and systematic approach to improving local authority performance. This will enable authorities to demonstrate to their electorate and to central government that they are achieving best value in carrying out their responsibilities. The Best Value regime will apply to all local government functions, including social services.

7.14 Best Value will be a duty to deliver services to clear standards - covering both quality and cost - by the most effective, economic and efficient means available. The aim of the Best Value process is to secure continuous improvements in performance, and to deliver services which bear comparison to the best. Local authorities will be accountable to local people and have a responsibility to central government in its role as representative of the broader national interest.

7.15 Local authorities will set targets for improvements in both quality and efficiency of these services. Meeting those targets will allow them to demonstrate best value. Government will provide a clear lead in relation to performance standards and targets where it judges the national interest requires it. For social services Government will set targets for both quality, as set out in the National Priorities Guidance, and efficiency.

> **' local authorities will be accountable to local people and have a responsibility to central government'**

The Best Value performance management framework



7.16 Analysis by the Department of Health and others, including the Personal Social Services Research Unit at the University of Kent, has shown falling efficiency in social services over several years. In simple terms, this means that for every extra 1 of funding, less than 1's worth of service has resulted. The findings of the Joint Reviews confirm this and suggest that there is considerable scope for social services authorities to make savings by improving efficiency. The reviews have found evidence of four and fivefold variations between authorities in the costs of providing the same service. The Government has therefore decided to set targets for improvements in the efficiency with which social services are delivered. In 1999/00, the target will be a 2 per cent improvement in efficiency. In 2000/01, by which time it is expected that the duty of Best Value will apply, a further 2 per cent improvement will be required, followed by a further 3 per cent improvement in 2001/02. The Government will closely monitor progress against these targets.

' evidence of four and fivefold variations between authorities in the costs of providing the same service'

7.17 Best Value will introduce new performance management arrangements into local government to ensure that best value is achieved. The Department of Health is reorganising its approach to performance management so that it is aligned with and builds upon the local Best Value arrangements. The main elements of local and national performance management activity to be introduced for social services are outlined below:

- local authorities will establish **authority wide objectives** and performance measures. Local objectives for social services will need to reflect the national objectives and the need to meet any Government-prescribed national standards or targets, such as those in the National Priorities Guidance (NPG)

- local authorities will carry out **fundamental performance reviews** of all their services over a five year cycle; the outcomes of these service specific reviews will inform the preparation of local performance plans, and be assessed as part of Joint Reviews

- the local planning process will be supported by information from a new statistical **performance assessment framework**. This will draw together the key statistical information on the performance of social services. The Best Value National Performance Indicators will be central in this framework, supplemented by a number of further performance indicators to give a more rounded and in-depth assessment of performance. The performance assessment framework will provide a basis for a common understanding between central and local government on performance, value for money and resourcing issues in social services, both at overall programme level and in terms of individual local authorities. The performance indicators from the framework will allow authorities to compare their performance on a consistent basis. A similar framework is being developed for the NHS. Taken together, the two frameworks will enable the performance of local and health authorities at this vital interface to be examined, and key issues identified for action. It will be important for social services to have sound and effective information systems in place, in order to have a good understanding of how well they are performing against national indicators and against their own indicators

- **local performance plans** will provide a clear practical expression of an authority's performance. The plans will identify targets for annual improvements against locally defined performance indicators and the National Best Value Performance Indicators reflecting the quality and effectiveness of social services. In those areas where it is judged necessary the Government will also set performance standards which all authorities will be expected to meet

  ' common understanding between central and local government on performance'

- the Department of Health through the Social Care Regional Offices, with appropriate contributions from the NHS Regional Offices, will carry out **annual reviews** of the social services aspects **of the local performance plan**. These reviews will also provide an opportunity to discuss the delivery of specific policy initiatives, to assess with the NHS Executive local joint working with the NHS, and to pick up any issues from recent SSI inspections and Joint Reviews. We will strengthen the Social Care Regional Offices to enable them to take a more active role in monitoring and reviewing social services performance

- **independent inspection** by the SSI both of individual authorities and on thematic issues across sample authorities will continue, the overall programme being discussed annually with the Local Government Association and the Association of Directors of Social Services. Methodologies for these inspections will increasingly be informed and underpinned by the data in the performance assessment framework

- **Joint Reviews** of every authority: the resourcing of the Joint Review programme will be expanded to enable each of the 150 local authorities to be reviewed every five years, rather than every seven years as at present, consistent with the five year cycle of the Best Value regime.

Social services performance assessment framework

The areas of performance to be covered by the performance assessment framework are shown in the table alongside the definitions for the areas and some example performance indicators. We will consult shortly on the details of the performance assessment framework.

Area of performance: national priorities and strategic objectives

Definition	Examples of possible performance indicators
• the extent to which local social services authorities (LSSAs) are delivering the national priorities for social care (as set out in the NPG), the national objectives and their own local strategic objectives	• the proportion of children looked after who have 3 or more placements in one year • emergency admissions to hospital of people aged over 75
Area of performance: cost and efficiency	
• the extent to which LSSAs provide cost effective and efficient services	• unit costs, composite measures for adult and children's services
Area of performance: effectiveness of service delivery and outcomes	
• the extent to which services are appropriate to need; in line with best practice; to agreed standards; timely; and delivered by appropriately trained staff and • LSSA success in using its resources to increase self sufficiency and social and economic participation; to increase life chances of looked after children; to provide safe	• emergency psychiatric readmissions • the proportion of children who were looked after at age 16 still in touch with social services at age 19 • the number of households receiving intensive home care per 1,000 households headed by someone aged 75 or over, adjusted by SSA • the percentage of inspections of residential homes for adults which should have been carried out that were carried out
Area of performance: quality of services for users and carers	
• user/carer perceptions and experiences of services; responsiveness of services to individual needs; continuity of provision; involvement of users/carers in assessment and review	• delayed discharge from hospital • proportion of residents provided with single rooms • user and carer satisfaction surveys
Area of performance: fair access	
• the fairness of provision in relation to need, the existence of clear eligibility criteria, the provision of accessible information about the provision of services	• people aged 65+ helped to live at home • daycare provision for adults per head of population, adjusted by

SSA

- children looked after per 1,000 population, adjusted by SSA

Sanctions and rewards

7.18 The framework set out above will provide local authorities with the evidence and tools they need to improve performance. The Government will consider means of rewarding local authorities that are delivering effective social services, and will not hesitate to intervene where services are failing.

> **' the Government will consider means of rewarding local authorities that are delivering effective social services, and will not hesitate to intervene where services are failing'**

8 Conclusion

Key themes
- social care in the next century
- modern, dependable services

modern social services

8.1 The modernisation of social services is a long-term programme. But we have already started making the necessary changes, and this White Paper maps out the further steps to be taken over the coming years to promote independence, improve protection and raise standards.

8.2 If we achieve the goals that we have set for improvement in social services, in the early years of the next century the people of this country will experience a modern and dependable service that matches the aspirations set out in the introductory chapter to this White Paper:

- services will promote and enhance people's independence, with better prevention and rehabilitation services established with the help of the additional funding the Government is providing; and many more people will use direct payments schemes to have real control over how their care needs are provided for

  ' services will promote and enhance people's independence, with better prevention and rehabilitation services'

- services will meet each individual's needs, with social services providing an integrated service with the NHS and other agencies, pooling budgets where appropriate

- care services will be organised, accessed, provided and financed in a fair, open and consistent way in every part of the country. National Service Frameworks will ensure that the services needed are available everywhere, and the Fair Access to Care initiative will bring fairness and transparency into the decisions on whether people qualify for support

- children looked after by local authorities will benefit from the radical improvements to be made to the care system, backed up by substantial extra funding. Better arrangements for their education and health care will be in place, and they can be assured of a better deal when they come to leave care and start their adult life

- everyone will be safeguarded against abuse, neglect or poor treatment while receiving care. Standards will be clearer, checks will be tighter and the regional Commissions for Care Standards will have strong and swift powers to put a stop to any abuse where it occurs

- social care staff will have clearer standards and better training arrangements, overseen by the General Social Care Council. This will benefit both the staff and the people receiving care, who can feel assured that the staff they deal with are safe, skilled and competent

- and people will be able to have confidence in their local social services, knowing that through the Best Value regime, checks are made both locally and nationally to ensure that services are up to scratch, and action can be taken where standards are not met.

8.3 A service that demonstrates all these features will be one in which public confidence can be restored, and one on which we can all rely.

> **' a service that demonstrates all these features will be one in which public confidence can be restored, and one on which we can all rely'**

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To obtain a copy of the draft regulatory impact appraisal for the proposals in Chapter 4, write to:

Barbara Erne, Room 625, Wellington House, 133-155 Waterloo Road, London SE1 8UG

or you can get it on the internet at:

http://www.doh.gov.uk/dhhome.htm

Carers

2.22 We recognise that carers have a wide range of needs - as diverse as the people they care for. Their work is vital and has often gone unrecognised. Support for carers is not just a matter for social services, but for a range of statutory and non-statutory agencies in the housing, employment, education and other fields. The Prime Minister announced on 10 June 1998 the development of a National Carers Strategy, bringing together activity across all Government Departments in support of carers which will take a comprehensive view across all these areas.

Supporting carers

The London Borough of Merton has established *Care Connect*, a partnership agency which brings together health, social services and the voluntary sector. The project provides a range of support to carers, including:

- drop-in facilities
- a helpline
- access to a wide-range of information via a database linked to the Internet
- respite care in the carer's own home.

Carers in Merton told SSI that they particularly liked respite care being brought to their own home - it was less disruptive than if the person they cared for had to go to residential or day care.

2.23 As well as assessing what key needs of carers may have been overlooked and setting out an integrated strategy for future action by Government, the key aims of the Strategy Project include:

- empowering carers so that they have more say about the types of services that they and the person they care for need
- considering how best carers who work can be supported so that they can remain in employment
- considering how the health needs of carers can better be met by the NHS and especially primary care groups
- looking to see how communities can better support carers especially through volunteering
- looking at the specific needs of other groups such as young carers and ethnic minority groups.

2.24 The strategy will seek to highlight existing good practice in a range of areas covering the needs of carers, and build on this. The National Carers Strategy is due to be published early next year.

National Carers Strategy

The terms of reference for the National Carers Strategy are as follows:

To draw together existing work within Government that impacts on carers; to take account of the emerging findings of the Royal Commission on Long-term Care; to gather examples of best practice in providing help for carers at local level, to assess whether any key needs of carers have been overlooked; to clarify the Government's objectives for carers; to set out an integrated strategy for future action by Government; and to report through the Parliamentary Under - Secretary of State for Health (now Minister of State at the Home Office), to the Prime Minister.

How will people see the benefits of our changes?

If we succeed in our plans to improve services for adults by promoting independence, the following benefits can be expected:

- people will be offered a service that is designed not just to keep them going, but to improve their capabilities and allow them the maximum possible independence
- when people need social services help, that help will be arranged in a way that lets them do as much as possible for themselves; and allows them wherever possible to live in their own homes

All authorities will develop and target a range of preventive services for adults, including respite care; and will agree an action plan in accordance with Department of Health guidance to be issued in the first half of 1999.

- many more people will be able to have real control over their care support through direct payments schemes
- health and social services will target their support especially on people who are at risk of losing their independence (for instance, elderly people living alone during the winter; people who have just left hospital, or who have a visual impairment, and are finding it hard to cope at home), to make sure that special efforts are made to avoid such people having to be admitted to hospital or a care home

We have set a national target to reduce the growth per capita in emergency hospital admissions of people over 75 to 3% by 2002 (against an average of 3.5% in recent years).

- carers who look after family members, neighbours or friends will be given greater support by social services and other agencies, to allow them to continue to care where that is what they and the person they are caring for want.

All authorities will provide carers with the support and services to maintain their health, and with the information they need on the health status and medication of the person they are caring for. As a first step, systems should be in place by April 2000 to identify primary care and social services users who are or who have carers.

Greater consistency

The problem

2.25 Many people feel that the care system is not fair. There are variations in who gets what services, inconsistencies in what types of provision are available in different parts of the country, and differences in how charging works.

2.26 Eligibility criteria should inform users about what sorts of people with what kinds of need qualify for what types of service. They should also help care managers to carry out effective assessments and then match services to assessed need. However, some eligibility criteria can be so broad or poorly framed that they help neither users nor staff. The ways in which needs are assessed, and the routes through which people get access to services, can vary from authority to authority, or even within a single authority. The 1998 Joint Reviews Annual Report noted: "There appears to be no consistent link between referrals, assessments and services either between councils, or indeed between different services of the same council".

> **' eligibility criteria should inform users about what sorts of people with what kinds of need qualify for what types of service'**

2.27 The result is that someone with long-term care needs might receive high level care in their own home from social services and the NHS in one place, whereas in another they might have to go into residential or nursing home care.

2.28 The social care charging system is also a cause of confusion and concern to many people. There is a national means tested framework for residential and nursing home care charges, which means that everyone is subject to the same system when it comes to care homes. But charges for other services, such as home care, meals on wheels and day centres, are discretionary, with each authority setting its own charges, and its own rules on how those charges work.

2.29 The differences in these discretionary charges can be considerable. The amount that authorities recover in charges - as a percentage of their spending on these services - varies from 4 per cent to 28 per cent. And the charging systems differ enormously from one council to another. For instance, one council might charge a standard hourly rate which everyone - whatever their income - pays, so that the amount paid depends on the amount of care received. Whereas another council might operate a sliding scale of charges according to income, regardless of how much care is received. Taking a random example, someone with a weekly income of 115 and receiving 12 hours of care per week could pay 13 per week in one area, and 48 per week in the other.

2.30 It has always been the case that the user has been expected to contribute to the cost of some services, particularly residential care, according to an assessment of income. However, there are strong criticisms of the system, both in terms of the fairness of the national charging system for residential care, and in terms of the variation, from one part of the country to another, of the discretionary charges for services in the community.

' users have always been expected to contribute to the cost of some social care services'

Action

2.31 There has to be a greater level of consistency and fairness in social care. The Government's action programme includes:

- taking a greater role nationally in setting objectives and standards for social services
- the introduction of National Service Frameworks, in partnership with the NHS
- a Fair Access to Care initiative
- action to establish greater consistency and fairness in charging.

' there has to be a greater level of consistency and fairness in social care'

New objectives and national priorities guidance

2.32 We believe that there should be greater national consistency of objectives and priorities in social services, for both adult and children's services. New national objectives for social services have been drawn up, and they are the foundation of the proposals in this White Paper. The objectives also feed directly into the National Priorities Guidance, a single statement of priorities for both health and social services, which all authorities around the country should follow.

2.33 This stronger direction at national level on the priorities for social services will ensure more consistent, high quality services everywhere in the country. The national objectives and National Priorities Guidance, and how they fit into the new performance monitoring arrangements for social services, are described in more detail in Chapter 7.

National Service Frameworks

2.34 National Service Frameworks (NSFs), announced in the NHS White Paper The new NHS, will set national standards and define service models for specific services or care groups. They will achieve greater consistency in the availability and quality of these services, addressing the whole system of care including social care and the wider local authority and their partners. The aim will be to reduce unacceptable variations in care and standards of treatment, based on research evidence on standards, outcomes and cost-effectiveness. One of the first NSFs is on mental health services, and is already being developed (see box).

National Service Framework for mental health services

This is one of the first two NSFs to be developed (the other is for coronary heart disease). Work is currently underway with the establishment of an External Reference Group (ERG) chaired by Professor Graham Thornicroft. The purpose of the NSF is to assist all agencies, statutory and non-statutory, in delivering the Government's strategy for safe, sound and supportive mental health services. The ERG has identified a set of standards to address the quality, comprehensiveness and accessibility of services.

The Government's overall strategy for mental health services, and the emerging findings of the ERG, will be published shortly. The strategy includes plans for substantial extra funding over the next three years, new arrangements for monitoring delivery of mental health services and a commitment to reviewing the Mental Health Act. Social services will be a full and equal partner in delivering this strategy.

2.35 The next National Service Framework to be developed will be on services for older people. This will provide explicit standards and principles for the pattern and level of services required, put in place programmes to support implementation, and establish performance measures. It will be developed, as with all NSFs, with the help of an expert reference group which will engage the full range of views, bringing together health and social care professionals, service users, carers, health and social services managers, partner agencies and other relevant groups.

Fair access to care

2.36 Alongside the National Service Frameworks for mental health, older people, and other groups or conditions as they are developed, we will also introduce greater consistency in the system for deciding who qualifies for those services. We will develop guidance on Fair Access to Care, which will set out the principles authorities should follow when devising and applying eligibility criteria, including the need for compatibility with NHS continuing care criteria. But it will go wider than eligibility criteria, as these are only part of the story. Key elements will be the need for authorities to show:

- **consistency** in the way that every person's needs are assessed, with fair and transparent procedures and criteria followed in every case
- clear **objectives**, based on the overriding need to promote independence, which should apply at all stages in the process, from initial screening, through to assessment, devising a care package, and monitoring it
- a common understanding of **risk assessment** on which to base decisions about services - what kind of risk someone faces, how serious, its cause, how likely, and so on. Most authorities already assess risk, but in different ways
- **regular reviews**. There needs to be more consistency not only about people accessing services for the first time, but about people already receiving services, to ensure that the services continue to meet objectives.

' we will develop guidance on Fair Access to Care'

Charging

2.37 There must be greater transparency and fairness in the contribution that people are asked to make towards their social care. We are committed to finding a way to fund long term care which is fair and affordable for the individual and the taxpayer.

' there must be greater transparency and fairness in the contribution that people are asked to make towards their social care'

2.38 That is why we set up a Royal Commission in December 1997 to examine the short and long term options for funding long-term care for elderly people, both in their own homes and in other settings. It will be making recommendations early next year. Although it is concentrating on older people, it has been asked to consider the implications of its recommendations for younger people with long-term care needs.

2.39 There is great inconsistency in the discretionary charging system for non-residential care. At the moment, every authority - if it operates a charging system - can develop its own rules for assessing income, which can mean that in one area a certain type of income is taken into account for charges while in another it will be disregarded. The Audit Commission is currently carrying out a major survey of authorities' charging practices, which we expect to show widespread differences in the way that discretionary charges work.

2.40 The Government believes that the scale of variation in the discretionary charging system, including the difference in how income is assessed, is unacceptable. We will consider how to improve the system in the light of both the Royal Commission's report and the Audit Commission survey.

> **' the Government believes that the scale of variation in the discretionary charging system, including the difference in how income is assessed, is unacceptable'**

How will people see the benefits of our changes?

Our plans to improve consistency and fairness in social services for adults should produce the following results:

- greater certainty about what services can be counted on in all parts of the country
- greater assurance of quality services everywhere, rather than having to live with second best
- fairer and more transparent rules for deciding who qualifies for services, and greater consistency in applying them around the country

By April 2001, every local authority will be working within the Fair Access to Care guidance

- a fairer system for paying for care, following the outcome of the work of both the Royal Commission and the Audit Commission.

Convenient, user-centred services

The problem

2.41 When the need for social services support or care arises, it is usually a time of great anxiety and fundamental change in the lives of individuals, their partners and families. Decision-making in these circumstances is difficult enough, but it is made even more so by the extraordinary complexity of the system. An array of agencies - NHS, social services, housing, the employment service, benefits - may all have important things to contribute. People need help through the maze. They need clarity about who is offering what, and what the options are. And they need to be provided with services that suit their own particular needs - they should not be asked to fit in willy nilly with whatever services happen to be available. There is no doubt that the situation has improved in recent years, but we are still a long way off having services that are really geared to the individual needs and interests of users.

> **' help through the maze'**

User feedback and consultation

2.42 Many users of adult services are satisfied with the services they receive. The Joint Reviews carried out so far show that an average of 71 per cent of service users rate the service received as excellent or good. However, this average covers a range from 84 per cent down to 59 per cent. And many users and carers report that they have not even been asked how things are going once they are receiving services.

2.43 More widely, service users and carers often play little or no part in shaping services. Attempts at consultation can often turn out to be public relations exercises, rather than genuine attempts to listen to what people want and their views of services. Genuine consultation can not only make services more responsive but also increase public confidence and trust in the services.

Consulting and involving service users

Sandwell Metropolitan Borough Council has a joint planning group which brings together the local authority, NHS, voluntary sector and users and carers. As a result of user involvement in this group, it became clear that the traditional services were failing to meet the needs and aspirations of physically disabled people of working age.

Following consultation, Sandwell therefore set up a Disability Living Centre which is managed by service users themselves. The Centre works in partnership with disabled people and carers, young and old alike, and is committed to empowering disabled people to recognise and achieve their full potential and abilities.

How will people see the benefits of our changes?

With a determined effort to improve both the legal framework for protection and the way in which authorities undertake their responsibilities for children, we should see:

- much tighter checks against abuse of children in care. We may never be able to eradicate abuse completely, but we can put an end to those cases where weaknesses in the system allow the abuse to go undetected, or fail to stamp it out effectively when discovered
- dangerous people effectively kept out of jobs with contact with children
- better handling of cases where a child may be at risk at home - schools, hospitals, and others who work with families will have clearer guidance on how to work with social services in these cases. And better procedures will mean that children no longer drift on and off the child protection register with no real improvement in their situation.

By 2002, the proportion of children who are re-registered on the child protection register will be reduced by 10% compared to the year ending March 1997.

Quality of care

3.24 Local authorities in England now look after some 55,000 children at any one time, and in any single year they accept responsibility for about 88,000 children, many of them for relatively short periods. When they accept the responsibility for looking after a child, whether by a court order or through an agreement with the child's parents, a local authority has an obligation to provide personal care and to support the child's development, help to access suitable health and education services, and protect the child's safety in the same way as any other responsible parent. They should aim, so far as is possible, to give the child the same chance of a fulfilling life as other children have. Evidence from inspections and other sources describe weaknesses in a number of aspects of local authority services for children:

- children are often not properly assessed when they first present for help, and many drift through a variety of short-term placements. Published Department of Health Statistics show that 10,300 children (that is 20%) looked after by authorities on 31 March 1997 had experienced three or more placements in the course of the previous year. An unpublished estimate from the same source suggests that about 2,000 of these had 6 or more placements. A settled life for a child in such circumstances is impossible
- many authorities do not have clear eligibility criteria for services. Families with disabled children are faced with a series of obstacles to overcome before receiving help. The help provided is often determined more by what service was readily available than a proper assessment of the family's needs
- there are weaknesses in the scale and type of fostering and residential care placement options, particularly for children with highly specialised needs
- there is evidence that adoption is regarded by some authorities as an option of last resort
- the quality of management, assessment and decision-taking in the public care system is patchy and unreliable. It can be as damaging to take a child into care unnecessarily as it can be to fail to take action

" The quality of assessment was extremely variable not only between Social Services Departments (SSDs) but also within SSDs There was often an abundance of information gathering which was unstructured and it was difficult to discern how decisions were derived from it."

" Every SSD had a problem in ensuring compliance with its policies and procedures and in addressing variability in practice."

" Only 9 out of 27 SSDs had care plans on all files."

" Many of the plans lacked detail or were out of date."

"**Someone Else's Children, SSI 1998**"

- many authorities have weaknesses in strategic planning and financial management
- while some authorities are making useful headway, many do not adequately identify trends in need and demand. Nor do they adequately assess and prioritise need and target services on the most serious problems. These are difficult issues requiring expertise which many authorities do not currently have
- there is a lack of good information on costs and outcomes. Information on the services provided is not matched up with information on expenditure. Only a very few authorities have developed their own systems to analyse costs and none have related expenditure to outcomes. This makes it difficult, nationally and locally, to judge whether best value is being obtained from the 2.25 billion a year spent by social services on services for children.

  ' local authorities should aim, so far as is possible, to give the child in public care the same chance of a fulfilling life as other children have'

Action

3.25 To tackle these problems, and to address all aspects of children's social services, the Government has already launched a major initiative, called Quality Protects. This is a three-year programme to remedy the defects in the standards of care offered to looked after children and other children needing social services' support. It will tackle problems of attitudes, standards, management, service delivery and training.

' a major initiative, called Quality Protects'

3.26 To support the Quality Protects programme the Government will make available 375 million of extra resources from the Social Services Modernisation Fund over the next three years. The amount of this Children's Services Grant in 1999/2000 will be 75m. It will rise to 120m in the following year and to 180m in 2001/2002.

3.27 Payments under the Children's Services Grant will be subject to the preparation and achievement of satisfactory action plans by each local authority. By 31 January 1999 each authority will be required to assess its performance in a number of key areas and propose action to remedy deficiencies. The grant will also fund eight regional development workers who will help authorities examine their need for reform, disseminate materials and methods, and exchange expertise and experience.

3.28 It is clear that while some issues will require immediate action on the part of authorities, others will require longer term initiatives. Key areas of work linked to improving the management of children's services in general, and strategic and financial management in particular, include:

- better systems for assessing children's needs in communities
- strengthening the planning of children's services by making it a council-wide function (see Chapter 6 for further detail)
- ensuring, through the national objectives for children's social services, and the National Priorities Guidance, that all services are working to common objectives and priorities
- introduction of a national collection of expenditure returns across all children and families served, in a way that generates financial management information authorities need for their own purposes
- dissemination of research relevant to the management of children's services, and the improvement of senior and

middle management capability

- introduction of quality assurance monitoring and internal auditing practices
- identifying centres of good practice to act as beacons for spreading excellence in children's services.

' it is clear that while some issues will require immediate action on the part of authorities, others will require longer term initiatives'

' identifying centres of good practice to act as beacons for spreading excellence in children's services'

Action to improve adoption services

Adoption should be seen as a positive option. There is good evidence from research that in the right circumstances adoption has good outcomes, and that the younger the child at the time of adoption the better the outcome. The Government has already issued fresh guidance designed to:

- bring back the adoption service into the mainstream of child care practice
- break down prejudices against the principle of adoption
- challenge rigid attitudes in the transracial placement of children for adoption if they are carried to the point of withholding the potential benefit of an adoption from a child simply because it cannot be matched with parents of the same ethnic group.

The Government will keep the working of the adoption service under careful review, and will consider whether fresh legislation would help to overcome some of the delays without denying the rights of birth families to take part in the process.

3.29 Service issues to be addressed as part of the initiative will include:

- improvements in assessment and decision making through further development and implementation of the assessment and planning tool *Looking After Children*, and publication of a new assessment model for children and families in need in the community
- use of the Children's Services Grant to review the supply of residential and fostering placements and take action, including greater support for recruitment and retention of foster carers and where necessary residential provision, and working in consortia to provide specialist placements
- identifying the needs and expectations of children and carers by involving children in decisions on their care, involving young people in developing policy, local strategies and staff training, and encouraging the provision by local authorities of children's rights services and independent visitors.

How will people see the benefits of our changes?

The Government's reforms and the Quality Protects initiative will lead to a transformation of children's social services. In relation to the quality of care, the key outcomes will be:

- clearer objectives for all actions taken by social services for children - if a child has to leave his/her family, social services will ensure that this is the best option, and will act as any decent parent would in making sure that the child's best interests are being met
- more stable care relationships for children looked after, with minimal disruption from being moved between placements

By 2001 all authorities will match the performance of the top quarter, so that the percentage of children looked after who

have 3 or more placements in one year will be no more than 16%.

- a wider range of foster care placements and residential accommodation in order to meet children's specific needs; and consideration of adoption in any case where a return to the child's own family will not be possible

- greatly improved management arrangements for children's social services, with better quality planning, assessment and decision-making in all areas.

Improved life chances

3.30 Although much has happened to disadvantage many children prior to their needing to be looked after, the fact remains that the outcomes for children in the care of local authorities are disappointing. Only with good assessment, well thought out and durable placements, proper planning for independence and partnership with other agencies can these children be offered the opportunities they are entitled to. All too often these have not been made available.

3.31 Information from the Looking After Children Programme suggests that while many children and young people have significantly greater health needs than their peers in the community they have greater difficulties in getting access to services. This is related both to the number of placements at some distance from the responsible authority, and also to the frequency of moves which interferes with prompt NHS treatment. Social services, education and the NHS do not work well enough together, the quality of services for care leavers is patchy, and the quality of assessment and planning does not always reach the levels we expect. The outcome of all this is that the life chances of children in care are unacceptably low, with poor opportunities while in care and low chances of successful settled lives once they leave care:

- an estimated 30% of children looked after have statements of special educational need, compared with 2-3% of children generally

- in some authorities as few as 25% of young people leave care with any educational qualification.

- one in four children looked after aged 14-16 do not attend school regularly and many have been excluded and have no regular educational placement

- 67% of children looked after have an identifiable mental health problem

- between 14% and 25% of young women leaving care are either pregnant or have a child, while in the general population only 3% of 20 year old women have a child

- up to a third of people sleeping rough have been looked after by local authorities at some point in their childhood

- 39% of male prisoners under 21, and 22% of all male prisoners, have been looked after by local authorities at some point in their childhood.

' the life chances of children in care are unacceptably low, with poor opportunities while in care and low chances of successful settled lives once they leave care'

' between 14% and 25% of young women leaving care are pregnant or have a child'

3.32 Good parents do not abandon their children unaided to face the challenges and chances of life alone at the age of sixteen or even eighteen. They continue to support them with advice, guidance and where necessary money. Many local authorities do make significant efforts to provide continuing support to young people who have spent considerable periods in public care. The SSI reported last year that it had found many examples of creative and innovative practice, especially in partnership with the voluntary sector. However, it also found that provision was patchy and that some areas offered poor services for care leavers.

Action

3.33 Government action to improve the life chances of children looked after includes:

- action to improve education for looked after children
- action to improve health services for looked after children
- legislation to extend the duty of a local authority for children in care from 16 to 18 years old, and new statutory obligations on local authorities to provide for the needs of children leaving care.

Education

3.34 Good educational opportunities are essential for improved life chances. The Government has set new targets to be met by all local authorities and is providing for the targets to be incorporated in Education Development Plans. It intends to consult next year on new guidelines - eventually to be given statutory force - on the education of looked after children, applying to education and social services alike. A national forum, with representatives of leading statutory and voluntary agencies, has been looking at a range of possible initiatives to improve the education and attainment of looked after children.

' good educational opportunities are essential for improved life chances'

3.35 Local education authorities are required to publish behaviour support plans by 31 December 1998 making reference specifically to looked-after young people and other groups who are recognised to be at risk of failing to fulfil their potential. The Government is shortly issuing for consultation new advice to help reduce exclusions and truancy. It is taking a series of initiatives to improve provision for children with emotional and behavioural difficulties, including looked after children. A particular aim is to identify emergent difficulties and intervene early to prevent them taking root.

3.36 The educational attainment of looked after children is a joint responsibility of education and social services, and the care system itself should ensure that educational opportunities are taken up. If a local authority is fulfilling parental responsibilities for its looked after children, that should extend to ensuring attendance at school, checking on the child's educational progress, attending open days at schools and so on. This is one of the areas covered by the Quality Protects initiative.

Health

3.37 In the White Paper *The new NHS* the Government set out proposals for a new statutory duty of partnership to ensure that health authorities work closely with local authorities and other agencies to improve the health of the local population. Health Improvement Programmes should identify groups such as children looked after who need particular attention.

3.38 Entry to care is a key opportunity to identify the health needs of the child or young person and to plan, with them, the necessary action to be taken. Guidance will be issued during 1999 to ensure that each child or young person entering care is offered a comprehensive health assessment. Particular areas for targeted health support will include improved child and adolescent mental health services; and work with young girls in care to reduce the rate of teenage pregnancies.

' entry to care is a key opportunity to identify the health needs of the child or young person'

Care leavers

3.39 As a matter of priority public care services must be improved in order to help looked after young people move into fulfilling independent lives in as stable a fashion as possible. We have made this a specific objective in the new objectives for children's services. We will also:

- legislate when Parliamentary time allows to create new and stronger duties on councils to support care leavers up to at least 18; and we will discourage discharge below that age in cases where it is premature. The local authority's responsibilities should correspond more closely with those of parents, including keeping in touch with more young people after they have left care
- develop new arrangements for each 16 to 18 year old leaving care to have a clear plan setting out a "pathway to independence". The aim will be to develop the care leaver's life skills and help the move from care to fully independent life. Details of the new arrangements will be announced by April 1999

- improve assistance to care leavers with obtaining suitable and affordable accommodation, including issuing guidance to housing and social services on the accommodation needs of care leavers and the support they require to maintain a stable tenancy

- recognise the specific needs of those in and leaving care in the further and higher education arrangements, and in the Government's instructions to The Careers Service

- require local authorities to provide suitable accommodation for care leavers in higher education during vacations

- exempt unemployed care leavers over 18 from the six month qualifying period for acceptance onto the New Deal.

' support care leavers up to at least 18'

Improving life chances for children in care

Leicester City Council has launched the Corporate Parent Initiative, which aims to ensure that children in the council's care enjoy the same opportunities as other children.

The council has set up a group of officers who act as "champions" in their departments for looked after children. The group develops ideas and introduces improvements. Achievements to date include:

- improving educational performance

- providing low-cost housing for care leavers

- providing free passes to the council's sports and leisure facilities

- getting jobs with the council for some young people leaving care

London Borough of Newham has appointed a team of teachers to work with young people accommodated and looked after. The initiative provides homework clubs, individual support, liaison with schools, home tuition, and support to return young people to mainstream and further education.

The Royal Borough of **Kingston upon Thames** provides a range of different types of accommodation to match the individual needs of care leavers. Young people who find it difficult to live independently in flats can be moved back to shared or supported accommodation. This is achieved through strategic planning and collaborative working between social services, housing and the voluntary sector.

3.40 The Social Exclusion Unit has also been set the priority task of considering how to reduce the number of 16-18 year olds who are not in education, training and employment. This work, in addition to the Unit's reports so far on rough sleepers and neighbourhood renewal (See Chapter 6), should have a positive impact on the lifestyles of care leavers.

How will people see the benefits of our changes?

Action to improve the life chances of children looked after will result in:

- better education services for children in care, and improved educational achievement by the time a child leaves care

The proportion of children leaving care at sixteen or later with a GCSE or GNVQ qualification will increase to at least 50% by 2001, and to at least 75% by 2003.

- better health services for looked after children, including comprehensive health assessment for every child on entry into care

- better support for young people making the difficult transition from the care system to independent adult life. Local authorities will help care leavers to sort out where to live, and how to move into employment or further education and training.

The level of employment, training or education among young people aged nineteen in 2001/02 who were looked after by local authorities in their seventeenth year on 1 April 1999 will be at least 60% of the level among all young people of the same age in their area.

Conclusion

3.41 Proposals elsewhere in this White Paper will also have an impact on the quality of social services for children, notably:

- the changes to regulation in children's services, and the establishment of regional children's rights officers, in Chapter 4
- the child care training strategy and other workforce improvements in Chapter 5
- the proposals on children's services planning and on youth justice, in Chapter 6.

