Department of Health
DEPARTMENTAL REPORT

The Government's Expenditure Plans - 1998-1999

Presented to Parliament by the
Secretary of State for Health
and the Chief Secretary to the Treasury
by Command of Her Majesty
April 1998

Cm 3912

published by The Stationery Office

£15.80 [sterling]

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Foreword by the Secretary of State

It gives me great pleasure to be able to present the eighth annual report of the Department of Health. The work of the Department contributes to the wider Government's drive to deliver on its manifesto commitments and to build a modern Britain built on a strong and stable economy and a decent and fair society.

This year marks both the 50th Anniversary of the National Health Service and the first year of a fresh start under the new Government a fresh start for the NHS, for public health and for social services.

Day in, day out, 24 hours of every day the million people who work in the NHS bind the wounds, heal the sick, comfort the dying and console the bereaved. For most people, in most places, for most of the time they provide a top quality service. It's my job to help them do it and that's what we are doing.

We want to modernise the NHS, making it more responsive to the needs of the people it serves and having the resources and the confidence to embrace new technology, new drugs and new methods of working for the benefits of patients. We are fortunate that the people working in the NHS share this ambition and are devoting their efforts to bringing about the changes and improvements we all want to see. That way everybody in the country will get better services.

We are also taking action to stop so many people getting ill in the first place. Most of all we are doing everything we can to reduce the inequalities in health and life expectation which mar our society. This will be best achieved by other Government Departments helping to get people back to work, to reduce poverty, build new homes, introduce a national minimum wage and cut pollution, crime and disorder.

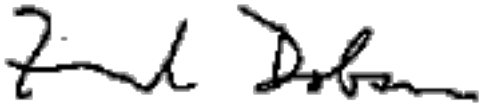
We are promoting better joint working between social services, hospitals, primary and community care so that services are moulded to meet the needs of local people and not the other way round. The close and effective joint working that coped so well during the winter was brilliantly successful and a great credit to all concerned.

Competition has been harming the NHS and it is being banished. The NHS was founded on the concept of partnership and that is what we are promoting again with all parts of the NHS working together instead of working against one another.

Since the new Government came into power on 1 May, we have:

- announced an extra £2 billion for the NHS over previous inherited spending plans;
- broken the logjam in the Private Finance Initiative in the NHS to establish a hospital building programme of over £1 billion the biggest in the history of the NHS;
- promised that £500 million for the NHS announced following the Budget will be targeted on reducing hospital waiting lists below the level inherited from the previous Government by April 1999;
- published plans in the White Paper *The new NHS: modern, dependable* to modernise the National Health Service, including plans to
  create new bodies to drive up standards of quality and efficiency in the NHS;
  create new Primary Care Groups to commission patient care locally;
  get £1 billion out of red tape and into patient care;
  create NHS Direct, a new, nationwide nurse-led telephone helpline to give advice and help to people 24hours a day;
- launched a Green Paper to improve the nation's health and narrow the health inequalities gap proposing four national targets to reduce deaths from heart disease and stroke, cancer, mental health and accidents;
- published White Paper plans to establish an independent Food Standards Agency;
- secured agreement on a common position for a European Directive to ban tobacco advertising;
- completed a review of London's health services to modernise health care in the capital;
- increased the number of women and ethnic minorities appointed to NHS trust boards;
- successfully coped with winter pressures treating record numbers of patients and taking a record number of patients

off the waiting lists thanks to a £300 million boost for the NHS for the winter;
- announced the setting up of Health Action Zones from April 1998, to overcome barriers between health and local authorities and between professions, particularly in areas of high deprivation;
- set up a Royal Commission to look at how long term care for elderly people is funded in the United Kingdom;
- announced the setting up of a Ministerial Task Force to take up the recommendations of the Utting Report a review of the safeguards for children living away from home;
- the launch of Primary Care Act Pilots to go ahead from 1 April 1998;
- set up a new NHS Efficiency Task Force to root out inefficiency;
- set up an independent review of health inequalities by Sir Donald Acheson to report later this year;
- accepted interim recommendations from Professor John Cash's review of Liverpool blood services and pledged further action;
- introduced changes to funding arrangements for students in health care professions following the Dearing Report, providing a new deal for medical and dental students;
- set up a programme to tackle inequality, discrimination and racism in the NHS;
- announced action to claw back millions of pounds owed to hospitals by insurance companies following road traffic accidents;
- announced that all GPs' information technology systems will be brought up to a national quality standard and connected to the *NHSnet*. Rolling programme to complete by 2002;
- set up a new Task Force to advise Ministers on involving staff in improving efficiency and working practices in the NHS. To include non-professional staff such as porters, maintenance workers and cooks as well as doctors, nurses and managers and not just the great and the good;
- launched NHS 50th anniversary year with an education resource pack explaining the workings of the NHS.



Rt Hon Frank Dobson MP

Secretary of State for Health

The purpose of this report is to present to Parliament and the public a clear and informative account of the expenditure and activities of the Department of Health.

If you would like further information on anything contained in the report, or have any comments or suggestions on its content or presentation, please write to:

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The Department also has a Public Enquiry Office which deals with general enquiries, 0171-2104850.

1. Introduction

DEPARTMENT OF HEALTH

1.1 This is the eighth annual report of the Department of Health, providing financial information about its spending programmes. The Department is responsible for the stewardship of over £37 billion of public funds. It advises Ministers on how best to use funding and other mechanisms to achieve their objectives; implements their decisions; and supports Parliamentary and public accountability.

1.2 The Department is responsible for health and personal social services in England. The health programme is funded mainly by central government. The Department sets overall policy on all health issues, including public health matters and the health consequences of environmental and food issues. Itis also responsible for the provision of health services, a function which it discharges through the National Health Service (NHS) and independent contractors such as General Practitioners (GPs), dentists, pharmacists and opticians. The NHS Executive is responsible for managing the performance of the NHS, including holding Health Authorities (HAs) and NHS trusts accountable for performance against their statutory responsibilities.

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

1.4 A complementary document, published by the Department, is the Annual Report of the Government's Chief Medical Officer[1.1], which reports on the state of public health in England, explains changes in the factors which influence public health and identifies areas where improvements could be made.

1.5 For the first time, in May 1998, the Government intends to publish a Government Annual Report. The core theme of the report will be the delivery of the Government's programme to create a modern Britain and a decent and fair society. It will stress that the Government is looking ten years ahead, and that its 1997 General Election manifesto[1.2] set out commitments for the five years of a Parliament.

Aims and Objectives

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

- supporting activity at national level to protect, promote and improve the nation's health;
- securing the provision of comprehensive, high quality health care for all those who need it, regardless of their ability to pay or where they live;
- securing responsive social care and child protection for those who lack the support they need.
- key objectives in pursuing these aims are set out in **Annex A**. The aims and objectives of the Department are being considered as part of the Comprehensive Spending Review (see paragraph 2.3 *etseq*.), and may be revised as a result.

1.7 Meeting these aims comprises the core business of the Department and involves: supporting Ministers, the Permanent Secretary, the Chief Executive, and the Chief Medical Officer to discharge their statutory responsibilities and accountability to Parliament; securing and allocating NHS, social care and other resources and ensuring value for money; managing and developing the organisation and its staff; and enabling the United Kingdom (UK) to play an effective part in the work of the European Union and other international health and social services bodies.

1.8 The main activities supporting these aims are set out in the chapters that follow, covering each of the Department's business areas: public health, the NHS, social care and managing the Department.

1.9 The allocation of Ministerial responsibilities is shown in **Annex D**. The organisation of the Department and of the NHS are shown at **Annex E** and **Annex F**.

Wider Government Objectives

1.10 The aims and objectives of the Department take account of the Government's goal of fostering economic growth and sustainable development. Health care influences economic capacity through the size and quality of the labour force. Health expenditure also influences the development of industries such as research, education, pharmaceuticals and medical devices. In addition, since health care services account for almost 6 per cent of Gross Domestic Product (GDP) in the United Kingdom (UK), the efficiency of this sector contributes substantially to the efficiency of the economy as a whole.

1.11 The aims and objectives support other wider government objectives, such as improving fairness and reducing social exclusion. Differences in expected mortality are the most final form of unfairness. Poor health can be a major barrier to leading a full life and to achieving the rewards society has to offer. Probably the greatest single cause of exclusion from social and economic activity is disability, whether mental or physical. Limiting illness and disability are strongly associated with below-average employment prospects.

Cash Plans

1.12 **Figure 1.1** summarises the cash plans for the Department; further details are given in **Annex B**. **Figure 1.2** summarises local authority expenditure. These sets of figures are discussed in greater detail in the chapters which follow. Only one forward year (1998-99) is presented instead of the normal three in Departmental Reports. The Government will announce its decisions on priorities and expenditure plans for the later years when its Comprehensive Spending Review (see paragraph 2.3 *etseq*.) has been completed.

1.13 Details of spending on health and personal social services programmes in Scotland, Wales and Northern Ireland are published in the Departmental Report of the relevant Office[1.3] [1.4] [1.5]. A breakdown of total government expenditure on these programmes within the UK for current and past years is given in table 1.2 of the *Public Expenditure Statistical Analyses*[1.6]. **Annex C** to this report summarises recent expenditure trends and future spending plans for the NHS in the UK.

1.14 The Departmental Report reflects the simplification of the *Supply Estimates*[1.7]. Additional information previously contained in the *Supply Estimates* can now be found in this Report;**Annex J** provides further information.

Figure 1.1: Summary Cash Plans

Figure 1.2: Local Authority Expenditure[1]

2. Expenditure

THE HEALTH AND PERSONAL SOCIAL SERVICES PROGRAMMES

2.1 The health and personal social services programmes consist of:

- NHS Hospital and Community Health Services (HCHS), providing all hospital care and a wide range of community services;
- NHS Family Health Services (FHS), providing general medical, dental, pharmaceutical and some ophthalmic services and covering the cost of medicines prescribed by general practitioners (GPs);
- Central Health and Miscellaneous Services (CHMS), providing services which are administered centrally, for example certain public health functions and support to the voluntary sector;
- provision of social care by local authorities, supported by the Department of Health and the Department of the Environment, Transport and the Regions programmes; and
- the administrative costs of the Department.

2.2 Provision for these programmes appears in the *1998-99 Supply Estimates*[1.7] for Class XI. Fulldetails of spending, performance and value for money of each of the sub-programmes are contained in the chapters which follow.

Comprehensive Spending Review

2.3 The Government gave a manifesto[1.2] commitment to ask about public spending the first question that a manager in any company would ask: can existing resources be used more effectively to meet our priorities? In June 1997 the Government launched a Comprehensive Spending Review (CSR), co-ordinated by the Treasury, to scrutinise expenditure across all government departments against the Government's objectives. Since then the Department, along with all government departments, has been undertaking a fundamental review of all its spending.

2.4 In the Department, the review is being carried out in the context of the Government's election manifesto commitments that spending on the NHS will increase in real terms each year and 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".

2.5 The outcome of the CSR across Government will be reflected in new spending plans for the remainder of the Parliament, to be announced later in 1998.

NHS Expenditure Plans

2.6 Spending on the NHS in 1998-99 reflects the priority being given to health. The Government gave a manifesto[1.2] commitment to increase spending on the NHS in real terms each year. In its July 1997 budget the Government announced an extra £1 billion for the NHS in England in 1998-99 (£1.2 billion across the United Kingdom, see **Annex C**).

2.7 In its March 1998 budget the Government announced a further £417 million for the NHS in England in 1998-99 (£500 million across the UK), as part of a package of measures to reduce NHS waiting lists and times (see paragraph 4.59 *et seq*.). Such measures have been under discussion as part of the Comprehensive Spending Review, and there were concerns that NHS patients should not have to wait longer than necessary for treatment. The Government therefore decided to implement the conclusions emerging from this part of the CSR.

2.8 The Government plans to increase its current spending on the NHS in England by £1.8 billion to £35,315 million in

1998-99, equivalent to 2.5 per cent in real terms. Government spending on NHS capital will be £1,194 million in 1998-99 and in addition to public capital receipts from sales of surplus land, the NHS is expected to benefit significantly next year from private sector capital investment under the Private Finance Initiative (PFI), see paragraph 4.29 *et seq*. In total the Government plans to increase its spending on the NHS to £36,509 million in 1998-99, equivalent to £1,777 per household. This is an increase of 3.2 per cent in real terms over the original plan for 1997-98 and 2.3 per cent in real terms over estimated outturn for 1997-98. Current spending on the HCHS will grow by 4.4 per cent in real terms over original plans, 2.9 per cent in real terms over estimated outturn for 1997-98. HCHS current allocations to HAs on 27October 1997 represented an average real terms growth of 1.9 per cent, using the forecast GDP deflator for 1998-99 at the time of 2.75 per cent. On this basis, the increase was the highest for five years.

2.9 In October 1997 the Government announced[2.1] that an additional £269 million, including £30million to be released from efficiency savings, had been made available in 1997-98 to help ease winter pressures in the NHS in England (£300 million across the UK). The bulk of this money (£159million) was allocated to Health Authorities (HAs); £80 million to family health services. A further £30 million is to be generated through efficiency savings by tackling prescription fraud (see paragraph 4.116 *et seq*.), increasing income from road traffic accidents (see paragraph 2.17) and other measures flowing from work on efficiency (see paragraphs 4.109 *et seq*.). These additional resources are non-recurrent, and have been used to improve services, relationships and systems in a way that will have longer term benefits and provide a platform for improvements in the future, for example by improving co-operation between HAs, social services departments, GPs and NHS trusts. See also paragraphs 4.68 and 4.99.

2.10 Full details of outturn and planned expenditure on the NHS both in total and for each of its sub-programmes are given in **figure 2.1**. This shows net expenditure (that is, spending financed by the Exchequer) as well as gross expenditure (that is, including the additional sums available to the health programme from receipts from the sale of surplus land, charges and income from private patients etc).

2.11 Figure 2.1 reflects the areas in which funds are spent. By contrast, **Annex B** reflects the classification used for technical reasons when funds are voted by Parliament for the NHS. The main difference from figure 2.1 is that in Annex B spending by GP fundholders on drugs is included with HCHS, not FHS. Full details of the adjustments made to the Annex B figures to produce the presentation used in figure 2.1 are given in the notes to the tables. All NHS figures quoted in the remainder of this report relate to figure 2.1. UKexpenditure figures are given in **Annex C** to this report.

Figure 2.1: National Health Service, England By Area of Expenditure

2.12 **Figure 2.2** compares net expenditure on the NHS in 1997-98 and the planned expenditure for 1998-99 with the figures published in last year's Departmental Report[2.2].

Figure 2.2: Comparison of Expenditure Plans for 1997-98 and 1998-99 with those in last year's Departmental Report (Cm 3612)

2.13 The main areas of change (£10 million or over) to the spending plans for the various parts of the programme are shown in **figure 2.3**.

Figure 2.3: Main Areas of Change (£10 million or over) to the Spending Plans presented in last year's Departmental Report (Cm 3612)

NHS Expenditure Trends

2.14 Net expenditure on the NHS in 1997-98 is forecast to be £34,688 million, an increase of 34per cent in real terms (measured by the GDP deflator) since 1987-88. Theequivalent gross figure is forecast to be £36,438 million. **Figure 2.4** shows how NHS expenditure has grown in real terms over the period.

Figure 2.4: Growth in Real Terms in NHS Gross Expenditure (1996-97 prices)

2.15 The largest part of NHS spending is on the Hospital and Community Health Services: outturn forecast at £25,184 million on current and £1,617 million on capital in 1997-98. Within the HCHS total, £819 million is forecast for Family Health Services (FHS) cash limited spending. The total non-cash limited FHS account for £8,703 million. The remainder will be spent on the Central Health and Miscellaneous Services and Departmental Administration (see **figure 2.5**).

Figure 2.5: NHS Gross Expenditure, 1997-98 (Estimated Outturn)

NHS Sources of Finance

2.16 The NHS is financed mainly through general taxation and an element of National Insurance Contributions. In 1997-98 it is estimated that 93.6 per cent of gross NHS spending in England will be met from these two sources: 80.8 per cent from the Consolidated Fund, that is, from general taxation, and 12.8 per cent from the NHS element of National Insurance contributions. Decisions taken in public spending rounds relate to the total amount of spending to be financed through public expenditure. Changes in the sums raised by the NHS element of National Insurance contributions (for example, because of an increase in earnings) therefore do not in themselves provide more or fewer resources for the NHS in total, but merely change the balance of funding between the taxpayer and the contributor. The remainder of NHS expenditure comes from charges and receipts, including land sales and the proceeds of income generation schemes (see **figure 2.6**). **Figure 2.7** shows how sources of finance have changed over time.

Figure 2.6: NHS Sources of Finance, 1996-97

Figure 2.7: NHS Sources of Finance[1]

Road Traffic Act Charges

2.17 In his budget speech on 2 July 1997, the Chancellor of the Exchequer said that action would be taken to recoup in full the cost of treating road traffic accident victims. A scheme for doing this is currently in preparation and, when fully operational, is expected to raise over £100 million a year, compared with current income of around £14 million. In the meantime, NHS trusts have been urged to step up their efforts to recover their costs under the current scheme.

Personal Social Services (PSS) Expenditure

2.18 The Department is also responsible for determining the necessary resources for the delivery of high quality social care through local authorities and other agencies. The resources provided for this from the Department's public expenditure programme are shown in **Annex B**. Full details of the range of services provided and how they are resourced are contained in Chapter 5.

2.19 **Figure 2.8** shows total local authority current and capital expenditure on personal social services (PSS). Local authority PSS net current expenditure has increased by over 80 per cent in real terms between 1987-88 and 1997-98. There has been a substantial increase in current expenditure from 1993-94, which reflects, amongst other things, the new responsibilities placed on local authorities as a result of the community care reforms[2,3] which took place in April 1993. The growth in net current expenditure is illustrated in **figure 2.9**.

Figure 2.8: Expenditure on Local Authority Personal Social Services

Figure 2.9: Growth in Real Terms in Net Current Expenditure on Personal Social Services, 1987-88 to 1997-98

3. Public Health

INTRODUCTION

3.1 The aim of the Public Health group is to support activity at national level to protect, promote and improve the nation's health. The provision for this aim appears principally in the 1998-99 *Supply Estimates*[1.7], Class XI, Vote 2. The aims and objectives for the Department of Health are set out in full at **Annex A**. They are subject to revision as part of the Comprehensive Spending Review. The Public Health group contributes to objective A.

3.2 The Public Health group is directly responsible for expenditure of approximately £325 million in 1998-99 which includes £39 million from Vote 1 for vaccine purchase. Additional expenditure on European Economic Area medical costs, grants to voluntary organisations and the Policy Research Programme (see paragraphs 3.4 and 3.5) also form part of the total expenditure of £619 million shown in **figure 3.1**.

3.3 The resources are used in three ways:

- to develop a **health strategy**. The Department's objective is to raise standards and set targets to galvanise and encourage widespread improvements in public health, and in particular a narrowing of current inequalities in health. This sets the framework for the efforts of central government, the NHS and local government and provides a focus for effective action;
- to **provide services** centrally. The Department works across government and with local agencies and groups on a range of measures designed to improve the health of the public. Anumber of these services can most effectively and efficiently be provided from the centre;
- to **provide information**. This is in line with the Department's objectives to provide accurate and accessible information on how to reduce the risk of illness, disease and injury; and to encourage people to live healthier lives.

Examples of new initiatives and current issues in these three areas are given at paragraphs 3.7 to 3.39 below.

RESOURCES

3.4 In addition to the resources of the Public Health group, the great majority of the Department's programme expenditure on public health functions is subsumed within NHS general funding. Direct Public Health expenditure is contained within the Central Health and Miscellaneous Services budget (see **figure 3.1**) and includes:

- the Welfare Food Scheme. This provides entitlement to free liquid and dried milk and vitamins for families with children under five and expectant mothers receiving Income Support or an income-based Jobseeker's Allowance; subsidised dried milk for families with children under one receiving Family Credit; and one-third of a pint of free milk daily to children under five in non-residential care;
- expenditure on European Economic Area (EEA) medical costs is for treatment given to United Kingdom (UK) nationals by other member states. This continues to grow as a result of increases both in the number of people treated and in the treatment costs in member states;
- some 94 per cent of expenditure on medical, scientific and technical services is for the Public Health Laboratory Service Board, the National Biological Standards Board, the Microbiological Research Authority and the National Radiological Protection Board (whose functions are described in **Annex H**). These public bodies also carry out much of the Department's research in the field of public and environmental health, partly in support of their own functions;
- grants to voluntary organisations go primarily to national organisations, across the spectrum of health and social services activity;
- some 71 per cent of expenditure on information services is for the Health Education Authority (its function is described in **Annex H**).

Figure 3.1: Central Health and Miscellaneous Services Gross Expenditure, 1997-98 (Estimate)

Policy Research Programme: Public Health

3.5 A significant contribution to developing effective public health strategies comes from the Department's Policy Research Programme (PRP)[3.1]. The research programme includes work on health inequalities, nutrition, sexual health, Human Immunodeficiency Virus (HIV) and Acquired Immuno-Deficiency Syndrome (AIDS), air pollution, skin cancer, occupational or environmental exposure to chemicals, hospital acquired infections, an immunisation strategy, hepatitis C and transmissible spongiform encephalopathies. In the region of £7 million or 26 per cent of the PRP budget is planned to be used to develop effective public health strategies. For further information about PRP expenditure see paragraphs 4.147 and 5.19.

Departmental Spending on Publicity and Advertising

3.6 In 1997-98 total expenditure on health promotion is expected to be £43.4 million. Abreakdown of the main components of spending across the Department in 1997-98 is shown in Chapter 6, figure 6.7. Amounts are listed individually for the main Health Education Authority (HEA) campaigns on smoking, drugs, physical activity, HIV/AIDS, vaccination and immunisation, contraceptive education, unwanted conceptions, alcohol and nutrition. In 1998-99 the total anticipated expenditure on health promotion is £40 million. However, the actual figure is likely to be higher due to projected HEA receipts from other sources.

PUBLIC HEALTH GROUP: OBJECTIVES AND PERFORMANCE

Objective

A Public Health Strategy:

- **raising standards and setting targets to galvanise and encourage widespread improvements in public health, and in particular, a narrowing of current inequalities in health.**

New Initiatives

Minister for Public Health

3.7 For the first time, the Government has appointed a Minister for Public Health. Public health is a broad remit involving many other government departments. As well as covering specific policies such as tobacco and food safety, the Minister's key policy issues include developing the Government's new health strategy for England, *Our Healthier Nation*[3.2]. The Minister will chair the European Union (EU) Health Council during the UK's EU Presidency. The Minister's responsibilities are set out at **Annex D**.

***Our Healthier Nation* Green Paper**

3.8 The Government published a Green Paper, *Our Healthier Nation*[3.2] in February 1998, for consultation through spring 1998. *Our Healthier Nation* addresses the manifesto[1.2] commitment that the Government would set goals for improving the health of the population, taking account of the effect of poverty, unemployment, poor housing and a polluted environment on health. The Green Paper emphasises the need for action at three levels: government, community and individual. The new strategy will replace *The Health of the Nation*[3.3] (see paragraph 3.22).

3.9 The final strategy will be published later in 1998. It will benefit not only from the responses to consultation but also

from Sir Donald Acheson's work on health inequalities (see paragraph 3.19) and the Interim Review of *The Health of the Nation* being conducted by the Nuffield Institute and the London School of Hygiene and Tropical Medicine, as well as experience and good practice gained from work on *The Health of the Nation*.

3.10 Schools and workplaces have a central role to play as the new public health strategy develops. The Department continues to work closely with the Department for Education and Employment to develop the healthy schools initiative. It also works with the Department of the Environment, Transport and the Regions and other Departments and agencies to improve and protect public health through improvements to the environment, such as the setting of health-based objectives in the National Air Quality Strategy[3.4].

Health Impact Assessment

3.11 Policy developments in areas outside the Department of Health's responsibilities frequently impact on the health of the public. In July 1997 the Government agreed that relevant policies should be subject to health impact assessments to measure the costs and benefits of relevant key policy developments in terms of the health of individuals and the population as a whole. Officials are working to identify suitable policies across government for assessment.

Smoking

3.12 Action to reduce smoking is a government priority. There is wide consensus among tobacco control experts that a broad package of measures is needed, and the Government is taking action on a number of fronts. For example, reducing smoking among children and young people is a key priority. **Figure 3.2** shows the prevalence of smoking among school children.

Figure 3.2: Prevalence of Regular Cigarette Smoking in Children Aged 11-15 Years, by Sex, England 1982-1996

3.13 The Government gave a pledge in its election manifesto[1,2] to ban tobacco advertising. At the European Union Health Council in December 1997, a common position was agreed on the European Community (EC) Directive banning tobacco advertising. The Directive will ban advertising on posters and in magazines, promotional activities, free distribution of tobacco products and indirect advertising. The common position text will now be examined by the European Parliament and formal adoption by the EC is expected to follow that process.

3.14 The Government will publish a White Paper on all aspects of tobacco control, together with its plans for implementing the ban on tobacco advertising, in summer 1998. Ministers decided to take the best national and international expert advice in formulating the White Paper. The Minister for Public Health hosted a summit in July 1997 where the full range of issues was considered, including: the scope of the advertising ban, consumer protection, price, tax and fiscal measures, public education, smoking in public places and helping people to stop smoking. The conclusions of the summit are being used to inform the content of the White Paper.

3.15 The NHS has a key role to play as the White Paper proposals are developed and implemented. The issues for the NHS range from achieving a Smoke Free NHS to developing the role of health professionals in smoking cessation services and public education.

3.16 The Report of the Scientific Committee on Tobacco and Health (SCOTH)[3.5] was published in March 1998. It concluded that long term passive smoking in non-smokers causes a 20-30 per cent increased risk of lung cancer. This could account for several hundred lung cancer deaths per annum in the UK. A detailed review of data linking exposure to environmental tobacco smoke and lung cancer was carried out for SCOTH by the Committee on the Carcinogenicity of Chemicals in Food, Consumer Products and the Environment and their statement was annexed to the SCOTH report.

The UK Anti-Drugs Co-ordinator (the "Drugs Czar")

3.17 The Government fulfilled its manifesto[1,2] commitment with the appointment of the UK Anti-Drugs Co-ordinator, Keith Hellawell, and his deputy, Mike Trace, to lead the development of the Government's new drugs strategy. They will report to Ann Taylor, President of the Council and chair of the Cabinet sub-committee on drug misuse. The Department is contributing to the strategy through its responsibilities for treatment, policy and publicising public health messages on prevention and reducing harm.

3.18 Key contributions will be the further reports of the *National Treatment Outcome Research Study* (NTORS) which is tracking 1,000 drug users through various forms of treatment over a five year period. The interim reports so far published[3.6 3.7] demonstrate significant benefits not only in levels of drug misuse, the health of individual drug misusers and risk-taking

behaviour, but also in terms of reducing criminal behaviour and improving social functioning. The Department is also providing funding of £580,000 over three years from 1997-98 for the new Substance Misuse Advisory Service to support and advise health and local authorities in their commissioning of drug and alcohol services, and will be publishing revised clinical guidelines for doctors treating drug misusers in 1998.

Health Inequalities

3.19 **Figure 3.3** shows how infant mortality affects different social classes, and **figure 3.4** shows how men's and women's life expectancy differs. In July 1997 the Secretary of State asked Sir Donald Acheson to carry out an independent inquiry into inequalities in health such as these. He is looking for trends in inequalities in health and is examining scientific and expert evidence on which areas for future policy development are likely to give feasible opportunities for interventions to reduce health inequalities. Sir Donald is due to report later this year.

Fig. 3.3:Infant Mortality by Social Class[1] England and Wales, 1996

Fig. 3.4:Life Expectancy at Birth in England, 1979-1996[1]

3.20 Other work on inequalities is proceeding on a number of fronts. Fair access to health services in relation to need, irrespective of geography, class, ethnicity or sex, is one of the six main areas of the new national performance framework, as set out in the White Paper *The new NHS: modern, dependable*[4.1]; there is a new programme of inequalities research; Health Action Zones are being established (see paragraph 4.54) to address the most pressing geographical inequalities in health; and healthy living centres are being established (see paragraphs 3.23 and 3.24).

Chief Medical Officer's Project on the Public Health Function

3.21 The Chief Medical Officer (CMO) announced in June 1997 the establishment of a project to consider the range of current public health activities at local, regional and national levels with a view to ensuring that there is a robust public health function to deliver the Government's public health strategy and agenda. A report[3.8] was published in February 1998 and a final report will be published in the summer of 1998.

Current Issues and Recent Trends

Health of the Nation **Monitoring**

3.22 As mentioned at paragraph 3.8 above, the *Health of the Nation* strategy is being replaced by the new strategy *Our Healthier Nation*[3.2]. While the new strategy is being developed, monitoring of the 27 *Health of the Nation* targets continues, and for most of these, progress is generally in the desired direction. The target for gonorrhoea incidence has been achieved, targets for cervical cancer incidence, giving up smoking in pregnancy and accidental deaths among children and young people have been reached ahead of schedule. However, the prevalence of schoolchildren smoking has continued to rise, and the *Health Survey for England*[3.9] shows an increasing proportion of men and women classified as obese.

Objective

- **Working across Government and with local agencies and groups on a range of measures designed to improve the health of the public.**

New Initiatives

Healthy Living Centres

3.23 The National Lottery Reform Bill[3.10] was introduced in the House of Lords in December 1997 and will establish a new "good cause" for health, education and the environment. One of the first initiatives to be funded by the new "good cause" will be a network of healthy living centres. The common purpose of healthy living centres will be to promote health, helping people of all ages to maximise their health and well being.

3.24 Healthy living centres will contribute to the Government's health strategy and give priority to schemes which reach those with worse health than average or who may not be accessing existing services. The initiative will complement the Health Action Zones initiative (see paragraph 4.54) which also aims to tackle inequalities in health and target areas of deprivation.

The Food Standards Agency

3.25 A White Paper, *The Food Standards Agency: a force for change*[3.11], was published in January 1998, fulfilling the Government's manifesto[1.2] commitment to introduce major changes in the arrangements for handling food safety and standards in the UK. *A force for change* sets out the Government's proposals for a Food Standards Agency to promote high standards throughout the food chain, from the point of production to the point of consumption. Under these proposals the Agency will take over responsibility from the Ministry of Agriculture, Fisheries and Food and Health Departments for all aspects of food safety and food standards and certain aspects of nutrition policy. The Agency will also provide information and educational material on food matters for the public. It will operate under guiding principles which put the protection of public health in relation to food as its first priority. TheGovernment proposes that the Agency will be a public body with advisory and executive powers. Itwill report to Health Ministers, with the Secretary of State for Health taking the lead.

3.26 Following a period of consultation on the White Paper ending in the spring, the Government intends to publish a draft bill for consultation in the summer of 1998. Subject to the passage of the necessary legislation, it is hoped that the Food Standards Agency will be established towards the end of1999.

Food Safety

3.27 In summer 1997 the Government accepted all of the recommendations made in the Pennington Report[3.12] on food safety. Significant recommendations for the Department included: enhanced enforcement at high risk premises; selective licensing for butchers; and accelerated introduction of Hazard Analysis Critical Control Point (HACCP) procedures. The Minister for Public Health announced additional funding of £19 million across Great Britain (GB) to strengthen enforcement and accelerate HACCP. Enforcement codes of practice[3.13 3.14] concerning Inspection Frequency and Hazard Warnings Systems have been revised to facilitate the relevant changes. Selective licensing proposals for butchers are being developed for consultation.

3.28 In September 1997 the Advisory Committee on the Microbiological Safety of Food (ACMSF) was asked to consider the results of a Department-commissioned survey on cows' raw milk for drinking, together with a study by the Public Health Laboratory Service (PHLS). Following the recommendation of the ACMSF that the sale of cows' raw drinking milk should be banned, there was consultation on the proposal from November 1997 to February 1998.

3.29 In July 1997, the Government announced that controls on the sale of vitamin B6 dietary supplements would be introduced, following advice from the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT) that high doses can cause toxicity. Advice on the safe levels of intakes of other vitamins and minerals sold as dietary supplements will be sought via an ad hoc expert group, which will report to the Food Advisory Committee in 1999.