3.42 Taken together, these developments and the Government's core proposals in this Chapter will provide a new start for children's social services. We intend to ensure that in future, every child who comes into contact with social services will gain real benefit from that contact; that children and families in need can count on social services to give them the support they need; that children in care are protected from harm; and that after many years of widespread mistrust, the general public can once again have faith in our public care system. We will work with local authorities and others to make sure these aims are achieved.

' in future every child who comes into contact with social services will gain real benefit from that contact'

Individually tailored services

2.44 The commissioning approach developed following the community care reforms has improved to a large degree authorities' ability to assess an individual's needs and tailor services according to those needs. More responsive services are now delivered in many authorities, using a mixture of public, private and voluntary service providers. But there is more to be done.

2.45 Recent reports from the Audit Commission (*Take your choice and The Coming of Age*), the Joint Reviews annual report, and research funded by the Department of Health and carried out by PSSRU and the Nuffield Institute for Health all identify similar concerns about authorities' commissioning processes. The main points are:

- the lack of a planned, information-based approach to commissioning, looking at population needs, mapping current provision and examining the effects of current purchasing arrangements
- budgetary arrangements that make it difficult for care managers to put together a tailored care service for individuals
- the need for better relationships with both independent providers (with whom relations are sometimes adversarial) and in-house providers (where quality control is characteristically poor)
- crude systems for setting contract prices, with poor links between quality levels and the amount paid for the service.

" Sometimes older people and their carers do not appear to have as much influence over their care as they should. In practice, care managers have limited choice to offer older people. Social services departments should ensure that care managers have greater influence over services by reducing restrictions on choice, introducing service level agreements with in-house providers and delegating budgets."
Audit Commission, "The Coming of Age", 1997

2.46 In particular, authorities are not using the commissioning process to secure appropriate services for specific groups of people who may not be best served by mainstream services. This is especially true of people from ethnic minorities. Three recent reports, from the Racial Equality Unit (*Social care and black communities*, 1996), the Commission for Racial Equality and others (*Race, culture and community care: an agenda for action*, 1997), and the SSI (*They look after their own, don't they?*, 1998) all concluded that social services in many places were not recognising sufficiently the specific needs of ethnic minority people. Problems included language barriers, assessment procedures and services which do not recognise cultural differences, and an over-reliance on the willingness and capacity of black families and carers to look after each other.

' social services not recognising sufficiently the specific needs of ethnic minority people'

"They look after their own, don't they?"

This SSI report was based on inspection visits to eight local authorities to look at services for ethnic minority older people. Examples of good practice were found in all visited authorities. However, the report also illustrates particular problems. For example:

- service choice was limited in many areas, and in some instances, basic services like meals-on-wheels were delivered in an inappropriate manner
- some local ethnic minority groups and agencies had developed innovative and effective ways of meeting the needs of ethnic minority elders and carers, but were not given the information, advice and support they needed to compete effectively for contracts
- where services were specifically commissioned for ethnic minority older people, they tended to be less intensive

and for people with lower dependency needs. People with, say, severe cognitive impairment could be poorly served by the help they received.

2.47 Obviously, councils work with finite resources, and a perfectly individualised care package will often not be possible. On the other hand, the evidence from Joint Reviews is that it is often the authorities that offer "one size fits all" services based around what suits the provider rather than the user, that are providing the least cost-effective services. If people are not getting the service that would most suit them, and the cost to local taxpayers is higher than it should be, then everyone is losing.

' if people are not getting the service that would most suit them, and the cost to local taxpayers is higher than it should be, then everyone is losing'

Action

2.48 Developing services that are more sensitive to individual needs, and putting the user at the heart of all social services, can only be delivered at local level. Councils must tackle these issues in partnership with other agencies, and importantly, in partnership with their local communities. Central government action in the following areas will help to ensure that this happens:

- development of a Long-term Care Charter
- work to make services easier and more convenient to use, including better information and consultation arrangements
- initiatives to improve commissioning and to make social services more responsive to individual needs.

Long-term Care Charter

2.49 We will introduce next year a Long-term Care Charter to set out more clearly at national level what people - both users and carers - can expect if they need support from health, housing and social services; and also what individuals' own responsibilities are in their dealings with the agencies.

Developing the Long-term Care Charter

The Government has been consulting with a very wide range of stakeholders to make sure that the Long-term Care Charter tackles the areas that people want it to, but so that it is also realistic and achievable. Our proposed approach to the Charter will:

- require local agencies to set standards in key areas
- tell local people the type of standard they can expect
- improve standards by empowering users and carers and through effective performance management
- improve transparency and accountability in long-term care services.

2.50 The purpose of the Charter will be twofold:

- **to empower users and carers** - by promoting awareness of local services; making it clear how agencies should respond to their needs; and providing information to help users and their carers pose the right questions to the agencies they come into contact with
- to **give authorities a tool against which they can set their local standards** and which can be used by those monitoring authorities' overall performance.

2.51 Users and carers themselves are contributing to the preparation of the Charter through a series of consultation groups, so that it can concentrate on the key areas of concern for them. We are also having discussions with a variety of statutory, professional and voluntary organisations and with front-line staff. This will ensure that we have a practical document on which we intend to consult formally early next year, with a view to publishing the final Charter in the Autumn. We intend to monitor progress on the Charter through the performance frameworks for health, social services and housing.

Making services easier and more convenient to use

2.52 We want to see easily-accessible services that do not make it difficult for someone who needs to get into the system. Clear and comprehensive information services are part of the answer, but it is also important that the system works together effectively for the benefit of users. We should not expect frail or vulnerable people to have to shop around for services, dealing separately with social services, housing, community health services and other agencies. When people get passed from pillar to post, it is a great cause of grievance and frustration. It is for agencies to collaborate, to ensure that an approach to one will automatically trigger contributions from partner agencies as required. This "one-stop shop" arrangement can help users to get all the services they need, whichever door they first use.

2.53 We will work to make this "one-stop shop" approach the norm in social services and other public agencies. It is at the heart of the Government's Better Government for Older People initiative (see box at the end of 2.54). We expect it to be a key feature of the Long-term Care Charter. And it is central to our plans for better joint working between the NHS and social services, with GPs, community nurses, hospitals and social services staff all working together to give people the service they need.

One-stop shops

Knowsley Metropolitan Borough Council opened the first of four one-stop shops in 1993. All are in convenient and accessible locations, usually in main shopping areas, The one-stop shops provide a single point of access not only to all council services but also other partner agencies, including community health services and the Benefits Agency.

The one-stop shops mean that Knowsley is able to deliver a service organised around people not buildings. For instance, a homeless man presented himself at 4.30pm on a Friday. The front-line member of staff recognised him as potentially vulnerable. With the support of housing, social services and finance staff, the man was admitted to an alcohol dependency unit that evening for rehabilitation. He left the one-stop shop with both the professional support and personal welfare rights advice he needed.

Better Government for Older People

The Better Government for Older People initiative is a central programme covering all the public services that older people regularly deal with, of which social services are an important part. The programme aims to:

- simplify access to services
- improve linkages between services provided for older people by a range of agencies
- provide clearer and more accessible information on older people's rights
- give older people a better say in the type of services they can get and make better use of the contributions they can make.

  Twenty pilot projects have been set up around the country. These will be evaluated and a best practice guide published in April 2000.

2.54 Through Health Improvement Programmes, which are to be introduced from April 1999 (see Chapter 6), we will expect the NHS and local authorities to develop plans for ensuring that services are coordinated and easily-accessible,

linking services and using "one-stop shops" where appropriate. We will then make this a key area to be looked at by Joint Reviews, and by the local user satisfaction surveys that we will be introducing (see paragraph 2.56).

Information and consultation

2.55 Better information for the public will also make it easier for people to know how to go about getting social services. And consultation with both service users and the wider public will help councils to be sure that they are meeting their local population's needs.

2.56 The Best Value regime will place a requirement on local authorities to find out what local citizens' service needs are, and what they think of how the council is doing. This gives councils an opportunity to develop more regular monitoring and more effective feedback systems so that they can see how well they are doing, and whether their services are getting better from one year to the next.

> **' Best Value will place a requirement on local authorities to find out what local citizens' service needs are, and what they think of how the council is doing'**

2.57 As part of the new arrangements for monitoring social services performance every council will carry out local surveys of user and carer experience of and satisfaction with social services. Whilst we will not be prescriptive about the detail of these surveys, we do intend to introduce a small set of questions that will be used by all authorities, and to get them to report the responses to the Department of Health. We will then make this information available through the new Performance Assessment Framework (see Chapter 7) to allow local authorities to compare their own performance in this area with that of others and to allow the Government to monitor progress nationally. We will work closely with local authorities in drawing up detailed proposals for a common set of questions for user and carer satisfaction surveys.

Emergency and out of hours services

2.58 Most social services are ongoing in nature, but councils need to make sure that they have proper systems for responding to emergencies when they arise. They need to provide reliable and sufficient emergency and out of hours services, in particular for mentally ill people, for urgent family situations where there are risks to children, and where medical or other emergencies affecting, for instance, an elderly person may lead to a need for immediate social services help. It is important that service users are informed of out of hours and emergency services so that they know how to get help quickly in a crisis - the need for good information and easy access is all the greater in such circumstances.

2.59 The SSI is currently undertaking an inspection of the provision of emergency and out of hours services in a sample of local authorities. They will be looking, among other things, at telephone helplines and the role that they can play. The findings will help all authorities in reviewing the way they manage, resource and deliver these services.

Services centred on users: listening to people

The following case example is taken from the findings of the Joint Review of Liverpool Social Services (July 1998). It illustrates how a better outcome can be achieved through user involvement.

Mrs X, a 72 year old lady is becoming frail but is cared for by her son who lives with her, and by other local family members.

October 1995: GP refers Mrs X to social services for home help which she declines "We're managing well and we don't need it"

December 1995: GP refers again for home help - Mrs X accepts temporarily while her son is away June 1997: Mrs X has a stroke and falls - accepts home help and subsequently admitted to hospital

September 1997: case conference: "the medical and social work consensus was for residential care - all agreed except Mrs X" (Cases file) Weekly cost 335

Mrs X accepts package of home help - 1 hour 3 times daily

December 1997: when visited by the review team Mrs X was delighted to still be in her home and her condition continues to improve. Weekly cost of care for the authority is less than half the cost of residential care.

Improving commissioning

2.60 Better commissioning will help to ensure that services meet people's specific individual needs, and that groups with particular needs, such as people from ethnic minorities, are better served. We shall ensure that authorities improve the standard of their commissioning by:

- publishing guidance around the turn of the year setting out the kind of information councils need to improve the impact of their commissioning. This will be based on a study of information needs carried out by the Department of Health, and will complement Audit Commission work.

- issuing a self audit tool to help councils review their care management arrangements, including how purchasing activities of care managers can better inform commissioning

- using Best Value service reviews, Joint Reviews and SSI Inspections to ensure that best practice is being implemented

- raising awareness about good practice through a series of workshops (a process we have already begun).

  ' better commissioning will help to ensure that services meet people's specific individual needs, and that groups with particular needs, such as people from ethnic minorities, are better served'

Four key elements of good commissioning

Needs analysis: commissioning should be based on an assessment of need within the general population that is thorough and based on local evidence. Where appropriate such assessments of need should cover not only social care, but also health, housing and other aspects. Information about gaps in services, services which users would prefer, service shortfalls, and provider performance (through contract monitoring) should be systematically collected during referral and assessment processes, and fed into planning processes.

Strategic planning: planning and planned changes should be in pursuit of agreed strategic objectives, and the planning process should be transparent to users and providers. Information about need, supply and service use should collected by commissioners, and fed into the planning process. It should be shared with providers and user and carer groups. The views and wishes of users and carers should be systematically sought, and fed into planning processes. Providers from all sectors should be encouraged, and provided with relevant information. Commissioners should ensure that commissioning funds are flexible and can be switched as required from services that are no longer needed to new ones that are.

Contract setting and market management: a variety of contract types should be used to deliver positive outcomes for users and reasonable security for good providers. Good commissioners should have mechanisms for stimulating new services where needs have been identified, and services are not available. Such mechanisms could involve some form of 'pump priming' such as the use of a block contract to reward a provider for providing new service with a guaranteed level of income. Contract prices should not be set mechanistically but with regard to providers' costs and planned outcomes for users.

Contract monitoring: general contracts and specific contracts should be monitored to ensure that providers are providing acceptable standards of care, and that individuals are receiving appropriate help at agreed prices. Commissioners should ensure that providers have their own quality assurance and control systems in place. Good commissioners take swift remedial action when contract monitoring or other information points to problems with individual providers or with a sector of the market. Contracts should be constructed and monitored in such a way as to enable commissioners to identify fraud and safeguard themselves against it.

2.61 An essential part of commissioning processes in future will be to ensure that the assessment of local needs takes

account of Health Improvement Programmes (see Chapter 6). Strategic planning for local social services must fit closely together with these wider programmes for improving health.

How will people see the benefits of our changes?

2.62 The benefits of a more user-centred approach to social services should be seen in:

- services that are suited to the needs of people, not the convenience of providers
- clearer information for the public on services and standards, building on the Long-term Care Charter
- less confusion and bureaucracy for users and carers to contend with, through better access arrangements and "one-stop shops"
- more choice, and services better suited to individual needs, based on improved user feedback and improved commissioning processes
- better targeted services for people from ethnic minorities
- an increase in service users' satisfaction levels, as measured in local surveys.

' services that are suited to the needs of people, not the convenience of providers'

All authorities will carry out local user satisfaction surveys, starting from April 2000.

Conclusion

2.63 All these measures, taken together with the proposals on regulation, on closer partnership working and on improved performance management outlined elsewhere in this White Paper, will set out a significant agenda for modernisation and improvement in adult social services over the coming years. The new pattern of social services for adults will be one where people will:

- understand how to get access to services, what is available for their level of needs, and what their own contribution might be
- be involved, with their carers, in working out support arrangements
- be confident that the support that is agreed will help them to lead their own lives as far as possible, to continue to live in their own home, and to do as much for themselves as possible
- be confident that if they lived in another area, the support they would get, and any contribution they make, would be similar.

' these measures set out a significant agenda for modernisation and improvement in adult social services'

Beacon services

7.19 Good practice should be recognised and rewarded. Social services are rightly criticised for their failings, but we hear too little praise for their successes. The new performance framework will help identify and publicise good performance, through the publication of authorities' performance against the indicators in the performance assessment framework and through the work of the SSI and Joint Reviews. The Social Care Regional Offices will be able to facilitate the exchange of good practice and the pairing of authorities who could learn from each other.

7.20 The best authorities will be able to apply for beacon status. Beacon councils will be recognised centres of expertise and excellence that everyone should look to. The Government will consult widely on the details of the beacon councils including the rewards associated with beacon status and how the scheme will apply to social services.

Interventions

7.21 The Government will work to help authorities to tackle poor performance, and will act in partnership with the Local Government Association where appropriate. Where there are serious failures, the Government will be prepared to take firm action to secure improvement, including using statutory powers to intervene when necessary. The Government will act to protect vulnerable people who are put at risk by poor services, and it will ensure that it has the statutory powers at its disposal to do this. The White Paper *Modern Local Government: In Touch with the People* sets out the range of interventions the Government intends to put in place through legislation to underpin Best Value. They include requiring:

- an authority to draw up an action plan for improvement, and deliver a specified level of performance by a set date
- an authority to accept external management help
- responsibility to be transferred to another authority or third party in case of serious service failure.

7.22 These powers will be available to the Secretary of State for Health to enable him to intervene where local social services authorities are failing to deliver best value.

Public and private sector provision

7.23 Best value must be secured in all social services, whether provided in-house or contracted out to the voluntary or private sector. This Government does not take an ideological approach to this issue, and has no preconception about whether the public or the voluntary or private sector should be the preferred providers. These decisions should be based entirely on judgements about best value and optimum outcomes for individual users, and authorities must be able to demonstrate that their arrangements are delivering this.

' Best value must be secured in all social services, whether in-house or contracted out'

7.24 By the same token, we are keen to remove any distorting effects there are in the current system for authorities to use one sector over the other, and keen to give councils as much flexibility as possible in making effective use of public money available for care. One example of this is the Residential Allowance. This allowance is a component of Income Support, and is payable to residents placed in voluntary or private residential care or nursing homes. It is not available to people placed in local authorities' own homes. The individual does not see the money, as it goes direct to payment of the placement. It provides a subsidy towards the costs to social services of providing this type of residential accommodation, thereby reducing their contribution to such placements. However, it can also act as a perverse incentive to place people in residential care because it would be less costly to social services than keeping them at home.

7.25 We believe there is a strong case for phasing out the payment of the Residential Allowance, and for transferring

resources, via a special grant, to local authorities. This would not be a loss to the individuals concerned, and in effect it would simply move funding from one part of the system to another. But it would create a level playing field between public, private and voluntary sector provision. In particular, it would support the agenda set out in this White Paper by giving authorities more flexibility to use the resources in promoting independence. This could include, for instance, better services to people at home, possibly through greater use of direct payments.

7.26 The Government would need to work through the implication of this change on overall costs. We would want, for example, to consider the implications for other areas of public expenditure and ensure that the change would not lead to a greater use of local authorities' own residential care homes where these cost more without a gain in quality of care. We will also need to assess the impact of any change on the take-up of other DSS benefits, and on independent sector care homes (although reduced use of residential care would provide new opportunities for independent domiciliary care providers). We will therefore consider the detailed options carefully and consult with both local authorities and voluntary and private sector interests before deciding whether and how to implement any change.

Member responsibilities and scrutiny

7.27 To go with the new national framework described above, local authorities have a corporate responsibility for ensuring that best value social services are being delivered to their citizens. It is important that this responsibility is given due importance by elected members in particular. Authorities will be in a position to improve delivery and efficiency by:

- having clear responsibilities for social services at member level, including arrangements for the review of policy and strong scrutiny arrangements for social services performance; and

- having management and accountability structures that provide the most effective services.

Mayors and cabinets: new structures in local government

The White Paper Modern Local Government: In Touch with the People set out the Government's programme to modernise local government, including significant changes to the committee-based system which has existed in local government for over a century. Authorities will be required to draw up proposals for new structures based on a clear distinction between executive responsibilities and the other roles of elected members. Instead of decision by committee, in future there will be streamlined and more accountable structures, with arrangements such as executive cabinets and executive mayors.

These changes will be positive for social services. The new structures are intended to provide stronger and clearer accountability to locally elected members, and the proposed new scrutiny arrangements will give 'backbench' councillors a better opportunity to hold the executive to account on social services performance.

7.28 It has been stressed elsewhere in this White Paper that where the welfare of children is at stake - and most particularly when the local authority is acting as corporate parent for children looked after - it is essential that elected members ensure that services are up to standard. This is true for all social services, and authorities will need to establish proper scrutiny arrangements to check how well they are performing.

7.29 Scrutiny is required at two levels. Firstly, those elected members who are responsible for social services (in future these may be the designated executive cabinet members rather than committee chairs) must ensure that they have the capacity to monitor and scrutinise the performance of the Director of Social Services and his/her staff - it is not generally acceptable for elected members to claim that they are shocked when evidence emerges of serious service failures. Such failures should not go unnoticed.

7.30 Secondly, under the new arrangements for political decision-making in local government, there will be scrutiny arrangements for "backbench" councillors to hold the executive to account. They will examine, in public, members of the executive and senior officers on the services being provided and the policies being pursued and proposed. They will also consider strategic issues and the overall performance of local social services. Authorities should ensure that they provide for full scrutiny of social services functions, perhaps through a specific scrutiny committee for social services.

Management structures

7.31 As a result of the changes to local government structures, the Local Authority Social Services Act 1970 will need significant amendment. In particular, there will in future be no requirement for a Social Services Committee, given that committees will no longer be the model for decision-making in local government. However, as stressed above, member responsibilities for social services will remain crucial under the new arrangements.

' member responsibilities for social services will remain crucial under the new arrangements'

7.32 The Government will retain the legal requirement for every social services authority to appoint a Director of Social Services, who must be directly accountable to the Chief Executive and must have direct access to elected members on social services matters. The Government has no wish to impose detailed management structures for authorities' social services - most authorities operate a "traditional" social services department, but an increasing number of authorities have adopted alternative and innovative arrangements. However authorities choose to structure their management, they must be in a position to show that they can meet all their statutory requirements and that their arrangements provide safe and effective social services.

' legal requirement for every social services authority to appoint a Director of Social Services'

7.33 In particular all authorities will need to identify:

- named councillor(s) who will carry the executive responsibility for the whole range of social services responsibilities
- how the elected member scrutiny arrangements will monitor the performance of the council's social services responsibilities
- clear accountability arrangements for all social services responsibilities to the Director of Social Services
- where social services functions are discharged across a number of separate internal management structures or council departments, clearly defined liaison and accountability arrangements (for example, those responsible for mental health services must ensure that they consider child welfare issues where a parent has a mental illness, and work with the child protection team wherever necessary)
- adequate arrangements for managing information relating to the social services functions as a whole (for example, dissemination of guidance, collection of financial and statistical data, liaison with the SSI and Joint Reviews).

7.34 While allowing authorities the freedom to manage their social services as they think best, the Government intends to monitor these arrangements as part of the performance management arrangements described earlier in this Chapter. In keeping with this approach, the Government will also remove the current requirement for Directors of Social Services to seek permission from the Secretary of State before taking on non-social services functions (Section 6(5) of the Local Authority Social Services Act 1970).

Conclusion

7.35 The proposals in this Chapter respond to the need for new political structures as part of the modernisation of local government and will remove existing impediments to this process. They also recognise the need for a greater emphasis on raising standards of performance in social services. The introduction of Best Value will provide social services authorities with a framework within which to assess their performance, establish standards and set targets for improvement. The Government will work alongside authorities to ensure that real improvements are delivered.

' the proposals in this Chapter respond to the need for new political structures as part of the modernisation of local government'

Our Healthier Nation

A Contract for Health

Presented to Parliament by the
Secretary of State for Health
by Command of Her Majesty,
February 1998

Cm 3852

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comments

The Department of Health

The new NHS
modern . dependable

Presented to Parliament by the
Secretary of State for Health
by Command of Her Majesty,
December 1997

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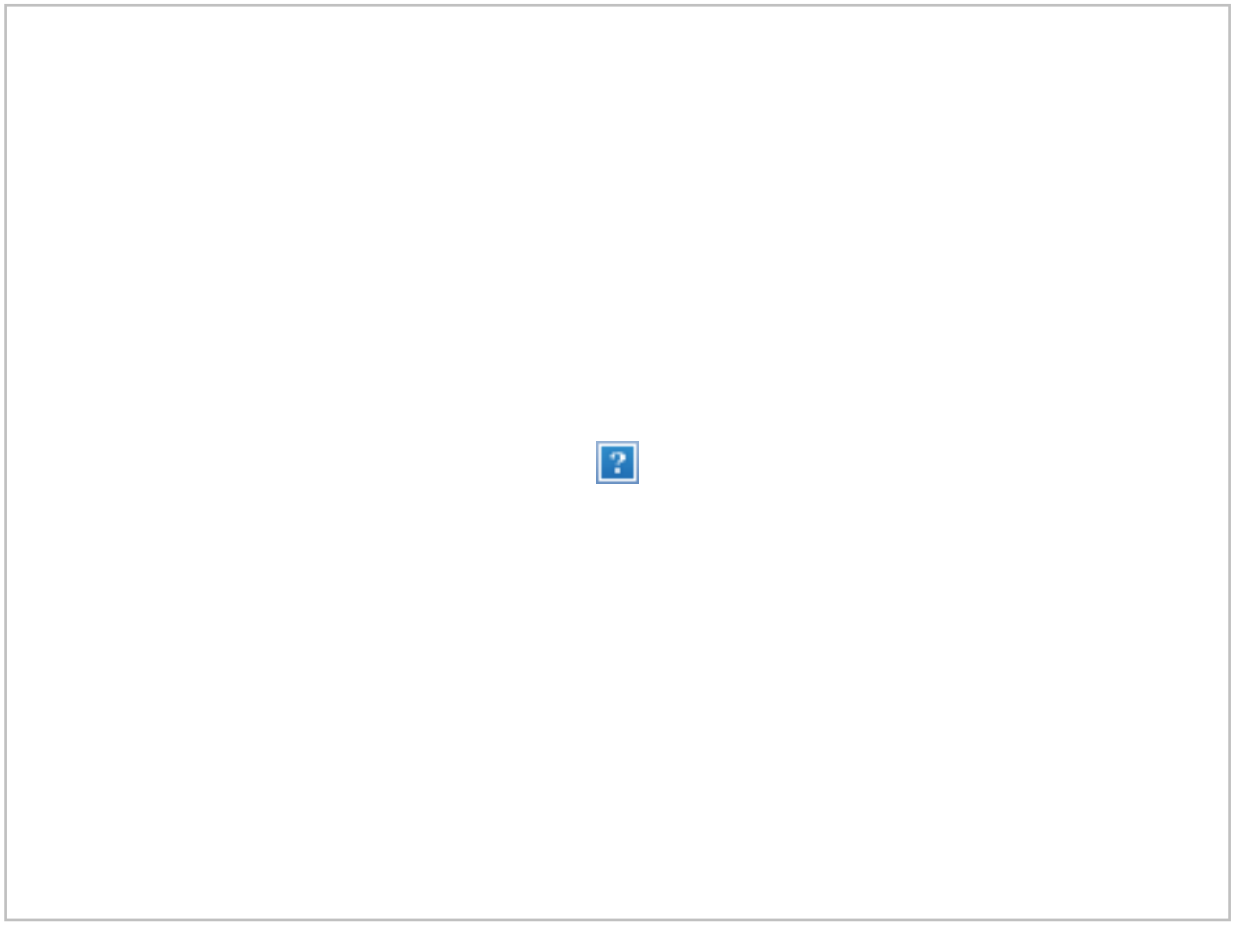
DoH logo



Foreword by the Prime Minister

Creating the NHS was the greatest act of modernisation ever achieved by a Labour Government. It banished the fear of becoming ill that had for years blighted the lives of millions of people. But I know that one of the main reasons people elected a new Government on May 1st was their concern that the NHS was failing them and their families. In my contract with the people of Britain I promised that we would rebuild the NHS. We have already made a start. The Government is putting an extra £1.5 billion into the health service during the course of this year and next. More money is going into improving breast cancer and children's services. And new hospitals are

being built. The NHS will get better every year so that it once again delivers dependable, high quality care - based on need, not ability to pay.

This White Paper marks a turning point for the NHS. It replaces the internal market with integrated care. We are saving £1 billion of red tape and putting that money into frontline patient care. For the first time the need to ensure that high quality care is spread throughout the service will be taken seriously. National standards of care will be guaranteed. There will be easier and swifter access to the NHS when you need it. Our approach combines efficiency and quality with a belief in fairness and partnership.

As we approach the fiftieth anniversary of the NHS, it is time to reflect on the huge achievements of the NHS. But in a changing world no organisation, however great, can stand still. The NHS needs to modernise in order to meet the demands of today's public. This White Paper begins a process of modernisation. The NHS will start to provide new and better services to the public. For example, a nurse-led helpline to provide advice round the clock. And new technology that links GP surgeries to any specialist centre in the country.

In short, I want the NHS to take a big step forward and become a modern and dependable service that is once more the envy of the world.

Of course we must get the funding right. The Government has already put large extra sums into the NHS, and will raise spending in real terms every year. With that money comes a responsibility within the service to change. To produce better care. Care when you need it. Care of uniformly high standards.

It is a big challenge but I am confident that with the support of the public, the dedication of NHS staff and the backing of the Government we can again create an NHS that is truly a beacon to the world.

Tony Blair
Prime Minister

Prepared 8 December 1997

Foreword

Good health. It's not just a toast. It's what everybody wants for themselves, their family and friends. If you are a parent, it's the supreme gift you'd like to give your children. For the sake of every individual, for society and for the economy, it should be a top priority for any Government. It is a top priority for this Government.

While health generally has improved, far too many people are still
falling ill and dying sooner than they should. The NHS is there to provide treatment and care when people fall ill. Our recent White Paper - *The new NHS* - spells out our proposals for a modern and dependable health service. But it's not enough to treat people when they fall ill. We've got to do more to stop them falling ill in the first place.

That means tackling the root causes of the avoidable illnesses. In recent times the emphasis has been on trying to get people to live healthy lives, where necessary by changing their lifestyle. Now we want to see far more attention and Government action concentrated on the things which damage people's health which are beyond the control of the individual.

Poor people are ill more often and die sooner. To tackle these fundamental inequalities we must concentrate attention and resources on the areas most affected by air pollution, poverty, low wages, unemployment, poor housing, crime and disorder, which can make people ill in both body and mind.

The new Government is already taking action to tackle all these problems. That will improve the health of the worst off and least healthy people and neighbourhoods.

This Green Paper sets out our proposals for concerted action by the Government as a whole in partnership with local organisations, to improve people's living conditions and health. It recognises that there are limits to what Government can do and spells out what the individual can do, if the Government do their bit. That's why we are proposing a 'contract for health'.

We put forward specific targets for tackling some of the major killer diseases and proposals for local action. But the Government doesn't believe we have a monopoly of concern and knowledge. So we are inviting everyone who is interested to let us have their comments on what we are proposing and to put forward suggestions of their own.

Frank Dobson
Secretary of State for Health

Tessa Jowell
Secretary of State for Public Health

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comments

OUR HEALTHIER NATION

Summary

Good health is treasured. It is the foundation of a good life.
Better health for the nation is central to making a better country.

'have major opportunities to improve people's health'

We have major opportunities to improve people's health. Almost 90,000 people die every year before they reach their 65th birthday. Of these, nearly 32,000 die of cancer, and 25,000 die of heart disease, stroke and related illnesses. Many of these deaths could be prevented.

Health inequalities are widening. The poorest in our society are hit harder than the well off by most of the major causes of death. In improving the health of the whole nation, a key priority will be better health for those who are worst off.

There are sound economic reasons for improving our health. 187million working days are estimated by industry to be lost every year because of sickness - a £12 billion tax on business.

'sound economic reasons'

Treating ill health is expensive. Heart disease, stroke and related illnesses cost the National Health Service an estimated £3.8 billion every year. By preventing avoidable illness we can concentrate resources on treating conditions which cannot yet be prevented.

Poor health has complex causes. Some are fixed - ageing, for instance, or genetic factors. Our priority is to concentrate on the factors which affect people's health, and on which we can all make an impact.

These include a range of factors to do with how we all live our lives - diet, physical activity, sexual behaviour, smoking, alcohol and drugs.

Social and economic issues play a part too - poverty, unemployment and social exclusion. So too does our environment - air and water quality, and housing. And so does access to good services, like education, transport, social services and the NHS itself.

'a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the

other'

Tackling these health issues involves a range of linked programmes, including measures on welfare to work, crime, housing and education, as well as on health itself.

In the proposals put forward in this consultative Green Paper, *Our Healthier Nation*, the Government has two key aims:

- To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.
- To improve the health of the worst off in society and to narrow the health gap.

To achieve these aims, the Government is setting out a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other.

Good health is no longer about blame, but about opportunity and responsibility.

While people on their own can find it hard to make a difference, when individuals, families, local agencies and communities and the Government work together deep-seated problems can be tackled.

Our third way is a national contract for better health. Under this contract, the Government, local communities and individuals will join in partnership to improve all our health.

'Government, local communities and individuals will join in partnership to improve all our health'

For its part, the Government will help assess the risk to health by making sure that people are given information on health which is accurate, understandable and credible. Where there are real threats to health we will not hesitate to take tough action - though regulation and legislation will be the exception, not the rule.

Health Authorities will have a key role in leading local alliances to develop Health Improvement Programmes, which will identify local needs and translate the national contract into local action.

Local Authorities will have a new duty to promote the economic, social and environmental well-being of their areas.

Businesses can bring new skills to bear, including marketing and communications - as well as improving the health and safety of their own employees.

Voluntary bodies can act as advocates to give a powerful voice to local people.

'to make real progress, we will focus on four priority areas'

Individuals can take responsibility for their own health.

To help enact the contract, we have identified three settings for action:

- Healthy schools - focusing on children
- Healthy workplaces - focusing on adults
- Healthy neighbourhoods - focusing on older people

And to make real progress, we will focus on four priority areas, setting clear targets for improvement in each:

By the year 2010:

- **HEART DISEASE AND STROKE.target**: to reduce the death rate from heart disease and stroke and related illnesses amongst people aged under 65 years by at least **a further third**
- **ACCIDENTS[Ý].target**: to reduce accidents by at least **a fifth**
- **CANCER.target**: to reduce the death rate from cancer amongst people aged under 65 years by at least **a further fifth**

- **MENTAL HEALTH.target**: to reduce the death rate from suicide and undetermined injury by at least **a further sixth**.

These are tough targets. They are challenging targets. With this consultation paper, we want to know what you think of them. There are strong personal, social and economic arguments for making our health better. This Government intends to act on them.

'tough targets... challenging targets'

[Ý] An accident is defined here as one which involves a hospital visit or consultation with family doctor.

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comments

Chapter 1

Fit for the 21st Century

The Case for Health

1.1 There are strong personal, social and economic arguments for making our health better. The Government intends to act on them.
We know that progress has been made, but more needs doing. There are still major opportunities to improve our health.

'progress has been made, but more needs doing'

The Personal Case

1.2 Good health is the foundation of a good life. Our own health and the health of our families and friends underpin our ability to enjoy life to the full. When we are well we are able to make the most of the opportunities that life has to offer and to play a full part in family, community and working life. No matter what goes wrong in life - money, work or relationship problems - good health helps sustain us. How often have we all heard someone say that although things may not be going well - at least they have their health. Good health is treasured.

'good health is the foundation of a good life'

1.3 Good health also means not living in fear of illness, constantly worried about our health or the health of those closest to us. It means being confident and positive and able to cope with the ups and downs of life. Better health for the nation is central to making a better country.

1.4 It's good that people are generally living longer and living healthier lives. But the level of illness remains a cause for concern. Estimates based on Government statistics show there are over 250 million visits to GPs and 70 million visits to hospitals every year. Now, in the 1990s, nearly 90,000 people die each year before they reach their 65th birthday. Of these people, more than 25,000 die of heart disease, stroke and related illnesses and 32,000 die of cancer. Many of these deaths could be prevented.

'good health is about quality of life'

1.5 But good health is not just about how long people live. It is also about quality of life and how well people are during those extra years, so that they are not robbed of their dignity and independence in later life. Figure 1 shows that although both men and women are living longer, they spend many of those years in poor health. What we want is a healthier country where people spend as little time as possible burdened by sickness, pain and disability.

Figure 1

The Social Case

1.6 In a modern and strong society, united by core values of fairness and compassion, it is vital that everyone gains from a national drive for better health.

1.7 A healthy country would be one where health was not dictated by accident of birth and childhood experience. Everyone should have a fair chance of a long and healthy life.