Current Issues and Recent Trends

Creutzfeldt-Jakob Disease (CJD)

3.30 The Department continues to monitor the incidence of CJD via the government-funded National CJD Surveillance Unit, which collects and analyses case history data on all CJD patients so that any emerging risk factors can be identified. The Unit was reviewed in 1997, and the Department is implementing the review's recommendations for strengthening the role of the Unit. The Department is also funding active surveillance of dementias in children and the elderly to determine if there are any newly-emerging diseases in these groups, and retrospective studies to ascertain whether previous cases have been missed.

3.31 In addition, a specialist group has been set up to assess the information on the epidemiology of new variant CJD (nvCJD) and develop advice on trends of the disease. There is still much not known about this disease, including important information on the incubation period, the route of infection, the level of exposure required to cause disease and the role of genetic susceptibility. It is therefore likely to be some years before soundly based forecasts of the likely future course of the disease in the population can be made.

3.32 Future research will be widened to include work on the safety of blood and blood products. Research into the human health aspects of transmissible spongiform encephalopathies (TSEs) remains a priority and the Department has allocated some £5 million for this over the two years 1997-98 to 1998-99.

3.33 The Department's first priority is the protection of public health, and it works closely with the Ministry of Agriculture, Fisheries and Food (MAFF) and other Departments to ensure that all TSE-relatedissues with potential public health implications are considered by the expert Spongiform Encephalopathy Advisory Committee (SEAC), and that any measures required to protect public health are put in place as quickly as possible. The Department is participating in the Bovine Spongiform Encephalopathy (BSE) Inquiry, which was announced in December 1997. This is a non-statutory Inquiry to establish and review the history of the emergence and identification of BSE and nvCJD in the UK, and of the action taken in response to it up to March 1996. The Inquiry is due to report its findings by summer 1999.

Human Immunodeficiency Virus (HIV) and Acquired Immuno-Deficiency Syndrome (AIDS)

3.34 In November 1997, Ministers established an Expert Working Group to undertake a stocktake of the HIV/AIDS treatment and care budget, to ensure that the way the budget is allocated keeps pace with the way services are changing in response to clinical advances. The Group, which is made up of leading clinicians, health authority (HA) and NHS trust chief executives and representatives of the voluntary sector, will take a thorough look at the current pattern of services and use of the budget, before making recommendations on a long-lasting allocation formula.

3.35 The risk of transmitting HIV from an infected woman to her child can be reduced if the infection is diagnosed before the birth. The Department is investigating ways to increase the uptake of HIV testing by pregnant women. A leaflet designed to provide pregnant women with the information to enable them to reach an informed decision about HIV testing will be piloted in some antenatal clinics in 1998.

Immunisation

3.36 Immunisation protects children and adults against many diseases. Record rates of immunisation have resulted in reducing childhood diseases to very low levels in England. Combating meningitis remains a priority and the 1997-98 awareness campaign was launched with the news that a £1 million meningitis vaccine research programme started in 1997. **Figure 3.5** shows progress in the take-up rates in immunisation between 1966 and 1996-97.

Figure 3.5: Immunisation: Percentage of Children Completing Selected Immunisations by their Second Birthday, England, 1966 1996-97

Objective

- **Provide accurate and accessible information on how to reduce the riskof illness, disease and injury; and**
- **to encourage people to live healthier lives.**

New Initiatives

Conceptions Among Under-16 Year Olds

3.37 England has one of the highest rates of conception among under-16 year olds in the developed world. There is considerable geographical variation and a strong correlation with social class and social exclusion. The Government is committed to working towards the reduction of teenage conception rates and to targeting resources on groups at highest risk, for example children looked after by social services, school truants and those excluded from school, those from the most socially deprived areas and runaway teenagers. Four cross-sector task groups have been set up to promote practical ways to reduce unwanted conceptions. The work is being progressed in close co-operation with the Department for Education and Employment. **Figure 3.6** shows conception rates among young women aged under-16 in England by geographical distribution.

Figure 3.6: Inequalities in Conception Rates Below Age 16, by District Health Authority, 1993-1995

Source: Public Health Common Data Set 1997.

Nutrition

3.38 The Committee on Medical Aspects of Food and Nutrition Policy (COMA) published a report on *Nutritional Aspects of the Development of Cancer*[3.15] early in 1998. The report contains recommendations on diet and nutrition to help reduce risk of cancers. These recommendations will be included in a briefing paper for professionals to be published jointly by the Department and the Health Education Authority.

3.39 The report of the 1995 survey of infant feeding[3.16], which covered all the UK, was published in May 1997. This showed that since 1990, rates of breastfeeding at birth had increased in England, Scotland, Wales and, particularly, Northern Ireland, though rates there remained below the UK average. The report of a survey of infant feeding in Asian families in England[3.17] showed that mothers from the Asian community in England have higher initial rates of breastfeeding than white mothers living in the same neighbourhoods though the breastfeeding pattern becomes more complex as the babies get older. The Department supports professional and voluntary groups in their work to promote and sustain breastfeeding.

4. National Health Service

NHS EXECUTIVE: AIM AND OBJECTIVES

4.1 The aim of the NHS Executive is to secure the provision of comprehensive, high quality health care for all those who need it, regardless of their ability to pay or where they live. Provision for this aim appears in the 1998-99 *Supply Estimates*[1.7], Class XI, Vote 1.

4.2 The aims and objectives for the Department of Health are set out in full at **Annex A**. They are subject to revision as part of the Comprehensive Spending Review. The NHS contributes to objectives A, B and C. Chapter 3 describes how the NHS helps to achieve objective A in partnership with the Department's own public health work. This chapter sets out activities supporting objectives B and C.

4.3 The NHS Executive is an integral part of the Department (see **Annex E**). It provides leadership and a range of central management functions to the NHS. It supports Ministers in developing policy on health and health services, and is responsible for the effective management of the NHS and the stewardship of NHS resources. In doing so it meets the requirements of public and Parliamentary accountability, and supports the NHS in improving the health of the population.

THE NHS: FUTURE DEVELOPMENT

4.4 The future shape and direction of the NHS has been set out in the White Paper *The new NHS: modern, dependable*[4.1], further details of which are set out at paragraph 4.41 *et seq*. The structure of the NHS, both now and as described in the White Paper are shown in **Annex F**.

4.5 The following areas for development in 1998-99 have been identified:

- development of a leading role for **primary care**;
- provision of comprehensive **mental health** services;
- improved **clinical and cost effectiveness**;
- giving greater **voice and influence to users**;
- meeting **continuing health care** needs;
- developing NHS organisations as **good employers**.

Fuller information on these areas for development are set out in *Priorities and planning guidance for the NHS: 1998-99*[4.2].

NHS 50th Anniversary

4.6 The 50th anniversary of the NHS is on 5 July 1998, "NHS Day", and the whole of 1998 is being treated as a year in which to celebrate the achievement of the service. The anniversary presents a series of opportunities:

- for the country as a whole to reflect on the contribution the health service has made to the life of the nation since 1948;
- for the NHS itself to promote better health and to involve people in the way it plans for the next fifty years;
- above all, to reaffirm the founding principles of the NHS and to further its core aims.

4.7 The focus of the anniversary will be local. NHS services touch everyone, wherever they live. The NHS locally, with its staff, patients, voluntary groups, social, sporting, leisure, arts and other partner organisations will be marking the occasion in ways which reflect the service's purpose and which suit them and their communities.

4.8 National support for local activities is provided by a National Steering Group of health and health-related organisations throughout the United Kingdom (UK), including representatives of professional bodies, Royal Colleges, trade unions, social

services, patients' interest groups and GPs. TheSteering Group has co-ordinated a core national programme of events and initiatives around three objectives, as set out below.

Promoting Better Health

4.9 Initiatives include:

- "The Ideal Health Show", at Olympia, from 3-6 July;
- Local Partnership Awards;
- an anniversary Web site containing a range of health information (at http:\\www.nhs50.nhs.uk).

Spreading Good Practice in Health and Health Care

4.10 There will be:

- an anniversary lecture series;
- an international conference: "All Our Tomorrows";
- an anniversary fellowships programme;
- a series of anniversary debates.

Improving Public Understanding of the NHS

4.11 The programme includes:

- an education resource pack "Your NHS - A Force For Health";
- a national photographic project "The NHS Now ... Towards The Future";
- events during Science Week 1998 and on "NHS Day".

RESOURCES

4.12 The Government has given a manifesto[1,2] commitment to increase spending on the NHS in real terms each year. For a full breakdown of NHS expenditure see figure 2.1 in Chapter 2.

Hospital and Community Health Services (HCHS) CurrentResources and their Allocation

HCHS Current Resources by Service Sector

4.13 **Figure 4.1** shows the breakdown by service sector of health authority (HA) gross expenditure on the Hospital and Community Health Services (HCHS) in 1995-96, the latest year for which disaggregated data are available. (The figures include capital charges, but do not include spending on General Medical Services (GMS) cash limited and other related services. For this reason the total differs from the figure shown in figure 2.1.)

Figure 4.1: Hospital and Community Health Services Gross Current Expenditure by Sector, 1995-96

4.14 Within total HCHS current spending:

- acute hospital services accounted for 49 per cent of the total;
- mental health and learning disability services accounted for around 16 per cent, just over a sixth of which was defined as being spent on community services;
- services specifically or mainly for elderly people, that is geriatric inpatient and outpatient services, day care, chiropody services and district nursing services, accounted for 11 per cent of total expenditure.

4.15 The predominance of spending in the acute hospital sector reflects the need to meet demands for emergency treatment, and to ensure that waiting lists and waiting times are kept in check (see paragraph 4.59 *et seq*.). Total expenditure on community health services accounted for £3.6 billion in 1995-96, 15 per cent of all HCHS spending. This proportion has

increased from 10 per cent of HCHS expenditure in 1985-86, reflecting changes in the pattern of care.

4.16 Since 1995-96 there has been government action to bear down on the management costs of the NHS, including action since May 1997 to reduce the bureaucracy associated with the internal market (see paragraph 4.109 *et seq*.).

HCHS Current Resources by Age Group

4.17 **Figure 4.2** shows that people aged 65 and over account for 41 per cent of total HCHS spending, a group which makes up only 16 per cent of the population. This is because over 40 per cent of acute expenditure, and significant proportions of expenditure on services for mentally ill people and other community services are for people aged 65 and over.

Figure 4.2: Hospital and Community Health Services Gross Current Expenditure by Age, 1995-96 (estimate)

4.18 **Figure 4.3** shows the estimated expenditure on the HCHS for each age group, expressed as a cost per head of population. High costs are associated with each birth, but costs per head then fall steeply, remaining low through young and middle age groups, before rising sharply above age 65. Thisreflects the greater use of health services by elderly people.

Figure 4.3: Hospital and Community Health Services Gross Current Expenditure Per Head, 1995-96 (estimate)

4.19 The number of elderly people in the population is expected to grow less quickly in the next ten years than in the previous ten. **Figure 4.4** shows that in the ten year period to 1995-96 demographic pressure averaged 0.8 per cent per year. Over the next ten years, to 2005-06, it is expected to average 0.3 per cent per year.

Figure 4.4: Estimated Growth in HCHS Expenditure Required due to Demographic Changes: Year on Year Percentage Increases

Allocation of HCHS Resources

4.20 **Allocations to HAs for 1998-99 were made in October 1997, and therefore the figures in paragragraphs 4.20 to 4.24 do not include the additional money made available at the March 1998 budget** (see paragraph 2.7). In October 1997, £28,231 million had been made available for HCHS current spending in 1998-99 (see **figure4.5**). In arriving at general allocations to HAs, adjustments were made to this sum to reflect the mechanism for financing of capital in the HCHS; and provision made for a number of services financed by special arrangements: top-sliced funding, national levies and special allocations. **Figure 4.5** summarises the way in which national HCHS revenue translates into HA general allocations.

Figure 4.5: Distribution of HCHS Resources, 1998-99

Top-sliced Budgets

4.21 These budgets fund statutory bodies. Those over £10 million are shown in **figure 4.6**.

Figure 4.6:Top-sliced Funding over £10 million, 1998-99

National Levies

4.22 **Figure 4.7** gives details of the national levies for 1998-99. National levies fund a number of different activities. There are two types of national levy:

service specific, which fund activities in the areas of education and training and research and development:

- Non-Medical Education & Training (NMET);
- Medical and Dental Education (MADEL);
- Service Increment for Teaching (SIFT);
- Research & Development (R&D) (see also paragraph 4.142 *et seq*.)

other centrally funded initiatives and services (CFIS).

Figure 4.7:National Levies, 1998-99

Special Allocations

4.23 Special allocations represent funds allocated to HAs under special distributional arrangements reflecting relative need for the services concerned. **Figure 4.8** gives details of the special allocations for 1998-99.

Figure 4.8:Special Allocations, 1998-99

General Allocations

4.24 The remaining £22.9 billion was distributed to HAs as general allocations. This represents an average cash increase of 4.70 per cent. All HAs received a cash increase of at least 4.14 per cent, with HAs under their weighted capitation target receiving a minimum increase of 4.70 per cent (see **figure4.9**). As a consequence, distances from targets have changed (see **figure 4.10**).

Figure 4.9: HCHS General Allocations Distribution of Cash Increase, 1997-98

Figure 4.10: Health Authorities' Distance from Target (DFT), 1997-98 and 1998-99

HCHS Capital Resources

4.25 **Figure 4.11** summarises planned capital spending from 1997-98 to 1998-99. The role of the Private Finance Initiative (PFI) in the NHS continues to grow. PFI investment is planned to rise from 3 per cent of total capital expenditure in 1997-98 to 17 per cent in 1998-99. See also **Annex I** for details of long term capital projects and an analysis of capital assets.

Figure 4.11: NHS Capital Spending, 1997-98 and 1998-99

4.26 **Figure 4.12** shows the sources and applications of HCHS capital.

Figure 4.12: Sources and Applications of HCHS Capital; Plans[1], 1997-98 and 1998-99

NHS Capital Programme

4.27 **Figure 4.13** shows all publicly-funded schemes with a works cost of £1 million or over which were reported within the current thresholds since 1992. The decrease in the number of schemes completed during 1996 reflects the introduction of PFI testing during the mid 1990s with the effect that fewer schemes started on site during 1994 and 1995. Further information about the PFI is in paragraph 4.29 *et seq*. Details of long term capital projects are in **Annex I**. **Figure 4.14** shows the works cost of publicly funded schemes.

Figure 4.13: Completions on Site of Publicly Funded Major Capital Schemes, 1992-1996

Figure 4.14: Works Cost of Publicly Funded Major Capital Schemes, 1992-1996

Backlog Maintenance

4.28 Backlog maintenance costs are amounts which need to be spent to bring all NHS buildings and engineering services up to Category B condition (that is, all building and engineering elements are considered sound, operationally safe, exhibiting only minor deterioration, and comply with firecode guidance). See **figure 4.15**.

Figure 4.15: NHS Backlog Maintenance Costs, 1992-93 to 1996-97

The Private Finance Initiative (PFI)

4.29 The Government committed itself to partnerships with the private sector and to overcoming problems with the PFI in its manifesto[1,2]. The Government believes that the PFI offers an opportunity for providing many new modern health care facilities now urgently needed in cases where it offers better value for money to the taxpayer than the publicly funded alternative. **Figure4.16** shows the estimated capital spending involving private finance in 1997-98 and 1998-99. See also paragraph 5.10 for details of the PFI in social care.

Figure 4.16: Projects Involving Private Finance

Review of the Private Finance Initiative

4.30 A review of the PFI was launched in June 1997 with the aim of securing the market for PFI projects and improving the PFI process and end product.

4.31 The first part of the review was successfully completed during the summer of 1997 with the passing of the *NHS (Private Finance) Act 1997*[4.3], which removed any doubts about the powers of NHS trusts to enter into PFI contracts. A prioritisation exercise was undertaken, in which a limited number of existing major PFI acute projects were selected to proceed on the grounds of health service need, stage reached and the ability to deliver a workable PFI solution. Resources have been concentrated on these prioritised projects (15 in total with a capital value of £1.2 billion), all of which have timetables to reach financial close on their contracts by the end of 1998. Dartford and Gravesham (£94 million) became the first major PFI project to reach financial close, in July 1997, and this was followed by schemes at Carlisle (£53 million), South Buckinghamshire (£45 million) and Norfolk and Norwich (£143 million). Work on site has started at all four.

4.32 The review of the PFI process has addressed issues such as: reducing the time and expense involved in procurement; improving value for money and affordability for the NHS; improving support and advice available to NHS bodies; and ensuring transparency and openness. Small scale and non-acute schemes have been allowed to continue their PFI projects and the review of the PFI is aimed at ensuring these schemes reach a successful conclusion. All the key stakeholders in the PFI have been consulted. The results of this part of the review will be announced in spring 1998. The changes will be incorporated into new comprehensive guidance on the PFI which will be published at the same time.

4.33 The Government made a manifesto[1.2] commitment that clinical services would not be included in PFI projects. The NHS Executive conducted an extensive consultation exercise to gather views on which NHS services should be regarded as such. The results will be announced in spring 1998. NHS trusts involved in PFI schemes will continue to provide NHS clinical services free at the point of delivery and will remain in control of the key planning and clinical decisions.

4.34 Ministers have honoured their commitment that no NHS staff will be transferred to the private sector under PFI schemes unless their employment contracts are protected by the *Transfer of Undertakings (Protection of Employment) Regulations*[4.4] (TUPE) and the private sector partner recognises trades unions.

Capital Prioritisation

4.35 On 5 December 1997, Ministers announced the formation of the NHS Capital Prioritisation Advisory Group (CPAG). CPAG will be responsible for making recommendations to Ministers on the national prioritisation of major capital schemes. It will consider schemes for both publicly and privately financed schemes with a capital cost of over £25 million. Prioritisation will be made on the basis of health service need. CPAG's first exercise is the prioritisation of schemes wishing to go forward in the second tranche of PFI. For PFI schemes, their deliverability under the PFI route will also be considered. The next group of major PFI schemes selected to proceed will be announced in spring 1998.

Family Health Services (FHS) Resources

4.36 **Figure 4.17** shows the distribution of gross expenditure on family health services (FHS) of £8,987 million in 1996-97 (including spending by General Practitioner (GP) Fundholders on drugs) among the constituent family health services. See paragraphs 4.75 to 4.96 for the activity and performance of these services.

Figure 4.17: Family Health Services Gross Expenditure, 1996-97

Drugs Bill

4.37 The drugs bill is the cash amount paid to contractors (mainly pharmacists) for drugs, medicines and certain listed appliances which have been prescribed by GPs, less Pharmaceutical Price Regulation Scheme (PPRS) receipts (see paragraph 4.148). In 1997-98 the drugs bill is expected to increase by 5.7percent in real terms, similar to the real terms increases of 4.8 per cent in 1996-97 and 5.6 per cent averaged over the last 10 years. The number of prescriptions dispensed increased by 2.8 per cent in 1996-97. The gross cost of each prescription dispensed (which includes the dispensing fee) rose by 2.2per cent in real terms in 1996-97 to £9.14.

4.38 **Figures 4.18 and 4.19** show the growth in the drugs bill over the last decade, in cash terms.

Figure 4.18: Family Health Services Drugs Bill (Cash), 1987-88 to 1996-97

Figure 4.19: Family Health Services Drugs Bill Percentage Growth (Cash), 1987-88 to 1996-97

FHS Gross Expenditure

4.39 A significant development has been the inclusion of a growing proportion of FHS expenditure within HAs' cash limits, and thus within HAs' financial management. Since its introduction, first to General Medical Services in 1990-91 and second to some drugs expenditure in 1991-92, cash limiting has grown to represent 29 per cent of total FHS expenditure. **Figure 4.20** shows the gross expenditure by service, the real terms increase and the growth of cash limiting.

Figure 4.20: Family Health Services Gross Expenditure, 1989-90 to 1997-98

FHS Charge Income

4.40 In 1996-97 income from dental and prescription charges represented 7.6 per cent of gross FHS expenditure on all services and in 1989-90 charges raised 10.9 per cent of gross FHS costs. In 1996-97 income from dental charges of £383 million represented 29 per cent of gross General Dental Services (GDS) costs, and prescription charge income of £296 million represented 6.5 per cent of the gross cost of all drugs and dispensing fees.

NHS EXECUTIVE: OBJECTIVES AND PERFORMANCE

New Initiatives

The newNHS: modern, dependable White Paper

4.41 *The new NHS: modern, dependable*[4.1] shows how the Government will build a modern and dependable health service fit for the twenty-first century a national health service which offers people high quality treatment and care when and where they need it. The scope of the White Paper is broad, and it underpins the delivery of all the Government's objectives for the NHS.

4.42 The Government is committed to the principle of an NHS with access based on need and not on ability to pay or district of residence. *The new NHS: modern, dependable* sets out how the internal market will be replaced by a system of integrated care, based on partnership and driven by performance. In total, £1 billion will be freed up from bureaucracy for patient care over the lifetime of the Parliament.

4.43 The NHS cannot stand still. It needs to modernise if it is to meet patients' aspirations for up-to-date, quicker, more responsive services. The White Paper sets out an ambitious and far reaching programme which will be achieved over ten years. The Government is committed to raising spending in real terms every year. It has promised to cut waiting lists for hospital treatment and will do so by the end of the current Parliament. There will be early, visible improvements to the quality of service people experience in their own homes, at their GP surgery or health centre, and in hospital.

4.44 Three developments will symbolise the new NHS:

- **home:** access to **NHS Direct**, a new 24 hour telephone advice line staffed by specially trained nurses and call takers. It will give on-the-spot advice and help. Three advance sites began in March 1998, by 2000 the whole country will be covered;
- **the community:** connecting every GP surgery and hospital to ***NHSnet***, leading to quicker test results, telemedicine (see also paragraph 4.153 *et seq*.), up-to-date specialist advice in the doctor's surgery and on-line booking of outpatients' appointments. By 2002 these services will be available across the country;
- **hospital:** every patient 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. These arrangements will be guaranteed for all cases of suspected cancer by 2000 (see also paragraph 4.64).

Principles of the new NHS

4.45 Six important principles guide the changes the Government is making. It intends to:

- renew the NHS as a genuinely national service;
- make the delivery of health care against these new national standards a matter of local responsibility;

- get the NHS to work in partnership;
- improve efficiency so that every pound in the NHS is spent to maximise the care for patients;
- shift the focus on to quality of care so that excellence is guaranteed to all patients;
- rebuild public confidence in the NHS.

New Roles and Responsibilities

4.46 The new NHS will mean new roles and responsibilities for HAs and NHS trusts and the Department. Primary Care Groups will be developed across the country. The new financing and accountability arrangements compared with those of the internal market are set out in **Annex F**.

Health Authorities (HAs)

4.47 HAs 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 responsibility. 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. HAs will allocate funds to Primary Care Groups on an equitable basis, and hold them to account. Links with social services will be strengthened.

Primary Care Groups

4.48 Primary Care Groups, will take responsibility for commissioning services. They will work closely with social services. Options for the structure of Primary Care Groups will include freestanding Primary Care NHS trusts, with responsibility for running community hospitals and community health services. None of the options affects the independent contractor status of GPs. Typically Groups may serve about 100,000 patients, but this will vary according to local circumstances. Primary Care Groups will mean fewer commissioners with more influence. They will have freedom to make decisions about how they use their resources, consistent with the Health Improvement Programme. No part of their budget will be artificially capped. Instead they will control a single unified budget to give maximum choice to GPs and other professions about how best to meet individual patient needs.

NHS Trusts

4.49 The White Paper sets out a new direction for NHS trusts. They will retain devolved operational responsibility, but will also 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 care groups (such as children) or disease areas (such as heart disease). In this way, hospital clinicians will be able to make a more significant contribution to service planning. NHS trusts will have new statutory duties of quality and partnership. NHS trusts will also be more accountable to the public and will publish details of their performance. They will also need to demonstrate the development and involvement of their staff.

National Framework for Assessing Performance

4.50 The White Paper set out proposals for a new national performance framework based on six areas: health improvement; fair access; effective delivery of appropriate health care; efficiency; patient/carer experience; and health outcomes of NHS care.

4.51 A consultation document[4.5], published in January 1998, set out the reasons for changing the approach to assessing the performance of the NHS. It moved the focus of NHS performance monitoring away from counting the numbers of patients treated, on to what matters for the health and well-being of the patient; from the Purchaser Efficiency Index to broader measures of the cost and quality of NHS care and the benefits patients receive from health care. The framework re-stated the White Paper's six areas of performance which, taken together, provide a broad-based approach to examining the range of work of the NHS.

4.52 The consultation document proposed an initial small set of high level indicators to provide an overview of HA performance across the areas of the new framework. The indicator set draws on existing returns, such as the Public Health Common Data Set, Primary Care Effectiveness Indicators and other indicator sets, covering all six areas of the framework. The indicators selected were not intended to cover all aspects of NHS activity but, within the constraints of available data, to throw light on health service objectives and activities. The consultation stage for the development of the national framework for assessing performance ended in March. Subject to the outcome of the consultation process, NHS Executive Regional Offices will work with HAs in 1998-99 to "road-test" the framework and the high-level indicators.

The National Dimension

4.53 The Department will work with the clinical professions to develop new National Service Frameworks on the Calman-Hine model, linked to national action to implement them across the NHS. For the first time, the NHS will conduct and publish annual national surveys to find out what patients and their carers think of NHS services. A new NHS Charter will set out new rights and responsibilities for patients. The Secretary of State will have reserve powers to intervene where HAs, Primary Care Groups and NHS trusts are failing. The Department will establish a new National Institute of Clinical Excellence and a Commission for Health Improvement to support quality improvement (see paragraph 4.70).

Rolling Out Change: Health Action Zones (HAZs)

4.54 New **Health Action Zones** (HAZs) will blaze the trail. Starting in around ten areas from April 1998, they will harness the dynamism of local people and organisations by creating alliances to achieve change. HAZs will bring together HAs, local authorities, community groups, the voluntary sector, local businesses and others locally to work together to address the causes of ill health and reduce health inequalities. They will provide opportunities for the development of new partnerships to modernise and reshape services in order to improve health outcomes for local people. The accent will be on partnership and innovation, finding new ways to tackle health problems and reshape local services. HAZs 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 HAZ will be to develop clear targets, agreed with the NHS Executive, for measurable improvements every year.

4.55 The White Paper sets a tough and challenging programme for the future. There will be evolutionary change rather than structural upheaval. The Government will work with the one million staff in the NHS to build a modern and dependable health service that responds to a changed and changing world, in which patients can expect services to be quickly available and of consistently high quality.

Objective

To treat people with illness, disease or injury quickly, effectively and on the basis of need alone. We shall do this by:

- **ensuring that the NHS prioritises treatments according to clinical need, not people's ability to pay, nor where they live, nor who is their GP.**

4.56 This objective underpins many of the proposals in the White Paper[4.1], as detailed above. Otheractivity is set out below.

New Initiatives

Equal Access to Services

4.57 The Government believes that clinical priority must be the main determinant of the timing of admissions to hospital. Guidance[4.6] issued in July 1997 encouraged HAs and GPs to ensure that this principle was applied in their agreements for 1998-99, and in particular required common maximum waiting time standards to apply to all residents of an HA, whether their care was commissioned by the HA or by a GP fundholder. For the future, the replacement of fundholding with Primary Care Groups, as announced in the White Paper[4.1], will end the fragmentation of commissioning in a locality and ensure greater fairness for patients. Work continues to ensure that NHS services are available to people no matter where they live, and work on fairness is detailed at paragraph 4.180 *et seq*.

Health Inequalities

4.58 The Government is committed to an NHS that does not just treat people when they are ill but works with others to improve health and reduce health inequalities. It will ensure that the NHS develops a strategy, in partnership with local authorities, employers and the voluntary sector, to deliver lasting improvements in the public's health. The Green Paper *Our*

Healthier Nation[3.2] outlines this strategy in more detail (see paragraph 3.8 *et seq*.).

Objective

To treat people with illness, disease or injury quickly, effectively and on the basis of need alone. We shall do this by:

- **reducing the number of people waiting, and the time they have to wait, for treatment.**

New Initiatives

Waiting Lists

4.59 The Government's election manifesto[1.2] stated that "As a start the first £100 million [of administrative costs] saved will treat an extra 100,000 patients". The Government has confirmed that this means that by the end of the present Parliament waiting lists will be shorter, and there will be reductions in waiting times. As a first step, 18 month waits for inpatient treatment were to have been eliminated by 31 March 1998.

4.60 Half of all admissions to hospital are immediate. The other half have a waiting time before the admission takes place. Of patients admitted from waiting lists, half are admitted within six weeks and around two-thirds within three months.

4.61 In May 1997 there were increasing numbers of patients waiting for admission to hospital, and lengthening inpatient and outpatient waiting times. The numbers of breaches of the Patient's Charter[4.7]18month guarantee for inpatient treatment, and of the 12 month standard for coronary revascularisation, were also growing. **Figures 4.21 and 4.22** show the average waiting times for patients on the waiting list between March 1992 and September 1997, and numbers of 12-18 month and over 18 month waiters during the same period.

Figure 4.21: Patients Waiting 12 Months or More, 1992 to 1997

Figure 4.22: Average Waiting Times, 1992 to 1997

Action Plan for Reducing NHS Waiting Lists and Times

4.62 In November 1997 the Secretary of State announced a new, wide-ranging action plan for reducing NHS waiting lists and times. Task forces have been set up in the eight English NHS regions to deliver local solutions to waiting list problems and to spread best practice. A national Waiting List Action Team will report to Ministers on progress made. The aim of the action plan is to improve the position in the medium term in line with the delivery of the Government's commitment to reduce waiting lists. HAs and NHS trusts are to undertake a thorough and critical appraisal of all their activities to ensure that they are making the best possible use of the resources available to them. In addition there is to be a renewed emphasis on ensuring that clinical priorities are maintained, linked to work to improve the clinical effectiveness of NHS services (see paragraph 4.69 *et seq.)*. £5 million released by efficiency savings in 1997-98 are being targeted at piloting new ways of cutting waiting lists, paying more attention to reducing the time patients have to wait for treatment.

4.63 In addition, in its March 1998 budget, the Government announced a further £417 million for the NHS in England in 1998-99 as part of a package of measures to reduce waiting lists and times. TheGovernment expects additional investment to be supported by improved performance, and the full package of measures will include:

- tough new targets for getting waiting lists down;
- encouragement for innovative schemes to manage waiting lists better;
- new incentives for good performance by the NHS at every level.

Waiting Times for Cancer Services

4.64 The Government gave a manifesto[1.2] commitment "to end waiting times for cancer surgery thereby helping thousands

of women waiting for breast cancer treatment". *The new NHS: modern, dependable*[4.1] cancer target guarantees that by the year 2000 everyone with suspected cancer will be able to see a specialist within two weeks of their GP deciding that they need to be seen urgently and requesting an appointment. To establish a baseline against which achievement can be measured, a systematic audit and assessment of the current waiting position is being undertaken. This will identify priorities for local and national action.

Ambulances

4.65 Ambulance services have traditionally given equal priority to all 999 calls. Following a review of performance standards they are now introducing systems which will enable control room staff to determine safely the priority of calls and to get the quickest response to the most serious cases. In the longer term these new procedures could help to save up to 3,000 more lives a year, mainly of cardiac arrest patients.

4.66 The emergency ambulance workload continues to rise, see **figure 4.23**.

Figure 4.23: Emergency Calls Resulting in an Ambulance Arriving on Scene, England, 1992-93 to 1996-97

Source: DH return KA34.

Emergency Services

4.67 The NHS *Priorities and planning guidance for 1998-99*[4.2] made it clear that the NHS must respond promptly and effectively to emergency need as and when it arises. Concerted action has been taken, both in the NHS and by local authority social services to improve the management of pressures that arise, especially in winter, from emergency admissions to hospital.