'everyone should have a fair chance of a long and healthy life'

1.8 The general improvement in health stems largely from improved living standards. But not all have shared in growing prosperity. Surveys over the last few years have shown a growing gap in wealth between the best and worst off people and the best and worst off neighbourhoods. Predictably the most recent figures[1] from the Office for National Statistics show that the health gap is growing as well.

1.9 The poorest in our society are hit harder than the well off by most of the major causes of death. Poor people are ill more often and die sooner. The life expectancy of those higher up the social scale (in professional and managerial jobs) has improved more than those lower down (in manual and unskilled jobs). This inequality has widened since the early 1980s (see figure 2).

1.10 In the past this social dimension was frequently neglected. Poor health was put down to bad luck, unhealthy behaviour, or inadequate healthcare.

1.11 Yet it is clear that people's chances of a long and healthy life are basically influenced by how well off they are, where they live and by their ethnic background. A child's chance of surviving to its first birthday relates to the country of birth of its mother, as figure 3 shows. Figure 4 shows how men's social class can influence their chances of dying from lung cancer before the age of retirement. Figure 5 shows how some areas are hit harder by deaths before the age of 65. Parts of Tyne Tees, Greater Manchester, the West Midlands and London have some of the highest rates of early death, whilst most of East Anglia and the South West have the lowest.

Figure 2
Figure 3
Figure 4
Figure 5

1.12 The Government recognises that the social causes of ill health and the inequalities which stem from them must be acknowledged and acted on. **Connected problems require joined-up solutions.This means tackling inequality which stems from poverty, poor housing, pollution, low educational standards, joblessness and low pay. Tackling inequalities generally is the best means of tackling health inequalities in particular**.

'tackling inequalities generally is the best means of tackling health inequalities in particular'

1.13 Within our overall programme to improve the health of the whole population a key priority will be to improve the health of those who are marginalised and worst off. We will seek to improve the absolute and relative positions of those people and areas which are hit hardest by poor health and premature death. That will narrow the gap between them and the better off .

1.14 Moreover, social exclusion can be both a *cause* and an *effect* of ill health. If people are too ill to work or to participate in everyday social life, isolated from the mainstream opportunities by illness or disability, then they can become socially excluded. If they are not in society's mainstream, they are more likely to damage their health by smoking or they may seek comfort in activities like illegal drug-taking and so damage their health.

'to succeed in the modern world economy, the country's workforce must be healthy as well as highly skilled'

The Economic Case

1.15 A healthy population is a key factor in a prosperous and modern economy. There are sound and hard-headed business reasons for making our health better.

1.16 To succeed in the modern world economy, the country's workforce must be healthy as well as highly skilled. The Confederation of British Industry has estimated that 187 million working days are lost each year because of sickness[2]. That's a £12 billion social tax on business every year, damaging to competitiveness and a brake on prosperity.

1.17 Cancer treatments cost the NHS an estimated £1.3 billion each year, whilst heart disease, stroke and related illnesses cost £3.8 billion. Treating accidents and other injuries costs some £1.2 billion and treating poor mental health in excess of £5 billion a year[3]. Illnesses caused by smoking cost the NHS between £1.4 and £1.7 billion each year. By preventing avoidable illnesses we can enable the NHS to concentrate its resources on treating those conditions which cannot yet be prevented.

'by preventing avoidable illnesses we can enable the NHS to concentrate its resources on treating those conditions which

cannot yet be prevented'

1.18 Investing in the country's health is partly about working for a fair and decent society. It is partly about using the resources of the health service to best effect. But, equally importantly, it is also part of the Government's determined drive to improve England's economic efficiency and performance.

Our Health Can Be Better

1.19 Our health today falls short of what we already know is possible. It is better here than in many other European countries. But it is hit harder than some countries by the big killer diseases. And, as figure 6 shows, people in England have less chance of a long life than people living in France, Italy or Sweden.

Figure 6

1.20 Compared with other countries, many people - particularly older people - still spend much of their lives in pain or discomfort, dependent on others for support. At a time when they should be free to make the very most of their lives too many spend their retirement unable to enjoy the independence that people who are well take for granted[4]. We want to ensure a more comfortable retirement which gives people the ability to live independently and to do things for themselves for as long as possible.

'we want to ensure a more comfortable retirement which gives people the ability to live independently'

Our Healthier Nation

1.21 So there is an overwhelming personal, social and economic case, based on common sense, for improving our health. The Government is determined to play its part in a concerted effort to make our health better.

1.22 It is obvious that problems that have persisted for decades will not be solved overnight. The results of our efforts may take years to show through in better health. Improvements in health will not be easy to secure. They will have to happen at a pace which people can accept and which the country can afford. There will be hard choices to be made by us all. But this is no excuse for inactivity and in time our efforts can and will make a real difference.

'the Government is determined to play its part in a concerted effort to make our health better'

1.23 The Government has two overriding aims for *Our Healthier Nation*.

Our Healthier Nation - Two Key Aims for improving the health of the population

- *To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.*
- *To improve the health of the worst off in society and to narrow the health gap.*

1.24 The Government has identified four priority areas for action - heart disease and stroke, accidents, cancer and mental health - and proposes to set a national target for each of them. These targets will give purpose and direction to the strategy and help us to assess overall progress.

'this Green Paper asks for your views'

1.25 This Green Paper sets out the Government's proposals on how, together, we can achieve our two overriding aims, and asks for your views on them. When your views have been taken into account, we will publish later this year a White Paper setting out a strategy for action.

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comments

Chapter 2

The Causes of Ill Health

Understanding the Causes of Ill Health

2.1 Our understanding of how and why people become ill has advanced in leaps and bounds in the past century, with British science and know-how often at the forefront of international efforts. For example, it has played a key role in proving the link between smoking and cancer, in the development of life-saving vaccines and in understanding the factors, such as air pollution, which cause other diseases. British medical science has also played a leading role in developing such treatments as antibiotics, anaesthetics and key-hole surgery. The Government will continue to support this British research. We are determined that this proud history will continue.

'the causes of ill health are complex'

2.2 But the causes of ill health are complex. There are still many illnesses which we do not fully understand and which can strike unexpectedly. Some are caused by genetic factors fixed before our birth, some by factors beyond our individual control, and others by the way we live. Whatever the causes of ill health we need a health care system to treat and care for people who fall ill. The Government's renewal of the health service, set out in the White Paper, *The new NHS[5]*, will ensure a modern and dependable NHS. This is especially vital for those who are poor or vulnerable, who are likely to have the worst general health and so the greatest need to use the NHS.

'the Government's renewal of the health service, set out in the White Paper, The new NHS will ensure a modern and dependable NHS'

2.3 Some of the main factors which influence our health are shown in the table overleaf. This sets out a whole range of factors - those which are beyond the influence of individuals and so require wider national and local efforts to secure progress, alongside those which are determined by individual behaviour.

Factors affecting health

Fixed	Social and Economic	Environment	Lifestyle	Access to Services
Genes	Poverty	Air quality	Diet	Education
Sex	Employment	Housing	Physical activity	NHS
Ageing	Social exclusion	Water quality	Smoking	Social Services
		Social environment	Alcohol	Transport
			Sexual behaviour	Leisure
			Drugs	

Fixed factors

2.4 Although our age, sex and genetic make-up have a major influence on our health, for most people there is little we can do about them.
But we can try to modify some of their predictable consequences. Within a few years we can expect developments in genetic science to make it possible to do much more than we can now.

'people's health is affected by their circumstances'

Social and Economic Factors

Poverty

2.5 People's health is affected by their circumstances. Well-being, a sense of control over your life, and optimism about the future is good for health. For example:

- low income can make it hard to afford to keep your house warm or protect yourself and your family from fire and accidents in the home, such as by buying smoke alarms or replacing faulty wiring;
- low income, deprivation and social exclusion all influence smoking levels. It's harder to stop smoking when you're worrying about making ends meet. One study found that while a third of children in the United Kingdom lived with at least one adult smoker, for low income families, the figure rose to 57%[6].
- if the nearest supermarket is miles away or the bus doesn't go there when you can, it can be difficult to buy food which is cheap and healthy;
- if the street outside your home is busy with traffic or there are drug dealers in the park then it's safer to keep the kids in front of the TV than let them out to play.

Employment

2.6 Being in work is good for your health. Joblessness has been clearly linked to poor physical and mental health. Figure 7 shows how those in work tend to live longer lives than those without jobs. Unemployed men and women are more likely than people in work to die from cancer, heart disease, accidents and suicide. Losing his job doubles the chances of a middle-aged man dying within the next five years.

'being in work is good for your health'

Figure 7

Social Exclusion

2.7 When social problems - poor housing, unemployment or low pay, fear of crime and isolation - are combined, as they often are, then people's health can suffer disproportionately. Social exclusion involves not only social but also economic and psychological isolation. Although people may know what affects their health, their hardship and isolation mean that it is often difficult to act on what they know. The best way to make a start on helping them live healthier lives is to provide help and support to enable them to participate in society, and to help them improve their own economic and social circumstances. That will help to improve their health.

'when social problems are combined, people's health can suffer disproportionately'

Environment

2.8 A safe, secure and sustainable environment is a pre-requisite for a healthy nation. The way in which the environment affects our health is sometimes easily explicable but more often involves a complex mix of factors. Such things as clean air and water and good quality housing are important to our health and well-being.

'a safe, secure and sustainable environment is a pre-requisite for a healthy nation'

Air Quality

2.9 People need to know that if they don't smoke, or if they are giving up smoking, then the Government, Local Authorities and businesses are also taking action to ensure that general pollution is not harming their health and that the quality of the air they breathe is good. A recent study has suggested that high levels of ozone in the air in the summer months lead to increased hospital admissions for respiratory disorders[7][8].

Housing

2.10 Housing has an important impact on health. Research has shown that the most significant risks from poor housing are

associated with damp, which can contribute to diseases of the lungs and other parts of the respiratory system [9][10][11][12]. Cramped living in poor conditions leads to accidents, sleeplessness, stress and the rapid spread of infections.

2.11 Many deaths each year are due to cold conditions. Older people and the very young are particularly vulnerable to cold weather. About a million homes in the United Kingdom have inadequate standards of energy efficiency, putting the health of those who live in them at risk when it's cold.

2.12 100,000 houses in the United Kingdom have high levels of radon gas. People want to be confident that if they are acting responsibly and protecting themselves from cancer by eating well and not smoking, then the Government and Local Authorities are actively engaged in reducing the health risk in those areas where radon gas in homes can increase the chances of developing lung cancer [13][14].

'families with small children and older people need plentiful supplies of water'

Water Quality

2.13 The quality of the water we drink is an important influence on health. Some of the very earliest public health measures were about tackling water-borne diseases such as cholera. Moreover families with small children and older people need plentiful supplies of water for washing at prices they can afford. The Government will set a stringent standard of 10μg/l to reduce lead in drinking water, as supplied to homes, to be met within 15 years. The Government will also ensure that water suppliers will continue to treat water to reduce its ability to dissolve lead and for most properties this will ensure that levels at the tap - that is after any contamination by the property owner's pipes - do not exceed 25μg/l. The Government will be preparing advice for homeowners to help them take an informed decision on options for action if they have lead pipes within their homes.

2.14 There are many other environmental influences on our health, including noise pollution, global warming, ozone depletion, and carbon monoxide in the home. But there is also the important context of ensuring that particular environments, such as work and the community, are healthy ones.

Social Environment

2.15 The quality of life in the community and the extent to which people respect and support each other can also be important to our health. Social exclusion can have damaging health consequences.
One study found that, compared to people with lots of social ties, the socially isolated were over six times more likely to die from a stroke and more than three times more likely to commit suicide [15].

'tackling crime and fear of crime in the community can have a direct impact on our health'

2.16 Neighbourhoods where people know and trust each other and where they have a say in the way the community is run can be a powerful support in coping with the day to day stresses of life which affect health. And having a stake in the local community gives people self-respect and makes them feel better.

2.17 Tackling crime and fear of crime in the community can have a direct impact on our health. Sadly, many people may be afraid to go out for walks alone. They may suffer stress from being victims of crime or from living in an area where crime is commonplace and so they live in fear. Measures to tackle youth crime and develop local crime prevention strategies will help people feel secure in their homes, and reduce some of the stresses in their lives caused by the fear of crime.

Lifestyle

2.18 How people live has an important impact on health. Whether people smoke; whether they are physically active; what and how much they eat and drink; their sexual behaviour and whether they take illicit drugs - all of these factors can have a dramatic and cumulative influence on how healthy people are and how long they will live.

'a good diet is an important way of protecting health'

Diet and Physical Activity

2.19 A good **diet** is an important way of protecting health. The amount of fruit and vegetables people eat is an important influence on health. Unhealthy diets, which tend to include too much sugar, salt and fatty foods, are linked to cancer, heart disease and stroke as well as tooth decay [16][17]. Research suggests that a third of all cancers are the result of a poor diet [18]. The amount of **physical activity** that people take is also an important factor in preventing heart disease, building healthy bones and helping to maintain good mental health.

Smoking

2.20 **Smoking** is the biggest cause of diseases which lead to early deaths in England. It is estimated to account for nearly a fifth of all deaths each year - 120,000 lives in the United Kingdom cut short or taken by tobacco [19]. Smoking is the main cause of lung cancer and is linked to heart disease, chronic bronchitis, asthma and cancers of the mouth, bladder, kidney, stomach and pancreas. Mothers who smoke increase the risk of cot deaths to their babies [20]. Figure 8 shows the range of risks that smokers face.

Figure 8

It has been estimated that for every 1,000 young smokers, one will be murdered, six will be killed in a road accident and 250 will die before their time because they smoke [21].

2.21 Some smokers do live long lives but the odds are still heavily stacked against smokers. In 1996 28% of boys aged 15 and 33% of girls aged 15 smoked regularly and these figures are rising.

Complementary Strategies

- smoking
- alcohol
- teenage
- conceptions
- HIV/AIDS
- drugs

2.22 And a recent study funded by the European Union estimated that passive smoking kills more than 20,000 people each year in Europe [22]. Because of the terrible toll that smoking takes on health, the Government is preparing a comprehensive strategy on reducing smoking to support *Our Healthier Nation*. This will be published later this year.

Alcohol

2.23 Many people who drink **alcohol** enjoy it and cause no harm to themselves or to others. Whether people drink sensibly can dramatically affect their physical and mental health and that of others. Drinking too much is an important factor in accidents and domestic violence and can impair people's ability to cope with everyday life. It has been estimated that up to 40,000 deaths could be alcohol related and in 1996 15% of fatal road accidents involved alcohol. The Government is preparing a new strategy on alcohol to set out a practical framework for a responsible approach.

'death rates of babies born to teenage mothers are more than 50% higher than the national average'

Sexual Health

2.24 Girls who become pregnant in their early teenage years can harm their own health and their career chances as well as the health of their babies [23]. Teenage girls who have to look after their young babies find that their education suffers. Their ability to get a job is diminished. Poor living standards can result, which in turn lead to problems with their own health in the long term. The death rates of babies born to teenage mothers are more than 50% higher than the national average[24]. The prevention of early teenage conceptions is being addressed through a separate national programme.

2.25 A safe and responsible approach to sex is an important part of a healthy life. It prevents the spread of sexually transmitted diseases. HIV/AIDS poses particular challenges which continue to require special attention. The Government is preparing a separate strategy to combat the spread of HIV infection and to meet the challenge to services which HIV and AIDS present.

Drugs

2.26 Illegal **drugs** threaten the health of those who take them and are damaging to society and the community[25]. The Government's new Anti-Drugs Coordinator and his deputy are currently reviewing the existing drugs strategy and will advise Ministers in the spring about how it can be improved and strengthened in the future.

Access to High Quality Services

Education

2.27 The Government wants to make sure that children learn at school both the theory and practice of healthy living. And it goes much further than that - **a decent education** gives children the confidence and capacity to make healthier choices and the ability to better themselves and their future families. Poor educational achievement and pregnancy in the early teenage years are closely linked. A range of research studies have suggested that education and particularly nursery education could have an important impact on health in later life [26][27]. The Government has made clear that this means better education for all.

'a decent education gives children the confidence and capacity to make healthier choices'

Health

2.28 **Top quality health services** which genuinely meet people's needs mean that people seek help quickly and get the advice and treatment they need on time. In a fair society there must be fair access to these services for all, regardless of where people live, who they are and how much they earn. But fair access to services is not yet a reality everywhere. For example, some Health Authorities where we would expect to have the greatest need for heart bypasses actually have lower rates for these operations. There is a lower uptake of health checks and breast and cervical cancer screening among some disadvantaged groups. Areas of relatively high deprivation tend to have a relatively low uptake of immunisation. There are particular concerns about the quality of the family doctor service available in some deprived areas. All these aspects of health care bear down hardest on the poorest in our society.

'in a fair society there must be fair access to top quality health services'

Social Services

2.29 **High quality social services** play a vital role in the health of the people that they serve. Decent support for older people, whether at home or in residential care; the protection and care of vulnerable children and young people; support for people with mental health problems; and helping people with disabilities to live more independent lives: health and social care are often one and the same. By protecting the vulnerable, caring for those with problems and supporting people back into independence and dignity, social services have a vital role in fostering better health.

Transport and Leisure

2.30 Finally, good **local transport** planning and affordable **leisure services** make it easier for individuals to be more physically active. Local Authorities in cities such as Leicester, York and Nottingham have been among the pioneers in integrated transport policies, combining measures such as city centre traffic calming and providing park and ride schemes with initiatives to encourage cycle use. As well as providing people with healthy transport choices, such schemes have shown

reduced pedestrian casualty rates.

'leisure services have a real influence on health'

2.31 For example, the City of York has a strategic approach to transport policy, based on encouraging environmentally sustainable transport initiatives, including traffic calming and a cycling network. The city enjoys a relatively high cycling rate of around 20% of all journeys, while accidents to cyclists and pedestrians have fallen by 33% and 41% respectively from the mid 1980s to the mid 1990s. Leisure services which allow people to relax and take a break from the pressures of day to day life can also have a real influence on health. Having a place - a public park or gardens, where you can take a walk or sit, without fear of crime - is a real benefit to health. Sport, rambling and other leisure opportunities can be equally important.

Inequalities in Health

2.32 For many of these factors the extent to which your health is affected depends on how well off you are, whether you are a man or a woman, where you were born and brought up and your ethnic background [1].

'ill health is not spread evenly across our society'

2.33 Ill health is not spread evenly across our society. It is concentrated in particular groups and places. For example, figure 9 shows large differences in coronary heart disease deaths in people who lived in this country but who were born elsewhere. Figure 10 shows that children in the bottom social class are five times more likely to die from an accident than those in the top social class. Figure 11 shows how deaths from suicide amongst women have fallen through the 1980s and early 1990s whereas such deaths amongst young men rose substantially across the same period.

'the link between poverty and ill health is clear. In nearly every case the highest incidence of illness is experienced by the worst off social classes'

2.34 Figure 12 shows that, whereas death rates from lung cancer have been falling for many years in men, amongst women there was a steady rise until the beginning of the 1990s. Many diseases occur more commonly in particular parts of the country. For example, figure 13 shows that more people die of lung cancer in the north of England than in the south.

Figure 9
Figure 10
Figure 11
Figure 12
Figure 13

2.35 There are many factors that appear to contribute to the differences in health that people experience. However the link between poverty and ill health is clear. In nearly every case the highest incidence of illness is experienced by the worst off social classes. That is why the Government's overall determination to tackle inequality and create opportunity will reduce the health gap.

'Government's overall determination to tackle inequality and create opportunity will reduce the health gap''the causes of ill health do not rest with individuals on their own or with Government on its own'

2.36 The causes of ill health do not, therefore, rest with individuals on their own or with Government on its own. They are shared by society. Chapter Three sets out a new way forward to pull together all who have a part to play in tackling poor health and health inequalities.

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comments

Chapter 3

A Contract for Health

New Public Health

3.1 In the past, efforts to improve health have been too much about blame. Individuals were to blame for failing to listen to well-intentioned but misdirected health advice. Or the Government was blamed for failing to embrace grand plans for social engineering which would make people healthier automatically.

'Our Healthier Nation sets out a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other'

3.2 In the past, arguments about health ranged between two extremes - individual victim blaming on the one hand and nanny state social engineering on the other. The broad majority who just wanted a normal healthy life for themselves and their families were ignored.

3.3 In a modern country these old positions must become obsolete. Health is not about blame, but about opportunity and responsibility. Everyone has a part to play - Government, national organisations, local services, communities, families and individuals. *Our Healthier Nation* sets out a third way of tackling the problems of ill health that our country faces.

3.4 Individuals on their own can find it hard to make a difference.
But with help from their families and support, when needed, from the community and local agencies they can make real changes. Local agencies need central Government to provide leadership and put in place the national building blocks and support. Without individuals, families and communities working together, Government achievements will be limited.

3.5 The new approach to public health also means finding more effective ways of using scarce resources, working together to maximise the impact of what we do and recognising the health benefits of investment in other areas. There are substantial additional resources for those elements of our strategy for health which are clearly associated with the promotion of good health - £300 million in the United Kingdom for Healthy Living Centres alone, and additional resources for the Healthy Schools Initiative. But it is the investment of time and resources such as the £5 billion Welfare to Work programme, the establishment of the National Minimum Wage and the reform of our welfare system to help support people back to independence which will be the most significant contributions to the strategy. The Government's Comprehensive Spending Review is considering the health implications of many Government policies and this work will be used to take forward the proposals in this Green Paper later this year.

'help support people back to independence'

A Contract for Health

3.6 To help bring the nation together in a concerted and coordinated drive against poor health, the Government proposes **a national contract for better health**. The contract sets out our mutual responsibilities for improving health in the areas where we can make most progress towards our overall aims of reducing the number of early deaths, increasing the length of our healthy lives and tackling inequalities in health.

3.7 The national contract recognises that the Government can create the climate for our health to be improved. It pledges to deliver key economic and social policies. It places requirements on local services to make progress in improving the public's health.

3.8 But for *Our Healthier Nation* to succeed it must engage everyone with a contribution to make to the national contract. The contract will only work if everyone plays their part, and if everyone is committed to fulfilling their responsibilities.

3.9 This is our new contract for health:

A Contract for Health

Government and National Players can:	**Local Players and Communities can:**	**People can:**
Provide national coordination and leadership.	Provide leadership for local health strategies by developing and implementing Health Improvement Programmes.	Take responsibility for their own health and make healthier choices about their lifestyle.
Ensure that policy making across Government takes full account of health and is well informed by research and the best expertise available.	Work in partnerships to improve the health of local people and tackle the root causes of ill health.	Ensure their own actions do not harm the health of others.
Work with other countries for international cooperation to improve health.	Plan and provide high quality services to everyone who needs them.	Take opportunities to better their lives and their families' lives, through education, training and employment.
Assess risks and communicate those risks clearly to the public.		
Ensure that the public and others have the information they need to improve their health.		
Regulate and legislate where necessary.		
Tackle the root causes of ill health.		

3.10 Provisional national contracts for each of the four national priority areas are set out in Chapter Four. So the proposed framework for the national strategy will be:

Our Healthier Nation - Two Key Aims

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.
- to improve the health of the worst off in society and to narrow the health gap.

A National Contract for Health

Four Priority Areas
- Heart Disease and Stroke
- Accidents
- Cancer
- Mental Health

A National Target for each of the Four Priority Areas

'coordination of health policy across Government'

What Government and National Organisations Can Do

Leadership and Coordinated Government

3.11 To deliver their part in each of the four national contracts, a range of Government Departments will need to work together. The Government has already taken two key steps to ensure that health is a central theme of Government policy.

- **First**, for the first time ever in England the Government has appointed a Minister for Public Health to ensure coordination of health policy across Government, not just in the Department of Health. The Government has set up a dedicated Cabinet Committee of Ministers from twelve different Departments, to drive the policy across Government.

- **Second**, the Government will apply health impact assessments to its relevant key policies, so that when they are being developed and implemented, the consequences of those policies for our health is considered. The Department of Health has already published guidance, called *Policy Appraisal and Health*, and if necessary this guidance will be revised in the light of experience.

'stronger role for Local Authorities'

3.12 The Chief Medical Officer is leading a project on public health at local, regional and national levels. One aim is to ensure that the public health function can play a full part in *Our Healthier Nation*. Emerging findings suggest that there is a wide range of expertise and enthusiasm in the public health function. But to build on this, we need:

- better partnership between Local and Health Authorities;

- greater impact from independent public health reports and a stronger role for Local Authorities in improving health;

- greater public involvement, in identifying health problems, developing local strategies to improve health and local community action;

- a stronger national network of experts and interested bodies.

3.13 Expertise in public health needs to be strengthened in all sectors. Developing education and training for the workforce must be a priority. Refocusing research and development on public health issues, rather than just health care, will also be important.

'public health needs to be strengthened'

3.14 As a signal of our commitment to the public health function the Government has decided to exempt public health professionals from the definition of Health Authority management costs, so that our efforts to curb bureaucracy in the NHS do not create a perverse incentive to weaken public health expertise at local level. Public health is a long term investment, not an administrative overhead.

3.15 The regional arms of Government will also have important roles in the strategy. Government Offices for the Regions coordinate the main Government programmes such as housing, planning, transport, training and investment in industry. The Regional Offices of the NHS Executive, with their Regional Directors of Public Health, oversee the work of the NHS locally. Working together these bodies should ensure that the potential of all Government programmes to support the health strategy is fully exploited.

International Role

3.16 The Government also has an important **international role** to play in delivering the national contracts. Just as we were able to play an important role in securing tougher environmental action at the Kyoto international Environment Summit, we will speak with a strong voice for the United Kingdom in the European Union, so that European policies are harnessed to the objective of protecting and improving our health. For example, we will continue to press for stronger international action to combat the depletion of the ozone layer. And we will continue to work with the World Health Organisation, at European and at global level, to play our part in international efforts to improve health, including the *Health for All* strategy.

'we will press for stronger international action'

Informed Government

3.17 Ministers and civil servants alone do not have the expertise and knowledge to make our strategy a success. *Our Healthier Nation* will need a great deal of expert advice to ensure that it makes maximum impact with the resources available. For example, the Government will need technical advice on monitoring progress and measuring improvements in health and the Chief Medical Officer's *Our Healthier Nation* group will bring together experts to assist in monitoring the national targets and to provide other expert advice. Government will also need advice on how best to involve the range of non-Government bodies who can play a part; and it will need support in making the most of the contribution of the NHS and Local Authorities.

'special task forces to accelerate action'

3.18 In the light of responses to this consultation document, the Government will consider whether to set up special task forces to accelerate action on these important issues. The Government will also need to consider what structures need to be established to ensure that all those involved in the national contracts have a voice in the implementation and development of the proposals.

3.19 Good information for policy making and for the public means we will continue to need high quality research and development and a way to ensure that research findings are widely disseminated and acted on. The Government will work across all Departments and with other funders to ensure that research to support *Our Healthier Nation* is put in place.

'the assessment and communication of health risks needs to be done better'

Assessing and Communicating Risk

3.20 Life is by its nature risky. It is the job of Government to identify risks to health, to assess them, and, where appropriate, either take action to reduce those risks or ensure that people who might be affected are aware of them. The Government believes that both the assessment and communication of health risks needs to be done better. This will require a more thoughtful approach.

3.21 It is important that scientific assessment and public perception do not get out of step. In the past, public concern has sometimes far outstripped the concern of the scientific and medical experts involved. On other occasions public response has been much less than the scientific and medical experts have felt to be appropriate. Neither situation is much help when it comes to trying to promote improvements in health.

'the public is entitled to know what the odds are so that individuals can make their own judgments'

3.22 To do this properly the Government must call on the best possible advice from people who command the respect of their professional colleagues. They must also be seen to have no axe to grind. But that isn't the end of the story.

3.23 The public is entitled to know what the odds are so that individuals can make their own judgments. If they feel that Government is telling them what to do that can actually be counterproductive. For people to be able to make an informed judgment on risk they need to be able to understand and weigh up the evidence. They need to be able to use the information provided. It is very important to communicate the right information in the right way.

3.24 There is no one single way to communicate health information but the Government's strategy will include:

- **Publicity campaigns** The Government will continue to use publicity campaigns on issues such as occupational health, road safety, drink-driving, anti-drugs initiatives, safe sex, and smoking. The Government and the new Food Standards Agency will make sure that protection of the consumer is the first priority in food policy and ensure that we as individuals have the information we need to be able to make informed decisions about what we eat.

- ***"Wired for health"*** With all schools and colleges in the country being linked up electronically on the internet through the National Grid for Learning every young person in the country will have access to the information they need to make responsible decisions about their health. The Department of Health and the Department for Education and Employment will be working together to ensure that young people and their teachers are able to access relevant and appropriate health information at the touch of a button and reach a new web-site, *Wired for Health*, which will link to accurate, clear and credible web-sites on a variety of health issues.

- **Advisory group** The Department for Education and Employment is planning to set up an Advisory Group on Personal, Social and Health Education to advise on the place of this work in schools.

'a new web-site, Wired for Health will link to accurate, clear and credible web-sites on a variety of health issues'

Regulation and Legislation

3.25 Governments have always taken action to legislate or regulate where this was the only way of providing effective protection for the general public or particuler groups such as employees or children.
The 1956 Clean Air Act is one example which was necessary to reduce the toll of respiratory disease and death caused by the smogs of the 1950s. Laws to require the wearing of seat belts and to control drinking and driving are examples where changes in social attitudes took place so that public pressure augmented the input of the law.

'we will engage the active support of the people...
the contract for health is about partnership and mutual responsibility'

3.26 Where old threats to health continue or new threats arise we will not hesitate to legislate or regulate if this is judged to be necessary.
But we will seek to engage the active support of the people affected rather than resort to coercion or unwarranted intrusion. The contract for health is about partnership and mutual responsibility, about working together to make it easier to be healthy. Regulation and legislation should be the exception, not the rule - a step taken only where voluntary action will not sufficiently protect the public's health.

'regulation and legislation should be the exception, not the rule'

3.27 That is why the Government has already taken decisive action to secure an end to tobacco advertising and sponsorship, while providing time and help for all sports to allow them to find alternative sources of sponsorship. The Minister for Public Health secured agreement at the European Union Health Council on a framework for an historic Tobacco Advertising Directive, after years of United Kingdom opposition, banning tobacco advertising and sponsorship within the European Union. But even here legislation alone is not enough to reduce the prevalence of smoking. A whole range of other actions is needed against tobacco if the maximum impact is to be achieved from the advertising ban and if we are to achieve the objective of reducing the number of children who take up smoking. This will be outlined in the White Paper on Tobacco to be published later this year.

'the Government's main task under the national contracts for health is to tackle the root causes of ill health'

Tackling the Root Causes of Ill Health

3.28 The Government's main task under the national contracts for health is to tackle the root causes of ill health. Most of these are social, economic and environmental. Most of them will therefore be tackled through those overall Government policies which target help on the worst off. This means that they will automatically be concentrating on those people who are ill the most often and who die the soonest, and on the places with the most deep-seated problems. The national contracts for health will ensure that we get the most out of the resources and effort being committed by Government Departments and their local partners.

3.29 The Government's programme is already well under way. The Welfare to Work Budget has set in hand an unprecedented programme to fight **joblessness** with a New Deal for young people, the long term unemployed and lone parents. Welfare to Work has also been extended to include people with a disability or a long standing illness. The worst excesses of **low pay** will be tackled through the National Minimum Wage. **Social exclusion** will be the subject of a long term, determined and coordinated Government effort, led by the Prime Minister's new Social Exclusion Unit. The Government is also working to foster **a new culture of partnership in business** between management and employees which will help impact on the problems of stress and insecurity in work.

3.30 Substantial additional resources - nearly £800 million over two years - for **decent housing** are being made available under the Government's Capital Receipts Initiative. This will help Local Authorities to meet priority housing needs and to improve existing housing. It will help to carry out repairs and improvements to Local Authority housing, housing association and private sector housing as well as build new homes.
The money will also be used to carry out energy efficiency improvements such as insulation, one of the most effective means of tackling health problems which are linked to cold homes. The Government is determined that older people should be able to keep warm and keep well in the winter. It has cut VAT on fuel to 5% and will be making a winter fuel payment of £20 to five million pensioner households and £50 to 1.7 million pensioner households on income support.

'a healthier environment for all'

3.31 An **Integrated National Transport Policy**, on which there will be a White Paper later this year, will ensure a healthier environment for all, as part of our commitment to sustainable development. The strategy will tackle congestion and pollution and their damaging consequences, promote cleaner and safer vehicles, and greater use of public transport, cycling and walking. The health benefits will include better air quality, improved levels of fitness, reduced levels of stress and fewer accidents. The Road Safety strategy and targets exercise announced by the Department of Environment, Transport and the Regions in October last year will complement the proposals on accidents in this Green Paper.

3.32 To ensure that initiatives on health and **the environment** have the maximum impact, the Government will ensure that the influence of the environment on health is fully recognised and integrated into major policy initiatives, particularly in the sustainable development strategy and the integrated transport strategy. To improve air quality more effectively and more rapidly, the Government is aiming to produce conclusions on its review of the National Air Quality Strategy by the end of 1998.

3.33 There is still unacceptably wide inequality in the levels of tooth decay in children. The evidence shows that **fluoridation** of the water supply to the optimum level of one part in a million can substantially reduce the amount of decay in children from similar backgrounds on this site.

Chapter 4

Targets for Health

Why Set Targets?

4.1 The national contracts for health will need to be clearly focused on areas where we need to make progress on our two key aims:

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness
- to improve the health of the worst off in society and to narrow the health gap.

'to improve the health of the population as a whole and narrow the health gap'

4.2 No one should doubt the seriousness of our approach. In particular, our determination to narrow the health gap between the worst off in society and the better off represents a very substantial challenge. This is because, as our first aim shows, we also want the health of the majority of our people to get better year on year. We will not seek to narrow the health gap by slowing the drive for further progress in improved health amongst the many. So to achieve our vision of narrowing health inequalities we will need to improve the health of the poorest sections of our society very significantly indeed. This will not be easy, nor are there any "quick fix" solutions. We are in this for the long haul.

'we are in this for the long haul...the strategy must be focused and disciplined'

4.3 But operating on too broad a front risks dissipating our energies on too many goals - and achieving none. The strategy must be focused and disciplined. That is why the Government has identified four priority areas:

- **heart disease and stroke**,
- **accidents**,
- **cancer**,
- **mental health**.

4.4 These have been selected because they are significant causes of premature death and poor health, there are marked inequalities in who suffers from them, there is much that can be done to prevent them or to treat them more effectively and because they are real causes of public concern. **To drive the contracts and encourage everyone to take part we propose to set four national targets, one in each of these four priority areas**. By setting targets it is possible to give direction to the strategy, to help everyone involved understand the size of the task we face, to ensure that the right resources are in place and to allow the strategy to be monitored.