4.68 In particular, some of the "winter money" resources (see paragraph 2.9) have been allocated to the following areas of work:

- helping hospitals cope with medical emergencies which are already known or likely to occur during the winter months, for example by improving staffing levels at times of peak pressure and through services opening extra hours;
- reducing delays in discharging patients, for example by improving rehabilitation and recuperation services, funding increased care at home, extra nursing and residential home places and more social services support;
- reducing the need for people to be admitted to hospital in the first place by strengthening primary, community and social services, providing more specialist nursing and therapy for people (particularly older people) in their own homes, nursing and residential homes, and through improved community and out of hours services.

Objective

To treat people with illness, disease or injury quickly, effectively and on the basis of need alone. We shall do this by:

- **improving clinical effectiveness in the NHS.**

New Initiatives

Clinical Effectiveness

4.69 The Government has made a clear commitment to put clinical quality at the heart of its plans for the NHS, and has taken a number of steps to support the NHS in making progress in this area:

- the *Priorities and planning guidance for 1998-99 (PPG)*[4.2] requires HAs to draw up plans to improve the extent to which their investment and disinvestment in services takes account of evidence of effectiveness;
- all HAs and regional offices (see **Annex F**) have been asked to review the effectiveness of NHS services locally, and agree plans to support strengthened in-year performance management in this area;

- a portfolio of supporting effectiveness information has been made available, and is made accessible through the *Clinical Effectiveness: Resource Pack*[4.8];
- a Clinical Effectiveness Performance Development Framework has been developed to help HAs monitor progress and develop capacity to ensure management and clinical practice is increasingly evidence based;
- a new *Clinical Audit Assessment Framework*[4.9] has been prepared, aimed at assisting NHS organisations to manage and monitor clinical audit programmes and projects effectively.

4.70 In addition, *The new NHS: modern, dependable*[4.1]White Paper sets out proposals to establish a **National Institute for Clinical Excellence** to integrate the existing and valuable clinical guideline and audit development work, currently supported through the national professional bodies and others into a single co-ordinated programme whose priorities are closely linked to national policy concerns. An independent **Commission for Health Improvement** will also promote the development of clinical governance in the NHS by helping to identify and address local problems, where they exist, either by the invitation of those delivering local services themselves or, on occasion, on the direction of the Secretary of State.

Current Issues and Recent Trends

National Screening Committee

4.71 The National Screening Committee (NSC) intends to publish its first report in spring 1998. Among its achievements the NSC has:

- defined a population screening framework;
- facilitated specialist workshops to consider emerging evidence; and
- given clear advice about national screening frameworks for antenatal screening for hepatitis B, and desisting from screening for prostate cancer.

It will undertake more comprehensive work on quality assurance frameworks and review a wide range of existing and new specialist screening programmes.

Clinical Negligence

4.72 Clinical negligence costs have been rising steadily, using resources which might otherwise be used to provide direct patient care. However, this should not of itself be taken as an indication that the NHS is failing. Patients are developing a better understanding of the treatment and services available to them as well as a greater tendency to seek compensation when something does, unfortunately, go wrong. Shifting the emphasis from less effective interventions towards effective ones and improving the quality of clinical care is one way of helping to reduce the risk of adverse incidents which may give rise to claims for compensation.

4.73 The Department is working closely with the Lord Chancellor's Department on proposals to reform the way cases involving clinical negligence are handled. The NHS Litigation Authority (see **Annex H**, paragraphs H.24 *et seq*.) oversees the Clinical Negligence Scheme for Trusts and the Existing Liabilities Scheme, ensuring that public money is used appropriately, promoting safer standards for patient care, and minimising the suffering resulting from those adverse incidents which do occur.

Confidential Enquiries

4.74 The Department supports four Confidential Enquiries, each focusing on different aspects of clinical care and making a valuable contribution towards improving clinical standards and effective practice.

- The National Confidential Enquiry into Perioperative Deaths published its sixth[4.10] and seventh[4.11] reports in September 1997. The sixth report once again provided evidence of the high standards of surgical and anaesthetic care in this country. The seventh report is an audit of starting times for surgical procedures and raises issues about appropriate levels of supervision and training for junior doctors, before the implementation of the Calman reforms[4.12].
- The fourth *Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy*[4.13] was published in July 1997. This made important recommendations for professional assessment and training and on various aspects of the care of women in labour and babies following delivery.

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, re-established at Manchester University from April 1996, made good progress in 1997 with the collection of data. The Enquiry's preliminary findings[4.14], published in December 1997, will be followed by a full report in the spring of 1999.
- The Confidential Inquiry into Maternal Deaths has made progress throughout the year and it is hoped a report will be published in late 1998.

Objective

To treat people with illness, disease or injury quickly, effectively and on the basis of need alone. We shall do this by:

- **providing family health services which are accessible to people wherever they live.**

5. Social Care

INTRODUCTION

5.1 The Social Care group aims to secure responsive social care and child protection for those who lack the support they need. Key objectives are to enable people who are unable to perform essential activities of daily living, including those with chronic illness, disability or terminal illness, to live as full and normal lives as possible, and to maximise the social development of children within stable family settings. The provision for these aims appears in the 1998-99 *Supply Estimates*[1.7] for Class XI, Vote 2.

5.2 The aims and objectives for the Department of Health are set out in full at **Annex A**. They are subject to revision as part of the Comprehensive Spending Review (see paragraph 2.3*et seq*.). TheSocial Care group contributes to objective D and, in conjunction with the NHS Executive, objectiveC.

5.3 Each of these aims requires close working between the Department, local authority social services, local education departments and the NHS. The Department's role, undertaken by the Social Care group, is to develop the policy and legislation and strategic framework for services; to identify and spread good practice; and to inspect services. Delivery of care is the responsibility of local authority social services departments.

RESOURCES

Funding

5.4 Each year the Government decides what it believes local authorities need to spend on social services, provision for which is made through the Revenue Support Grant (RSG) and special or specific grants. Authorities may spend more or less in the light of local priorities and circumstances.

Allocation of Resources

5.5 RSG is distributed on the basis of standard spending assessments (SSAs) for each local government service, which take account of measures of relative need. Examples of factors used to allocate resources for social services are:

- the age profile of local population;
- the number of older people with a long term illness; and
- the number of children of lone parents.

5.6 The resource allocation formulae are reviewed each year and some significant changes were made for the 1998-99 allocations. The changes are described in guidance[5.1] issued by the Department of the Environment, Transport and the Regions (DETR).

5.7 'special and specific grants are distributed in a variety of ways. Some use a combination of the SSA formulae, others are distributed by competitive bidding or on the basis of the number of local service users.

Capital

5.8 Government provides capital resources for personal social services by means of credit approvals (permission to borrow), and a specific grant for secure accommodation for young people. Credit approvals may be either used for any local authority service (basic credit approvals, BCAs), or are targeted on particular services or projects (supplementary credit approvals, SCAs).

5.9 Local authorities may also use revenue and certain receipts from the sale of capital assets on capital projects. Capital

receipts can be spent on any local priority, including personal social services.

The Private Finance Initiative (PFI)

5.10 The Department began administering a new PFI initiative in 1997-98 for the personal social services. Five local authorities have had their PFI projects approved so far and have been awarded £43million of PFI credits. (PFI credits reimburse local authorities who contract with the private sector to provide facilities for that element of the contract price which relates to the repayment and servicing of funds borrowed to provide the facilities.) The Department is considering bids for its initial allocation of £30 million of PFI credits for 1998-99. The policy priority for these projects is social exclusion. For details of the PFI in the NHS see paragraph 4.29*et seq*.

How the Resources are Used

5.11 The pie chart (**figure 5.1**) shows gross expenditure by client group in 1995-96. **Figure 5.2** details the figures underlying the pie chart.

5.12 Almost 50 per cent of local authorities expenditure was on services for older people. Thebiggest single item of expenditure was residential care for older people (over 25 per cent of all gross personal social services expenditure).

Figure 5.1: Local Authority Gross Expenditure on Personal Social Services by Client Group, 1995-96

Figure 5.2: Client Group Related Personal Social Services Gross and Net Expenditure, 1995-96

Revenue Resources

5.13 The Government has provided £8,293 million for social services for 1998-99. That represents a cash increase of 5.7 per cent over the 1997-98 level. **Figure 5.3** shows how the total is made up.

Figure 5.3: Personal Social Services Provision, 199899

5.14 Trends in the number of adults receiving services, by client group, are shown in **figure 5.4**. Thepie charts, **figures 5.5** and **5.6**, show the significance of each one of the client groups in respect of residential places and day centre places respectively. **Figure 5.7** illustrates how the independent sector has grown since 1990-91 in the provision of residential places.

Figure 5.4: Personal Social Services for Adults, 199091 to 199697

Fig. 5.5: Residential Places by Client Group, 199697

Fig. 5.6: Local Authority Funded Day Care Centre Places by Client Group, 199697

Figure 5.7: Residential Places by Type of Accommodation, 1990-91 to 1996-97

Capital

5.15 For 1998-99 the BCAs for personal social services will be £39.0 million. Annual capital guidelines (ACGs) of £45.0 million will be distributed to local authorities for personal social services (ACGs comprise BCAs plus receipts taken into account). SCAs will be available for services for mentally ill people (£11.6 million) and for people with AIDS/HIV (£3.1 million). An £8.2 million capital grant will be available for the provision of additional secure accommodation for children.

Special Transitional Grant (STG)

5.16 The new Government has decided to maintain the Community Care Special Transitional Grant (STG) for 1998-99. The STG of £350 million is ring-fenced and can only be spent on community care services. The grant is distributed using a particular combination of the SSA formulae for the elements relating to services for older people and other adults. In announcing the maintenance of the STG for 1998-99 in December 1997, the Government placed a new condition on the STG: that some funds should be invested in services with the objective of improving joint procedures for needs assessment, hospital discharge arrangements and preventing persons being admitted unnecessarily to hospital or to residential or nursing home care following discharge from hospital. This condition reflects the importance the Government attaches to the joint planning of the provision of community care services and NHS services by local authorities and health bodies respectively.

Direct Payments

5.17 The *Community Care (Direct Payments) Act 1996*[5.2] came into force in April 1997. The Act gives local authorities the power to give cash payments to people for the community care services they have been assessed as needing, rather than arranging those services for them. Direct payments develop further the principles of user choice and independence, and have been warmly welcomed by disabled people. Direct payments can only be made to disabled people under the age of 65, but the Government intends to review the eligibility criteria after the Act has been in force for one year.

Best Value

5.18 The Government gave a manifesto commitment[1.2] to replace Compulsory Competitive Tendering (CCT) with a duty on local authorities to achieve best value when arranging or providing services. Although personal social services have not been affected by CCT, the Department is co-operating with DETR in the development of this new regime. Thirty-seven local authorities have been selected to act as pilot sites for the implementation of best value. The Department will be working with the authorities whose pilots have a significant personal social services element, and will ensure that the lessons learned are widely publicised.

Policy Research Programme: Social Care

5.19 In the region of £6 million, or 22 per cent of the Department's Policy Research Programme (PRP)[3.1] budget, is planned to support research and development which contributes to the development of social care policy. Studies include longer term programmes to evaluate the development of community care policy, and address issues concerning the social care of children including studies which cover families and parenting, foster care, child residential care, monitoring and evaluation of the *Children Act*[5.3], adoption, adolescent and juvenile justice, care of elderly people, older people with dementia, people with disabilities, people with mental health problems, care management, inter-agency collaboration, workforce issues and outcomes of social care for adults. For information about other parts of the PRP, see paragraphs 3.5 and 4.147.

SOCIAL CARE GROUP: OBJECTIVES AND PERFORMANCE

Objective

To enable people who are unable to perform essential activities of daily living, including those with chronic illness, disability or terminal illness, to live as full and normal lives as possible. We shall do this through the NHS programme (see Chapter 4) and through local authority social services by:

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

New Initiatives

Establishment of a Royal Commission on Long Term Care

5.20 In December 1997 the Government established a Royal Commission on the funding of long term care for elderly people, as promised in its election manifesto[1.2]. The Commission is undertaking an independent and comprehensive review of how long term care for the elderly should be funded throughout the whole of the United Kingdom (UK). It will make practical, costed recommendations by the end of 1998 on the best options for funding arrangements in both the immediate and longer term future, and will operate in an open and consultative manner. The Commission has its own secretariat, with

the Department leading on liaison for the Government.

Partnership Between the NHS and Local Authorities

5.21 The Department is committed to improving services for users through better joint working. The Department encourages authorities to collaborate so that effective partnerships develop. Recent work has included:

- the NHS *Priorities and Planning Guidance*[4.2] identifying partnership and co-operation as one of the four key priorities for the NHS 1998-99 commissioning round;
- issuing *Making partnerships work in community care*[5.4] in October 1997, which complemented the January 1997 publication, *Housing and community care establishing a strategic framework*[5.5].

5.22 The Department is looking at existing mechanisms to aid collaboration to see if they should be adapted or renewed. A discussion document will be published in 1998 setting out the various options for promoting better co-ordination both at the level of service planning and commissioning locally, and in assembling packages of care for individual users. Some of the options would require changes to legislation.

5.23 The Government is keen to encourage the development of health and social care services available to older people. In October 1997 the Department advised health and local authorities to focus on social care services for older people which optimise independence through timely recuperation and rehabilitation opportunities. Innovative schemes such as intensive domiciliary support schemes, community rehabilitation schemes and home from hospital schemes are to be developed further. In 1998-99 health authorities (HAs) and local authorities are expected jointly to review their recuperation and rehabilitation services for older people and in 1999-2000 they will be expected to put service development plans in place.

5.24 Other NHS/local authority partnership initiatives include:

- **Health Action Zones (HAZs)**, which are discussed in more detail at paragraph 4.54*et seq*., will be introduced from 1 April 1998. HAZs will bring together agencies, including social services, to develop local health strategies;
- a commitment to the further development of **continuing health care**, which is discussed in more detail at paragraph 4.99.

Services for People with Disabilities

5.25 The Department continues to promote the development of social care services for disabled people including those with physical disabilities, mental health problems, learning disabilities and sensory impairments. This includes:

- working closely with the Department for Education and Employment and the Department of Social Security on the "New Deal" initiative which is intended to help sick and disabled people of working age find and stay in employment;
- working with the Lord Chancellor's Department and other government departments on the issue of mental incapacity and decision making;
- working with the Home Office and other government departments on the issue of vulnerable and intimidated witnesses;
- working to follow up on a range of Social Services Inspectorate (SSI) inspections for these client groups;
- working in partnership with local authority interests to build information on mental health service provision in the personal social services sector in order to improve performance assessment and local performance management.

Objective

To maximise the social development of children within stable family settings. We shall do this by enabling local authorities, with resources and guidance, to:

- **secure appropriate and effective social care to prevent significant neglect or abuse and to support families;**

- **assume where necessary sufficient parental responsibility in relation to individual children.**

New Initiatives

Assessment

5.26 'systematic gathering and evaluation of information has an important part to play in child protection, since the quality of initial assessments is known to relate directly to the quality of outcomes for children and their families. Work has begun on developing a framework for needs-led assessments of children and their families. It will focus on children in need, and reflect an holistic approach to addressing children's needs, including the need for protection, within a broad context rather than focusing mainly on incidents of abuse.

5.27 The Department is also focusing on improving the capacity of parents to meet the needs of children. Adult and children's services need to provide an integrated service to parents to ensure children's welfare is safeguarded. This is particularly important where adult mental health, substance misuse and domestic violence problems result in impairment of the health and development of children, or in their abuse.

Utting Report

5.28 In November 1997 Sir William Utting, former Chief Inspector of the Social Services Inspectorate, published his review[5.6] of the safeguards for children living away from home. The report covers children in a range of residential settings including foster care, children's homes, schools, hospitals and penal institutions.

5.29 The recommendations in the report are wide ranging and cover the policy interests of a number of government departments, including the Department of Health. The main recommendations include:

- developing strategies for the provision of residential and foster care;
- paying better attention to the education and health needs of children looked after by a local authority;
- commissioning a code of practice for recruiting, selecting, training and supporting foster carers;
- introducing registration of private foster carers;
- extending welfare inspections to all residential schools;
- assessing and meeting the need for treatment of children who have been abused;
- undertaking a comprehensive review of arrangements for prosecuting sexual offenders against children.