'contracts for health reflect the full range of social, economic and environmental factors'

4.5 These priority areas, as well as being important in their own right, will also be indicators of overall progress on our two key aims. They are not intended to be a comprehensive measure of all the important factors which contribute to health, but to give a spur to action and an overall indication of the direction and speed of travel.

4.6 Although the targets themselves will be focused on particular diseases and causes of ill health, the essence of the contracts for health is that they reflect the full range of social, economic and environmental factors which impact on these diseases. Action will be needed in all these areas and it is expected that other health benefits will be seen. For example better access to

facilities for physical activity will give a health benefit not only in the area of heart disease but also in prevention of osteoporosis which can cause considerable disability in older people.

4.7 The suggested targets for each of the four priority areas are set out later in this chapter. We believe that they are both **realistic** - not simply wishful thinking with no hope of being reached - and **challenging** - they will require real effort from a wide range of players if they are to be reached.

Getting the Right Targets

4.8 There are two key reasons for setting a small number of targets. **First**, if everything is to be a priority then nothing will be a priority.
So there are tough choices to be made if we are to end stalemates in health and health inequalities that have persisted for many decades. While best efforts on all aspects of health must continue from everyone concerned, hard decisions have to be made if overall health is to improve.

'the rate of improvement for many illnesses can taper off as the easier ways of tackling that illness are implemented'

4.9 So while in consultation we will pay careful attention to arguments for adopting **different** priority areas, **additional** priorities which will dilute our efforts will need a very strong case for inclusion. We need nationally to take responsibility together for the priorities we adopt, so suggestions during consultation for new national priorities will also need to argue their merits against those which have been proposed by showing how they would deliver greater progress on the two key aims of *Our Healthier Nation*.

4.10 Our **second** key reason is that by keeping to a small number of national targets, we will ensure the maximum room for Health Improvement Programmes to set local targets reflecting local priorities.

Getting the Targets Right

4.11 Evidence shows that the rate of improvement for many illnesses can taper off as the easier ways of tackling that illness are implemented. For example, figure 14 shows that deaths from stroke in people under 65 declined at a fairly steady rate during the 1980s, but in recent years the rate of decline has levelled off.

'Health of the Nation was limited, because of its reluctance to acknowledge the social, economic and environmental causes of ill health'

Figure 14

4.12 The previous health strategy - *Health of the Nation* - included targets. But its vision for health was limited, mainly because of its reluctance to acknowledge the social, economic and environmental causes of ill health. Health and Local Authorities and others achieved some progress on the ground and we recognise and applaud their efforts. But:

- many of the improvements in health over recent years were relatively easily and quickly secured because they related to those in professional and skilled groups who are often responsive to health promotion messages. We want to tackle the much harder task of improving the health of the unskilled and socially excluded as well;
- some of the crucial factors leading to a higher risk of heart disease and stroke, such as smoking and obesity, are currently worsening or not improving, making that task even harder. We need to turn these figures around before we can hope to see real health gains;
- it would be highly misleading to assume that even encouraging trends, such as declining numbers of deaths from accidents, are certain to continue. Indeed the evidence points to the need to redouble our combined efforts to reach those groups who have entrenched health problems.

'international comparisons give an idea of the scope for improvement but imply caution for many diseases'

4.13 When formulating our proposed targets, we looked at the experience of comparable countries and their rates of improvement in health. International comparisons give an idea of the scope for improvement, but also help to indicate the timescale over which improvements may be achieved. Those comparisons imply caution for many diseases.

4.14 A number of the suggested targets are for people aged under 65. Many such people are children, breadwinners or responsible for holding a family together. Preventable death and disease in such groups creates suffering well beyond the individual concerned. In addition, it is in these groups that improvements - for example those resulting from changes in

lifestyle - are likely to show benefit first. Information about under 65s can act as a sensitive early indicator of progress overall and for all ages. Signs of improvement in targets for the under 65s should in due course reflect real improvements to the health of people who are over 65.

4.15 But the health of people of all ages is vital to overall success and will be centrally monitored as part of the strategy. We know that the policies and programmes set out in *Our Healthier Nation* are relevant to **all** age groups - giving up smoking, regular physical activity and eating healthily is good for everyone - regardless of age. The overall aims of the strategy are to improve health and to reduce inequalities in health for **all** ages. The final national and local contracts for health will reflect this.

'the policies and programmes set out in Our Healthier Nation are relevant to all age groups'

4.16 A target year of 2010 is proposed for each of the four targets, because the benefits of the initiatives and activities needed to tackle the determinants of ill health will take several years to be reflected in health improvements. We also intend, after consultation, to set intermediate targets for 2005 so that we can check our overall progress at the mid-point. We would welcome views on whether these time periods are the right ones.

4.17 The Department of Health will continue to fulfil its responsibilities to monitor national trends in health, covering all the main aspects of the country's health and looking at all age groups and sections of the population. We will publish regular updates on progress on *Our Healthier Nation* and progress through Health Improvement Programmes will be monitored on an annual basis.

'achievement of our targets would prevent over 15,000 of the approximate 90,000 deaths under age 65 which occur each year'

Targeting Heart Disease and Stroke

4.18 **Heart disease and stroke**, (which, for the purposes of targets, will include all other circulatory diseases) have been selected as a priority area because:

- they are a major cause of early death, accounting for about 18,000 deaths (a third of all deaths) in men and 7,000 deaths (one fifth of all deaths) in women aged under 65 years [see figure 15];
- deaths from coronary heart disease alone account for more than a million years of life lost each year amongst those aged under 75 years;
- these illnesses accounted for an estimated 12% (£3.8 billion) of the total expenditure on health and social services in 1992/93[3]; they also accounted for almost a quarter of total days of certified incapacity in men and 10% in women in the early 1990s;
- they limit the ability of people who live with them to enjoy their lives to the full;
- heart disease and stroke can often be prevented;
- they show marked inequalities: for example, women born in West Africa or the Caribbean are over 50% more likely to die of a stroke than other women [see figure 16].
- similarly men of working age in the bottom social class are more than 50% more likely to die from coronary heart disease than men in the overall population [see figure 17]; and
- by making headway in tackling their causes we should make progress in other areas, such as cancer and mental health.

'Heart disease and stroke can often be prevented'

figure 15
figure 16
figure 17
figure 18

4.19 Death rates from heart disease and stroke have been decreasing for some years in both men and women. Nevertheless, there is considerable scope for further improvement. We, therefore, propose to set a target to **reduce the death rate from heart disease and stroke and related illnesses amongst people under 65 years by at least a further third (33%) by 2010 from a baseline at 1996** (see glossary).

'if we can achieve the proposed target it would bring us to the level which some of the best performing countries currently experience'

4.20 A target based on the number of people developing heart disease, a stroke or a related condition focuses attention on steps we can all take to prevent such diseases. However, mortality data currently offer the most robust basis on which to set a numerical target. A reduction of this order would, if it had occurred in 1996, have resulted in nearly 8,500 deaths being avoided in this age group.

4.21 Figure 18 shows how this country compares with other European Union countries in respect of death from circulatory disease. The United Kingdom is at present clearly one of the worst performing countries. If we can achieve the proposed target it would bring us to the level which some of the best performing countries currently experience. This represents a major challenge and reflects the Government's determination to deal with the underlying causes of circulatory disease.

4.22 Further progress is not inevitable - in Australia marked reductions in coronary heart disease are now showing signs of slowing and, in this country the rate of reduction in stroke mortality has slowed in recent years. We would welcome views on whether the target suggested strikes the right balance.

'the contract shows that effective action to reduce heart disease and stroke will depend on public, voluntary and private sector players'

4.23 A draft national contract for tackling heart disease and stroke is set out in the table overleaf. It shows some of the key elements which may need to feature in the final contract in the White Paper. As with all the contracts in this Green Paper, they neither exhaustively cover all possible action to tackle heart disease and stroke nor prioritise such actions, as the local component of the contract will need to be agreed by local players in the light of local circumstances. In addition, the Government's role in the contracts will need to be refined in the light of its Comprehensive Spending Review and the responses received in the consultation period. But the contract does show that effective action to reduce the toll of heart disease and stroke will depend on the support and contribution of the range of public, voluntary and private sector players.

A National Contract on Heart Disease and Stroke	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	Continue to make smoking cost more through taxation. Tackle joblessness, social exclusion, low educational standards and other factors which make it harder to live a healthier life.	Tackle social exclusion in the community which makes it harder to have a healthy lifestyle. Provide incentives to employees to cycle or walk to work, or leave their cars at home.	Take opportunities to better their lives and their families' lives, through education, training and employment.
Environmental	Encourage employers and others to provide a smoke-free environment for non-smokers.	Through local employers and others, provide a smoke-free environment for non-smokers. Through employers and staff, work in partnership to reduce stress at work. Provide safe cycling and walking routes.	Protect others from second-hand smoke.

Lifestyle	End advertising and promotion of cigarettes. Enforce prohibition of sale of cigarettes to youngsters. Develop Healthy Living Centres. Ensure access to, and availability of, a wide range of foods for a healthy diet. Provide sound information on the health risks of smoking, poor diet and lack of exercise.	Encourage the development of healthy schools and healthy workplaces. Implement an integrated Transport Policy, including a national cycling strategy and measures to make walking more of an option. Target information about a healthy life on groups and areas where people are most at risk.	Stop smoking or cut down, watch what they eat and take regular exercise.
Services	Encourage doctors and nurses and other health professionals to give advice on healthier living. Ensure catering and leisure professionals are trained in healthy eating and physical activity.	Provide help to people who want to stop smoking. Improve access to a variety of affordable food in deprived areas. Provide facilities for physical activity and relaxation and decent transport to help people get to them. Identify those at high risk of heart disease and stroke and provide high quality services.	Learn how to recognise a heart attack and what to do, including resuscitation skills. Have their blood pressure checked regularly. Take medicine as it is prescribed.

Targeting Accidents

4.24 The Government has chosen accidents as a national priority because:

- more than one person every hour died of accidental causes in England during 1996;
- the 1996 Health Survey for England estimated that the annual accident rate, (an "accident" being defined as one sufficiently severe to require medical attention either at hospital or from a family doctor) was 21 for every 100 adult men and 15 for every 100 adult women. Among children aged 2 to 15 it was 31 for every 100 boys and 22 for every 100 girls [32].
- treating injuries costs the NHS in the region of £1.2 billion each year[3];
- accidents are the greatest single threat to life for children and young people;
- accidents, and particularly falls, are a major cause of death and disability in older people;
- childhood injuries are closely linked with social deprivation. Children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off families - and that gap is widening [33];
- there are significant geographical inequalities in accidental deaths amongst young people mainly due to road accidents, and a particular problem in districts which have a significant rural population [35] (see figure 19);

  Figure 19
  Figure 19a
  Figure 19b

- there were nearly a quarter of a million road accident casualties in 1996 of whom more than 3,000 died.

'children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off

families'

4.25 Targeting accidents will allow us to focus on our key aims, increasing the number of years of life free from poor health, and tackling inequalities in health.

'many people suffer prolonged distress and poor quality of life as the result of a serious accident'

4.26 It is clearly important that we continue to reduce the number of deaths from accidents. However in addition many people suffer prolonged distress and poor quality of life as the result of a serious accident. We are able to measure the rate of accidents, through the Health Survey for England. We therefore propose to set a target **to reduce the rate of accidents -** here being defined as those which involve a hospital visit or consultation with a family doctor **- by at least a fifth (20%) by 2010, from a baseline at 1996** (see glossary). A reduction of this order, if it had occurred in 1996, when it is estimated that there were nearly ten million such accidents overall, would have resulted in nearly two million of these accidents being avoided.

4.27 The data on non-fatal accidents are not reliable enough to enable us to predict future trends accurately. There is some evidence that rates have slightly increased between the late 1980s and the mid 1990s, although data sources may not be directly comparable. Overall trends in accidents can sometimes mask more worrying trends specific to a particular age group or type of accident. The proposed target is based on the scientific information we have, but given its imprecise nature, we would welcome views on whether the proposed target is challenging but achievable.

4.28 The draft national contract below sets out some of the action needed to meet a national accident target. As with all the contracts, local contributions to the contract will need to be agreed in the light of local circumstances, and the national contribution reviewed in the light of the Government's Comprehensive Spending Review.

A National Contract on Accidents	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	Improve areas of deprivation through urban regeneration. Tackle social exclusion and joblessness.	Tackle social exclusion and joblessness in the community.	Take opportunities to combat poverty through education, training and employment.
Environmental	Improve safety of roads. Ensure compliance with seatbelt requirements and other road traffic laws. Help set standards for products and appliances. Promote higher standards of safety management.	Improve facilities for pedestrians and cycle paths. Develop safer routes for schools. Adopt traffic calming and other engineering measures and make roads safer. Work for healthier and safer workplaces. Make playgrounds safe. Provide child pedestrian and cycling training.	Check the safety of appliances and use them correctly. Install smoke alarms. Drive safely. Take part in safety management in the workplace.
Lifestyle	Provide information on how to avoid osteoporosis so that accidents don't lead to broken bones. Run public safety campaigns. Ensure strategies are coordinated across	Ensure those in need have aids to prevent accidents, like car seats for babies. Work for whole school approaches to health and safety.	Adopt safe behaviour for themselves and their children. Wear cycle helmets. Wear a seatbelt. Not drink and drive.

	coordinated across Government Departments and Agencies. Provide information on ways to avoid accidents.	Target accident prevention at those most at risk.	Keep physically fit. Eat a balanced diet which contains enough calcium and vitamin D, take regular exercise and stop smoking to protect themselves from osteoporosis.
Services	Encourage health professionals to give appropriate advice. Ensure professionals are trained in accident prevention.	Provide appropriate treatment to high-risk groups to prevent osteoporosis.	Have regular eye-tests. Know emergency routine.

Targeting Cancer Deaths

4.29 The Government has chosen cancer as a priority area, but recognises that a single target in this area will encompass a wide range of different cancers, with different trends, different causes and different scope for prevention, early detection and treatment.

'many cancer deaths are preventable either by tackling factors such as diet, smoking or the environment which cause them or by ensuring speedy diagnosis and treatment'

4.30 Not all cancer deaths are preventable. But many are, either by tackling factors such as diet, smoking or the environment which cause them or by ensuring speedy diagnosis and treatment. *The new NHS* White Paper has committed the health service to ensuring that everyone with suspected cancer will be able to see a specialist within two weeks of their family doctor deciding that they need to be seen urgently. These arrangements will be in place for everyone with suspected breast cancer by April 1999 and for all other cases of suspected cancer by 2000.

'cancers are amongst the commonest causes of death in this country, accounting for one out of every four deaths'

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comments

Chapter 5

Your Views on Better Health

(vi) How should local priorities be determined? On what evidence and by what process?

'national contracts for each priority area will set out clearly who is responsible for delivering progress''your views will be taken into account'

5.1 The potential for improving health and preventing disease is enormous, but it will require a long term and concerted national effort. By focusing on four national priorities we will concentrate our effort. The national contracts for each priority area will set out clearly who is responsible for delivering progress. With targets to focus our action and indicate our progress, there are real opportunities open to improve our country's health and begin to narrow the gap between the health of the worst off and the best off.

5.2 We must encourage as many people as possible to support this approach and to play their part in achieving its ends. Your views will be taken into account when we finalise it later this year. Some of these questions are set out below but all comments on the strategy will be helpful in getting it right.

Chapter Three: A Contract for Health

(i) What are the obstacles to partnerships at local level and how can national Government and local players help to overcome them?
Are there good practice examples from which we can learn?

(ii) Is the overall contract for health comprehensive, or are there other elements which should be added to the national, local and individual roles?

(iii) How can public health research be strengthened?

(iv) What task forces might be required to aid implementation of the strategy? What sort of people should be involved in them?

(v) Have we omitted organisations with a role from this chapter? Are there good practice examples of their contribution?

(vi) How should opinion on fluoridation be tested in local areas?

(vii) What further action should Health Improvement Programmes require?

(viii) How can the Local Authority role in health be strengthened and supported?

(ix) How can we encourage and foster local community action to improve health? Are there examples of good practice?

(x) What structures are needed to ensure effective joint planning at local level?

(xi) What action is need to make healthy schools, healthy workplaces and healthy neighbourhoods a reality? Are there examples of good practice? What are the obstacles to success and how can these be overcome?

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comments

Glossary and Technical Notes

Chapter Four: Targets for Health

(i) Are the priority areas, ie heart disease and stroke, accidents, cancer and mental health the right ones on which to focus the strategy?

(ii) Have the targets been set at the right level?

(iii) Is the approach that is suggested for intermediate targets (i.e. for 2005) appropriate?

(iv) What would you add to the draft national contracts on heart disease and stroke, accidents, cancers and mental health? A blank contract is attached.

(v) How should local inequality targets best be centrally monitored?

(vi) How should local priorities be determined? On what evidence and by what process?

5.3 You can send your responses by detaching and completing the form *Your Views on Better Health* at the end of this Paper, or write to:

The Health Strategy Unit

Room 535

Department of Health

Wellington House

133-155 Waterloo Road

London SE1 8UG

5.4 This Green Paper can be found on the internet at **http://www.open.gov.uk/doh/ohn/ohnhome.htm**

You can also send responses by e-mail to **ohn@doh.gov.uk**

5.5 A summary of this Green Paper is available in English, Hindi, Punjabi, Gujurati, Urdu, Bengali, Chinese, Vietnamese, Greek, Turkish, Somali and Arabic and a taped audio version are available from the **Health Literature Line, 0800 555 777**.

5.6 The closing date for responses to this Green Paper is 30 April 1998.

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comments

References

Proposed National Targets - to reduce mortality from: Heart Disease and Stroke and related illnesses; Cancer; Suicide; and to reduce Accidents.

Target year:

2010 for all four targets.

Baseline year:

Mortality targets: the average of the European age standardised rates for the three years 1995, 1996 and 1997. [NB 1997 data not available until mid-1998, i.e. White Paper stage].

Accident target: the average of the accident rates for the years 1995 and 1996.

Sources of data:

Mortality targets: Office for National Statistics (ONS) mortality statistics from death registrations. Mortality rates are age standardised to allow for changes in the age structure of the population (using the European standard population as defined by the WHO).

Accident target: Estimated "major" accident rates from the Health Survey for England.

Definitions:

Heart Disease and Stroke and related illnesses - includes all circulatory diseases - International Classification of Diseases (ICD) codes 390-459 inclusive.

Age group: under 65.

Target reduction by year 2010 - at least **a further third (33%)**.

Cancer - all malignant neoplasms - ICD codes 140-208 inclusive.

Age group: under 65.

Target reduction by year 2010 - at least **a further fifth (20%)**.

Suicide - suicide and undetermined injury - ICD codes (E950-E959) plus (E980-E989) minus E988.8

Age group: all ages.

Target reduction by year 2010 - at least **a further sixth (17%)**.

Accidents - defined as an accident which is sufficiently severe to require medical attention either at hospital or from a family doctor. Respondents to the Health Survey for England are asked if they had had one or more such accident in the 6 months prior to interview. For children aged 2-15, an adult is asked to respond on their behalf.

Age group: ages 2 and above.

Target reduction by year 2010 - at least **a fifth (20%)**.

Standardised Mortality Ratio (SMR)

The SMR is used to compare mortality rates in different population groupings because it takes account of differences in the age structure of the population. For example, in Figure 5, mortality in different geographical areas of the country is compared with a national standard (SMR for England = 100). If a Health Authority (HA) area has an SMR greater than 100, then the population of that HA has a mortality rate higher than the average for England (after taking account of differences in the age structure of the HA population and the national population).

The **SMR** is calculated as:
Observed number of deaths X 100
Expected number of deaths

The observed number of deaths is the actual number of deaths occurring in the geographical area or subgroup of the population. The expected number is calculated by applying the national age specific mortality rates to the population of the HA area or population subgroup.

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comments

Your Views on Better Health

We want to hear your views on the plans in this document, and would be grateful if you could spare the time to complete this form and return it to us by **30 April 1998**. If you need more space please continue your comments on a separate piece of paper indicating which question you are answering. Please feel free to photocopy this form.

Please detach and send your completed questionnaire to:

The Health Strategy Unit

Room 535

Department of Health

Wellington House

133-155 Waterloo Road

London SE1 8UG

Alternatively, you can send your responses by e-mail to:
ohn@doh.gov.uk

Important Note: Under the code of practice of open government, any responses will be made available to the public on request, unless respondents indicate that they wish their response to remain confidential.

Please tick this box if you want your comments to remain confidential

Questions from Chapter Three

3 (i) What are the obstacles to partnerships at local level and how can national Government and local players help to overcome them? Are there good practice examples from which we can learn?

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3 (ii) Is the overall contract for health comprehensive, or are there other elements which should be added to the national, local and individual roles?

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3 (iii) How can public health research be strengthened?

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3 (v) Have we omitted organisations with a role from this chapter? Are there good practice examples of their contribution?

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3 (x) What structures are needed to ensure effective joint planning at local level?

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Questions from Chapter Four

4 (i) Are the priority areas the right ones on which to focus the strategy?

4 (ii) Have the targets been set at the right level?

4 (iii) Is the approach that is suggested for intermediate targets (ie for 2005) appropriate?

4 (iv) What would you add to the draft national contracts on heart disease and stroke,

accidents, cancers and mental health? A blank contract is attached.

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4 (v) How should local inequality targets best be centrally monitored?

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4 (vi) How should local priorities be determined? On what evidence and by what process?

Q. (M) Personal Details

Title: Mr/Mrs/Ms/Other (please specify)

Surname

First name(s)

Which County/Metropolitan area do you live in?

Is your response a personal one, or are you responding on behalf of an organisation?

Personal Organisation

Organisational respondents only:

1) Please state your organisation's name

---

2) What type of organisation do you represent?

NHS:

Trust

Health Authority

Primary Care provider

Academic

Voluntary/Charity:

Charitable service provider

Other non-statutory group

Local Authority:

Education Department

Environmental Health Department

Social Services Department

Local Authority - Other (please specify department)

Commercial Organisation
(please specify nature of business)

Other (please specify)

Which version of the Green Paper do you have?

Full version

Summary version

Where did you obtain your copy of the Green Paper?

Department of Health mailing

Internet

Other source (please specify)

Unsure

Where did you learn about the Green Paper?

Newspaper/TV/Radio

Journal

Department of Health Communications

NHS Executive Communications

Internet

Other medium (please specify)

What is your overall opinion of the proposals in the Green Paper?

I/we mostly support the proposals

On balance, I/we support the proposals

I/we mostly disagree with the proposals

On balance, I/we disagree with the proposals

Thank you for taking the time to let us know you views. We're sorry that we cannot acknowledge individual responses.

Contract with England to tackle ...	**Government and National Players can:**	**Local Players and Communities can:**	**We all can:**
Social and Economic			
Environmental			
Lifestyle			
Services			

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comments

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comments

The New NHS

DoH logo

Modern · Dependable

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Prepared 8 December 1997

1 A modern and dependable NHS

DoH logo

there when you need it

Key themes

- £1 billion from red tape into patient care
- NHS Direct - 24-hour nurse helpline
- NHS information superhighway
- guaranteed fast-track cancer services

The new NHS

1.1 The Government is committed to giving the people of this country the best system of health care in the world. At its best the National Health Service is the envy of the world. But often it takes too long for patients to get treated. Quality is variable. And NHS staff feel too much of their time and effort is diverted from treating patients into pushing paper. This White Paper explains how the Government, working with those one million staff, will build a modern and dependable health service fit for the twenty first century. A national health service which offers people prompt high quality treatment and care when and where they need it. An NHS that does not just treat people when they are ill but works with others to improve health and reduce health inequalities.

1.2 Achieving this vision means we have to change our approach to tackling ill-health and inequality. The Government will ensure the NHS works locally with those who provide social care, housing, education and employment, just as the Government itself will work nationally across Whitehall to bring about lasting improvements in the public's health. The forthcoming Green Paper Our Healthier Nation will outline this strategy in more detail.

1.3 But we also have to change the way that the NHS itself is run. The introduction of

the internal market by the previous Government prevented the health service from properly focusing on the needs of patients. It wasted resources administering competition between hospitals. This White Paper sets out how the internal market will be replaced by a system we have called 'integrated care', based on partnership and driven by performance. It forms the basis for a ten year programme to renew and improve the NHS through evolutionary change rather than organisational upheaval. These changes will build on what has worked, but discard what has failed.

1.4 The needs of patients will be central to the new system. Abolishing the internal market will enable health professionals to focus on patients, making the NHS better every year. Individual patients, who too often have been passed from pillar to post between competing agencies, will get access to an integrated system of care that is quick and reliable. Local doctors and nurses, who best understand patients' needs, will shape local services. Patients will be guaranteed national standards of excellence so that they can have confidence in the quality of the services they receive. There will be new incentives and new sanctions to improve quality and efficiency. Frontline patient services will be backed by more investment and better technology. These changes will bring a more responsive and dependable service to every community in England.

1.5 The Government has committed itself anew to the historic principle of the NHS: that if you are ill or injured there will be a national health service there to help; and access to it will be based on need and need alone - not on your ability to pay, or on who your GP happens to be or on where you live. The NHS has stood the test of time for fifty years. But the Government was elected with a mandate to change the NHS for the better. This White Paper will modernise the NHS so that it is prepared for the next fifty years.

The Goverment's Commitment

If you are ill or injured there will be a national health service there to help: and access to it will be based on need and need alone - not on your ability to pay, or on who your GP happens to be or on where you live.

1.6 The speed of change in science and medicine and the potential of modern information and communication systems require the NHS to embrace change. A modern and dependable national health service will capture developments in modern medicine and information technology. It will be built around the needs of people, not of institutions and it will provide prompt reliable care. It will learn from those at the leading edge of good practice and will make the best available to all.

1.7 Realising this vision of a modern and dependable NHS means providing:

- **at home:** easier and faster **advice and information** for people about health, illness and the NHS so that they are better able to care for themselves and their families
- **in the community: swift advice and treatment in local surgeries and health centres** with family doctors and community nurses working alongside other health and social care staff to provide a wide range of services on the spot
- **in hospital: prompt access to specialist services** linked to local surgeries and health centres so that entry, treatment and care are seamless and quick.

1.8 Some of these developments are already available to some patients, but not everywhere. The Government wants to see them available to all as part and parcel of the new NHS.

1.9 This is an ambitious programme which cannot happen overnight. It will be achieved over ten years with demonstrable improvements each year. We have already made a start. The process of modernisation began on May 2nd, the day after the election. Since then the worst excesses of the internal market have been tackled and extra resources devoted to patient care.

1.10 The changes in this White Paper will take forward the modernisation of the NHS. The Government has pledged to cut waiting lists for hospital treatment. By the end of this Parliament we will have done so. But more needs to be done at all levels if the vision is to be made real. Three developments will symbolise our new approach.

1.11 At home: we will provide easier and faster advice and information through NHS Direct, a new 24 hour telephone advice line staffed by nurses. We will pilot this through three care and advice helplines to begin in March 1998. The whole country will be covered by 2000.

1.12 In the community: patients will benefit from quicker test results, up-to-date specialist advice in the doctor's surgery and on-line booking of out-patient appointments, when we connect every GP surgery and hospital to NHSnet, the NHS's own information superhighway. It could also mean less waiting for prescriptions in the pharmacy because of electronic links between GPs and pharmacists. As a first step, by the end of 1998 demonstration sites will be established in every Region to pilot how the NHSnet can be used to bring direct benefits to patients. As a second step, by the end of 1999 all computerised GP surgeries will be able to receive some hospital test

results over NHSnet. By 2002, these services will be available across the country.

1.13 In hospital: we will improve prompt access to specialist services so that everyone with suspected cancer will be able to see a specialist within two weeks of their GP deciding they need to be seen urgently and requesting an appointment. We will guarantee these arrangements for everyone with suspected breast cancer by April 1999 and for all other cases of suspected cancer by 2000.

1.14 These developments, along with the pledge to cut waiting lists, will chart progress to a quicker and more responsive NHS. They will demonstrate that services to patients are getting better every year.

The Challenge

1.15 Some say that this vision is not just ambitious, but unachievable; that tailoring the NHS to meet the needs of individual patients is simply beyond its capacity. They believe that the NHS is being overwhelmed by three big pressures: growing public expectations, medical advances and demographic changes.

1.16 It is certainly true that people do expect more, especially in speed of service and range of treatment. The pace of medical advance does create demands for new techniques to be assimilated and spread. And rising numbers of elderly people are looking to the NHS for a level of active treatment which would have been unimaginable in the past.

1.17 Those who argue that the NHS cannot accommodate these pressures say that it will need huge increases in taxation, a move to a charge-based service, or radical restrictions in patient care.

1.18 The Government rejects this analysis. So do the public. The recent British Social Attitudes Survey showed that three-quarters of people want the NHS to remain a universal health service. Two-thirds believe that health care should be available to all on the basis of need, not ability to pay. Nor are the arguments in favour of rationing or charging convincing.

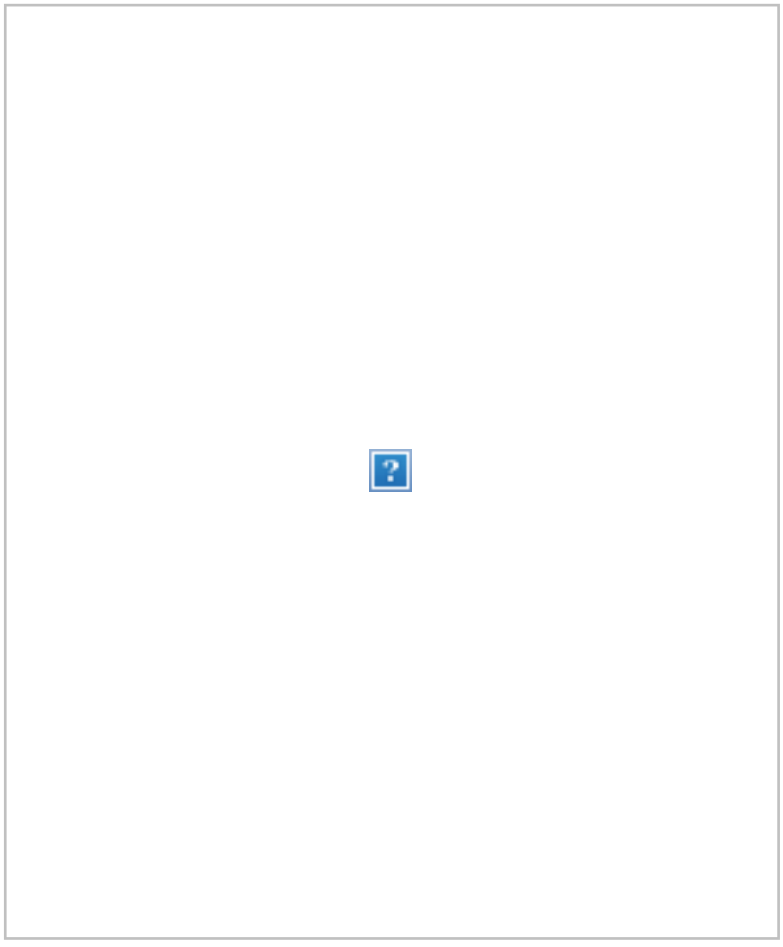
1.19 First, the pressures on the NHS are exaggerated. Indeed they have always been exaggerated. It was Nye Bevan who noted some 50 years ago that "expectations will always exceed capacity". Rising public expectations should be channelled into shaping

services to make them more responsive to the needs and preferences of the people who use them. Many women, for example, have welcomed the opportunity to plan the arrangements for the birth of their child with midwives as well as doctors. Our new NHS Charter will balance the patient's rights of access to NHS services with their responsibility to use services wisely.

1.20 The health service is a strong and resilient organisation. It has risen to daunting challenges over the past ten years, such as AIDS, more operations for coronary artery bypass grafts, and new drugs for stomach ulcers. Of course many new problems lie ahead but not all will increase the health care bill. As technology advances, allowing less invasive and hence cheaper treatments, costs in certain areas will be reduced. Heart catheters, in some cases, could increasingly replace bypass grafts, for example, or more day surgery could reduce expensive inpatient care. Taking a longer term view, the Government's new emphasis on improving public health and tackling inequalities will also help.

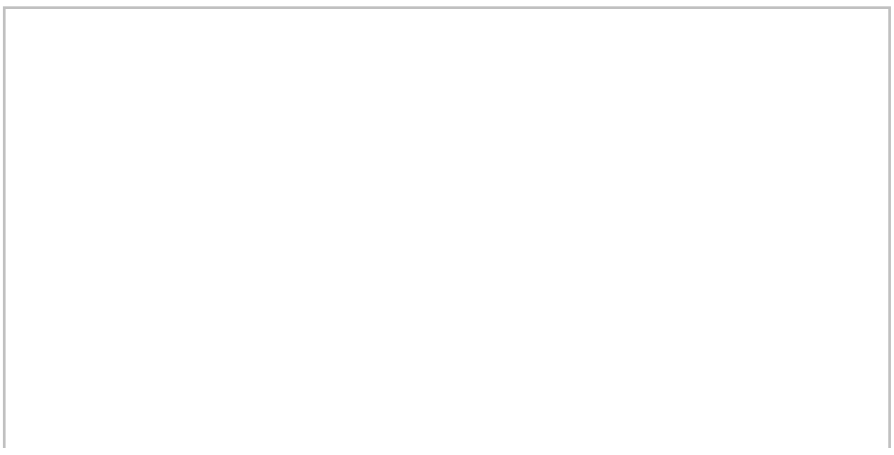
1.21 Likewise demographic pressures can be overstated. Over the next decade the NHS expects to provide services for an extra 100,000 people aged 85 and over; but that is just one-third of the increase that it has coped with over the last decade.