5.30 The Government set up a Ministerial Task Force in March 1998, led by the Secretary of State for Health, to address the recommendations. It involves Ministers from all the relevant departments and a small number of expert advisers from outside Government. Its first job is to prepare the full government response to the report. There will be wide consultation with public and independent sector agencies.

Current Issues and Recent Trends

5.31 The number of children receiving certain social services are shown in **figure 5.8**. This shows how the number of children looked after by local authorities in England has declined since 1992 and the proportion of foster placements has gradually risen. The number of children in local authority day nurseries has declined sharply since 1994. The number of children on child protection registers, after falling in 1992-93, has remained relatively stable.

Figure 5.8 Numbers of Children Receiving Selected Local Authority Services

Foster Care

5.32 A UK Joint Working Party on Foster Care was set up in autumn 1997, to which the Department contributed £60,000. A series of recent reports and research findings have identified areas of concern in the delivery of foster care services and the absence of clearly defined national standards of care for children placed with foster carers. The Working Party will identify examples of best practice and produce published standards of care by March 1999, which every foster care agency will be expected to meet.

Domestic Violence

5.33 The implementation of Part IV of the *Family Law Act 1996*[5.7] in October 1997 provided a new set of civil remedies available to those suffering domestic violence. These include occupation and non-molestation orders and powers to exclude an alleged abuser from the home during care proceedings, rather than having to move the child to a new address.

Early Years Service

5.34 The Department intends to transfer certain policy responsibilities for day care services under the *Children Act 1989*[5.8] to the Department for Education and Employment (DfEE), by 1 April 1998. The aim is to ensure that, both nationally and locally, day care and early years education services will be co-ordinated and integrated. Linked to the development of early years planning and partnerships, this will complement the National Childcare Strategy (expected to be published, for consultation, in spring 1998) which aims to stimulate growth in the provision of good quality early years services.

5.35 In partnership with the DfEE, the Department intends to publish a consultation paper in Spring 1998 with the aim of seeking consensus on the development of a new and single regulatory framework for day care and early years services.

Youth Justice

5.36 The Department has contributed to the three consultation papers[5.9, 5.10, 5.11] and a White Paper[5.12] on youth justice issued by the Home Office. It is also engaged with the Home Office on the Crime and Disorder Bill which, subject to Parliamentary approval, will be enacted during the present session of Parliament. The Department is represented on the Ministerial Group for Youth Justice and the Task Force on Youth Justice, which were set up to drive forward the measures to be included in the Bill.

Children's Rights

5.37 Under the United Nations (UN) Convention on the Rights of the Child[5.13], which the United Kingdom ratified in December 1991, State Parties are required to submit a report to the UN Committee two years after entry into force and a further report every five years. The UK's first report[5.14] was submitted in 1994. Preparation is now under way for the second UK report which will be submitted by January 1999. Plans include establishing close liaison with other government departments and key voluntary children's organisations throughout the report's preparation as well as engaging directly with children to ensure their views are fully reflected.

Adoption

5.38 A series of regional seminars were held in March 1998 to present adoption as a positive option rather than an option of last resort, with the aim of:

- maximising the contribution adoption can make to providing permanent families for children in appropriate cases;
- reducing the period children remain looked after before being placed for adoption.
- Department will seek to improve the efficiency of inter-country adoption, by:
- reducing unnecessary delay and bureaucracy;
- entering into formal agreements with other countries.

Personal Social Services Initiatives Supporting All Social Care Group Objectives

New Initiatives

Regulation

5.39 The Government made a manifesto[1.2] commitment to introduce an independent regulation service for residential care homes and nursing homes, and to introduce the regulation of domiciliary care services. It intends to publish a White Paper in the summer of 1998 to set out its proposals in this area. The White Paper proposals will follow on from the recommendations of the Burgner Report[5.15], published in October 1996.

Social Care Training and the General Social Care Council

5.40 The Government launched a fundamental review, in July 1997, of the functions of the statutory body charged with

regulating social work training, the Central Council for Education and Training in Social Work (CCETSW) (see **Annex H** paragraph H.1 for further details about CCETSW). Over thirty recommendations for improving effectiveness and value for money were made.

5.41 The Government accepted the report of the review of CCETSW as paving the way for the creation of a General Social Care Council (GSCC). In particular, the Government considered there was no need for a separate body to regulate social care training, effectively signalling the demise of CCETSW when the GSCC is created. The Government plans to have detailed discussion with all the key stakeholders about its proposals for the GSCC. Arrangements for the operation of the Council will include the involvement of users, employers in all sectors, staff, professional bodies and Government. The Government's proposals for the new body will be set out in the social services White Paper to be published in the summer of 1998.

Current Issues and Recent Trends

Joint Reviews

5.42 A programme of joint reviews organised between the Social Services Inspectorate and the Audit Commission began in 1996. The reviews examine the performance of the whole of a social services authority. They consider how well each authority responds to individual people who need information or help, plans for its population as a whole and how it uses its resources in arranging and providing social services. At the end of each review the authority prepares an action plan which is monitored by the Social Services Inspectorate and District Auditor.

5.43 Twenty joint reviews were undertaken in 1997-98, and a further twenty are programmed for 1998-99. The reports of authorities reviewed in 1997-98 revealed a wide range of performance, with many authorities being commended for their services but others being judged to be not serving their citizens well. An annual report[5.16] of the joint reviews is produced to identify key management issues that have emerged, and to promote good practice.

6. Managing the Department of Health

INTRODUCTION

6.1 The Departmental Resources and Services (DRS) group is responsible for the management of the Department itself, providing services and support to Ministers, the Permanent Secretary and the other business groups in their work. This includes corporate functions such as resource management, personnel and financial support, accommodation provision, office services, information services, telecommunications and IT; and professional services such as statistics, economic and operational research and public relations.

6.2 The provision for these functions appears in the 1998-99 *Supply Estimates*[1.7] for Class X1, Vote 2.

RESOURCES AND MANAGEMENT

6.3 The Department has two broad objectives in this area:

- **to manage itself efficiently and effectively;**
- **to be a good employer.**

Efficient and Effective Management

New Initiatives

The National Asset Register

6.4 In November 1997 the Government published a *National Asset Register*[6.1]. The Register is intended to be a key element in the Government's plans to improve the management of assets within the public sector. The Department provided a contribution to the Register which covered the assets of the Department itself and those of all the bodies sponsored or funded by it, including NHS trusts.

6.5 Much of the information in the Department's contribution to the Register is already in the public domain (eg in the accounts of NHS trusts which are published locally). Nevertheless, collating the information in a single place is a step forward in terms of accountability and openness.

Current Issues and Recent Trends

Organisational Development

6.6 Through organisational development programmes at corporate level and in individual business groups, the Department is seeking to improve its efficiency so that it can discharge all its responsibilities fully and effectively. In particular, the focus of the work is to develop the organisation so that it can respond more efficiently to change, and can deliver the new Government's objectives effectively. This approach will continue, with an emphasis on developing and promoting good working practices and encouraging the flexible management of resources.

Running Costs

6.7 In 1998-99 the Department's running costs allocation will be 1.1 per cent less in real terms than in 1997-98. **Figure 6.1** gives further information.

Figure 6.1: Running Costs

Staff Numbers

6.8 As a result of organisational changes, the Department has managed a substantial reduction in staffing numbers and costs (see **figures 6.1 and 6.2**).

Figure 6.2: Staff Numbers

Regional Office Integration

6.9 'staff in the eight NHS Executive Regional Offices (ROs) (formerly Regional Health Authority staff) have been successfully integrated on to the Department's pay and terms and conditions. Only a small number of RO staff now retain NHS pay and terms.

Senior Civil Service Salaries

6.10 Details of Senior Civil Service Salaries in the Department are given in **figure 6.3**.

Figure 6.3:Salaries in the Department of Health for Senior Civil Service Staff in Post at 1 April 1997 divided into £5,000 bands

Efficiency and Value for Money

6.11 The Department uses a range of efficiency techniques to manage the substantial reduction in staffing numbers and costs it has faced, and continues to face. These techniques have included repackaging and retendering a number of services already outsourced, such as facilities management, resulting in further savings.

6.12 In line with the Department's strategic approach to reducing the size of the estate, the costs of accommodation in London continue to fall, with a reduction from £30.3 million in 1995-96 to £26.1million in 1996-97 to an expected £24.6 million in 1997-98. Other measures to promote more efficient working include efficiency reviews to determine how work and structures might be reorganised or delivered more effectively. The Department's four business groups have each adopted their own approaches, often using locally-based trained change facilitators.

6.13 Further improvements to the information technology (IT) and telecommunications facilities underpin the drive for more efficient working. For example, a common external address list database for the NHS and other contacts will reduce duplication, and support the Department's Communications Strategy through more efficient targeting of Departmental mailings. A strategic review of IT was undertaken in 1997-98. The outcome will be to upgrade the Department's IT office systems and network for Year 2000 compliance, to meet changing business needs and to enable easier electronic communication with the NHS and external organisations.

Payment of Bills

6.14 The Department complies with the Confederation of British Industry's prompt payment code and the British Standard[4.23] on prompt payment. The Department's policy is to pay bills in accordance with agreed contractual conditions or, where no such conditions exist, within 30 days. Where appropriate, departmental contracts also require contractors to make payments to sub-contractors within 30 days of receipt of an invoice. **Figure 6.4** shows the percentage of invoices paid within the contracted period or, where no terms were set, within 30 days of the presentation of a valid invoice.

Figure 6.4: Payment of Bills

Regional Office Integration

Maladministration

6.15 In 1997 the Department paid £107,000 following two instances of maladministration. These concerned personal injury, and inaccurate pension advice to a former employee.

Environmental Stewardship

6.16 Continuing progress has been made in implementing the Department's second Environmental and Energy Action Plan. Last year energy consumption in the Department's main buildings fell for the third consecutive year, by a further 8 per cent,

reducing carbon dioxide (CO_2) emissions by 175 tonnes and saving over £78,000. The recent extension of Building Management Systems into more London buildings to monitor energy consumption in detail, and a heat recovery capability being incorporated as part of a major air conditioning refurbishment, will provide opportunities for further savings. Increased use of electronic mail for the distribution of internal publications continues to reduce the volume of waste paper, about 120 tonnes of which were recycled last year in London alone. Aluminium cans are also being recycled, and opportunities for recycling a greater range of office waste such as fluorescent lighting and technical waste are being explored.

6.17 The Department's "Green Minister" is Tessa Jowell mp whose other responsibilities are detailed at **Annex D**. The official "green housekeeping" contact is Andrew Waring, Head of Accommodation Strategy and Policy, tel: 0171 972 5740.

A Good Employer

New Initiatives

6.18 The Department has introduced a career management and development programme designed to improve its management capability and help staff take responsibility for their own careers. It includes initiatives such as workshops to help staff identify and address their development needs, and a system linking training and development opportunities to specific levels in the Department's competence framework.

Current Issues and Recent Trends

Personnel Policies

6.19 There has been significant progress, such as the successful first year of operation of the new integrated pay arrangements (for staff formerly in unified grade 6 and below), and monitoring continues to confirm that objectives are being met, that progress is being maintained, and that further developments are taken forward from a sound base. The range of action and initiatives includes:

- a review, with the trade unions, of the operation of the Department's integrated pay system with the intention of streamlining and clarifying the new arrangements;
- introduction of a new performance appraisal system for staff outside the Senior Civil Service. Thesystem continues to be based on the assessment of performance against objectives and competencies, but is designed to sharpen the focus on how to improve performance;
- introduction of a new grievance procedure for staff, with more emphasis on line management responsibility for finding resolutions, and a move away from a quasi-judicial process to one based on conciliation;
- a full programme of management training skills, based on a successful pilot in 1996; and
- a planned programme of audits as part of the "equity assurance" process, following successful completion of pilot audits during 1997 on line management operation of the pay and job specific selection arrangements.

6.20 The Department is aiming to achieve accreditation as an Investor in People (IIP) by the end of 1998 through the separate assessment of ten business areas. Seven of these business areas were assessed and judged to meet the IIP standard in 1997 and early 1998.

Equal Opportunities

6.21 A number of new initiatives have been developed and taken forward as part of the Department's continuing commitment to equal opportunities. The Department:

- has undertaken a fundamental review of its equal opportunities complaints procedure;
- has set up a network of general harassment advisers;
- has set up a focus group for staff who are women and from an ethnic minority background to discuss double disadvantage;
- for 1998-99, aims to develop equal opportunities action plans. A reference group of line managers will produce advice on how to draw up action plans and implement them;
- will hold an open day focused on disability as part of a programme to raise awareness of disability issues;
- has reviewed child care in the Department, as part of the commitment to family friendly policies.

6.22 The overall representation of women, people with disabilities and people from minority ethnic groups in the

Department on 10 November 1997 was 55.9 per cent, 3.9 per cent and 14.3 per cent respectively.

Recruitment

6.23 The Department has systems in place to ensure that all external recruitment is carried out on the basis of fair and open competition in accordance with its policies and with the requirements of the *Civil Service Commissioners'Recruitment Code*[6.2].These systems are subject to internal checking. The Department's external recruitment systems were audited by PE International in June 1997 on behalf of the Commissioners and were found to be generally satisfactory.

6.24 The number of successful candidates in external competitions is shown in **figures 6.5 and 6.6** and, as required by the Code, gives the numbers of women, ethnic minorities and disabled people successful at each level. All recruitment was conducted by fair and open competition in accordance with the Civil Service Commissioners Recruitment Code, apart from the following permitted exceptions (where exceptions were made relating to the Senior Civil Service they were with the permission of the Office of the Civil Service Commissioners):

- one extension of a casual appointment beyond 12 months;
- 12 secondments without fair and open competition;
- two conversions of fixed term appointments to permanency;
- two secondees made permanent;
- one fixed term appointment of less than 12 months;
- three short term appointments under 12 months.

Figure 6.5 : Recruitment to the Senior Civil Service in Department of Health: Successful Candidates by Sex, Ethnic Origin, and Disability (January 1997 to December 1997)

Figure 6.6 : Posts at Former Unified Grade Six and Below: Successful Candidates by Sex, Ethnic Origin, and Disability (January 1997 to December 1997)

ACCOUNTABILITY

6.25 The Department has two main objectives in this area:

- **to serve Parliament and the public** with clear and timely information;
- to ensure transparency and probity in dealings with **Agencies** and **Non Departmental Public Bodies** (NDPBs).

Serving Parliament and the Public

New Initiatives

Better Government

6.26 In accordance with the manifesto[1.2] commitment to rebuild the bond of trust between Government and the people, the Cabinet Office intends to publish a White Paper on Better Government in spring 1998. This will examine various ways in which four main themes are being addressed across Government. The themes are:

- cleaning up politics and opening Government out;
- rooting out waste and getting results;
- listening to people and delivering services that better meet their needs;
- breaking down institutional barriers and working better together.

Open Government and Freedom of Information

6.27 The introduction of a Freedom of Information Act is a manifesto[1.2] commitment for this Government. The policy, set out in the White Paper *Your Right to Know*[6.3], published in December 1997, has implications for all staff who handle official information. Through guidance and awareness training a culture of greater openness is being promoted. In the meantime, the *Code of Practice on Access to Government Information*[6.4] continues to influence the way in which the Department handles official information.

Better Regulation

6.28 The Department fully accepts the importance of adopting the principles of "Better Regulation" as an integral part of its work to ensure public safety and protect human health. There is a strong commitment throughout the Department and its Agencies to put in place and maintain quality regulations targeted on risk, which avoid unnecessary burdens, and which are fair to all parties, properly costed, practical to enforce and straightforward to comply with. Draft regulatory appraisals covering costs and benefits will be published for consultation to give those who have an interest (consumers, business, particularly small business, and the voluntary sector) a clear voice in framing new and amending regulations.

6.29 The Department is keen to promote use of "Direct Access Government" (a one stop shop on the Internet for regulatory guidance and forms) and is continually looking at ways to expand its site. There are now 16 areas of work on the Department's web site (which also gives access to the web sites of the Medicines Control Agency, the Medical Devices Agency and the Human Fertilisation and Embryology Authority). The web site address for Direct Access Government is http://www.open.gov.uk/gdirect.

6.30 As part of its plans to reduce "red tape", the Department reviewed 17 (23 per cent) of its administrative forms sent to business and the voluntary sector in 1997-98. This resulted in simplification of seven forms:

- one application form for registration as a voluntary children's home;
- five forms for voluntary organisations providing services for alcohol and drugs misuse;
- one registration form (and guidance) on Medical Devices Regulations 1994.

In 1998-99 the Department plans to review a further 51 forms.

Resource Accounting and Budgeting

6.31 The White Paper *Better accounting for the taxpayer's money: the government's proposals for resource accounting and budgeting in government*[6.5] was published in July 1995. The Government is committed to implementing Resource Accounting and Budgeting, with 1999-2000 being the first year for which resource accounts will be published and laid before Parliament. Subject to Parliamentary approval, the Department's first resource-based Supply Estimates will be presented to Parliament for 2001-2002 and, from that year, resource accounts will replace cash Appropriation Accounts.

6.32 A resource-based system of public expenditure planning and control should improve management and value for money for the taxpayer by:

- making decision-makers focus more sharply on resources consumed rather than on cash spent;
- treating capital expenditure in a way which better reflects its economic significance; and
- encouraging a greater emphasis on outputs and the achievement of aims and objectives.

6.33 The Department is on target to produce its first set of resource accounts on a trial basis for the financial year 1997-98. The existing accounting system is being modified to meet the requirements of resource accounting.

Current Issues and Recent Trends

6.34 The Department answered 2,393 Parliamentary Questions in 1997. It also has one of the largest postbags in Whitehall. 29,293 pieces of correspondence were received in 1997. Ministers replied to 14,547 of these letters and the remainder were dealt with by officials.

The Citizen's Charter

6.35 'six Whitehall standards for how government departments and their agencies deal with the public were set out in a 1996 Cabinet Office White Paper, *The Citizen's Charter Five Years On*[6.6]. In spring 1998 the Cabinet Office will be reviewing the performance of all departments against the standards and publishing the results.

6.36 The Department's main directly-provided service to the public is providing information on request. Particular attention has been paid in the last year to the following standards:

- answering all correspondence within 20 working days. In the period from 1 January 1997 to 31December 1997 a survey showed that 76 per cent of correspondence was replied to fully or with a substantive holding reply within the target set;

- aiming to see all visitors within 10 minutes of any appointment made at its offices. The Department conducted a survey of visitors and found that 97 per cent of appointments were kept within the waiting time target.

6.37 The Department is currently working on the standards about:

- providing clear and straightforward information;
- consulting users about the services for which it is responsible;
- having appropriate complaints procedures; and
- making services available to everyone.

Departmental Spending on Publicity and Advertising

6.38 The Department runs a number of publicity campaigns directly and places contracts for others with the Health Education Authority (HEA) and other organisations. Forecast outturn in 1997-98 is estimated to be £42.2 million. The main components of this are given in **figure 6.7**. The balance of £11.6 million includes a number of other smaller campaigns run by the HEA or other providers and funded from Departmental core expenditure.

Figure 6-7: Departmental Spending on Publicity and Advertising, 199798

Non Departmental Public bodies (NDPBs) and Agencies

New Initiatives

Non Departmental Public Bodies (NDPBs) and NHS Bodies

6.39 The Government's Consultation Paper on QUANGOs[6.7], published in November 1997, set out the Government's future policy on, and initiatives towards, public bodies and appointments to them. In support of this initiative the Department is improving the accountability and openness of its NDPBs and NHS bodies, for example by introducing open meetings, and reports of meetings, wherever practicable. It is also encouraging advisory NDPBs to produce annual reports and adopt codes of conduct for members wherever possible. Further details of NDPBs and NHS bodies are set out in **Annex H**.

6.40 The Department is also examining the opportunities for reducing the number of QUANGOs, and intends to keep the number of its unelected bodies to the minimum necessary and to ensure that those remaining are open, accountable, efficient and responsive.

6.41 To increase the accountability of NHS trusts to the communities they serve, the Department requires them to hold their board meetings in public and intends to enforce this through legislation.

Current Issues and Recent Trends

Executive Agencies

6.42 The Department set up four **executive Agencies** under the *Next Steps*[6.8] programme:

- **Medical Devices Agency** (MDA). A Prior Options review of the MDA will take place in 1999;
- **Medicines Control Agency** (MCA). A Prior Options review of the MCA will be carried out in 1999;
- **NHS Pensions Agency**. A Prior Options review will be completed in 1998;
- **NHS Estates Agency.** Ministers have decided that NHS Estates should retain its current agency status. A Prior Options review of the Agency will take place in 1998.

6.43 The relationship between the Department and its Agencies is set out in the relevant Framework Documents which are available direct from the Agencies. Further details about the management of the Agencies are set out at **Annex G**.

Public Appointments

6.44 The Commissioner for Public Appointments published guidance[6.9] has been in operation since April 1996. All appointments made by the Department since then have followed that guidance. The Department's second annual report of

appointments to NHS bodies and Executive NDPBs will be published in spring 1998, which will give details of the approximately 3,500 people appointed to these bodies.

6.45 In order to make NHS boards more representative of local communities, the Department has endeavoured to move the balance of board membership towards local community carers and users of NHS services. The qualities required of candidates have been reviewed to reflect this movement.

6.46 New and more open appointment procedures have been adopted for appointments in 1998-99, which include a major advertising campaign in the national and ethnic presses combined with an invitation to all MPs and local authorities to use their local knowledge to nominate candidates who may wish to apply.

6.47 The Department remains committed to equal opportunities and to improving the representation of women and people from ethnic minorities on the bodies it sponsors. See **figure 6.8**.

Figure 6-8: The Appointment of Women and People from Ethnic Minorities to NDPBs, NHS trusts and Health Authorities, as at 30 September 1997

ANNEX A

Department of Health: Aims and Objectives

Note: The following Aims and Objectives are in draft at time of going to press, and may be subject to revision.

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

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

Our key objectives in pursuing these aims are:

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

We shall do this by:

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

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

We shall do this by:

- providing family health services which are accessible to people wherever they live;
- reducing the number of people waiting, and the time they have to wait, for treatment;
- improving clinical effectiveness in the NHS;
- ensuring that the NHS prioritises treatments according to clinical need, not people's ability to pay, nor where they live, nor who is their general practitioner (GP).

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

We shall do this through the NHS programme by:

- providing care according to individual need regardless of organisational boundaries;
- helping people to live independently, and supporting them wherever possible in their own homes;
- giving people who need it access to effective palliative care;
- through local authority social services, by:
- securing appropriate and effective social care for those who lack the means or other support to get the help they need;

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

We shall do this by enabling local authorities, with resources and guidance, to:

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

The Department of Health is committed to making progress in a way which:

- is **fair**, excluding no part of the community, and directing action and resources to areas of greatest need;
- is **responsive** to the views and preferences of patients, clients and their carers;
- improves the **quality** of care by investing in the education and training of staff, and makes best use of their skills;
- the services, in partnership with the private sector, by ensuring that patients and clients have access to suitable facilities and can benefit from new technologies;
- strengthens the **scientific and research base** of services through partnership with industry and universities;
- reduces waste and maximises **efficiency**, including by making full use of capital assets and working across institutional boundaries.

ANNEX B

Cash Plans Tables

Figure B1: Cash Plans Hospital, community health, family health and related services, Department of Health administration, miscellaneous health and personal social services, England

The expenditure in this figure relates to the 1998-99 *Supply Estimates*[1,7] for Class XI Votes 1 and 2.

								£ million
Vote Section		1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	1997-98 estimated outturn	1998-99 plans
	Department of Health							
	Central government expenditure							
	Health Services							
	Voted in Estimates							
1A	**Hospital, community health, family health (cash limited), related services and NHS trusts**							
	Current expenditure[1, 2]	20,260	21,692	23,308	24,788	26,312	27,873	30,037
	Capital expenditure[3]	1,316	883	852	696	315	326	112
	Total	**21,576**	**22,575**	**24,160**	**25,484**	**26,627**	**28,199**	**30,148**
	Family health services (non-cash limited)[1]							
1B	General medical services	1,766	1,839	1,901	1,966	2,073	2,208	2,188
1C	Drugs	2,346	2,323	2,221	2,203	1,980	1,920	1,551
1D	Dispensing costs	658	677	679	706	746	770	793
1E	Prescription charge income	242	265	287	299	296	322	336
1F	General dental services	911	855	896	908	940	956	1,007
1G	General ophthalmic services	172	192	213	223	237	244	263
1H	Other family health services	2	2	2	2	1	1	1
	Total	**5,613**	**5,622**	**5,625**	**5,709**	**5,681**	**5,776**	**5,466**
	Departmental administration and agencies							
2A	Central department	318	268	261	259	248	236	228
2B	NHS Estates Agency	1	#	1	1	1	#	#
2C	NHS Pensions Agency	10	21	20	17	17	12	15
2D	Medical Devices Agency	10	11	11	8	7	7	10
2E	Youth Treatment Service	4	4	6	4	2	1	#
	MCA	#						
	Total	**340**	**303**	**296**	**287**	**273**	**255**	**252**
	MCA Trading Fund[4]		**5**					

	Central health and miscellaneous services							
2F	Non departmental public bodies and special health authorities	74	77	79	78	79	79	78
2G	Other services including medical, scientific and technical services, grants to voluntary bodies, research and development and information services	160	160	161	160	171	162	159
2H	Welfare food and European Economic Area medical costs	193	214	222	259	280	277	286
	Total	**427**	**451**	**462**	**497**	**530**	**517**	**523**
	Total voted in Estimates	**27,957**	**28,956**	**30,543**	**31,977**	**33,111**	**34,748**	**36,391**
	Of which:							
	Central government's own expenditure	*27,732*	*28,618*	*29,966*	*31,541*	*32,926*	*34,504*	*36,369*
	Public corporations	*225*	*333*	*577*	*436*	*185*	*244*	*22*
	Trading funds		*5*					

Figure B1 : continued

£ million

Vote		**1992-93 outturn**	**1993-94 outturn**	**1994-95 outturn**	**1995-96 outturn**	**1996-97 outturn**	**1997-98 estimated outturn**	**1998-99 plans**
Section	**Department of Health**							
	Other (non-voted)							
	National Health Service hospital, community health, family health (cash limited) and related services and NHS trusts							
	Current expenditure		#		#			
	Capital expenditure	2	30	14	35	83	77	100
	Total	**2**	**30**	**14**	**36**	**83**	**77**	**100**
	National Health Service family health services (non-cash limited)[1]							
	General medical services							
	Drugs			#				
	Dispensing costs							
	Prescription charge income							
	General dental services							
	General ophthalmic services							
	Other family health services	#		#				
	Total	**#**		**#**				
	Departmental administration							
	Central department	16	17	16	17	17	17	17
	NHS Estates							
	NHS Pensions Agency			#				
	Medical Devices Agency			#				
	Youth Treatment Service			#				

	MCA							
	Total	**16**	**17**	**16**	**17**	**17**	**17**	**17**
	MCA Trading Fund							
	Current expenditure							
	Central health and miscellaneous services							
	Non departmental public bodies and special health authorities							
	Other services including medical, scientific and technical services, grants to voluntary bodies, research and development and information services	1	1	2	1	2		
	Welfare food and European Economic Area medical costs							
	Total	**1**	**1**	**2**	**1**	**2**		
	Total other (non-voted)	**13**	**14**	**28**	**19**	**67**	**60**	**118**
	Of which:							
	Central government's own expenditure	*16*	*16*	*14*	*16*	*16*	*17*	*17*
	Public corporations (excluding nationalised							
	industries)	*2*	*30*	*14*	*35*	*83*	*77*	*101*
	Total Health Services	**27,970**	**28,942**	**30,570**	**31,958**	**33,044**	**34,688**	**36,509**
	Of which:							
	Central government's own expenditure	*27,746*	*28,632*	*29,979*	*31,557*	*32,941*	*34,520*	*36,385*
	Public corporations (excluding nationalised							
	industries)	*223*	*303*	*590*	*401*	*102*	*167*	*122*
	Trading funds		*5*					*1*

Figure B1 : continued

£ million

Vote Section		1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	1997-98 estimated outturn	1998-99 plans
	Department of Health							
	Other Services							
	Voted in Estimates							
2I	**Personal social services**							
	Current expenditure	30	32	32	31	30	32	32
	Capital expenditure	2	3	#	1	#	#	#
	Total	**31**	**34**	**32**	**30**	**30**	**32**	**32**
	Total voted in Estimates	**31**	**34**	**32**	**30**	**30**	**32**	**32**
	Of which:							
	Central government's own expenditure	*32*	*36*	*33*	*31*	*31*	*34*	*33*
	Total other (non-voted)							
	Of which:							

	Central government's own expenditure							
	Public corporations (excluding nationalised							
	industries)							
	Total central government expenditure	**28,002**	**28,976**	**30,602**	**31,988**	**33,073**	**34,721**	**36,540**
	Of which:							
	Central government's own expenditure	*27,779*	*28,668*	*30,012*	*31,587*	*32,971*	*34,553*	*36,418*
	Public corporations (excluding nationalised industries)	*223*	*303*	*590*	*401*	*102*	*167*	*122*
	Trading funds		*5*					*1*
	Central government grants to local authorities							
	Voted in Estimates							
	Current grants within AEF							
2J	Training support programme for social services staff	29	32	33	35	35	35	35
2K	Services for people with HIV and AIDS	15	12	13	13	13	14	14
2L	Services for alcohol and drug misusers	2	2	2	3	2	2	2
2M	Services for people with mental illness	30	34	36	47	58	67	73
2N	Community care grant		565	736	648	418	325	350
2O	Provision for secure accommodation		#		#	#	#	#
2P	Unaccompanied asylum-seeking children					3	3	3
2Q	Services for people seeking asylum					10	87	90
2	Guardian *ad litem* and reporting officer service	6	6	6	6	6	6	
2	Long-term care capital disregard increase					64		
	Capital grants							
2O	Provision for secure accommodation	1	2	5	21	27	13	8
1I	Rehousing of displaced families	#					#	#
	Total central government grants to local authorities	**83**	**654**	**831**	**772**	**638**	**553**	**576**
	Of which:							
	Current within AEF	*82*	*652*	*827*	*752*	*611*	*540*	*568*
	Capital	*1*	*2*	*5*	*21*	*27*	*13*	*8*
	Credit approvals	**126**	**132**	**140**	**145**	**105**	**69**	**54**
	Total central government support to local authorities	**209**	**786**	**972**	**918**	**743**	**622**	**630**
	Total Department of Health	**28,211**	**29,762**	**31,574**	**32,906**	**33,816**	**35,342**	**37,170**
	Of which:							
	Voted in Estimates	*28,072*	*29,644*	*31,406*	*32,780*	*33,779*	*35,333*	*36,998*

1 HCHS current expenditure includes provision for drugs prescribed by GP fundholders (£295 million in 1992-93, £628 million in 1993-94, £1,009 million in 1994-95, £1,296 million in 1995-96, £1,794 million in 1996-97, and £2,204 million in 1997-98 and provisional figures for 1998-99).

2 HCHS current expenditure includes that element of trust capital expenditure which they fund from their charges to health

care purchasers (£363million in 1992-93, £696 million in 1993-94, £975 million in 1994-95, £1,053 million in 1995-96, £1,106 million in 1996-97 and £943 million in 1997-98, and provisional figures for 1998-99).

3 HCHS capital expenditure includes the net expenditure on Secretary of State loans and Public Dividend Capital advances used to finance trust capital expenditure (£225 million in 1992-93, £333 million in 1993-94, £577 million in 1994-95, £436 million in 1995-96, £185 million in 1996-97, an estimated £244 million in 1997-98 and provisional funds for 1998-99).

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

5ÊThe expenditure in this table relates to the 1998-99 Supply Estimates for Class XI Votes 1 and 2.

6 Totals may not sum due to rounding.

7 Cash amounts below £0.5 million are not shown but are indicated by a #.

Figure B2: Cash Plans Ð National Health Service (Superannuation, etc) England and Wales

The expenditure in this table relates to the 1998-99 Supply Estimates1.7 for Class XI Vote 3.