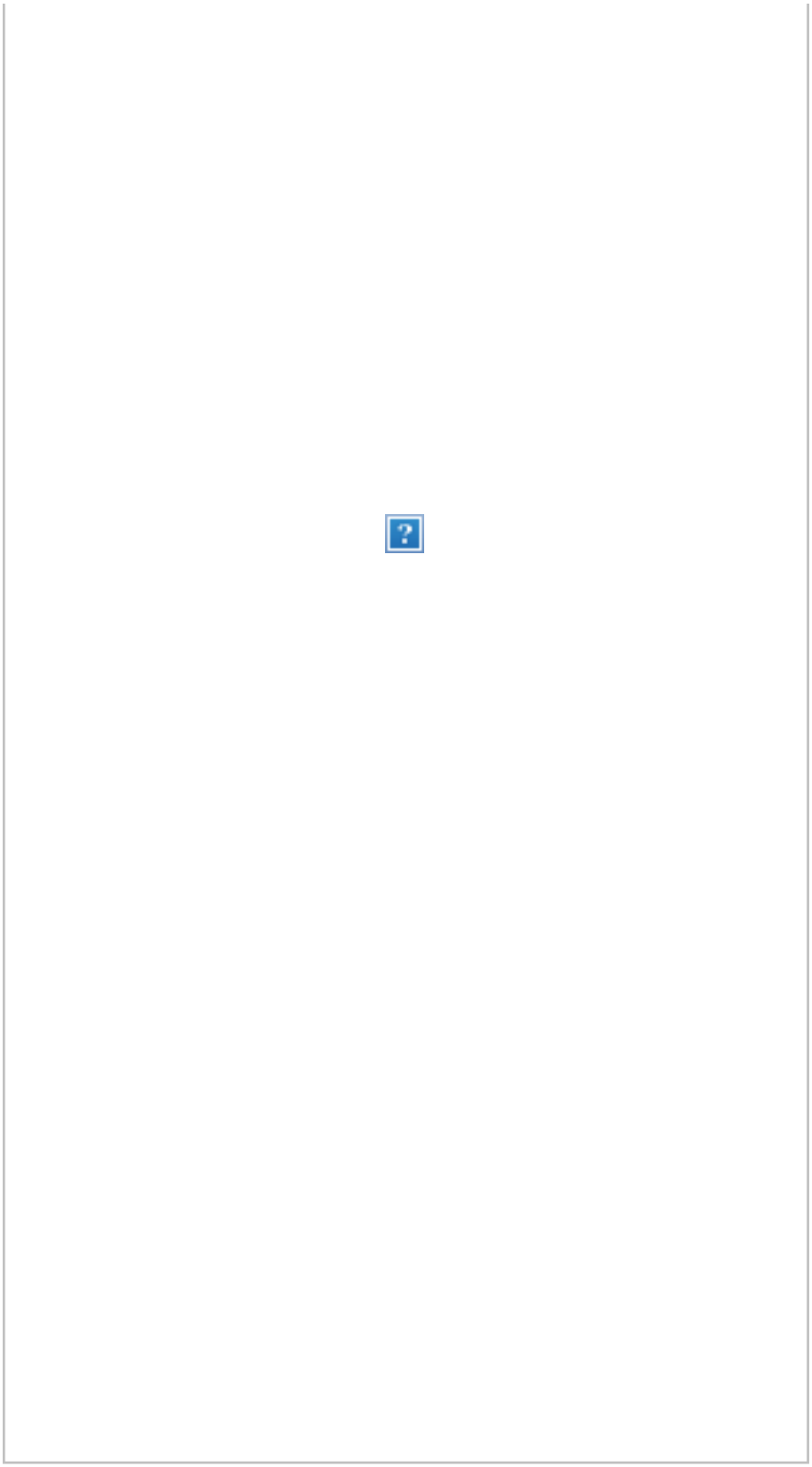
Demographic pressures



1.22 Second, the choice posed between unaffordable levels of funding or charges and rationing is a false dilemma. No-one denies that the NHS needs more money every year. With this Government the health service will get it. We are committed to increasing spending on the NHS in real terms every year. But there are three other changes that will ensure better value for money in the NHS:

- the NHS needs to make better use of its resources. The internal market has driven up administrative costs. The Government's changes will reduce costs by £1 billion over the lifetime of the current Parliament. Fragmentation in decision-making has lost the NHS the cost advantages that collaboration can bring. Cooperation and efficiency go hand in glove. The proposals in this White Paper will produce a new drive on efficiency, quality and performance in the NHS
- the NHS should harness new developments rather than be driven by them. There are already mechanisms in place to evaluate new technologies, and to measure the clinical and cost-effectiveness of treatments. NHS funded research has, for example, already shown that universal screening for prostate cancer would not be worthwhile and new approaches to prescribing in primary care are helping to deliver better care at lower cost. But the take-up of research findings on clinical and cost-effectiveness is uneven and unsystematic. For example there are big variations in day case rates. In order to sustain the NHS, while making it both modern and dependable, this White Paper proposes a new drive for quality. Two new national bodies will lead rigorous assessment of clinical and cost-effective treatments and will ensure good practice is adopted locally
- decisions about how best to use resources for patient care are best made by those who treat patients - and this principle is at the heart of the proposals in this White Paper. For the first time in the history of the NHS the Government will align clinical and financial responsibility to give all the professionals who make prescribing and referring decisions the opportunity to make financial decisions in the best interests of their patients. That will better attune local services to meet local needs. But the Government will set a framework of national standards and will monitor performance to ensure consistency and fairness.





1.23 There is another reason why it makes sense to sustain the NHS as a universal service. The health of the economy depends on the health of the NHS. It helps ensure a healthy workforce. But it does much more besides. The NHS funded through general taxation is the fairest and most efficient way of providing health care for the population at large. Systems in other countries cost more, are less fair, and deliver little overall extra benefit. The cost-effectiveness of the NHS helps to reduce the tax burden

to well below the European Union average, encouraging investment and strengthening incentives to work and save. The alternatives - rationing or a 'charge-based' system - would dissipate these advantages.

1.24 But it is clear there are tough choices facing the NHS. It has to improve its performance if it is to deliver the sort of services patients need. There will have to be big gains in quality and big gains in efficiency across the whole NHS. The two go together. They will bring about marked improvements in services to patients over the next ten years. This White Paper spells out how the NHS will meet that challenge. There can be no standing still. The next two chapters outline the Government's approach. The subsequent chapters set out the arrangements in detail, showing how they will work in practice. They are the means to deliver a modern and dependable health care system that will once again lead the world. A new NHS for a new century.

 Prepared 8 December 1997

Chapter 1

Fit for the 21st Century

Figure 1.
Life expectancy and healthy life expectancy

At birth, Great Britain 1994

Source: Bebbington and Darton (1996),
from Office for National Statistics (ONS) data.

*Limiting long-standing illness - based on a positive response to the following questions in the General Household Survey:
(1) Do you have any long-standing illness, disability or infirmity?
(2) Does the illness or disability limit your activities in any way?

This chart presents Healthy Life Expectancy calculated on the basis of self-reported "limiting long-standing illness". Extra years of life gained over recent years have on the basis of this methodology, been years of mild to moderate disability. Other research however suggests that with respect to measures of more severe disability, healthy life expectancy at age 65 years has shown some improvements alongside total life expectancy. The extra years of life have not therefore been years of severe disability.

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Chapter 1

Fit for the 21st Century

Figure 2.
Life expectancy by social class

Males at birth England and Wales 1972-1991

Source: adapted from Drever and Whitehead (eds), Health Inequalities, ONS, (1997), using data from ONS Longitudinal Study

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Chapter 1

Fit for the 21st Century

Figure 3.
Infant mortality rate*

By mother's country of birth, deaths in England and Wales
1994-1996 combined

*Deaths before age 1 per 1,000 live births.

Source: ONS Monitors DH3 (1995, 1996, 1997).

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Chapter 1

Fit for the 21st Century

Figure 4.
Mortality from lung cancer by social class

Men, aged 20-64 England and Wales 1991-1993

Source: Drever and Whitehead (eds), Health Inequalities ONS, (1997) using data from death registrations and 1991 Census.

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Chapter 1

Fit for the 21st Century

Figure 5.
Geographical inequalities in mortality

By Health Authority, persons aged 15-64 1994-1996

Standardised Mortality Ratios (SMRs) from all causes.
(see glossary)

Source: Public Health Common Data Set 1997 (from ONS data)

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Chapter 1

Fit for the 21st Century

Figure 6.
Expectation of life at birth

European Union circa 1995*

*Data for 1995 except for Austria 1996; Denmark and France 1994; Ireland, Italy and Spain 1993; Belgium 1992.

Figures for England calculated by Government Actuary's Department, by slightly different methodology to WHO figures, (however this does not affect the ranking of the countries).

Source: WHO Health For All statistical database and Government Actuary's Department.

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Chapter 2

The Causes of Ill Health

Figure 7.
Employment, unemployment* and mortality

By sex, England and Wales 1981-1992

*Unemployment = People currently unemployed but seeking work. The chart does not include those who are permanently sick or disabled, or inactive for other reasons.

Source: Drever and Whitehead (eds), Health Inequalities ONS, (1997) using data from ONS Longitudinal Study.

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Chapter 2

The Causes of Ill Health

Figure 8.
The health risks of cigarette smoking

Source: based on Smoke-free for Health, DOH (1994), from US Office on Smoking and Health, Centers for Disease Control and Prevention Report, (1990).

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Chapter 2

The Causes of Ill Health

Figure 9.
Mortality from coronary heart disease

Males, aged 20-69 by selected country of birth,
deaths in England and Wales 1989-1992

Source: S Wild & P McKeigue (1997),
BMJ volume 314 (from ONS data).

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The Causes of Ill Health

Figure 10.
Mortality from injury and poisoning in children aged 0-15 years

By social class England and Wales 1989-1992

Source: I Roberts & C Power (1996),
BMJ volume 313 (from ONS data).

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Figure 11.
Mortality rates*from suicide and undetermined injury

By age and sex, England1969-1996

3 year average rates

*Each age group has been separately age standardised, ie
adjusted for differences in the age structure of the population.

Source: ONS Mortality Statistics (ICD E950-E959,E980-E989 less E988.8).

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Figure 12.
Mortality rates from lung cancer

By sex, England1969-19963 year average rates

3 year average rates

Source: ONS Mortality Statistics (ICD 162).

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Figure 13.
Mortality rates from lung cancer

By Regional Office Area, males aged under 75, England1996

Age Standardised Mortality Rate per 100,000.

Source: Public Health Common Data Set 1997(from ONS data).

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comments

A Contract for Health

on this site.

Figure 14.
Mortality rates[Ý] from Stroke

England 1969-1996
All persons aged under 65

3 year average adjusted rates*

ÝRates are calculated using the European Standard
Population to take account of differences in age structure.

*The rates for 1984 to 1992 have been adjusted to be on broadly the same basis as those for 1969 to 1983 and 1993 to date, using factors provided by ONS. There is a small discontinuity between the years 1978 and 1979 due to a change in coding from ICD8 to ICD9 which slightly affects the comparability of data.

Source: ONS (ICD 430:438).

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Figure 15.
Major causes of mortality

Under 65 years by sex, England1996

*Deaths occurring at ages under 28 days are included in the totals but are not allocated to a specific cause of death. These are therefore included in "Other". The major categories presented in this figure are those which have been identified as priority areas for *Our Healthier Nation*. All remaining causes of death have been assigned to the "Other" category.

Source: ONS Mortality Statistics.

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Figure 16.
Mortality from stroke

Females, aged 20-69 by selected country of birth,
deaths in England and Wales 1989-1992

Source: S Wild & P McKeigue (1997),
BMJ volume 314 (from ONS data).

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Figure 17.
Mortality from coronary heart disease by social class

Men, aged 20-64 England and Wales1991-1993

Source: Drever and Whitehead (eds), Health Inequalities, ONS, (1997) using data from ONS death registrations and 1991 Census.

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Figure 18.
Mortality from circulatory diseases

European Union aged under 65 circa 1995*

*Data for 1995 except for Austria 1996; Denmark and France 1994; Ireland, Italy and Spain 1993; Belgium 1992.

Source: WHO Health For Allstatistical database.

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Figure 19.
Inequalities in mortality rates from accidents in young people aged 15-24

By Health Authority,1994-1996
10 highest and 10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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Figure 19 cont.
Inequalities in mortality rates from accidents in young people aged 15-24

By Health Authority,1994-1996
10 highest and 10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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Figure 19 cont.
Inequalities in mortality rates from accidents in young people aged 15-24

By Health Authority,1994-1996
10 highest and 10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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Targets for Health

4.31 **Cancer deaths** have been chosen as a national target because:

- cancers are amongst the commonest causes of death in this country, accounting for one out of every four deaths - almost 130,000 each year. An even greater percentage of deaths occur at younger ages, one in three deaths under the age of 65 years - a total of nearly 32,000 deaths each year;
- the chance over a lifetime of being diagnosed as having cancer is almost 4 in 10 for men and only marginally less in women;
- cancer is the threat to our health which many of us fear most;
- there is much that can be done to reduce the death rate from cancers. The main causes of cancer deaths are illustrated in figure 20;
- there is very marked social class inequality in who dies from cancer. For example amongst men of working age the most recent figures show that the death rate for all cancers combined was twice as great in unskilled workers as in professionals. This inequality was worse for some types of cancers such as stomach cancer (three times as great in unskilled workers) and particularly lung cancer (four times as great);
- marked geographical inequalities also exist with, for example, death rates from lung cancer being about 20% higher in the north of the country than the national average. Death rates from cancer of the cervix follow a similar geographical pattern, but, by contrast, for malignant melanoma of the skin the highest rates occur in the southernmost parts of the country (see figure 21).

'there is very marked social class inequality in who dies from cancer'

- many of these cancer deaths could be avoided, either by preventing the disease (for example in lung cancer) or by early detection and treatment (for example in breast cancer). Prevention and early diagnosis which focuses particularly on cancers such as lung, breast, cervix, malignant melanoma of the skin, and colorectal cancer could have a major impact on reducing the overall burden from this disease;
- progress in tackling the factors which lead to preventable cancer deaths should help us to make progress in other areas which affect our health.

'progress in tackling the factors which lead to preventable cancer deaths should help us to make progress in other areas which affect our health'

Figure 20
Figure 21
Figure 21a
Figure 21b

4.32 We intend to set a single cancer target, **to reduce the death rate from cancer amongst people aged under 65 years by at least a further fifth (20%) by 2010 from a baseline at 1996** (see glossary). A reduction of this order, if it had occurred in 1996, would have resulted in some 6,000 deaths in this age group being avoided.

4.33 Figure 22 shows that Finland and Sweden are the best performing countries in the European Union. If we can achieve our target it would bring us to the levels currently experienced by these countries. The proposed target therefore represents a considerable challenge.

Figure 22

4.34 This is further illustrated by the fact that the target encompasses all cancers including those such as colorectal cancer

where opportunities for reducing incidence and mortality are not as clear cut as is the case with lung or breast cancer. There is also evidence that the incidence of cancer overall may have been increasing in recent years. Whilst reduction of risk factors such as smoking is of considerable importance in reversing this trend, progress remains challenging.

4.35 There remains, however, scope for improving the management and treatment of cancers, and this is being taken forward through the implementation of the Calman/Hine report in the context of the Government's strategy for cancer services and its overall commitment to improving the quality of care in the NHS. Thus prevention and better management both have a role to play in achieving the proposed target.

'if we can achieve our target it would bring us to the levels currently experienced by the best performaning countries in the European Union'

4.36 A draft national contract on cancers, which sets out some, but not all, of the action necessary, is set out opposite.

A National Contract on Cancer	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	Continue to make smoking more costly through taxation. Tackle joblessness, social exclusion, low educational standards and other factors which make it harder to live a healthier life.	Tackle social exclusion in the community to make it easier for people to make healthy choices. Work with deprived communities and with businesses to ensure a more varied and affordable choice of food.	Take opportunities to better their lives and their families' lives through education, training and employment.
Environmental	Encourage employers and others to provide a smoke-free environment for non-smokers. Encourage local action to tackle radon in the home. Continue to press for international action to restore the ozone layer.	Through local employers and others, provide a smoke-free environment for non-smokers. Tackle radon in the home.	Protect others from second-hand smoke. Cover up in the sun.
Lifestyle	End advertising and promotion of cigarettes. Prohibit sale of cigarettes to youngsters and ensure enforcement. Support Healthy Living Centres. Provide reliable and objective information on the health risks of smoking, poor diet and too much sun.	Encourage the development of healthy workplaces and healthy schools Target health information on groups and areas where people are most at risk	Stop or cut down smoking and watch what they eat. Be careful when they are in the sun and ensure that young children are not exposed to too much sun. Follow sensible drinking advice.
Services	Encourage doctors and nurses and other health professionals to give advice on prevention. Ensure that healthy schools work with pupils and parents to improve health. Implement effective and high-quality cancer screening programmes. Ensure equal access to high-quality treatment and care.	Provide help in stopping smoking to people who want to stop. Improve access and availability to a variety of affordable food in deprived areas. Ensure hard-to-reach groups come forward for cancer screening services. Ensure rapid treatment for cancers when they are diagnosed.	Attend cancer screenings when invited. Seek medical advice promptly if they are worried.

'mental health is a key component of a healthy active life'

Targeting Mental Health

4.37 The Government proposes to adopt a national target for mental health because:

- the national strategy must reflect more than just the absence of physical disease and be a basis for efforts which acknowledge a more rounded idea of good health;
- mental health is a key component of a healthy active life and poor mental health is a risk factor for many physical health problems;
- mental health problems are a major cause of ill health: the 1995 Health Survey for England showed that 20% of women and 14% of men may have had a mental illness [35]; mental disorders accounted for an estimated 17% (more than £5 billion) of total expenditure on health and social services in 1992/93 (the largest single cause) [3] they also accounted for 15% and 26% of days of certified incapacity in the early 1990s in men and women respectively;
- there is evidence of an increase in poor mental health in children and young people over the last three decades, particularly in young people who are socially disadvantaged [36]. Early action in a child's life may improve their health and mental health in later life;
- there are marked inequalities in who suffers most from mental health problems; for example men of working age who are unskilled workers are more than twice as likely to commit suicide than men in the overall population (see figure 23) and women are more likely to suffer from anxiety, depression, phobias and panic attacks (see figure 24);
- similarly women born in Sri Lanka, India and the East African Commonwealth are approximately 50% more likely to commit suicide than women in the population as a whole (see figure 25);
- suicides are a significant cause of early death, and are responsible each year for nearly half a million years of life lost in those aged under 75 years.

Figure 23
Figure 24
Figure 25

4.38 The causes of poor mental health are complex and the Government would welcome views on how best to monitor progress with a single national target.

'to hit this target will require significant successes in suicide prevention among groups of people in which this is particularly difficult, such as the severely mentally ill'

4.39 Overall suicide rates have been falling in recent years (though the pattern is different in different population groups such as young men, or women from certain ethnic minority groups). Nevertheless, there is considerable scope for further improvement. A possible target in this area would be **to reduce the death rate from suicide and undetermined injury by at least a further sixth (17%) by 2010, from a baseline at 1996** (see glossary). A reduction of this order, if it had occurred in 1996, would have saved about 800 lives.

4.40 To hit this target will require significant successes in suicide prevention among groups of people in which this is particularly difficult, such as the severely mentally ill.

4.41 An alternative option would be to develop a target which tracked poor mental health rather than mortality and we would welcome views on whether this would be practicable.

4.42 A draft national contract is set out opposite, covering some of the measures that might be taken to meet the national target.

A National Contract on Mental Health	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	Tackle joblessness, social exclusion and other factors	Develop local support networks, eg for recently widowed/bereaved, lone	Develop parenting skills.

	which make it harder to have a healthier lifestyle. Tackle alcohol and drug misuse.	parents, unemployed people and single people. Develop court diversion schemes. Develop job opportunities for people with mental illness. Develop local strategies to support the needs of mentally ill people from black and minority ethnic groups.	Support friends at times of stress - be a good listener. Participate in support networks. Take opportunities to better their lives and their families' lives through education, training and employment.
Environmental	Continue to invest in housing and reduce homelessness. Encourage employers to address workplace stress. Reduce isolation through transport policy. Promote healthy schools. Address levels of mental illness amongst prisoners.	Develop effective housing strategies. Reduce stress in workplace. Improve community safety.	Improve workload management.
Lifestyle	Increase public awareness and understanding of mental health. Reduce access to means of suicide. Support Healthy Living Centres.	Focus on particular high- risk groups, eg young men, people in isolated rural communities. Encourage positive local media reporting. Develop and encourage use of range of leisure facilities.	Use opportunities for relaxation and physical exercise and try to avoid using alcohol/smoking to reduce stress. Increase understanding of what good mental health is.
Services	Develop standards and training for primary care and specialist mental health services. Improve recruitment/ retention of mental health professionals. Identify/advise on effective treatment and care. Develop protocols to guide best practice.	Promote high-quality pre-school education and good mental health in schools and promote educational achievement. Ensure mental health professionals are well trained and supported. Develop a range of comprehensive mental health services for all age groups and alcohol and drug services for young people and adults. Support carers of people with long-term disability and chronic illness. Provide advice on financial problems. Develop culturally sensitive services.	Contribute information to service planners and get involved. Contact services quickly when difficulties start. Increase knowledge about self-help.

'the broader nature of these national targets offers additional challenges and opportunities compared with the previous

strategy'

Continuity

4.43 The four national targets in *Our Healthier Nation* build on any success already achieved under *Health of the Nation*. The small number of national targets proposed for *Our Healthier Nation* will offer greater flexibility to focus on particular local health problems and on health inequality. And the broader nature of these national targets offers additional challenges and opportunities compared with the previous strategy. For example:

- the accidents target now addresses a much wider range of accidents, rather than focusing only on fatal accidents;
- the new cancer target includes all cancers, so cancers which were not covered in the earlier strategy will have to be addressed through improved prevention, diagnosis and treatment as part of *Our Healthier Nation*.

'health Improvement Programmes will identify additional priorities'

Local Priorities and Targets

4.44 One reason for limiting the number of national priority areas is to maximise the scope for local flexibility in setting additional local priorities which reflect the particular health problems of local communities.

4.45 In addition to local strategies and local targets for meeting the national targets, Health Improvement Programmes will identify a small number of additional priorities to tackle particular pressing local problems and to reduce health inequalities. For example, although nationally we are concerned that teenage conceptions are damaging the health and social well-being of young mothers and their babies, the incidence is not spread evenly across the country, so setting a national target in this area might be less relevant for some localities. For others it will be a high priority and they will want to target this problem locally.

4.46 The Government is considering how progress on these local targets can be monitored nationally and whether progress on similar problems in different localities can be aggregated nationally.

4.47 Some of the possible local priority areas are set out opposite.

Possible Local Priorities and Targets

Asthma and other respiratory problems -*Asthma is a common condition which can not only lead to death, with over 1,200 dying in 1996, but disrupts education, and is a medical condition often cited by adults as impairing their ability to play a full part in life. Better ways of managing this illness can reduce the health and social problems it can cause.*

Teenage Pregnancy -*Teenage conceptions (particularly for the under 16s) can harm both the health of the mother and the baby and we have high rates compared with the rest of Europe.*

Infant Mortality -*Although trends show improvement, the continuing inequalities in this area mean that it will be an important focus for action in many areas.*

Back Pain, Rheumatism and Arthritis -*In a survey of people over 65 in Great Britain in 1994, 18% said they had longstanding problems with arthritis, 7% said they had "problems with bones" and 4% had back problems.*

Environment -*In areas where housing, homelessness, pollution, or radon are of concern, Health Improvement Programmes may include targets to tackle these influences on health.*

Diabetes -*Diabetes affects more than one in fifty people in the population and can lead to blindness, kidney failure, amputations and heart disease. In addition to prevention efforts, better management of the disease can help to reduce these problems.*

Oral Health -*There are serious inequalities in the levels of tooth decay, both socially and geographically.*

Vulnerable Groups -*In order to address the health needs of specific groups of people whose health is of particular concern, local strategies might address the needs of different minority ethnic groups, homeless people, single parents, socially isolated people, people with learning disabilities, people on low income or refugees.*

4.48 To ensure some continuity, Health Improvement Programmes could, where possible, also include progress against the old health strategy's targets as indicators of progress on the health of the local population.

4.49 In localities where health is already better than suggested by the targets we must safeguard against complacency and ensure that further improvements are still achieved. Areas in this position may need to use benchmarks based on the standards achieved in other countries in order to seek further improvements to the health of their populations, or seek to target particular inequalities in health in their local populations.

Targeting Inequality

4.50 Inequalities in health have worsened in the past two decades. They are a consequence of the widening of social and economic inequalities. While inequalities can worsen in a matter of years, improvements can take much more time, even decades, to achieve. Whilst for some conditions it may be possible to close the gap more quickly, it must be recognised that the overall inequalities in health will only be resolved through long term, sustained and coordinated efforts and not through quick fixes. A sense of realism on the difficulties we face in addressing health inequalities is vital, because false optimism and unreasonable expectations in the short term will only sabotage the long term effort.

'for the first time ever the health strategy will require local policy makers to set targets for reducing health inequalities'

4.51 The NHS White Paper signalled that for the first time ever the health strategy will require local policy makers to set targets for reducing health inequalities. The groups and areas who suffer the most from ill health and early death must be a key focus of both local and national activity. Progress on the national targets must not be secured simply by targeting social or ethnic groups whose health problems are more easily tackled. This could have the effect of widening health inequalities. In addition to looking at the health of the whole population, each Health Improvement Programme will need to set out how progress is to be achieved by tackling the health problems of those local neighbourhoods or groups which suffer more from poor health than others. Taken together this will mean a pioneering concerted national effort to reduce health inequalities, fully monitored by the Regional Offices of the NHS Executive. We would welcome views on how local inequalities targets can best be monitored centrally.

The Independent Inquiry into Health Inequalities

The Government has asked Sir Donald Acheson, former Chief Medical Officer, to report on the main trends in health inequalities and to identify the areas of policy which evidence suggests are most likely to make a difference. His report will help the Government in developing the White Paper for *Our Healthier Nation* later this year. The terms of reference of the Inquiry are:

- "To moderate a Department of Health review of the latest available information on inequalities in health, using data from the Office for National Statistics, the Department of Health and elsewhere. The data review would summarise the evidence of inequalities of health and expectation of life in England and identify trends.

- In the light of that evidence, to conduct - within the broad framework of the Government's overall financial strategy - an independent review to identify priority areas for future policy development, which scientific and expert evidence indicates are likely to offer opportunities for Government to develop beneficial, cost effective and affordable interventions to reduce health inequalities.

- The review will report to the Secretary of State for Health. The report will be published and its conclusions, based on evidence, will contribute to the development of a new strategy for health."

4.52 The Government will consider the scope for national targets on inequalities in the light of consultation on the Green Paper and the Independent Inquiry into Health Inequalities.

'the Government will consider the scope for national targets on inequalities in the light of consultation on the Green Paper'

Monitoring Progress

4.53 Technical details on monitoring the targets will be published with the White Paper. We will also need to consider ways of monitoring and evaluating local processes to build and share knowledge on the effectiveness of different strategies, techniques and activities.

4.54 In monitoring progress, we will be able to draw on a range of sources of data, such as mortality statistics, cancer registration, hospital episode data, general practitioner data, and various national surveys, for example the Health Survey for England and National Food Survey. The new health strategy will be very broadly based. For the determinants of health, for instance, in addition to the data sources described above, national and local data from, for example, education, employment, transport and the environment will be relevant to the development of the strategy and the monitoring of progress and interpretation of change. We will make full use of sources of comparative information like the Public Health Common Data Set to assist in the presentation of health data in a consistent and comparable form at local level. Other local sources will need to be exploited.

Questions for Consultation

(i) Are the priority areas, ie heart disease and stroke, accidents, cancer and mental health the right ones on which to focus the strategy?

(ii) Have the targets been set at the right level?

(iii) Is the approach that is suggested for intermediate targets (ie for 2005) appropriate?

(iv) What would you add to the draft national contracts on heart disease and stroke, accidents, cancers and mental health? A blank contract is attached.

(v) How should local inequality targets best be centrally monitored?

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comments

Figure 20.
Main causes of cancer mortality

By sex, England 1996

Source: ONS Mortality Statistics.

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comments

Figure 21.
Inequalities in mortality rates from malignant melanoma

By Health Authority,1994-1996
10 highest and10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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comments

Figure 21 cont.
Inequalities in mortality rates from malignant melanoma

By Health Authority,1994-1996
10 highest and10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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Figure 21 cont.
Inequalities in mortality rates from malignant melanoma

By Health Authority,1994-1996
10 highest and10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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comments

Figure 22.
Mortality from all cancers

European Union aged under 65 circa 1995*

*Data for 1995 except for Austria 1996; Denmark and France 1994; Ireland, Italy and Spain 1993; Belgium 1992.

Source: WHO Health For All statistical database.

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comments

Figure 23.
Mortality from suicide by social class

Men, aged 20-64 England and Wales1991-1993

Source: Drever and Whitehead (eds), Health Inequalities, ONS, (1997) using data from ONS death registrations and 1991 Census.

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comments

Figure 24.
Prevalence of any neurotic disorder*

By sex and age, Great Britain 1993/1994

Adults aged 16-64

*Includes anxiety, depression, phobias, panic disorder

Source: ONS Psychiatric Morbidity Survey Report 1 (1995).

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comments

Figure 25.
Mortality from suicide

Females, aged 15-64 by selected country of birth, deaths in England and Wales 1988-1992

Source: V Soni Raleigh (1996), Ethnicity and Health 1 (from ONS data).

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comments

2 A new start

DoH logo

what counts is what works

Key themes

- the third way
- keeping what works
- discarding what has failed

The third way

2.1 In paving the way for the new NHS the Government is committed to building on what has worked, but discarding what has failed. There will be no return to the old centralised command and control systems of the 1970s. That approach stifled innovation and put the needs of institutions ahead of the needs of patients. But nor will there be a continuation of the divisive internal market system of the 1990s. That approach which was intended to make the NHS more efficient ended up fragmenting decision-making and distorting incentives to such an extent that unfairness and bureaucracy became its defining features.

2.2 Instead there will be a 'third way' of running the NHS - a system based on partnership and driven by performance. It will go with the grain of recent efforts by NHS staff to overcome the obstacles of the internal market. Increasingly those working in primary care, NHS Trusts and Health Authorities have tried to move away from outright competition towards a more collaborative approach. Inevitably, however, these efforts have been only partially successful and their benefits have not as yet been extended to patients in all parts of the country.

2.3 This White Paper will put that right. It builds on the extensive discussions we have held with a wide range of NHS staff and organisations. It will develop this more collaborative approach into a new system for the whole NHS. It will neither be the model from the late 1970s nor the model from the early 1990s. It will be a new model

for a new century.

Six key priciples

2.4 Six important principles underlie the changes we are now proposing:

- first, to renew the NHS as a genuinely **national** service. Patients will get fair access to consistently high quality, prompt and accessible services right across the country
- but second, to make the delivery of healthcare against these new national standards a matter of **local** responsibility. Local doctors and nurses who are in the best position to know what patients need will be in the driving seat in shaping services
- third, to get the NHS to work in **partnership**. By breaking down organisational barriers and forging stronger links with Local Authorities, the needs of the patient will be put at the centre of the care process
- but fourth, to drive **efficiency** through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients
- fifth, to shift the focus onto quality of care so that **excellence** is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service
- and sixth, to rebuild **public confidence** in the NHS as a public service, accountable to patients, open to the public and shaped by their views.

Keeping what works

2.5 There are some sound foundations on which the new NHS can be built. Not everything about the old system was bad. This Government believes that what counts is what works. If something is working effectively then it should not be discarded purely for the sake of it. The new system will go with the grain of the best of these developments.

2.6 The Government will retain the separation between the planning of hospital care and its provision. This is the best way to put into practice the new emphasis on improving health and on meeting the healthcare needs of the whole community. By empowering local doctors, nurses and Health Authorities to plan services we will

ensure that the local NHS is built around the needs of patients. Hospitals and other agencies providing services will have a hand in shaping those plans but their primary duty will be to meet patients' requirements for high quality and easily accessible services. The needs of patients not the needs of institutions will be at the heart of the new NHS.

2.7 The Government will also build on the increasingly important role of primary care in the NHS. Most of the contact that patients have with the NHS is through a primary care professional such as a community nurse or a family doctor. They are best placed to understand their patients' needs as a whole and to identify ways of making local services more responsive. Family doctors who havebeen involved in commissioning services (either as fundholders, or through multifunds, locality commissioning or the total purchasing model) have welcomed the chance to influence the use of resources to improve patient care. The Government wishes to build on these approaches, ensuring that all patients, rather than just some, are able to benefit.

Primary and Community Services

Most people look first to their family doctor or local pharmacist for advice on health matters. Dentists, optometrists and ophthalmic medical practitioners also provide essential care to meet everyday needs.
Community health service staff offer a range of services for people wherever they are, in their homes, schools, clinics and even in the streets. These services include health visiting, school nursing, chiropody, occupational, speech and language therapy. Services such as district nursing, community psychiatric nursing and physiotherapy can enable people with short or long term disability to be cared for in their own homes. Other specialist staff such as midwives provide care across hospital and community settings.

2.8 Finally, the Government recognises the intrinsic strength of **decentralising responsibility for operational management.** By giving NHS Trusts control over key decisions they can improve local services for patients. The Government will build on this principle and let NHS Trusts help shape the locally agreed framework which will determine how NHS services develop. In the future the approach will be interdependence rather than independence.

Discarding what has failed

2.9 The internal market was a misconceived attempt to tackle the pressures facing the NHS. It has been an obstacle to the necessary modernisation of the health service. It created more problems than it solved. That is why the Government is abolishing it.

Ending fragmentation

2.10 The internal market split responsibility for planning, funding and delivering healthcare between 100 Health Authorities, around 3,500 GP fundholders (representing half of GP practices) and over 400 NHS Trusts. There was little strategic coordination. A fragmented NHS has been poorly placed to tackle the crucial issue of better integration across health and social care. People with multiple needs have found themselves passed from pillar to post inside a system in which individual organisations were forced to work to their own agendas rather than the needs of individual patients.

2.11 To overcome this fragmentation, in the new NHS all those charged with planning and providing health and social care services for patients will work to a jointly agreed local Health Improvement Programme. This will govern the actions of all the parts of the local NHS to ensure consistency and coordination. It will also make clear the responsibilities of the NHS and local authorities for working together to improve health.

Health Improvement Programme

An action programme led by the Health Authority to improve health and healthcare locally will involve NHS Trusts, Primary Care Groups and other primary care professionals, working in partnership with the local authority and other local interests. See chapter 4.

Ending unfairness

2.12 The internal market created competition for patients. In the process it created unfairness for patients. Some family doctors were able to get a better deal for their patients, for financial rather than clinical reasons. Staff morale has been eroded by an emphasis on competitive values, at odds with the ethos of fairness that is intrinsic to the NHS and its professions. Hospital clinicians have felt disempowered as they have been deliberately pitted against each other and against primary care. The family doctor

community has been divided in two, almost equally split between GP fundholders and non-fundholders.

2.13 In the new NHS patients will be treated according to need and need alone. Cooperation will replace competition. GPs and community nurses will work together in Primary Care Groups. Hospital clinicians will have a say in developing local Health Improvement Programmes.

Ending distortion

2.14 The market forced NHS organisations to compete against each other even when it would have made better sense to cooperate. Some were unwilling to share best practice that might benefit a wider range of patients in case they forfeited competitive advantage. Quality has been at best variable.

2.15 In the new NHS, there will be new mechanisms to share best practice so that it becomes available to patients wherever they live. A new national performance framework for ensuring high performance and quality will, over time, tackle variable standards of service.

Ending inefficiency

2.16 Under the internal market, the Purchaser Efficiency Index was the only real measure of performance. But it distorted priorities and - to the universal frustration of NHS staff - institutionalised perverse incentives which got in the way of providing efficient, effective, high quality services. In addition, budgets for emergency care, waiting list surgery and drug treatments were artificially divided, reducing flexibility.

2.17 In the new NHS, the Purchaser Efficiency Index will be replaced by better measures of real efficiency as part of a broader set of performance measures. They will assess the NHS against the things which count most for patients, including the costs and results of treatment and care. National reference costs will allow NHS Trusts to benchmark their performance. And partitioned budgets will be unified so that total resources can be matched locally against the needs of patients, ensuring more efficient and appropriate care.

Internal market bureaucracy

Evidence shows that:

- one fundholder with a contract worth £150,000 received 1,000 pieces of paper per year
- a Health Authority in the south processed 60,000 invoices per year representing 8% of its healthcare budget
- an inner city Trust contracted with over 900 funds and sent out 40,000 invoices per year

Ending bureaucracy

2.18 The internal market sent administrative costs soaring to unsustainable levels. In recent years effort and resources have been diverted from improving patient services. With so many players on the field, transaction costs in the NHS inevitably spiralled.

2.19 This White Paper will cap management costs and cut the number of commissioning bodies from around 3,600 to as few as 500. The Government has already taken steps to reduce transaction costs and along with the changes in this White Paper £1 billion in administration will be saved over the lifetime of this Parliament for investment in patient services.

Ending instability

2.20 The internal market forced NHS Trusts to compete for contracts that at best lasted a year and at worst were agreed on a day-to-day basis. Such short-term instability placed a constant focus on shoring up the status quo rather than creating the space to plan and implement major improvement.

2.21 This White Paper will scrap annual contracts. Instead, the new NHS will work on the basis of longer-term three and in some cases five year funding agreements that will allow clinicians and managers to focus on ways of improving care.

Unacceptable variations

At its best, the NHS leads the world. But the degree of local variation means that individual patients cannot be sure of receiving that best:

- the death rate from coronary heart disease in people younger than 65 is almost three times higher in Manchester than in West Surrey
- emergency readmissions to hospital are 70% higher in one area than in another
- the proportion of women aged 25-64 screened for cervical cancer varies from 67% to 93% in different areas
- the number of hip replacements in over 65s varies from 10 to 51 per 10,000 of the population
- the number of outpatients seen within 13 weeks of written GP referral varies from 71% to 98%
- the number of outpatients admitted for elective treatment who have waited less than 3 months since a decision to admit varies from 56% to 82%
- the percentage of drugs prescribed generically varies from below 50% to almost 70%
- the percentage of consultant episodes carried out as day cases varies from below 50% to almost 70%.

Ending secrecy

2.22 Under the internal market hospitals became 'self-governing trusts' run as businesses, focused on finance, and required to compete with each other for short-term contracts. Increasingly NHS Trust Boards meeting in secret made it hard for local people to find out what their local hospital was planning and how it was performing. GP fundholders could make significant purchasing decisions without reference to the local community.

2.23 In the new NHS, all NHS Trusts will be required to open up their board meetings to the public. They will have new statutory duties on quality and on working in partnership with others. Comparative information on NHS Trust performance will be published. Openness and public involvement will be key features of all parts of the new NHS.

2.24 These developments will place the traditional values of the NHS into a modern setting. They will be backed by the Government's commitment to extra investment in

the NHS, year on year. But that extra money has to produce major gains in quality and efficiency. Otherwise the health service will simply not keep pace with the needs of the public it is there to serve. The NHS has to make better use of its resources to ensure that it delivers better, more responsive services for patients everywhere. It has to share best practice and eliminate poor performance so that patients have a guarantee of excellence. The next chapter describes how quality and efficiency will be instilled in all parts of the NHS.

How are we replacing the Internal Market with Intergrated Care

Internal Market

Fragmented responsibility between 4,000 NHS bodies. Little strategic planning. Patients passed from pillar to post

Competition between hospitals. Some GPs get better service for their patients at the expense of others. Hospital clinicians disempowered

Competition prevented sharing of best practice, to protect 'competitive advantage'. Variable quality

Perverse incentives of Efficiency Index, distorting priorities, and getting in the way of real efficiency, effectiveness and quality. Artificially partitioned budgets

Soaring administrative costs, diverting effort from improving patient services. High numbers of invoices and high transaction costs

Short term contracts, focusing on cost and volume. Incentive on each NHS Trust to lever up volume to meet financial targets rather than work across organisational boundaries

NHS Trusts run as secretive commercial businesses. Unrepresentative boards. Principal legal duty on finance

Integrated Care

Health Improvement Programmes jointly agreed by all who are charged with planning or providing health and social care

Patients treated according to need, not who their GP is, or where they live. Co-operation will replace competition. Hospital clinicians involved

New mechanisms to share best practice. New performance framework to tackle variable standards of quality

Efficiency Index replaced by new reference costs. Broader set of performance measures. Budgets unified for maximum flexibility and efficiency

Management costs capped. Number of commissioning bodies cut from 3,600 to 500. Transaction costs cut

Longer term service agreements linked to quality improvements. NHS Trusts share responsibility for appropriate service usage

NHS Trusts with representative boards and end to secrecy. New legal duties on quality and partnership

Prepared 8 December 1997

3 Driving change in the NHS

DoH logo

quality and efficiency hand in hand

Key themes

- raising quality standards
- increasing efficiency
- driving performance
- new roles and responsibilities

3.1 The new NHS will work as one. There will be clear roles and responsibilities for each part of the health service. It will work to new standards of quality and efficiency that will guarantee better services for patients. The new NHS will be performance driven. This chapter summarises the main features of the new system and describes the key role each part of the NHS will play. Later chapters give greater detail.

Driving quality

3.2 The new NHS will have quality at its heart. Without it there is unfairness. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality care when they need it. Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality. This must be quality in its broadest sense: doing the right things, at the right time, for the right people, and doing them right - first time. And it must be the quality of the patient's experience as well as the clinical result - quality measured in terms of prompt access, good relationships and efficient administration.

3.3 There is much to build on. Clearing away the distraction of the market will help staff get attention back where it counts. But new and systematic action is needed, to

raise standards and ensure consistency. There have been some serious lapses in quality. When they have occurred they have harmed individual patients and dented public confidence.

3.4 This White Paper sets out three areas for action to drive quality into all parts of the NHS: **national standards and guidelines** for services and treatments; **local measures** to enable NHS staff to take responsibility for improving quality; and a new **organisation to address shortcomings.**

3.5 Nationally there will be:

- new evidence-based **National Service Frameworks** to help ensure consistent access to services and quality of care right across the country
- a new **National Institute for Clinical Excellence** to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service.

National Service Frameworks

National Service Frameworks will bring together the best evidence of clinical and cost-effectiveness, with the views of service users, to determine the best ways of providing particular services. See also chapter 7.

3.6 Locally there will be:

- teams of **local GPs and community nurses** working together in new Primary Care Groups to shape services for patients, concentrating on the things which really count - prompt, accessible, seamless care delivered to a high standard
- explicit quality standards in local **service agreements** between Health Authorities, Primary Care Groups and NHS Trusts, reflecting national standards and targets
- a new system of **clinical governance** in NHS Trusts and primary care to ensure that clinical standards are met, and that processes are in place to ensure continuous improvement, backed by a new **statutory duty** for quality in NHS Trusts.

3.7 A new **Commission for Health Improvement** will be established to support and oversee the quality of clinical services at local level, and to tackle shortcomings. It will be able to intervene where necessary. The Secretary of State will also have reserve powers to intervene directly when a problem has not been gripped.

Driving efficiency

3.8 Efficiency and quality should go hand in hand. Both are essential in a modern and dependable NHS. Both are essential to fairness. Patients suffer if resources are not used efficiently or to best effect, just as they suffer if quality standards vary. This White Paper outlines five ways to ensure the NHS delivers universally high standards in the efficient and effective use of resources and in financial discipline.

3.9 First, clinical and financial responsibility will be aligned. Primary Care Groups will be able to take devolved responsibility for a single unified budget covering most aspects of care so that they can get the best fit between resources and need. It will provide local family doctors and community nurses with maximum freedom to use the resources available to the benefit of patients, with efficiency incentives at both Group and practice level.

Single unified budget

For the first time funding for all hospital and community services, prescribing and general practice infrastructure will be brought together into a single stream at Health Authority and Primary Care Group level.

3.10 Second, **management costs will be capped** in Health Authorities and Primary Care Groups. The Government will also continue to bear down on NHS Trust management costs, benchmarking performance. This approach will get the maximum NHS resources into frontline patient services.

3.11 Third, the Government will develop a national schedule of '**reference costs**' which will itemise what individual treatments across the NHS cost. By requiring NHS

Trusts to publish and benchmark their own costs on the same basis, the new arrangements will give Health Authorities, Primary Care Groups and the NHS Executive a strong lever with which to tackle inefficiency.

3.12 Fourth, there will be **clear incentives** to improve performance and efficiency. Health Authorities which perform well will be eligible for extra cash. NHS Trusts and Primary Care Groups will be able to use savings from longer term agreements to improve services for patients.

3.13 Fifth, there will be **clear sanctions** when performance and efficiency are not up to standard. Health Authorities will be able to withdraw freedoms from Primary Care Groups. They, in turn, will have a range of new powers to lever up standards and efficiency at local NHS Trusts and as a last resort will be able to change provider if, over time, performance does not meet the required standard. And the NHS Executive will be able directly to intervene to rectify poor performance in any part of the NHS.

Bring quality and efficiency together

3.14 The Government will bring these developments together in a new approach to measuring the performance of the NHS and holding it to account. Experience shows that the way in which performance is measured directly affects how the NHS acts; the wrong measures produce the wrong results. New arrangements will concentrate on measuring what really counts for patients through a new Performance Framework. It will focus on more rounded measures - health improvement, fairer access to services, better quality and outcomes of care and the views of patients - as well as real efficiency gains.

3.15 This new approach will demonstrate how the pursuit of quality and efficiency must go together if the NHS is to deliver the best for patients. The new Performance Framework will be used to get all parts of the NHS working together to ensure that both the local health service and the health of local people are getting demonstrably better every year.

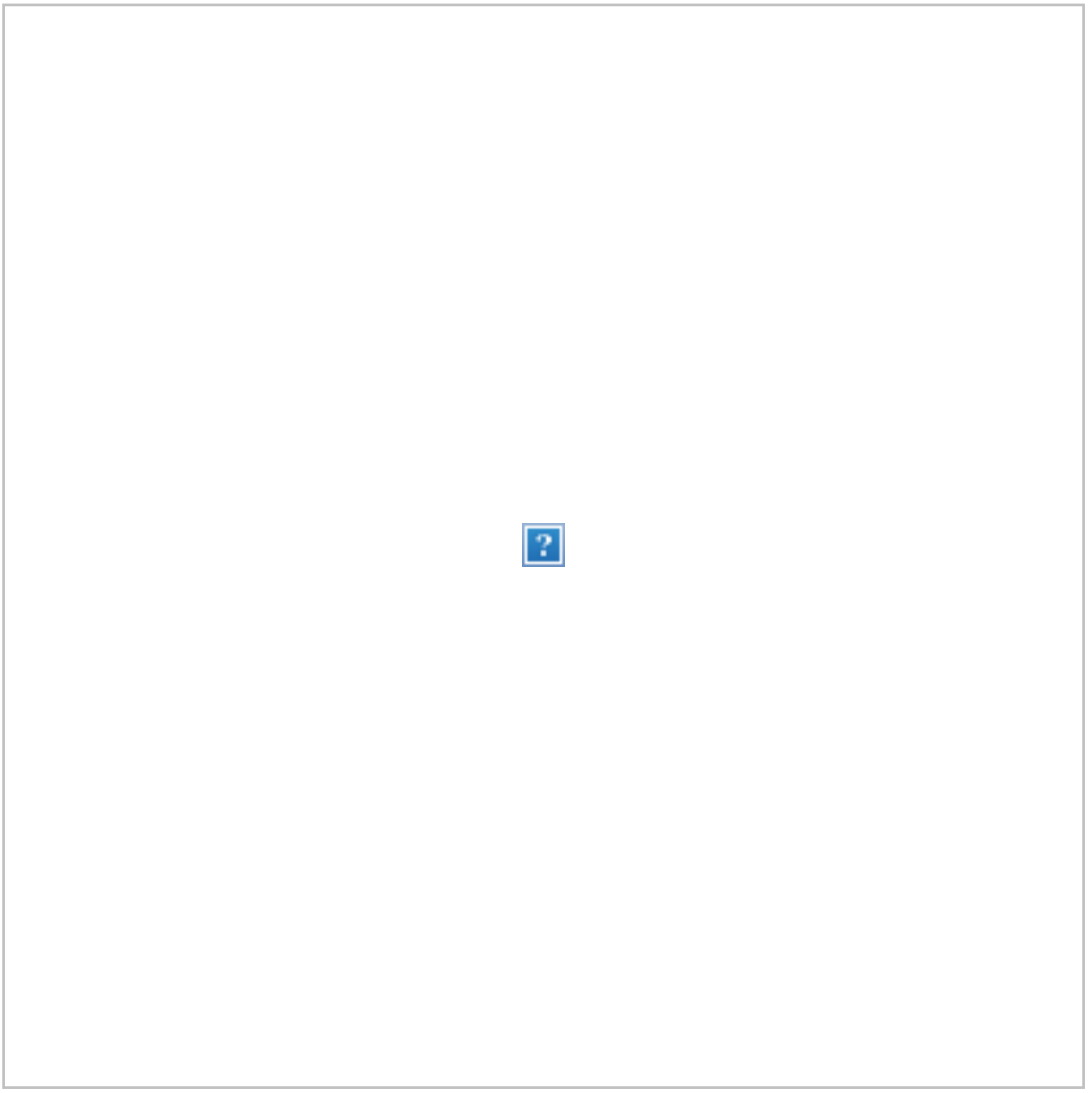
New information technology - supporting quality and efficiency

A modern and dependable NHS needs to be supported by accurate and up-to-date information and information technology. In recent years, information technology in the NHS has been focused on supporting the transaction processes of the internal market. This has been at the expense of realising the potential of IT to support frontline staff in delivering benefits for patients. In 1998, the Government will publish a new Information Management and Technology Strategy for the NHS which will harness the enormous potential benefits of IT to support the drive for quality and efficiency in the NHS by:

- making patient records electronically available when they're needed
- using the NHSnet and the Internet to bring patients quicker test results, on-line booking of appointments and up-to-date specialist advice
- enabling accurate information about finance and performance to be available promptly
- providing knowledge about health, illness and best treatment practice to the public through the Internet and emerging public access media (e.g. digital TV)
- developing telemedicine to ensure specialist skills are available to all parts of the country

There will be robust safeguards to protect patients' confidentiality and privacy. The aim will be to create a powerful alliance between knowledgeable patients advised by knowledgeable professionals as a means of improving health and healthcare.

Figure 1: Financing and accountability arrangements in the new NHS compared with the old



Role and responsibilities

3.16 The new NHS will mean new roles and responsibilities for Health Authorities, NHS Trusts and the Department of Health. Primary Care Groups will also be developed across the country. The facing page sets out the new financing and accountability arrangements compared with those of the internal market.

3.17 **Health Authorities** will be leaner bodies with stronger powers to improve the health of their residents and oversee the effectiveness of the NHS locally. Over time, they will relinquish direct commissioning functions to Primary Care Groups. Working with local authorities, NHS Trusts and Primary Care Groups, they will take the lead in drawing up three-year Health Improvement Programmes which will provide the framework within which all local NHS bodies will operate. These will be backed by a new duty of partnership. Health Authorities will allocate funds to Primary Care Groups on an equitable basis, and hold them to account. Links with social services will be strengthened. Fewer Health Authorities covering larger areas will emerge as a product of these changes, flowing from local discussion rather than national edict.

3.18 **Primary Care Groups** comprising all GPs in an area together with community nurses will take responsibility for commissioning services for the local community. This will not affect the independent contractor status of GPs. The new Primary Care Groups will replace existing commissioning and fundholding arrangements. All Primary Care Groups will be accountable to Health Authorities, but will have freedom to make decisions about how they deploy their resources within the framework of the Health Improvement Programme. Over time, Primary Care Groups will have the opportunity to become freestanding Primary Care Trusts.

3.19 **NHS Trusts,** the bodies that provide patient services in hospitals and in the community, will be party to the local Health Improvement Programme and will agree long term service agreements with Primary Care Groups. These service agreements will generally be organised around a particular care group (such as children) or disease area (such as heart disease) linked to the new National Service Frameworks. In this way, hospital clinicians will be able to make a more significant contribution to service planning. National model agreements will be developed. NHS Trusts will have a statutory duty for quality.

3.20 The **Department of Health,** and within it the NHS Executive, will shoulder responsibility for action genuinely needed at a national level. It will integrate health and social services policy to give a national lead which others will be expected to follow locally. It will also work with the clinical professions to develop National Service Frameworks, linked to national action to implement them across the NHS. For the first time, there will be an annual national survey to allow systematic comparisons of the experience of patients and their carers over time, and between different parts of the country. A new NHS Charter will set out new rights and responsibilities for patients. The Secretary of State will have reserve powers to intervene where Health Authorities, Primary Care Groups and NHS Trusts are failing.

3.21 To reflect the new partnership and interdependence at local level, NHS Executive Regional Offices will integrate their performance management functions. The Regional Offices will have new responsibilities for ensuring that Primary Care Groups and Health Authorities work together to make proper arrangements for commissioning specialist health services at a regional level. Regional Chairs will take a stronger role in ensuring local partnerships are developed between the NHS and Local Authorities.

3.22 The following chapters set out the proposals in more detail, showing how they will work and how they will meet the Government's objective of a modern and

dependable NHS for patients.

Prepared 8 December 1997

4 Health Authorities

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leading and shaping

Key themes

- new focus on improving health
- new Health Improvement Programmes to shape local healthcare
- lead strategic role for local NHS

Strategic leadership

4.1 Health Authorities will give strategic leadership on the ground in the new NHS. They will lead the development of local Health Improvement Programmes which will identify the health needs of local people and what needs to be done to meet them. Health Authorities will work closely with NHS Trusts, the new Primary Care Groups, Local Authorities, academic and research interests, voluntary organisations, and the local community in devising this new strategic approach to the planning and delivery of healthcare.

4.2 A stronger, clearer strategic role for Health Authorities will help overcome the fragmentation which characterised the internal market. Now there will be common goals so that each part of the local health service works in concert with one another and in partnership with local government and others. Health Authorities will be freed from unnecessary administrative activities so that they are properly able to lead the local NHS and ensure it delivers. Patients in all parts of the country will feel the benefit through coordinated, high quality and accessible services.

Healthy Aurthority functions

4.3 Health Authorities will have a number of key tasks:

- **assessing the health needs** of the local population, drawing on the knowledge of other organisations
- drawing up a strategy for meeting those needs, in the form of a **Health Improvement Programme**, developed in partnership with all the local interests and ensuring delivery of the NHS contribution to it
- deciding on the **range and location of health care services** for the Health Authority's residents, which should flow from, and be part of, the Health Improvement Programme
- determining **local targets and standards** to drive quality and efficiency in the light of national priorities and guidance, and ensuring their delivery
- supporting the **development of Primary Care Groups** so that they can rapidly assume their new responsibilities
- **allocating resources to Primary Care Groups**
- **holding Primary Care Groups to account.**

Improving the publics health

4.4 Lead responsibility for improving overall health and reducing health inequalities will be at the heart of the new Health Authority role. Following publication of the Green Paper Our Healthier Nation, the Government will introduce legislation to place a new statutory duty on Health Authorities to improve the health of their population.

4.5 But Health Authorities will not work alone. They will act in partnership with Local Authorities and others to identify how local action on social, environmental and economic issues will make most impact on the health of local people. Their public health functions include health surveillance and the control of communicable diseases; assessing health needs; monitoring health outcomes; and evaluating the health impact of local plans and developments. The Chief Medical Officer will recommend shortly how the public health function can be strengthened to support this work.

4.6 The independent annual report by their Director of Public Health will inform the decisions of both the Health Authority and its partners. It will be the starting point for

the Health Improvement Programme.

Health Improvement Programmes

4.7 The Health Improvement Programme will be the local strategy for improving health and healthcare. It will be the means to deliver national targets in each Health Authority area. The Health Authority will have lead responsibility for drawing up the Health Improvement Programme in consultation with NHS Trusts, Primary Care Groups, other primary care professionals such as dentists, opticians and pharmacists, the public, and other partner organisations.

4.8 To give substance to the cooperation necessary to bring about improvements in health there will be a new statutory duty of partnership placed on local NHS bodies to work together for the common good. This will extend to Local Authorities, strengthening the existing requirements under the 1977 NHS Act. The Government intends to place on Local Authorities a duty to promote the economic, social and environmental well being of their areas. This will ensure they have clear powers to develop partnerships with a wide range of other organisations, including NHS bodies, to address the needs of local communities.

4.9 The Health Improvement Programme will cover:

- the most important **health needs** of the local population, and how these are to be met by the NHS and its partner organisations through broader action on public health
- the main **healthcare requirements** of local people, and how local services should be developed to meet them either directly by the NHS, or where appropriate jointly with social services
- the **range, location and investment required in local health services** to meet the needs of local people.

4.10 The initial Health Improvement Programme will cover a three year period. It will be updated progressively, with a part of it reviewed each year. It is envisaged that the first Health Improvement Programmes will be in place by April 1999.

4.11 The Health Authority will monitor the implementation of the Health

Improvement Programme by NHS Trusts, Primary Care Groups and others. It will decide on and be required to ensure the delivery of the NHS components. It will therefore have reserve powers to ensure that major investment decisions (such as capital developments or new consultant medical staffing appointments) are consistent with the Health Improvement Programme.

4.12 The Health Authority will also need to ensure the local NHS works in partnership to coordinate plans for the local workforce. Local education consortia should ensure training and education arrangements are in place to provide the skills needed across the hospital and community sectors, primary care and social care. And in order to guarantee that patients have quicker access to local services, the Health Authority will coordinate information and information technology plans across primary care, community health services and secondary care.

Local Education Consortia

Consortia bring together representatives from NHS Trusts and Health Authorities to assess the workforce and development requirements of local healthcare services. They provide a forum to ensure workforce planning reflects local service needs.

4.13 Health Authorities will work more closely with local social services and other partners on planning care for patients. At present, the quality of cooperation varies considerably. Inevitably, the consequence is unfairness between different parts of the country.

4.14 In the future, patients with continuing health and social care needs will get access to more integrated services through the joint investment plans for continuing and community care services which all Health Authorities are being asked to produce with partner agencies. The Government will also be exploring the scope for even closer working between health and social services through, for example, pooling of budgets. The benefits will be particularly felt by patients, such as those with disability or mental health problems, who need the support of both health and social care systems.

Developing responsibility

4.15 Health Authorities will devolve responsibility for direct commissioning of services to new Primary Care Groups as soon as they are able to take on this task. Such an approach provides a 'third way' between stifling top-down command and control on the one hand, and a random and wasteful grass roots free-for-all on the other. This 'third way' builds on the successes that commissioning groups and fundholders have achieved over recent years. It harnesses the strategic abilities of Health Authorities and the innovative energies of primary care commissioners for the benefit of patients.

4.16 Although most commissioning will pass to Primary Care Groups, Health Authorities will need to work together to commission some specialist services - those organised to serve the population of several Health Authorities, such as bone marrow transplants. The detailed arrangements for specialist services commissioning are described in chapter 7.

Setting standards and targets

4.17 The Health Improvement Programme will need to include the new targets which emerge following consultation on the Green Paper Our Healthier Nation as well as the performance framework set out in chapter 8. Health Authorities will need to agree and set targets for Primary Care Groups in discussion with them. In turn, Primary Care Groups will build them into their service agreements with NHS Trusts. These targets will be measurable, published and deliver year on year improvement in local health and healthcare services.

Holding to account

4.18 The Health Improvement Programme will set the framework, within which Primary Care Groups will consider how best to commission and provide services for their local community. Key objectives including the standards and targets agreed with the Health Authority will be expressed in an annual accountability agreement between the Health Authority and Primary Care Group. Progress will be monitored against this and the Health Authority will hold the Primary Care Group to account for carrying out

its agreed role effectively. The detailed arrangements are set out in chapter 5. The service agreements which Health Authorities and Primary Care Groups reach with NHS Trusts will be the chief means of holding NHS Trusts to account for service delivery against the Health Improvement Programme. Where there is a disagreement between a Primary Care Trust and NHS Trusts, it will be for the Health Authority to resolve.

Rebuilding public confidence

4.19 The new arrangements need to be transparent so that they command public confidence. The Government expects Health Authorities to play a strong role in communicating with local people and ensuring public involvement in decision making about the local health service. The maxim to which Health Authorities will work is simple - the NHS, as a public service for local communities, should be both responsive and accountable. Some Health Authorities have been successful in developing new approaches to reflect this maxim. The Government will seek to build on what has worked to ensure this applies everywhere. Health Action Zones will offer opportunities to explore new ways of involving local people. In the meantime, Health Authorities will need to:

- involve the public in developing the Health Improvement Programme
- ensure that Primary Care Groups have effective arrangements for public involvement
- publish agreed strategies, targets and details of progress against them
- participate in a new national survey of patient and user experience (detailed in chapter 8).

Health Action Zones

A new initiative to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people. Up to 10 zones, generally covering an area of at least Health Authority size, will be selected to go live from April 1998.

4.20 The Government will also take action to rebuild public confidence in the NHS. A new NHS Charter will replace the more limited Patient's Charter. The Government wants a strong public voice in health and healthcare decision-making, recognising the important part played by Community Health Councils in providing information and advice, and in representing the patient's interest. The Government attaches particular importance to strengthening public confidence in the way major changes in local services are planned. We will explore new ways of securing informed public and expert involvement in such decisions. For the first time there will be a clear set of principles for decision-making and criteria for ensuring that due process is observed.

The new NHS Charter

The new NHS Charter will tell people about the standards of treatment and care they can expect of the NHS. It will also explain patients' responsibilities.

Making it happen

4.21 To support and equip Health Authorities for their significant new role, the Government will:

- revise and clarify their formal responsibilities, with new and specific **statutory responsibilities** for improving the health of the population, and for working in partnership with NHS and other local bodies (which will also be reflected in the duties of partner organisations)
- align NHS Trust and Primary Care Groups' responsibilities and lines of accountability with the new Health Authority role, so that they all work within the local Health Improvement Programme. This will include a specific **reserve power** for the Health Authority to ensure that capital investment and new consultant medical staffing decisions do not cut across the strategy set out in the Health Improvement Programme
- provide for **Local Authority Chief Executives** to participate in meetings of the Health Authority. The Government will also consider further with the NHS and local government how partnership arrangements can be further strengthened, drawing on the experience of Health Action Zones
- work with Health Authorities to **streamline their administrative functions,** including the sharing of functions between Authorities, so as to release time, effort and resources for higher priorities. Fewer authorities covering larger areas

will emerge as a product of these changes. Local decision rather than national edict will determine the future Health Authority map.

Ensuring progress

4.22 It will be crucial that Health Authorities make a success of their new role. The NHS Executive will monitor their performance closely, supporting and rewarding good progress, and taking prompt action where necessary to address weaknesses. This will be achieved in three ways:

- firstly, without compromising the principle of allocating resources on the basis of need, Health Authorities which demonstrate most progress against the targets and objectives agreed with the NHS Executive will be eligible for modest extra non-recurrent funding for local projects which support their Health Improvement Programme
- secondly, particular emphasis will be put on benchmarking and on the sharing of good practice
- thirdly, where there are poorly performing authorities, Regional Offices will monitor progress more closely, offer targeted management support, and ultimately will be able to intervene directly to strengthen existing management.

Milestones

The initial steps will be:

1998

- prepare the way for development of Primary Care Groups
- first national survey of patient and user experience
- establishment of Health Action Zones
- prepare Health Improvement Programmes

1999

- (subject to legislation) introduction of Health Authorities' new statutory duties

- support for Primary Care Groups in their first year
- the first Health Improvement Programmes begin

Prepared 8 December 1997

5 Primary Care Groups

DoH logo

going with the grain

Key themes

- development of primary and community health care
- family doctors and community nurses in the lead
- a spectrum of opportunities beyond fundholding

The first line of support and care

5.1 The family doctor or community nurse is often the first port of call for patients when they need health advice or treatment. Primary care professionals are also the way into the rest of the NHS for most patients. They understand patients' needs and they deliver most local services. That is why they will be in the driving seat in shaping local health services in the future. New Primary Care Groups will be established in all parts of the country to commission services for local patients. They will have control over resources but will have to account for how they have used them in improving efficiency and quality. They do not affect GPs' independent contractor status.

5.2 The new role envisaged for GPs and community nurses will build on some of the most successful recent developments in primary care. These professionals have seized opportunities to extend their role in recent years. Practice nurses are taking on new disease management roles while community pharmacists are increasingly a source of advice for both GPs and patients. GPs have been developing new services within their surgeries. Health visitors, school nurses, and district nurses have enhanced the delivery of care in homes, schools and the community.

5.3 Community health services have been able to take account of the special health needs of black and minority ethnic patients. They have also been able to help people not in regular contact with other parts of the health services, such as homeless people.

Community health staff, such as midwives, can also draw attention to the wider health needs of the community, where the real solution may lie in action on education, housing, transport or reducing air pollution.

Locality commissioning groups

Groups of GPs who work closely with their Health Authority to plan and commission services.

GP fundholding

A GP whose practice manages a budget for its practice staff, certain hospital referrals, drug costs, community nursing services and management costs.

Multifunds

Groups of GP fundholders who agree to pool their budgets and work together.
Total purchasing projects
Total purchasers comprise groups of GPs who together purchase hospital and community health services outside fundholding on behalf of their patients, working closely with their Health Authority. Legal responsibility for these services remains with the relevant Health Authority.
GP commissioning group pilots
Pilot projects preparing to go live from April 1998. Based around groups of fundholding and non-fundholding GPs, will manage a prescribing budget. Will work closely with their local Health Authority to develop health strategies and advise on service developments for local populations.

Going with the grain

5.4 Extended roles in providing primary and community healthcare have been matched by greater influence in shaping hospital services. Multifunds, locality commissioning groups, individual fundholders, and total purchasing projects all have helped lead the

way. Each has undoubtedly brought benefits to patients. The new GP commissioning pilots will extend the range of opportunities. The Government's plans go with the grain of these developments.

5.5 Despite its limitations, many innovative GPs and their fund managers have used the fundholding scheme to sharpen the responsiveness of some hospital services and to extend the range of services available in their own surgeries. But the fundholding scheme has also proved bureaucratic and costly. It has allowed development to take place in a fragmented way, outside a coherent strategic plan. It has artificially separated responsibility for emergency and planned care, and given advantage to some patients at the expense of others.

5.6 So the Government wants to keep what has worked about fundholding, but discard what has not. The potential of primary care commissioning will continue to be developed using mechanisms that evolve far beyond single practice standard fundholding. The argument between fundholding and non-fundholding is yesterday's debate. The time has come to move on, taking the best of both approaches.

5.7 All of the local community should benefit from the best that primary and community health services have to offer. It is at this level - close to patients and the community - that decisions can best be taken on using the resources of the NHS to meet the health and healthcare needs of individual patients.

5.8 The Government therefore intends to establish Primary Care Groups across the country, bringing together GPs and community nurses in each area to work together to improve the health of local people. Primary Care Groups will grow out of the range of commissioning models that have developed in recent years but will give a sharper focus to their work. They will have the benefit of strong support from their Health Authority and the freedom to use NHS resources wisely, including savings. With these new opportunities will go the need to account for their actions. They will be subject to clear accountability arrangements and performance standards.

Community health services

Community health services are provided for people wherever they are, such as in homes, schools, clinics and even on the streets. Examples are health visiting, school

nursing, chiropody, speech and language therapy. Services such as district nursing, community psychiatric nursing and physiotherapy can enable people with short or long term illness or disability to be cared for in their own homes.

Functions

5.9 The main functions of the new Primary Care Groups reflect the approaches which are already being adopted in many parts of the country. Primary Care Groups will:

- contribute to the Health Authority's **Health Improvement Programme** on health and healthcare, helping to ensure that this reflects the perspective of the local community and the experience of patients
- **promote the health of the local population,** working in partnership with other agencies
- **commission health services** for their populations from the relevant NHS Trusts, within the framework of the Health Improvement Programme, ensuring quality and efficiency
- **monitor performance** against the service agreements they (or initially the Health Authority) have with NHS Trusts
- **develop primary care** by joint working across practices; sharing skills; providing a forum for professional development, audit and peer review; assuring quality and developing the new approach to clinical governance; and influencing the deployment of resources for general practice locally. Local Medical Committees will have a key role in supporting this process
- **better integrate primary and community health services** and work more closely with social services on both planning and delivery. Services such as child health or rehabilitation where responsibilities have been split within the health service and where liaison with Local Authorities is often poor, will particularly benefit.

Local Medical Committee

The statutory Local Representative Committee for all GPs in the area covered by a Health Authority. The Health Authority has a statutory duty to consult it on issues

including GPs' terms of service, complaints and the investigation of certain matters of professional conduct.

Structure

5.10 The precise form of Primary Care Groups will be flexible to reflect local circumstances. In some areas there are already well established GP-led groups of commissioners or fundholders, while in others, community NHS Trusts have taken a lead role. Successful local arrangements will be built upon, not discarded. The approach will be bottom-up and developmental.

5.11 There will be a spectrum of opportunities available for local GPs and community nurses. Primary Care Groups will develop over time, learning from existing arrangements and their own experience. None will affect the independent contractor status of GPs. There will be four options for the form that Primary Care Groups take. They will:

i at minimum, support the Health Authority in commissioning care for its population, acting in an advisory capacity

ii take devolved responsibility for managing the budget for healthcare in their area, formally as part of the Health Authority

iii become established as freestanding bodies accountable to the Health Authority for commissioning care

iv become established as freestanding bodies accountable to the Health Authority for commissioning care and with added responsibility for the provision of community health services for their population.

5.12 Primary Care Groups will begin at whatever point on the spectrum is appropriate for them. They will be expected to progress along it so that in time all Primary Care Groups assume fuller responsibilities. Some Primary Care Groups may proceed directly from option ii to option iv.

5.13 The Government will bring forward legislation to establish a new form of Trust - a Primary Care Trust - for Primary Care Groups which wish to be freestanding

(options iii and iv) and are capable of being so. Such Trusts may include community health services from existing NHS Trusts. All or part of an existing community NHS Trust may combine with a Primary Care Trust in order to better integrate services and management support. Annex A sets out further details of how Primary Care Trusts might work. (Elsewhere in this document, the term Primary Care Group is used to cover both Groups and Trusts, unless the context makes it clear that Groups alone are covered).

5.14 The new Trusts will not be expected to take responsibility for specialised mental health or learning disability services. On mental health, where health and social care boundaries are not fixed and where joint work is particularly important, and where an integrated range of services from community to hospital care is required, specialist mental health NHS Trusts are likely to be the best mechanism for coordinating service delivery. Primary Care Trusts will be well placed to develop strong links with such services. In this way, specialist NHS Trusts, Primary Care Trusts and social services will be able to make complementary contributions to delivering the full range of care. Similar considerations apply in the case of specialist learning disability services.

5.15 Whatever functions they take on there will be a common core of requirements for all Primary Care Groups. Each Group will be accountable to the Health Authority and required to:

- be representative of all the GP practices in the Group
- have a governing body which includes community nursing and social services as well as GPs drawn from the area
- take account of social services as well as Health Authority boundaries, to help promote integration in service planning and provision
- abide by the local Health Improvement Programme
- have clear arrangements for public involvement including open meetings
- have efficient and effective arrangements for management and financial accountability.

Local Medical Committees will continue to be consulted on, and have a key role in, ensuring that general medical services resources are used wisely.

5.16 The intention is that Primary Care Groups should develop around natural communities, but take account also of the benefits of coterminosity with social services. Practices based close to the borders of a Group will be able to choose to join

with others in the way which makes best sense locally. Primary Care Groups may typically serve about 100,000 patients. But there will be flexibility to reflect local circumstances and emerging evidence about the effectiveness of different size groupings. Primary Care Groups will generally grow out of existing local groupings, modified as needed to meet the criteria set out above.

Finance

5.17 Each Primary Care Group will have available their population's share of the available resources for hospital and community health services, prescribing and general practice infrastructure. These resources will allow the Group and its members to commission and provide services. Within this single cash limited envelope, the Group will have the opportunity to deploy resources and savings to strengthen local services and ensure that patterns of care best reflect their patients' needs.

5.18 For the first time in the history of the NHS all the primary care professionals, who do the majority of prescribing, treating and referring, will have control over how resources are best used to benefit patients. By cutting through the artificial barriers that have been erected between drug budgets, hospital referral budgets and emergency admission budgets the Government will give real choices about how GPs and community nurses deploy their cash. In this way Primary Care Groups will extend to all patients the benefits, but not the disadvantages, of fundholding. By virtue of their size and financial leverage, they will have far greater ability to shape local services around patients' needs.

Unified Primary Care Group Budgets

- Hospital and Community Health Services
- Prescribing: the cost of drugs prescribed by GP and nurses
- GMS infrastructure: the current 'GMS cash-limited' budget which reimburses GPs for a proportion of the cost of their practice staff premises and computers.

5.19 Groups, rather than individual practices, will reach service agreements with NHS Trusts about the quality and level of care that should be provided in hospitals for their patients. Primary Care Groups will also work with their practices to ensure the best use of resources for their patients. Over time, the Government expects that Groups will extend indicative budgets to individual practices for the full range of services, but no individual element will be artificially capped. It will be open to the Group to agree

practice-level incentive arrangements associated with these budgets, approved by the Health Authority, where this helps promote best use of resources. Initially every practice will have a prescribing budget, as most do now.

Management cost

5.20 Primary Care Groups will have their own dedicated management support, but will be expected to share, not duplicate, functions. In particular, they will work closely together and with their Health Authority to share scarce expertise such as public health skills. Where support functions can most cost-effectively be delegated back to Health Authorities, Primary Care Groups will be expected to do so.

5.21 A combined Health Authority and Primary Care Group management cost envelope will be set for each Health Authority area. The Government will support the development of Primary Care Groups in all parts of the country by fairly redistributing, over time, the management costs that have supported GP fundholding as well as those that have supported Health Authorities' direct commissioning role. GP fundholding only covers part of the country and part of local health services, so by cutting the number of commissioning bodies and scrapping both short-term contracts and individual case contracts, the new arrangements will also cut transaction costs and bureaucracy. That will allow management resources to be used more effectively. It will also help all practices to develop the information systems needed for integrated health care.

5.22 Redeployment of the GP Fundholding Practice Fund Management Allowance will provide about £3 per head of population to support the running costs of Primary Care Groups as part of the overall Health Authority/Primary Care Group cost envelope available locally. Further management support costs will be redeployed over time from Health Authorities as Primary Care Groups take on more responsibilities. GPs who take on key responsibilities within Primary Care Groups will have their time appropriately reimbursed from within the Group's management support.

5.23 Where a Primary Care Group merges with a Community NHS Trust the management cost envelope will be further adjusted. The Government will require such mergers to bring significant overall savings in management costs as functions, overheads and support services are combined.

Accountability

5.24 Primary Care Groups and Primary Care Trusts will be accountable to Health Authorities for the way in which they discharge their functions, including financial matters. This will ensure that they work within the Health Improvement Programme and that financial discipline and probity are maintained. In addition the Health Authority and the Primary Care Group will agree targets for improving health, health services and value for money. These will be set out in an annual accountability agreement.

5.25 Before securing increased responsibility, Groups will need to satisfy the Health Authority that they have adequate management arrangements (including designation of an Accountable Officer), risk management plans for their budgets, and a proper range of partner and public involvement.

5.26 No barriers will be placed in the way of Primary Care Groups which are making good progress. But where a Primary Care Group is falling behind its peers Health Authorities will need to support it through closer monitoring, advice and guidance and greater direction. In the rare event that a Primary Care Group got into serious difficulty the Health Authority would have the power to withdraw some or all of the devolved responsibility or require a change in its leadership and management.

Commissioning better services

5.27 The arrangements set out above will give Primary Care Groups the responsibility as well as the tools and incentives with which to develop prompt, accessible and responsive services for local people. They will be encouraged to play an active part in community development and improving health in its widest sense. Health visitors and health promotion professionals will have a strong contribution to make in identifying health needs and implementing the programmes that best address them. Other primary care professionals, such as dentists, optometrists and pharmacists, will need to be drawn in to contribute as appropriate to the planning and provision of services. This must be a coming together of equals with each profession recognising the distinctive

contribution of the others. Dentists, pharmacists and optometrists also have their own separate and distinct contributions to make to the NHS and the Government will continue its dialogue with them about how they can best develop it.

5.28 As part of the commissioning process, Primary Care Groups, Health Authorities and hospital clinicians will agree whether a service should be commissioned for the whole population across the Health Authority, or more locally. Quality standards, service protocols and agreements should be set by direct discussion between clinicians to ensure primary and secondary care services are properly integrated and programmes of care developed to reflect patient needs.

5.29 National Service Frameworks, and guidelines issued by the new National Institute for Clinical Excellence, will help ensure greater local consistency between Health Authorities and Primary Care Groups in the provision of top quality services for major diseases and conditions. In this way devolved commissioning will go hand in hand with greater equity for the most important services, so that two-tierism becomes a thing of the past.

5.30 Primary Care Groups will be able to make choices about cost-effective patterns of services and will be free to switch resources over time to support them. They will redeploy savings to meet local needs and promote local developments.

Developing primary and community services

5.31 The internal market has over-emphasised the role of primary care as commissioner of hospital services, at the expense of improving the provision of primary care services themselves. Primary Care Groups will set that right. They will be encouraged to use their freedoms to improve primary and community health care for their patients. The independent contractor status of GPs will continue. Working with Health Authorities, Primary Care Groups will be able to use the NHS (Primary Care) Act to pilot local flexibilities in delivering general medical services. Health Authorities will have reserve powers in respect of payments made by Primary Care Groups/Primary Care Trusts to GP practices, for example from general medical services allocations and payments under Section 36 of the Primary Care Act.

Primary Care Act Pilots

Under the NHS (Primary Care) Act 1997, different more flexible ways are being piloted of providing primary care to attune it better to local needs. Pilots will be established from April 1998 to:

- improve the quality, range and accessibility of services
- tackle unmet need for specific groups of people
- improve the recruitment, retention, and develop skills of GPs, nurses and other clinical providers
- establish new organisational models for better providing integrated primary and community healthcare.

5.32 Primary Care Trusts will be able to run community hospitals and other community services. By integrating primary and community healthcare, Primary Care Trusts will provide a focus for improved rehabilitation and recovery services. Too often in the past community hospitals have been sidelined. Their potential contribution to managing the pressures of rising emergency admissions has often been ignored. Patients will be able to use local community hospitals to the full rather than having to travel to more distant acute hospitals. This will be particularly significant in rural areas.

5.33 Primary Care Groups will be expected to help primary care professionals to enhance the quality of their care. There is much on which to build. Clinical audit is now becoming well established in general practice and the NHS Executive is working with the profession to develop indicators to assess the effectiveness of primary care at national and Health Authority level.

5.34 But more is needed. As part of the development of clinical governance in the NHS (discussed in more detail in chapter 6) each Primary Care Group will nominate a senior professional to take the lead on standards generally and on professional development within the Group. To extend this approach through primary care, individual practices will be encouraged to identify lead responsibility on the same basis. Many practices are very small organisations, however, and it will be important to apply the principles of clinical governance sensitively. In order to achieve Primary Care Trust status, Primary Care Groups will need to demonstrate that they have a systematic approach to monitoring and developing clinical standards in practices. This requirement will also be applied to community health services included in the Trust.

Beyond fundholding

5.35 Primary Care Groups build on best of existing practice. They offer an opportunity for innovative GPs and community nurses to spread the benefits of their experience more widely. This will ensure that those who are willing and able to lead can do so in a way which benefits all, without requiring every GP to take on a lead management role.

5.36 Primary Care Groups are where the future lies for GP fundholders. The Government will discuss with those concerned an orderly transition covering:

- future arrangements for services currently funded through the fundholding scheme so that those that are cost-effective, including those in GP practices, can continue to be provided, and spread to others
- arrangements for fundholding staff, currently supported from the Practice Fund Management Allowance, so that those skilled in primary care commissioning are wherever possible retained at the practice, Primary Care Group or Health Authority level
- arrangements for winding up Practice Funds, including how savings can be used for the benefit of patients subject to appropriate value-for-money tests.

5.37 The Government will bring forward legislation to provide for the move from GP fundholding to Primary Care Groups and to create the new Primary Care Trusts. Subject to the availability of Parliamentary time for the necessary legislation, Primary Care Groups will succeed fundholding from April 1999. In the meantime, there will be no new admissions to the fundholding scheme.

5.38 In parallel the NHS Executive will:

- explore with all interested parties what can be learned from existing commissioning models, drawing on the extensive programme of research and evaluation currently underway
- ensure Health Authorities work with primary care and community health services locally to develop Primary Care Groups, build on existing local initiatives, and devolve responsibility as new Groups demonstrate the capacity to take it.

Milestones

The development of Primary Care Groups will be evolutionary, building on existing models and the convergence which is already apparent.

1998

- GP Commissioning Group pilots begin
- early action will concentrate on the transition to the new Primary Care Groups

1999

- new Primary Care Groups in place
- GP fundholders, Total Purchasing Projects, multifunds, and locality commissioning GPs will move on to Primary Care Groups and, subject to legislation, the fundholding scheme will be wound up
- Primary Care Groups will take on additional responsibilities at a pace to be agreed locally.

Prepared 8 December 1997

6 NHS Trusts

DoH logo

Partnership and performance

Key themes

- new role helping plan local health services
- responsible for operational management
- new statutory duties for quality and partnership
- new emphasis on staff involvement

A new direction

6.1 NHS Trusts provide hospital and community health care for millions of patients. They employ the vast majority of NHS staff. Their expenditure accounts for some 72% of the total NHS budget. In partnership with local universities and other research bodies, many NHS Trusts also carry important education and research responsibilities alongside their commitment to patient care. The new NHS will give them a new focus on patients' needs.

6.2 By contrast, market-style incentives drove NHS Trusts to compete to expand their 'business' irrespective of whether this reflected local NHS priorities. Their role was further distorted by the almost exclusive emphasis on their statutory financial duties. The potential contribution of NHS Trusts to both national and local health strategies was undermined.

6.3 Many NHS Trusts tried to overcome the limitations of the market but most found themselves driven by these inappropriate incentives. The proposals in this White Paper will free NHS Trusts to use their managerial and clinical expertise to concentrate on providing improved services for patients. There will be clear incentives available to help NHS Trusts succeed. They will be backed by a tough approach to performance management to drive improvements in quality and efficiency.

6.4 In the new NHS:

- in place of competition, NHS Trusts will as a matter of right **participate in strategy and planning** by helping shape the local Health Improvement Programme
- there will be new **standards for quality and efficiency explicit in local agreements** between Health Authorities, Primary Care Groups and NHS Trusts alongside new measures of efficiency
- **doctors, nurses, and other senior professionals will be much more closely involved** in designing service agreements with commissioners, and in aligning NHS Trust financial priorities with clinical priorities
- **clinical governance** arrangements will be developed in every NHS Trust to guarantee an emphasis on quality
- NHS Trusts will be able to share and **reinvest efficiency gains** to improve services in a way consistent with the local Health Improvement Programme
- **public confidence will be rebuilt** through openness, improved governance and public commitment to the values and aims of the NHS.

6.5 These changes will enable NHS Trusts to retain full local responsibility for operational management so that they can make best use of resources for patient care. They will do so within a local service framework that they themselves have played a significant part in creating. They will be accountable to Health Authorities and Primary Care Groups for the services they deliver, and to the NHS Executive for their statutory duties.

Shaping services

6.6 The Government will establish a new statutory duty for NHS Trusts to work in partnership with other NHS organisations. The duty of partnership will require their participation (alongside Primary Care Groups, universities and Local Authorities) in developing the Health Improvement Programme under the leadership of the Health Authority. In turn, the Health Improvement Programme will set the framework for the services NHS Trusts provide and the detailed agreements they make with Primary Care Groups.

6.7 Partnership will be dependent on sharing of information with other NHS organisations. The days of the NHS Trust acting alone without regard for others are over. As well as information on progress against service agreements, NHS Trusts will be required to make available their annual operating plans and regular reports on progress against them to local Health Authorities and Primary Care Groups. Key strategic investment decisions, for example in capital, equipment, or in a new consultant post, will need to be consistent with the local Health Improvement Programme.

Focusing on quality

6.8 There will be a new focus on quality in NHS Trusts, so that patients get the twin guarantee of consistency and responsiveness from their local health services. Quality standards will be central to the new local service agreements between Health Authorities, Primary Care Groups and NHS Trusts. New national policies will build on the professional traditions of standard-setting and self-regulation and the good practice which already exists in so many parts of the NHS.

6.9 The Government will establish best practice through the national policies set out in chapter 7. It will strengthen continuing professional development. It will introduce a system of 'clinical governance' in NHS Trusts to guarantee quality.

6.10 In an NHS based on partnership it will be increasingly important for the staff of NHS Trusts to work efficiently and effectively in teams within and across organisational boundaries. Integrated care for patients will rely on models of training and education that give staff a clear understanding of how their own roles fit with those of others within both the health and social care professions. The Government will work with the professions to reach a shared understanding of the principles that should underpin effective continuing professional development and the respective roles of the state, the professions and individual practitioners in supporting this activity.

Acute and community nursing

The Government is particularly keen to extend the recent developments in the roles of nurses working in acute and community services. Expert nurses are taking on a leadership role, monitoring and educating nurses and other staff, managing care, developing nurse-led clinics and district-wide services. They work across organisational and professional boundaries ensuring continuity and integration of care. The Government is committed to encouraging and supporting the development of nursing practice in these ways.

6.11 NHS Trusts will be expected to strengthen the contribution that nursing can make. To support them in this, the Government will be launching a national consultation on a strategy for nursing, midwifery and health visiting.

Clinical governance

6.12 Professional and statutory bodies have a vital role in setting and promoting standards, but shifting the focus towards quality will also require practitioners to accept responsibility for developing and maintaining standards within their local NHS organisations. For this reason the Government will require every NHS Trust to embrace the concept of 'clinical governance' so that quality is at the core, both of their responsibilities as organisations and of each of their staff as individual professionals.

A quality organisation will ensure that:

- quality improvement processes (eg clinical audit) are in place and integrated with the quality programme for the organisation as a whole
- leadership skills are developed at clinical team level
- evidence-based practice is in day-to-day use with the infrastructure to support it
- good practice, ideas and innovations (which have been evaluated) are systematically disseminated within and outside the organisation
- clinical risk reduction programmes of a high standard are in place
- adverse events are detected, and openly investigated; and the lessons learned promptly applied
- lessons for clinical practice are systematically learned from complaints made by patients

- problems of poor clinical performance are recognised at an early stage and dealt with to prevent harm to patients
- all professional development programmes reflect the principles of clinical governance
- he quality of data collected to monitor clinical care is itself of a high standard.

6.13 This new approach to quality will be explicitly reflected in the responsibilities and management of NHS Trusts. Under the internal market, NHS Trusts' principal statutory duties were financial. The Government will bring forward legislation to give them a new duty for the quality of care. Under these arrangements, Chief Executives will carry ultimate responsibility for assuring the quality of the services provided by their NHS Trust, just as they are already accountable for the proper use of resources.

6.14 Chief Executives will be expected to ensure there are appropriate local arrangements to give them and the NHS Trust board firm assurances that their responsibilities for quality are being met. This might be through the creation of a Board Sub-Committee, led by a named senior consultant, nurse, or other clinical professional, with responsibility for ensuring the internal clinical governance of the organisation.

6.15 These arrangements should build on and strengthen the existing systems of professional self-regulation and the principles of corporate governance, but offer a framework for extending this more systematically into the local clinical community. It is important that these arrangements engage professionals at ward and clinical level. NHS Trust boards will expect to receive monthly reports on quality, in the same way as they now receive financial reports, and to publish an annual report on what they are doing to assure quality. Quality will quite literally be on the agenda of every NHS Trust board.

Driving performance

6.16 In the new NHS, the performance of NHS Trusts will be assessed against new broad-based measures reflecting the wider goals of improving health and healthcare outcomes, the quality and effectiveness of service, efficiency and access. Performance will be judged by greater use of comparative information. Details are contained in chapter 8.

6.17 NHS Trusts and their clinical teams will be held to account on this new basis through their service agreements with Health Authorities and increasingly Primary Care Groups. These will stipulate quality measures so that patient services meet demanding targets for responsiveness. They will be longer-term agreements often covering a minimum of three years (see chapter 9 for more details) rather than the current annual contracts. The longer-term agreements will provide NHS Trusts with incentives to ensure appropriate levels of service usage, replacing incentives simply to increase hospital admissions, whether they were required or not.

6.18 With longer-term agreements will come greater stability for NHS Trusts so that they can confidently plan ahead for changes and improvements in the services they provide. The best NHS Trusts of the future will play their full part in shaping and delivering quality healthcare for the local community, confident of the distinctive contribution they have to make, but respecting the contribution of others, and where appropriate willing to see services move to other organisations.

6.19 NHS Trusts will be accountable to the relevant NHS Executive Regional Office for fulfiling their statutory duties and for their effective operation as public bodies. The effect of their new statutory duties will be to broaden their accountability which until now has rested largely on financial performance. In future they will need also to be able to demonstrate that they have the necessary systems in place to assure quality, and are working in partnership within the framework of the Health Improvement Programme.

6.20 In the new NHS, when performance is not up to scratch in NHS Trusts there will be rapid investigation and, where necessary, intervention. This will take five forms:

- firstly, Health Authorities will be able to call in the NHS Executive Regional Offices when it appears that an NHS Trust is failing to deliver against the Health Improvement Programme
- secondly, NHS Executive Regional Offices will be able to investigate if there is a question over compliance with their statutory duties
- thirdly, the Commission for Health Improvement could be called in to investigate and report on a problem
- fourthly, Primary Care Groups will be able to signal a change to their local service agreements, where NHS Trusts are failing to deliver
- fifthly, the Secretary of the State could remove the NHS Trust Board.

Promoting efficiency

6.21 Efficiency will be enhanced through incentives at both NHS Trust and clinical team level. Many NHS Trusts already devolve budgetary responsibility to clinical teams and involve senior professionals from them directly in the management of the NHS Trust. All NHS Trusts should be developing these approaches. Increasingly, clinical teams will develop and agree the new longer term service agreements with Primary Care Groups. Clinician to clinician partnership will focus service agreements on securing genuine health gain. The efficiency incentives that come with budgetary responsibility will be reinforced by longer term service agreements that allow a share of any savings made to be redeployed by the clinical teams, in a way consistent with the NHS Trust's priorities and the local Health Improvement Programme.

6.22 Partnerships between secondary and primary care clinicians and with social services will provide the necessary basis for the establishment of 'programmes of care', which will allow planning and resource management across organisational boundaries.

Programmes of care

An example is services for patients with diabetes covering support both in primary care and from specialist hospital services, planned as an integrated whole to meet patients' needs over time.

6.23 The requirement for benchmarking will encourage rigorous scrutiny of NHS Trusts' costs and performance. All NHS Trusts will in future publish the costs of the treatments they offer, so that inefficient performance can be identified and tackled. Further details are in chapter 9. The new performance framework described in chapter 8 will ensure over time that data are available locally on the areas that matter most to patients as a basis for planning change and measuring progress.

6.24 Efficiency will also be achieved by bearing down on bureaucracy. The abolition of the internal market will mean a significant reduction in transaction costs, the end of extra-contractual referrals and progressive improvements in efficiency. Together these changes will make it possible to redeploy £1 billion into patient care over the lifetime of this Parliament.

6.25 The move from the market will allow NHS Trust managers to refocus their efforts on the core purposes of the NHS. They will have a critical role in leading the developments set out in this White Paper. The Government wants to see less bureaucracy and administration, but more good management. They are quite different things.

6.26 The Government certainly does not want to see reorganisation for the sake of it. Given the intended integration of primary and community health services, merging community with acute NHS Trusts will not generally be encouraged. Nor will amalgamation of smaller community NHS Trusts be encouraged if this inhibits closer working with local primary care teams. Other mergers arising from local decisions will be considered on their merits, on the basis of demonstrable benefits in health and healthcare, and savings in administration.

Involving staff

6.27 To succeed in the NHS of the future, NHS Trusts will need to develop and involve their staff. In the past this has not been a high priority. In the new NHS it is - for one simple reason. The health service relies on the commitment and motivation of its staff. That is why there will be a new approach to better valuing staff and NHS Trusts will spearhead it.

6.28 NHS Trusts will retain their role as local employers within the NHS. In a national health service, the current mix of national and local contracts is divisive and costly. The Government's objective for the longer term is therefore to see staff receive national pay, if this can be matched by meaningful local flexibility, since current national terms of service for a multitude of staff groups are regarded as inequitable and inflexible. Exploratory discussions on these issues are already under way with staff organisations and NHS employers.

6.29 Pay is but one factor in how staff are rewarded. The Government will work with the NHS to give a higher priority to human resource development. We are currently consulting on a new direction for human resources to encompass action on all issues that affect the quality of the working lives of NHS staff. It will particularly emphasise the need to bring equality and development issues into the mainstream work of the

NHS.

6.30 The NHS Executive has already asked NHS Trusts to tackle a range of immediate human resource priorities. These include measures to promote health at work, through strategies to minimise accidents, avoid violence, and address stress; to recognise and deal with racism; to develop flexible, family-friendly employment policies; to ensure junior doctors have reasonable standards of food and accommodation when on call; and to make sure that staff can speak out when necessary, without victimisation.

6.31 Involving staff in service developments and planning change, with open communication and collaboration, is the best way for the NHS to improve patient care. In the future, NHS Trusts will be expected to be open with and involve their own staff. Open communication, including early discussion of any changes, is part of good management, and all staff should have greater opportunities to contribute their ideas for service improvement. All NHS Trusts should work imaginatively through staff consultative committees and other local arrangements to improve dialogue about decisions affecting local health services.

6.32 Nationally, the Government will establish a Taskforce on improving the involvement of frontline staff in shaping new patterns of healthcare. This will identify and explore new approaches and examples of good practice within the NHS and elsewhere. The Taskforce will involve NHS staff, unions, professional bodies, employers and others. It will provide targeted support and advice, and help developing networks of NHS Trusts interested in taking forward this approach locally. It will not duplicate established NHS industrial relations processes.

6.33 There will be two further changes:

- NHS Trust Boards will be required to review regularly whether they are doing enough to involve staff
- in their annual reports, NHS Trusts will outline their local policy on staff involvement and include the outcome of any negotiations or local initiatives which have been undertaken throughout the year.

6.34 The best NHS Trusts are already promoting greater involvement of clinical professionals in their management. In the future it will be essential for the professional and managerial environment in every NHS Trust to support clinical behaviour which maximises the quality of care patients receive, minimises waste in the way care is offered and makes best use of the skills of nurses, consultants, junior doctors, and

other clinical professionals and support staff.

6.35 It will be important for the right information to be made available to clinicians and for high professional standards to be set and monitored. Equally that the substantial sums invested in education and training support the service objectives of the NHS, and that contractual obligations and incentives support quality, efficiency and effectiveness.

6.36 The NHS Executive and its Regional Offices will provide support through a specific development programme to support the changes set out in this White Paper. The Regional Education Development Groups and local Education Consortia will need to ensure that connections are made between personal and organisational development, and that local and national programmes are complementary.

Regional Education Development Groups

Regional Education and Development Groups bring together the key human resources interests at regional level. They advise Regional Offices on the coherence of consortia workforce plans and on the strategic direction of education and training, and ensure that education responds to service needs and developments.

Rebuilding public confidence

6.37 Greater involvement among staff in NHS Trusts will help rebuild public confidence in the NHS. That confidence was badly dented by the sense that the ethos of the internal market was at odds with health service values.

6.38 In the internal market, NHS Trusts were established as independent statutory corporations, owning assets, and with a financial regime modelled on the private sector. In abolishing the internal market, the Government will amend the NHS Trust financial regime to make it more transparent and more suitable for a public service based on partnership. Control of the estate, comprising land and property, will be retained by NHS Trusts, but Health Authorities will be responsible for monitoring its utilisation to ensure consistency with Health Improvement Programmes and locally

agreed estates strategies. The Government will take reserve powers to ensure that the estate is managed in ways which are consistent with local strategies and the broader requirements of the NHS.

6.39 In addition, the Government will make NHS Trusts more open and accountable. Already action has been taken to ensure that NHS Trusts hold their meetings in public and that Board membership is more representative of the local community. To buttress these changes, no management information in the future will be classified as 'commercial in confidence' between NHS bodies. Such a classification is simply not appropriate for organisations that are publicly funded and accountable and are expected to operate as trusted partners working together to the common goal of better health and healthcare for local people.

6.40 Finally NHS Trusts will be expected to publish annually details of their performance, explicitly reflecting the six new dimensions of performance outlined in chapter 8. From 1999 - 2000, their annual accounts will have to include a statement detailing their clinical governance arrangements, drawing on the approach above.

Making it happen

6.41 The new arrangements go with the grain of what NHS Trusts and their staff want. The expectations laid on NHS Trusts are challenging, requiring good leadership and a positive approach to partnership. The commitment of all concerned will be needed to develop their new role as full participants in the local health service. Formal changes in duties will be introduced through legislation but the new approach to partnership is already developing (for example in the 1998-99 commissioning round) and will continue to grow.

Milestones

1998

- new partnership arrangements will develop, and NHS Trusts will participate in preparation of the first Health Improvement Programmes

- a strategic plan for improving human resource management in the NHS will be published

1999

- (subject to legislation) the new framework of statutory duties will be put in place
- new clinical governance arrangements will be put in place to the same timetable

Prepared 8 December 1997

7 The national dimension

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a one-nation NHS

Key themes

- national leadership to support local development
- new National Institute for Clinical Excellence
- new Commission for Health Improvement

7.1 The White Paper aims to renew the NHS as a one-nation health service offering fairness and consistency to the population as a whole. At the same time, the proposals in the White Paper ensure that the NHS delivers a personal service which is sensitive and responsive to the needs of individual patients. The Department of Health, and within it the NHS Executive, have key roles in helping to achieve an appropriate balance between national consistency and local responsiveness.

7.2 The development of new roles and responsibilities for Health Authorities, Primary Care Groups and NHS Trusts will help the NHS meet these objectives. But it is the job of the Department of Health and the NHS Executive with its Regional Offices to provide leadership and support to enable changes to take place across the NHS. They will give national drive to improved quality and improved performance in all parts of the health service.

7.3 The Department of Health will integrate policy on public health, social care and the NHS so that there is a clear national framework within which similar service development can take place locally. The NHS Executive will develop and implement policy for the NHS.The Government will continue to ensure the costs of the Department of Health and NHS Executive are subject to the same rigour as management costs within the NHS itself. As fewer and larger Health Authorities emerge alongside the development of Primary Care Groups, the role of NHS Executive Regional Offices will need to be kept under review.

Leading on quality

7.4 The NHS Executive and its Regional Offices will be charged with ensuring that quality and responsiveness are instilled at all levels in the NHS. Of course, service quality is essentially determined at local level, through the personal interaction between NHS staffand patients, and the leadership of local management in creating an environment where quality is always to the fore. But there are steps that need to be taken nationally to improve equity and provide a framework for local action.

7.5 The Government is determined that the services and treatment that patients receive across the NHS should be based on the best evidence of what does and does not work and what provides best value for money (clinical and cost-effectiveness). At present there are unjustifiable variations in the application of evidence on clinical and cost-effectiveness. All too often in the past, the same problem has been partially solved in different areas. Best practice has not been shared as it should have been. As a result patients have not had fair access to the best the NHS has to offer.

7.6 The Government will spread best practice and drive clinical and cost-effectiveness in a number of ways:

- by ensuring through the **Research and Development Programme** the provision and dissemination of high quality scientific evidence on the cost-effectiveness and quality of care
- by developing a programme of new **evidence-based National Service Frameworks** setting out the patterns and levels of service which should be provided for patients with certain conditions
- by establishing a new **National Institute of Clinical Excellence** which will promote clinical and cost-effectiveness by producing clinical guidelines and audits, for dissemination throughout the NHS
- by establishing a new **Commission for Health Improvement** to support and oversee the quality of clinical governance and of clinical services
- by working with the professions to strengthen the existing systems of **professional self-regulation**

Research and Development

7.7 The NHS R&D programme already supports a major programme of research assessing the clinical and cost-effectiveness of health technologies. A new programme of work on service delivery and organisation will look at how care is organised. It will provide research-based evidence about how services can be improved to increase the quality of patient care. In addition, the NHS Executive will take a systematic approach to scanning the horizon for emerging clinical innovations. This will help to set research priorities, to provide information for planning services, and to identify the need for clinical and service guidelines which the new National Institute may be commissioned to develop. The R&D programme will also work to improve access to research findings across the NHS, including the development of a new database.

National Service Frameworks

7.8 The Government will work with the professions and representatives of users and carers to establish clearer, evidence-based **National Service Frameworks** for major care areas and disease groups. That way patients will get greater consistency in the availability and quality of services, right across the NHS. The Government will use them as a way of being clear with patients about what they can expect from the health service.

7.9 The new approach to developing cancer services in the Calman-Hine Report, and recent action to ensure all centres providing children's intensive care meet agreed national standards, point the direction. In each case, the best evidence of clinical and cost-effectiveness is taken together with the views of users to establish principles for the pattern and level of services required. These then establish a clear set of priorities against which local action can be framed. The NHS Executive, working with the professions and others, will develop a similar approach to other services where national consistency is desirable. There will be an annual programme for the development of such frameworks starting in 1998.

Calman Hine Cancer Report

The report A Policy Framework for Commissioning Cancer Services was commissioned in response to concerns about variations in treatment across the country. It recommended that cancer services should be organised at three levels: primary care; cancer units in local hospitals with multi-disciplinary teams able to treat the commoner cancers; and cancer centres situated in larger hospitals to treat the less common cancers and support cancer units with services such as radiotherapy, not available in smaller hospitals.

Clinical and cost-effectiveness

7.10 There is a growing body of evidence on which treatments, drugs and other aspects of clinical practice are the most effective and offer best value. But it is not always easy for frontline doctors and nurses to find the evidence they need. Research results are not readily accessible and it is often difficult for busy health professionals to find their way through the proliferation of emerging guidelines, some of which are of variable quality. To ensure consistent access to beneficial care right across the NHS, the Government believes stronger arrangements are needed to promote clinical and cost effectiveness, both for drugs and other forms of treatment.

National Institute for clinical Excellence

7.11 A new National Institute for Clinical Excellence will be established to give new coherence and prominence to information about clinical and cost-effectiveness. It will produce and disseminate:

- clinical guidelines based on relevant evidence of clinical and cost-effectiveness
- associated clinical audit methodologies and information on good practice in clinical audit
- in doing so it will bring together work currently undertaken by the many professional organisations in receipt of Department of Health funding for this purpose
- it will work to a programme agreed with and funded from current resources by

the Department of Health.

7.12 The National Institute's membership will be drawn from the health professions, the NHS, academics, health economists and patient interests. It will need to have access to an appropriate range of skills, including economic and managerial expertise as well as specialist input on specific issues. The Government will consider developing the role and function of the National Institute as it gathers momentum and experience.

Commission for Health Improvment

7.13 To ensure the drive for excellence is instilled throughout the NHS, the Government will create a new **Commission for Health Improvement.** It will complement the introduction of clinical governance arrangements. Past performance on quality has been variable, and the health service has sometimes been slow to detect and act decisively on serious lapses in quality. As a statutory body, at arm's length from Government, the new Commission will offer an independent guarantee that local systems to monitor, assure and improve clinical quality are in place. It will support local development and 'spot-check' the new arrangements. It will also have the capacity to offer targeted support on request to local organisations facing specific clinical problems.

7.14 Where local action is not able to resolve serious or persistent problems, the Commission will be able to intervene on the direction of the Secretary of State or by invitation from Primary Care Groups, Health Authorities and NHS Trusts. In these instances, the Commission will both investigate and identify the source of the problem, and work with the organisation on lasting remedies. It will also be able to recommend to the Secretary of State other immediate action. He will have powers to remove NHS Trust Chairs and non-executive directors where there is evidence of systematic failure. The Commission may also undertake an agreed programme of systematic service reviews, following through implementation of the National Service Frameworks and the guidelines developed by the Institute. The Commission will have a membership drawn from the professions, NHS, academic and patient representatives. It will be funded from existing resources.

Professional self-regulation

7.15 Together, these arrangements should ensure that there are stronger systematic measures to monitor, maintain and improve quality. In the rare instances of serious

service difficulty, there will now be the capacity for prompt and effective intervention. But the Government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice. Professional self-regulation must remain an essential element in the delivery of quality patient services. It is crucial that the professional standards developed nationally continue to be responsive to changing service needs and to legitimate public expectations. The Government will continue to work with the professions, the regulatory bodies, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation by ensuring that they are open, responsive and publicly accountable.

Leading on performance

7.16 The NHS Executive will be responsible for ensuring that the changes in this White Paper are implemented effectively and deliver the improvements that must be made.

7.17 NHS Executive Regional Offices will hold Health Authorities to account for progress in their new strategic leadership role. There will be annual agreements and longer term objectives agreed between the Regional Office and Health Authority on the basis of the local Health Improvement Programme. The Health Authority will be held to account for progress against these.

7.18 Regional Offices will hold NHS Trusts accountable for their new range of statutory duties, with powers to intervene on behalf of the Secretary of State if difficulties - over quality, or over local partnership working within the Health Improvement Programme - cannot be promptly resolved locally.

7.19 To reflect the new partnership and interdependence at local level Regional Offices will integrate their performance management functions. They will also look beyond the roles of individual parts of the NHS to take an overview of the way all parts of the health service in an area are together serving their local population.

7.20 They will look at performance in the round. The new performance framework set out in chapter 8 identifies the range of areas on which the NHS needs to make progress, and sets action in train to measure and manage progress on each of them. This new approach will enable management at all levels to look both at what is being achieved by the NHS as a whole for the local population and to examine the

contribution of individual institutions. Regional Offices will drive the new approach to benchmarking, ensuring poor practice is challenged and good practice is identified and spread.

7.21 Looking beyond the NHS, Regional Offices with the Department's Regional Social Services Inspectorate will jointly lead and monitor local action to strengthen partnerships across health and social care and will jointly review progress in areas such as continuing care and mental health. In addition, better integration of policy-making will require closer working relationships between Regional Offices and other parts of Government operating at a regional level.

7.22 The Regional Offices under the direction of the NHS Executive will also give increased priority to supporting and developing the local leaders who will be critical to the new NHS. Regional Offices will participate in the appointment of Health Authority and NHS Trust Chief Executives as well as supporting and monitoring their development.

Commissioning specialist services

7.23 There is a further new function that will be central to the Regional Office role - providing the means to commission specialist hospital services. The internal market's fragmentation between multiple fundholders and Health Authorities made it difficult to ensure properly coordinated commissioning arrangements for these very specialised services. They are needed for highly complex treatments (such as bone marrow transplants and medium secure psychiatric services) where one centre covers the population of a number of Health Authorities.

7.24 Although Health Authorities have begun to work together voluntarily to plan and fund these services, the results are patchy. A more systematic approach is needed if fair access is to be guaranteed and if clinical staff are to be supported in developing the most suitable and effective care. The Government will therefore introduce new arrangements for planning and commissioning specialist services.

7.25 As a first step, the NHS Executive will discuss with healthcare professionals and managers which services need to be commissioned for populations larger than those of a single Health Authority but below the national level covered by the existing National

Specialist Commissioning Advisory Group and the High Secure Psychiatric Services Commissioning Board.

7.26 Regional Offices will be accountable for ensuring that effective arrangements for commissioning these services are established in each Region. There are a number of ways in which such arrangements have been and could be established, but the principles are clear. Health Authorities and Primary Care Groups will be required to participate in them. The arrangements should be capable of commanding the confidence of the clinical units concerned, while being clearly accountable to the Health Authorities and Primary Care Groups on whose behalf they will be commissioning services. Regional Offices will need to ensure that clear quality control and assurance mechanisms are in place, while bureaucracy is minimised.

7.27 The NHS Executive will discuss with the professions, Health Authorities and NHS Trusts the best way of achieving these aims, drawing on the recent recommendations of the Audit Commission. Regional Offices will ensure that proper arrangements are in place so as effectively to commission specialist services from 1 April 1999.

7.28 Regional Offices have a further role - to make sure breast cancer and cervical cancer screening programmes are subject to proper mechanisms of quality assurance.

Rebuilding public confidence

7.29 The NHS Executive will support the range of initiatives set out in this White Paper on greater involvement for the public, patients and carers. Regional Chairs will promote regional and local partnerships with the community, including stronger working links between the NHS and local government. They will work with local NHS Trust and Health Authority Chairs and non-executive directors, to ensure they are ready to lead their organisations to build the new NHS of the future. At the same time the NHS Executive will involve users and carers in its own work programme.

Milestones

1998

- new Information Management and Technology Strategy for the NHS published
- consultation document on quality issues includes proposals for new National Institute for Clinical Excellence, and Commission for Health Improvement
- discussions with the professions, regulatory bodies, NHS and patient representative groups to strengthen professional self-regulation

1999

- subject to legislation, Institute and Commission established
- new arrangements for commissioning specialist services

Prepared 8 December 1997

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8 Measuring Progress

better every year

Key themes

- new measures of NHS performance
- action to tackle unacceptable service variations
- new national survey of patient experience

Measuring what counts

8.1 The changes in this White Paper equip Health Authorities, Primary Care Groups and NHS Trusts to discharge their new roles and responsibilities. There are clear incentives and sanctions to help them improve performance.

8.2 There must be improvements in quality and efficiency. Improvements in speed of access to care. Improvements in health, tackling past inequalities. The Government requires the new NHS to make progress on all these fronts. A new national performance framework, measuring how local services are progressing against their targets, will help shape NHS services to meet the challenge.

8.3 Under the NHS internal market, performance was driven by what could readily be measured: the financial bottom line and the numbers of 'finished consultant episodes'. The Purchaser Efficiency Index, by being based on these measures, failed to reflect the breadth of what patients expect of the service, and of what staff want to provide. It has had a perverse impact on NHS performance. NHS Trusts, for example, were rewarded for hospitalising patients even where more appropriate treatments may have been given in the community. The experience of the internal market has shown that the way performance is measured and targets are set drives the way the NHS performs. Too narrow a focus or the wrong choice of measures distort priorities within the health service.

The new framework

8.4 The new national performance framework will focus on six areas of performance, selected to capture what really counts for patients and for staff. There will no longer be a narrow obsession with counting activity for the sake of it. Use of the new framework will make it clear to the public and to all those working in the NHS where performance needs to improve. The success of the new NHS will be judged on whether it makes improvements across all areas of the new framework.

8.5 The new framework will demonstrate progress on the overall goals of the NHS, on the key steps the NHS must take to deliver those goals, and on the outcomes it is achieving. It will have six dimensions:

i. **Health improvement**
To reflect the overall aim of improving the general health of the population, which is influenced by many factors, reaching well beyond the NHS.

For example, changes in rates of premature death, reflecting social and economic factors as well as healthcare.

ii. **Fair access**
To recognise that the NHS contribution must begin by offering fair access to health services in relation to people's needs, irrespective of geography, class, ethnicity, age or sex.

For example, ensuring that black and minority ethnic groups are not disadvantaged in terms of access to services.

iii. **Effective delivery of appropriate healthcare**
To recognise that fair access must be to care that is effective, appropriate and timely, and complies with agreed standards.

For example, increasing provision of treatments proven to bring benefit such as hip replacements, provision of rehabilitation at the point when it can offer most benefit, sustained delivery of health and social care to those with long-term needs, and reducing inappropriate treatments.

iv. **Efficiency**
The way in which the NHS uses its resources to achieve value for money.

For example, length of hospital stay; day surgery rates; unit costs; labour productivity; management overhead; capital productivity.

The NHS will be able to assess the impact it has made through offering **fair access** to **effective** care, **efficiently** delivered, by two further measures:

v. **Patient/carer experience**
Through measuring the way in which patients and carers view the quality of the treatment and care that they receive, ensuring the NHS is sensitive to individual needs.

New national patient survey, new NHS Charter.

vi. **Health outcomes of NHS care**
And finally, through assessing the direct contribution of NHS care to improvements in overall health, completing the circle back to the overarching goal of improved health.

For example, trends in infectious diseases for which immunisation programmes are available.

How the new performance framework might work for coronary heart disease

- variations in death rates and risk factors (such as smoking, diet and exercise) across different population groups, for example women or ethnic minorities (health improvement)
- ensuring that services are provided fairly, in relation to need, for effective treatments such as cholesterol-lowering therapy or angioplasty (fair access)
- reducing the time it takes for heart attack patients to receive clot-busting drugs (effective healthcare delivery)
- where appropriate, reducing the length of stay in intensive care after coronary heart surgery; or variations in the cost of coronary artery bypass surgery (efficiency)
- increasing patient satisfaction with the management of their care for coronary heart disease, including shorter waiting times for heart operations (patient/carer experience)
- success in increasing survival rates and reducing illnesses (such as angina or second heart attacks) in patients treated for known coronary heart disease (health outcomes of NHS care)

8.6 The new framework will allow a more rounded assessment of NHS performance. For this reason, without letting up on the drive for genuine efficiency, the Government will be replacing the Purchaser Efficiency Index from 1 April 1999 with measures based on the new broader performance framework. This approach represents a huge break with the past.

8.7 The public expects a one-nation NHS, with consistent standards and services, wherever they live. The single-minded focus on the old market-driven measures of performance disguised the wide variations that exist in the level and quality of services provided. The new performance framework will encourage greater benchmarking of performance in different areas, and the publication of comparative information will allow people to compare performance and share best practice. Coupled with the new National Service Frameworks, the Government will use these measures for a systematic drive to challenge and reduce unacceptable variations in all aspects of performance across the NHS.

8.8 The new framework will be used to chart progress for the population of a Health Authority or Primary Care Group, or to focus on the performance of a particular organisation. It can also be used to examine progress in tackling a particular health problem, and to take a wider look at the delivery of care at the interface between health and social services.

8.9 As part of the new framework, the Government will take special steps to ensure the experience of users and carers is central to the work of the NHS. The current Patient's Charter was introduced without adequate consultation, and concentrated too much on narrow measures of process. A new NHS Charter will therefore be developed in partnership with NHS users and carers and the staff of the service. It will place greater emphasis on the outcomes of treatment and care. It will focus on things that really matter.

8.10 But more is needed. The NHS does not have systematic information about what patients feel about the care it offers. The Government will therefore introduce a new national survey of patient and user experience. It will be carried out annually, at Health Authority level, and the results will be published both locally and nationally. This means that for the first time in the history of the NHS there will be systematic evidence to enable the health service to measure itself against the aspirations and experience of its users, to compare performance across the country and to look at trends over time. The survey will give patients and their carers a voice in shaping the modern and dependable NHS. The first survey will take place in 1998.

Next Steps

8.11 The Government will shortly be publishing a consultation document on the details of the new performance framework and proposals for taking it forward. Subject to the results of the consultation, the NHS Executive will develop new high level indicators as a basis for tracking the six areas of performance through all aspects of the way the new NHS is managed. The Green Paper will develop further targets on improving the nation's health.

8.12 Targets for progress against the six parts of the performance framework will be built into:

- the performance agreements between the NHS Executive's Regional Offices and Health Authorities
- local Health Improvement Programmes
- accountability agreements between Primary Care Groups and Health Authorities
- the long term agreements between the new Primary Care Groups and NHS Trusts
- and the way in which the NHS accounts to the public for its performance.

Milestones

1998

- consultation document on the detail of the new performance framework
- the NHS Executive will roadtest a high level indicator, set with Health Authorities, to begin measuring progress on the new basis
- the first national survey of patient and user experience

1999

- end of Purchaser Efficiency Index and introduction of new performance framework
- the NHS will begin to report performance on this new basis, nationally and locally

Prepared 8 December 1997

9 How the money will flow

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from red tape to patient care

Key themes

- promoting quality and efficiency
- stable funding
- fair budgets
- £1 billion from bureaucracy

The starting point

9.1 The NHS spends more than £1,000 every second. The Government will introduce new arrangements to ensure that NHS cash is spent wisely and effectively. NHS money will flow around the system in a way that supports quality and efficiency. Such a change will be welcomed by both managers and clinicians. They have struggled with a financial system under the internal market that proved chaotic and costly to run.

9.2 In the internal market, NHS Trusts received their funding under annually negotiated contracts with 100 Health Authorities and some 3,500 GP fundholding groups. Many treatments were individually funded on a 'cost-per-case' or 'extra-contractual-referral' basis. The arrangements were built around adversarial negotiations on the cost and volume of services, with little room left to address quality and outcomes.

9.3 The financial regime for NHS Trusts, constructed on a quasi-commercial model, encouraged them to compete for marginal extra income. Health Authorities and GPs, for their part, were expected to attempt to shop around for the 'best buy'. Some family doctors had control over some parts of their budgets but some did not. The result was short-termism that prevented the NHS from planning sensibly for change. Nor did the internal market system prove to be financially disciplined or efficient as record financial deficits and administrative costs both demonstrated.

9.4 The NHS needs funding arrangements which reflect the long-term interdependence of local communities and their local health service, which bring clinicians together to plan improvements over sensible timescales, and which encourage real efficiency as a means to a fair and high quality service.

Funding quality and efficiency

The new financial arrangements will promote access to high quality care right across the country by:

- fairly distributing resources through Health Authoritiesto inclusive Primary Care Groups
- establishing new unified budgets for Primary Care Groups covering hospital and community services, GP prescribing and the general practice infrastructure
- allowing clinicians to influence the use of resources by aligning clinical and financial responsibilities

- Promote efficiency in all areas of NHS activity by:
- offering greater stability and incentives through long-term agreements between Health Authorities, Primary Care Groups and NHS Trusts

- bearing down on costs through benchmarking and a new schedule of national 'reference costs'

- removing the perverse incentives of the market

- reducing bureaucracy by abolishing the internal market.

Fairness

9.5 The Government will raise spending on the NHS in real terms every year and a greater proportion of every pound spent will go on patient care not bureaucracy. In England, the Government has already delivered on this commitment by making available an extra £1 billion for the NHS in 1998-99, and an extra £269 million in 1997-98 to tackle immediate winter pressures and begin the task of modernising the NHS for the long term. Meantime the stream of action to abolish the internal market, culminating in this White Paper, is already redeploying resources to patient services.

9.6 The Government will put in place new mechanisms to distribute NHS cash more fairly. A new Advisory Committee on Resource Allocation will further improve the arrangements for distributing resources for both primary and secondary care. The healthcare needs of populations, including the impact of deprivation, will be the driving force in determining where cash goes. There will be a national formula to set fair shares for the new Primary Care Groups, as there is now for Health Authorities. It will be for Health Authorities to determine the pace of change at which individual Primary Care Groups within their area should move towards their fair share. Regional Offices will monitor progress.

9.7 The Government is putting in place new arrangements to ensure that health service need is the key determinant of funding major capital development in the NHS. This process began with the prioritisation of major acute sector Private Finance Initiative (PFI) schemes. The inherited logjam in PFI has now been broken. The result - the biggest new hospital building programme in the history of the NHS. The Government is establishing a Capital Prioritisation Advisory Group to assess which major capital development projects should proceed. We are also exploring the potential of extending public - private partnerships into non-acute areas, such as information technology and community health services.

Flexibility

9.8 The Government will give clinicians greater control and flexibility over the resources they receive. That means unifying into a single stream of funds three currently separate budgets - for hospital and community health services; family health services prescribing; and cash limited funding for GP practice staff, premises and computers. In the future there will be one stream of cash-limited funds flowing through Health Authorities to Primary Care Groups. That will give GPs the maximum choice about the treatment option that best suits individual patients, free from the constraints imposed by artificially distinct budget headings. It will align clinical and financial responsibility so that those who prescribe, treat and refer have control over the financial decisions they make.

9.9 Within the new framework, the NHS will ensure that all patients have proper access to the medicines they need. The large number of GPs who already have local prescribing budgets have demonstrated the patient care advantages of giving family doctors financial responsibility for their prescribing decisions. The NHS Executive will put in hand work with all the interested players to prepare for a smooth transition to these new arrangements.

9.10 It is equally important to integrate health and social care resources so that patients genuinely get access to seamless services. There are already initiatives in place that channel both health and social care funding to provide a single service for patients. The Government will build on these developments. In 1998, we will consult on ways in which still closer relationships at working level, including joint operation and planning of budgets, might help break down traditional barriers and promote a better service for users and carers. We will require joint investment plans from 1999-2000 for continuing care and community care services.

Stability

9.11 In the new NHS, the short-termism of the market will be replaced by a more stable framework based on longer-term relationships. Locally the Health Improvement Programme will set a shared context - within which Health Authorities, Primary Care Groups and NHS Trusts will reach long-term agreements. These agreements will last for at least three years, but could extend in some circumstances for five to ten years, if that was the appropriate time horizon for implementing a programme of development and change.

9.12 Renewal of agreements will be dependent on satisfactory progress against local objectives, including both cost and quality targets. Primary Care Groups will be able to signal if they wish to make a change either in the nature of the agreement, or in the service provider they use, within the context of the Health Improvement Programme.

9.13 If there are problems with performance, the first step will be for the Primary Care Group and the NHS Trust to explore the difficulty and plan to put it right. The long term agreement could link an element of future payment to satisfactory progress. If there are serious concerns over clinical quality that cannot be resolved locally it will be possible to seek help from the Commission for Health Improvement. If the problem is still not resolved, or there are other reasons to press for change, the Primary Care Group will need to give due notice of the intended change, and to explore its plans with the Health Authority and other users of the service. In this way crucial services for some users will not be destabilised by the actions of others.

9.14 Long-term agreements will replace the annual contracts of the internal market, which wasted so much time, effort and resources throughout the NHS. They will increasingly reflect dialogue between clinicians in primary and secondary care, rather than purely between managers. They will be based around specific services - linked where appropriate to the new National Service Frameworks - rather than whole hospitals. The move away from the annual round to a pattern in which a number of agreements are due for renewal each year will make it possible to look in more depth at service issues and to engage clinicians in planning for improvements over a sensible time horizon.

Long-term agreements

- will focus on service delivery objectives, with primary and secondary care clinicians coming together to develop better integrated patterns of care
- address health and quality objectives, as well as cost and volume, reflecting the new rounded approach to performance
- increasingly focus on 'programmes of care' for the population, and pathways for patients that cross traditional organisational boundaries
- recognise that NHS Trusts must share responsibility for ensuring activity does not get out of kilter with funding.
- provide for the benefits of greater efficiency to be shared between the commissioner, on behalf of the community, and the NHS Trust, for investment consistent with the Health Improvement Programme
- contain incentives for improvement, with funding conditional in part on satisfactory progress against key targets

9.15 To help develop the new approach, the NHS Executive will work with the NHS to assemble a range of default model agreements which local players could use. The aim will be to share good practice as it develops, while minimising unnecessary duplication of local management and clinical effort.

9.16 The combination of new high-level commissioning arrangements for specialist services (as outlined in chapter 7), and long-term agreements which reflect the views of all local GPs, should ensure that all but a small minority of GP referrals to hospitals are covered by these new agreements. On occasion, however, a patient's special clinical needs or personal circumstances will require a GP to make individualised arrangements. It is important that the new system should allow for such cases, but without the bureaucracy associated with the old style 'extra contractual referrals' (ECRs) of the internal market.

9.17 In the ECR system, patients could often find themselves the subject of heated debate between GPs, Trusts and Health

Authorities about whether they were covered by a 'contract' and, if not, whether their care would be paid for. These arrangements added substantially to the bureaucracy of the internal market. The ECR system will be abolished and replaced by simplified arrangements that minimise bureaucracy and eliminate incentives to 'play the market'. A new system will be introduced, based on adjustments to Primary Care Group and Health Authority allocations, rather than invoicing. This will align clinical and financial responsibility, coupling the freedom to refer with the ability to fund. The NHS Executive will issue guidance on the details of implementation by summer 1998, to enable new arrangements to be put in place from April 1999.

Efficiency

9.18 Efficient use of resources will be critical to delivering the best for patients. It is important that managers and clinicians alike have a proper understanding of the costs of local services, so that they can make appropriate local decisions on the best use of resources.

9.19 The pricing arrangements of the market have proved complex, time-consuming, and ultimately unsuccessful in driving efficiency. A more transparent approach is needed. Priorities and performance in the NHS have been distorted by an obsession with measuring changes in the 'Purchaser Efficiency Index' without the same regard for improvements in other areas. Quality has suffered and incentives to increase activity have flown in the face of effective financial management. The old style Purchaser Efficiency Index will be replaced by demanding and better measures of efficiency by 1 April 1999. Chapter 8 has set out plans for a new, balanced approach to assessing the NHS's performance against the things that count most for patients, setting new measures of efficiency within a wider context.

9.20 The new approach will include demanding targets on unit cost and productivity throughout the NHS. The Government will develop a programme which requires NHS Trusts to publish and benchmark their costs on a consistent basis. This will provide a national schedule of 'reference costs' which will itemise the cost of individual treatments across the NHS. Costs for major areas of hospital activity will be available in time to inform long-term agreements for 1999-2000.

9.21 Where the schedule indicates poor performance, Health Authorities, Primary Care Groups and NHS Trusts will need to investigate why, sort out plans to tackle inefficiencies, and build these into long-term agreements. Primary Care Groups will be expected to bear down on NHS Trusts costs over time so as to achieve best possible value for their local community. Where NHS Trusts prove unable to make satisfactory progress over a period of time, the Regional Office will investigate and, if necessary, intervene.

9.22 This new approach replaces the internal market mechanisms with a stronger national drive, consistent with other action to promote comparative information. The new cost data will be made available to the public alongside other data on NHS Trust performance. Over time, this approach will be developed to support the formation of long-term agreements built around programmes of care for patients with different needs, rather than individual treatments.

Cutting bureaucracy

9.23 When it came into office, the Government began the process of dismantling the internal market. In the process it has cut unnecessary red tape and shifted resources into patient care. This White Paper, by completing the abolition of the internal market, will release further resources from bureaucracy.

9.24 NHS Trust management costs will be cut, as a result of reduced transactions, the abolition of ECRs, and progressive improvements in efficiency as part of the drive to improved and more consistent performance. Health Authority costs will be cut, through measures to improve efficiency, to share and streamline core functions, and to reduce administration and transaction costs. Removing the bureaucracy of GP fundholding (which covered only a minority of hospital and community services for half the population) will make it possible to support Primary Care Groups covering all services across the whole of the population while containing expenditure to a level below that planned by the previous Government for fundholding administration in 1997-98.

9.25 In total, £1 billion will be freed up from bureaucracy for patient care over the lifetime of the Parliament. Activities that served the bureaucracy of the market will be stripped away. Future arrangements for measuring and monitoring management costs will reflect the new approach. A modern NHS will need strong leadership, committed to ensuring that all management

activity supports the core purpose of improving health and health care.

Cutting bureaucracy

The Government's action to end the internal market will cut bureaucracy by:

- replacing the annual contract round with long-term agreements
- abolishing ECRs and cost-per-case contracts
- moving from GP fundholding to inclusive Primary Care Groups
- reshaping Health Authorities with savings in core administrative functions to allow reinvestment in their new role
- ending competition and bearing down on NHS Trust management and administrative costs generated by the internal market
- integrating primary care and community trusts, and sharing support functions between NHS organisations.

Milestones

1998

- consultation on steps to improve joint working between health and social care
- first tranche of long-term agreements
- publication of NHS Trusts costs and the schedule of 'reference costs'

1999

- introduction of new combined HCHS, GP prescribing and cash-limited GMS budgets from April 1999

Prepared 8 December 1997

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10 Making it Happen

Rolling out change

Key themes

- building on what works
- Health Action Zones to blaze the trail
- a rolling programme of development

Modernising the NHS

10.1 This White Paper marks a watershed for the NHS. It sets a clear direction for the NHS as a modern and dependable service. But it will not mean a wholesale structural upheaval, generating costs and disruption that get in the way of patient care. The NHS has had all too much of that. There is no appetite amongst patients or staff for such an upheaval. But there is an appetite for change that goes with the grain of the NHS and its traditional values.

10.2 Indeed the NHS has to change. It has to modernise to meet the demands of a new century. The modernisation programme outlined in this White Paper provides the means to deliver easier, faster access to more consistent and higher quality care for patients. Although it cannot all be achieved at once, some improvement will begin immediately. The Government wants to see the NHS getting better every year.

10.3 We have already made a start with early action on each of the themes in this White Paper:

- action to raise standards across the country in breast cancer services and paediatric care, in a single **national** health service
- announcement of new Health Action Zones to explore **new, flexible, local** ways of delivering health and healthcare
- a new approach to **partnership** in the NHS for the 1998-99 commissioning round
- action to improve **efficiency** by reducing management costs
- action teams to tackle inherited rising waiting lists and times, improving **performance** across the country
- rebuilding **public confidence** by opening NHS Trust Board meetings to the public and launching consultation on a new NHS Charter.

10.4 The Government will work closely with those in the NHS, users and carers, and partner organisations on implementation. There will be early consultation papers on some issues. Others will be taken forward locally, but with arrangements to identify and share good practice as it develops. In parallel, the NHS Executive will work with the health service locally to promote the organisational and personal development that must support clinicians and managers as they put these new arrangements in place and respond to the new challenges.

10.5 Early steps will be taken to clear out of the way the obstacles created by the internal market and put in place some building blocks - for example the new Primary Care Groups, and new Institute and Commission to drive the new focus on

quality. The chart at the end of the chapter sets out the early milestones. The main new components of the systems set out in this White Paper will, subject to the availability of Parliamentary time for the necessary legislation, be in place and operational by 1999.

10.6 New Health Action Zones will blaze the trail. Starting in up to ten areas from April 1998, they will bring together all those in a Health Authority area or wider, to improve the health of local people. The accent will be on partnership and innovation, finding new ways to tackle health problems and reshape local services. Health Action Zones will be concentrated in areas of pronounced deprivation and poor health, reflecting the Government's commitment to tackle entrenched inequalities. An early task for each Health Action Zone will be to develop clear targets, agreed with the NHS Executive, for measurable improvements every year.

10.7 The same process of planning and delivering measurable improvements year by year must apply throughout the NHS, nationally and locally. Our programme will develop a new 24 hour nurse-led advice line, reduced waiting times for patients with suspected cancer, and better services in the community through the NHS's own information superhighway. They will all provide faster, modern, reliable services for patients. The forthcoming Green Paper Our Healthier Nation will consult on new national targets for promoting better health. We are already consulting on a new NHS Charter to be published in 1998. The new NHS performance framework will help target further areas for improvement, both nationally and locally.

10.8 This is a tough and challenging programme. On some fronts there will be early progress. Others may be for the long haul. Some may take time to show visible improvement. But the end result will be an NHS that responds to a changed and changing world. Where patients can expect services to be quickly available of consistently high quality. Where medical advance can be harnessed and made more locally available. Where care is there for people when they need it, where they need it. An NHS that is accessible and responsive. An NHS which gets better every year. A modern and dependable NHS.

Early Milestones

1998

- three telephone advice helplines set up
- projects established to demonstrate benefits of NHS' own information superhighway
- new Information Management and Technology Strategy for the NHS published
- consultation documents on quality and performance issued
- Public Health Green Paper Our Healthier Nation issued
- Health Action Zones begin
- new NHS Charter
- first survey of users and carers
- Health Authorities begin work with partner organisations on prototype Health Improvement Programmes for the period beginning 1999-2000
- GP Commissioning Pilots begin
- development work on Primary Care Groups, on new financial arrangements, and on new performance indicators

1999

(Precise timing subject to legislation)

- two week waiting time for urgent suspected breast cancer cases
- new Primary Care Groups begin, subsuming GP fundholding
- new statutory duties on partnership, health and quality
- development of local clinical governance, the new National Institute for Clinical Excellence and Commission for Health Improvement
- new unified local health budgets for hospital and community services, GP prescribing and the general practice infrastructure
- new funding arrangements for NHS Trusts in place

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Annex

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Primary Care Trusts

1. The Government will establish a new form of Trust - the Primary Care Trust - for Primary Care Groups which wish to be independent and are capable of being so. The Government will issue detailed proposals for discussion in due course, but such Trusts could be managed by a board of GPs (drawn from the practices involved), community nurses and managers, and include social services and lay members. The Trust would hold the resources for General Medical Services cash-limited allocations, hospital and community health services and prescribing. One option would be for the Trust to hold a wider range of resources under the so-called 'unified budget' option under the Primary Care Act. GPs who wished to retain their existing independent contractor status under Part II of the (1977) NHS Act would do so.

2. Community health services, and in many cases the NHS Trusts which provide them, will have an important part to play in contributing to the work of Primary Care Groups in commissioning services and in integrating their provision with that of primary care. There will be scope, where a Primary Care Trust is established, for appropriate community health services and their management to become an integral part of the Trust.

3. In such cases it is envisaged that the Primary Care Trust will employ all relevant community health staff and run community hospitals and other community facilities, ensuring these work effectively as part of an integrated system. The precise arrangements will, however, depend on local circumstances.

4. The new Trusts will not be expected to take responsibility for specialised mental health or learning disability services.

5. The Government envisages that the criteria for a Primary Care Group to become independent would include:

    - proper arrangements for financial accountability, including the appointment of the Chair or Chief Executive as the Accountable Officer, and arrangements to ensure the Trust balances its budget and meets its cash limit
    - well developed arrangements for monitoring activity and developing practice-level clinical standards
    - making an effective contribution and working within the Health Improvement Programme set by the Health Authority and partner organisations
    - agreed standards and targets set with the Health Authority
    - broad support locally for the establishment of such a Trust, including amongst those GPs affected.

Primary Care Trusts will be accountable to the local Health Authority.

The Government will evaluate early progress with these arrangements before enabling them to evolve generally.

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Glossary

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A C E G H L M N P R S T

Acute Services
Medical and surgical treatment and care mainly provided in hospitals.

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Calman-Hine Cancer Report
The report A Policy Framework for Commissioning Cancer Services which was commissioned in response to concerns about variations in treatment across the country. It recommended that cancer services should be organised at three levels: primary care; cancer units in local hospitals with multi-disciplinary teams able to treat the commoner cancers; and cancer centres situated in larger hospitals to treat the less common cancers and support cancer units with services such as radiotherapy, not available in smaller hospitals.

Capital
Capital expenditure is spending on the acquisition of land and premises, and on the provision, adaption, renewal, replacement or demolition of buildings, items or groups of equipment and vehicles etc where the expenditure exceeds £5,000.

Cash Limit
The amount of money the Government proposes to spend or authorise on certain services or blocks of services during one financial year.

Clinical Governance
A new initiative in this White Paper (chapter 6) to assure and improve clinical standards at local level throughout the NHS. This includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care.

Clinician
A health professional who is directly involved in the care and treatment of patients, for example nurses, doctors, therapists, midwives.

Commission for Health Improvement
A new national body proposed in this White Paper to support and oversee the quality of clinical governance and of clinical services.

Community Health Councils
Independent statutory bodies which were established in 1974 and represent the interests of the public in the health service in their area.

Community Nurses
Includes practice nurses, district nurses, health visitors, school nurses.

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Extra Contractual Referrals (ECRs)
An arrangement under the NHS internal market to cover a referral to an NHS Trust for which there was no existing contract with the patient's Health Authority of residence or GP fundholder.

Top

General Medical Services
General medical services are services provided by family doctors (GPs) and their staff, as provided for in Section 29 of the 1997 Act, and framed in the General Medical Services Regulations 1992.

GP Commissioning Groups
Pilot projects preparing to go live from April 1998. Based around groups of fundholding and non-fundholding GPs. Will manage a prescribing budget. Will work closely with their local Health Authority to develop health strategies and advise on service developments for local populations.

GP Fundholding
A GP whose practice manages a budget for its practice staff, certain hospital referrals, drug costs, community nursing services and management costs.

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Health Action Zones
A new initiative to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people. Up to 10 Zones, generally covering an area of at least Health Authority size, will be selected to go live from April 1998.

Health Authority
Chapter 4 sets out the role and responsibilities of Health Authorities within the new NHS.

Health Improvement Programmes
An action programme to improve health and healthcare locally and led by the Health Authority. Will involve NHS Trusts, Primary Care Groups, other primary care professionals, working in partnership with the local authority and engaging other local interests. See chapter 4.

Hospital and Community Health Services (HCHS)
The main elements of these are the provision of hospital services, and certain community health services, such as district nursing. These services are provided in the main by NHS Trusts.

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Local Medical Committee
The statutory Local Representative Committee for all GPs in the area covered by a Health Authority. The Health Authority has a statutory duty to consult it on issues including GPs' terms of service, complaints and the investigation of certain matters of professional conduct.

Long-Term Service Agreements
Agreements between Health Authorities or Primary Care Groups and NHS Trusts on the service to be provided for a local population. These replace the annual contracts of the internal market and cover a minimum of three years to offer greater stability. See chapter 9.

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Multifunds
Groups of GP fundholders who agree to pool their budgets and work together.

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National Institute of Clinical Excellence
A new Institute which will be set up to promote clinical and cost-effectiveness and the production and dissemination of clinical guidelines. See chapter 7.

National Schedule of Reference Costs
NHS Trusts will be required to publish their costs on a consistent basis, and the data published in a national schedule of 'reference costs' so that performance on efficiency can be benchmarked. See chapter 9.

National Service Frameworks
National Service Frameworks will bring together the best evidence of clinical and cost-effectiveness with the views of service users to determine the best ways of providing particular services. See chapter 7.

NHS Executive
The NHS Executive is part of the Department of Health, with offices in London and Leeds and eight Regional Offices across the country (see below). It supports Ministers and provides leadership and a range of central management functions to the NHS.

NHS Trusts
NHS Trusts are public bodies providing NHS hospital and community healthcare.

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Performance Framework
The Government will shortly be publishing a consultation document on the new national performance framework set out in this new White Paper. The framework is designed to give a rounded picture of NHS performance and will cover six areas: health improvement; fair access to services; effective delivery of appropriate healthcare; efficiency; patient/carer experience; and the health outcomes of NHS care. See chapter 8.

Personal Medical Services Primary Care Act Pilots
The NHS (Primary Care) Act 1997 allows members of the NHS 'family', ie: an NHS Trust, an NHS employee, a qualifying body and suitably experienced medical practitioners capable of providing general medical services to submit proposals to provide services under a pilot scheme and contract with the Health Authority to do so.
Note: Personal Medical Services are the same types of services that are currently known as General Medical Services.

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

Practice Fund Management Allowance
The public money paid to GPs to meet the extra administrative costs of running a fundholding scheme.

Primary Care
Family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

Primary Care Groups
These new Groups, announced in this White Paper, will bring together family doctors and community nurses. They will contribute to the local Health Improvement Programme and have a budget reflecting their population's share of the available resources for hospital and community health services, the general medical services cash limited budget, and prescribing. These Groups will have the opportunity to become freestanding Primary Care Trusts. See chapter 5.

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Regional Offices
See NHS Executive.

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

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Secondary Care
Specialist care, typically provided in a hospital setting or following referral from a primary or community health professional.

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Total Purchasing Projects
Total purchasers comprise groups of GPs who together purchase hospital and community care services not covered by the fundholding scheme on behalf of their patients, working closely with the Health Authority. Legal responsibility for these services remains with the relevant Health Authority.

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