						£ million	
		1993-94	**1994-95**	**1995-96**	**1996-97**	**1997-98**	**1998-99**
Vote		**outturn**	**outturn**	**outturn**	**outturn**	**estimated**	**plans**
Section	**NHS Pensions Agency**					**outturn**	
3A	Pensions, etc: annual pensions, lump sums, death gratuities, widows and dependants	1,107	1,181	1,297	1,385	1,527	1,653
	Superannuation benefits payable in compensation cases	159	211	219	233	250	286
	Pensions increase: annual pensions, lump sums, death gratuities, widows and dependants	471	474	482	511	531	565
	Payments made to local authorities	19	19	16	16	14	13
	Payment of transfer values	65	34	26	36	26	26
	Repayment of Superannuation contributions (net of Income Tax)	8	6	7	8	7	8
	Payment of Income Tax on repayments of contributions	1	1	2	1	1	2
	Contributory payments in respect of persons subject to other Superannuation arrangements	#	#	#	#	#	#
	Contributions Equivalent Premiums to the State Pension Scheme	9	6	6	7	6	6
	Appropriations in Aid						
	Superannuation contributions	1,190	1,218	1,240	1,339	1,472	1,543
	Transfer values	25	29	32	57	85	283
	Deductions from returns of contributions and lump sum payments towards payments in lieu of graduated contributions	#	#	#	#	#	#
	Certified amounts of Contributions Equivalent Premiums	2	2	2	2	2	2
	Recovery of Contributions Equivalent Premiums from the State Pension Scheme	2	1	1	1	1	1
	Total NHS Pensions Agency	**620**	**682**	**780**	**798**	**802**	**730**

1 Cash amounts below £0.5 million are not shown, but are indicated by a #.

Figure B3: Reconciliation between cash plans table and Supply Estimates[1.7]

			£ million
	1996-97 outturn	**1997-98 estimated outturn**	**1998-99 plans**
Public Expenditure within the Control Total (as in cash plans table)	33,816	35,342	37,170
Less non-Voted expenditure within the Control Total	38	9	172
Voted Expenditure included in the Control Total	33,779	35,333	36,998
Voted Expenditure not included in the Control Total			
Department of Health			
Trust debt remuneration	1,000	1,207	1,236
NHS contributions	4,451	4,790	4,994
Other (Vote 1)		1	1
Other (Vote 2)	#	#	#
Pensions	798	802	730
Total Voted Expenditure not included in the Control Total	2,653	2,780	3,027
Total Voted Expenditure	31,125	32,554	33,972

1 Totals may not sum due to rounding.

2 Cash amounts below £0.5 million are not shown, but are indicated by a #.

ANNEX C

National Health Service, United Kingdom by Area of Expenditure

Figure C1: National Health Service, United Kingdom[1] By Area of Expenditure

	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	1997-98 estimated outturn	£ million 1998-99 plans
Central government expenditure							
National Health Service hospital, commmunity health, family health (cash limited) and related services and NHS trusts	26,972	27,997	29,432	30,779	31,810	33,342	35,108
National Health Service family health services (non-cash limited)	8,003	8,388	8,825	9,244	9,709	10,219	10,591
Departmental administration[2]	407	358	350	341	328	317	310
MCA trading fund[3]		5	0	0	0	0	1
Central health and miscellaneous services	852	732	749	795	839	841	835
Total							
Gross	36,233	37,481	39,357	41,159	42,686	44,719	46,844
Charges and receipts	1,611	1,656	1,607	1,721	1,862	1,932	1,857
Net	34,623	35,825	37,750	39,438	40,824	42,787	44,987
Total at 1996-97 prices (using GDP deflator)							
Gross	40,038	40,246	41,634	42,364	42,686	43,544	44,327
Percentage real terms change		+0.5	+3.4	+1.8	+0.8	+2.0	+1.8
Net	38,258	38,469	39,934	40,593	40,824	41,662	42,570
Percentage real terms change		+0.6	+3.8	+1.7	+0.6	+2.1	+2.2

1 Supporting figures for Northern Ireland are estimates, due to the integrated nature of health and personal social services provision in Northern Ireland.

2 Excludes departmental administration of health programme in Scotland and Wales.

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

4 Cash amounts below £0.5 million are not shown.

5 Figures may not sum due to rounding.

ANNEX D

Ministerial Responsibilities

Secretary of State: The Right Honourable Frank Dobson mp

D.1 *Has overall responsibility for* the work of the Department

Minister of State: Alan Milburn mp

D.2 *Responsibility for:* Strategy and Planning; NHS structure/organisation; Commissioning; Primary Care; General medical services; General dental services; General ophthalmic services; Pharmaceutical services (including prescribing and drugs bill); Human resources; NHS pay and conditions; Training and education; Workforce planning; Equal opportunities; London; NHS finance; Public Expenditure Survey; Resource allocation; Central budgets; Performance monitoring; Management costs; Private Finance Initiative; Statistics; Information Management and Technology; NHS estates; Communications; Policy on NHS appointments; NHS appointments (North Thames, South Thames regions).

Minister of State for Public Health: Ms Tessa Jowell mp

D.3 *Responsibility for:* Public health strategy including Health Standards (H) Cabinet Committee, and health monitoring; Substance misuse (alcohol, tobacco and drugs) including Health Standards (D) Cabinet Committee; Notifiable and other communicable diseases (including AIDS); Health inequalities, health promotion and ethnic health; International business; Public health aspects of other policies; Ethical issues, confidentiality, family planning and end of life decisions; Microbiology of the environment and food, including Transmissible Spongiform Encephalopathies (TSEs); Food Safety, including Miscellaneous 1 Cabinet Committee and communicable disease control; Health aspects of the environment, including Green Ministers Group and welfare foods; Chemical toxicology, radiation, nutrition and public health bodies; Women's issues, including Health Standards (W) Committee; Public health in the NHS; Clinical effectiveness and clinical audit; NHS appointments (North West, Trent regions).

Minister of State (Lords): Baroness Jay of Paddington

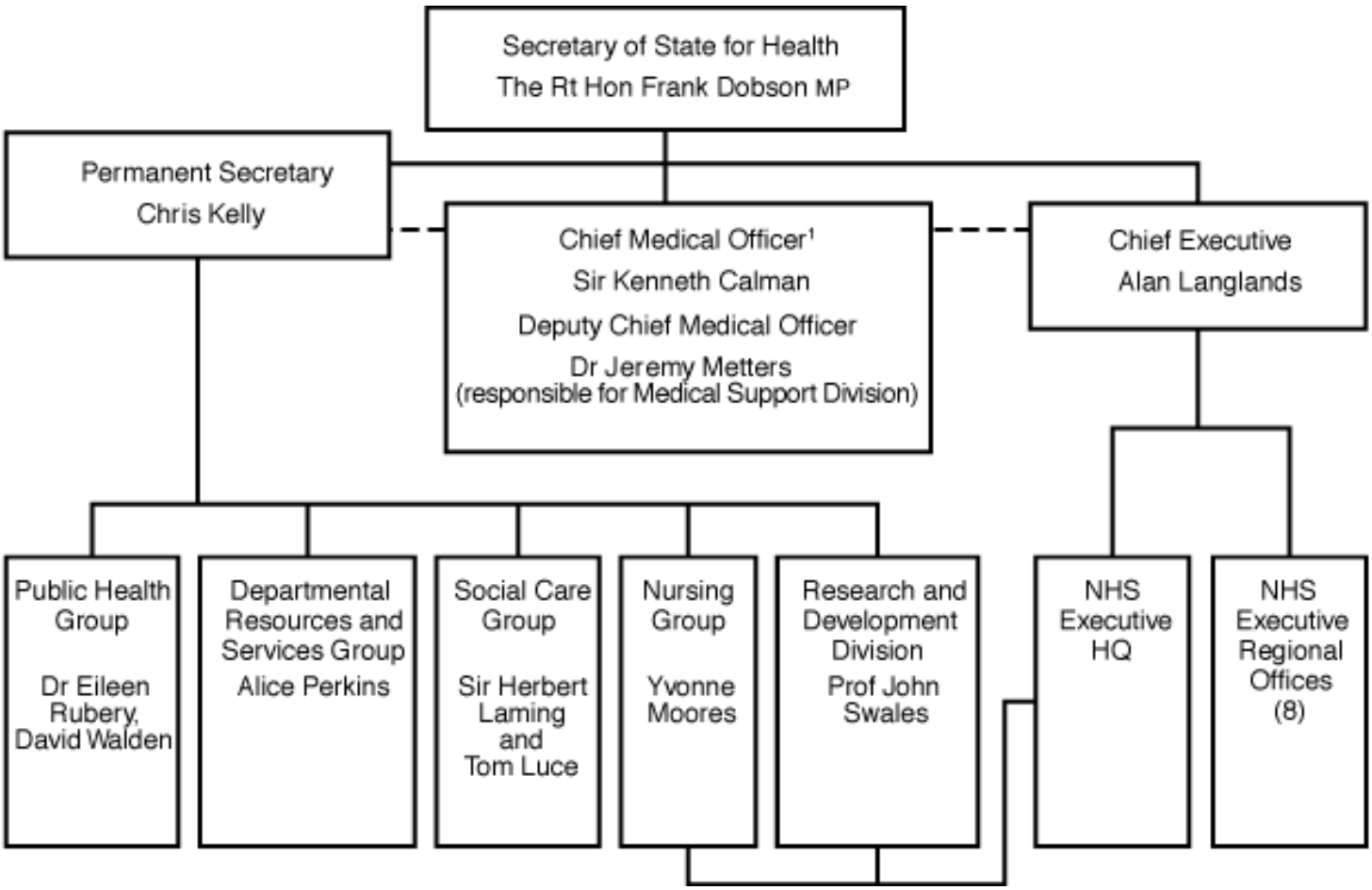
D.4 *Responsibility for:* Blood; Transplants; Cancer; Emergency services; Maternity and child health; Quality; Medicines (including licensing); Medical devices (including licensing); Pharmaceutical industry (including Pharmaceutical Price Regulation Scheme); Emergency Preparedness; All Lords Parliamentary business; Operational Policy; Procurement; Market testing; Independent health care sector; Nursing; Professions allied to medicine; Research and development; Department of Health management including: Agencies; Better Regulation; NHS Charter; Waiting times; Complaints; Clinical negligence; Community Health Councils; NHS Appointments (South & West, Northern & Yorkshire regions).

Parliamentary Under Secretary of State: Paul Boateng mp

D.5 *Responsibility for:* General Social Services including community care and carers; Services for elderly people including NHS continuing care; Services for people with mental illness including special hospitals; Child and adolescent mental health; People with learning disabilities; Services for people with physical disabilities; Children's services (including adoption, fostering, child protection), Department of Health aspects of juvenile offenders, Children Act, children's residential care, children's day care and the Youth Treatment Service; Voluntary sector (including Section 64 grant scheme); Family Policy; NHS appointments (Anglia & Oxford, West Midlands region).

ANNEX E

Structure of the Departmentof Health



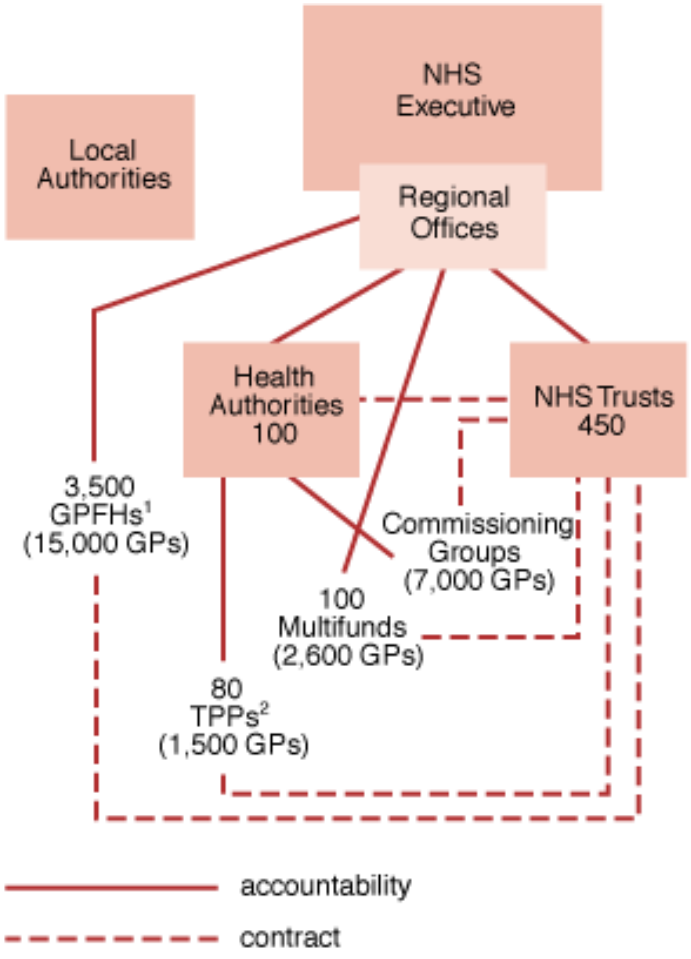
1 The Chief Medical Officer provides medical advice to the whole Department.

2 Departmental Agencies and Non Departmental Public Bodies are not shown.

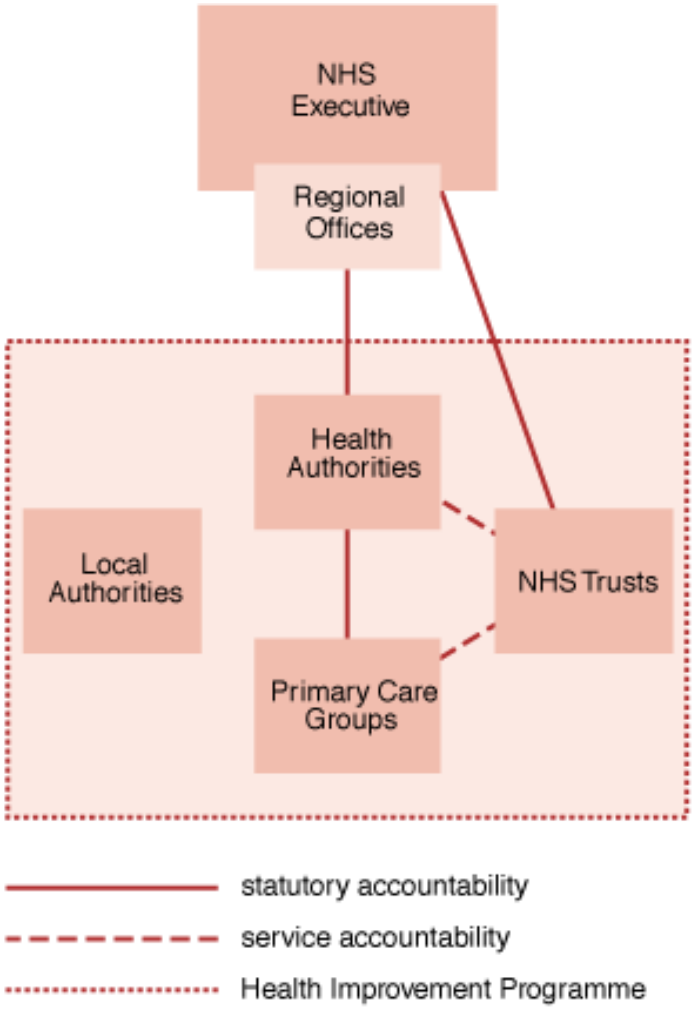
ANNEX F

Structure of the NationalHealth Service Old and New

The old NHS



The new NHS



1 General Practice Fundholders.

2 Total purchasing pilots.

ANNEX G

Executive Agencies of the Department of Health

Medical Devices Agency

G.1 The Medical Devices Agency (MDA) was launched in September 1994. It safeguards public health by ensuring that medical devices and equipment for sale or use in the United Kingdom (UK) meet appropriate standards of safety, quality and performance. It has some 140 staff, mainly in London but with some in Blackpool and Surrey, and running costs of £9.7 million, offset by income of £2.5million.

G.2 The Agency analyses and investigates reports from users about adverse incidents involving devices and issues safety warnings; manages a product evaluation programme; helps set national and international safety and performance standards; and offers advice on medical devices to a wide range of customers. It leads for the UK in negotiating and implementing a series of European Directives. As the Competent Authority for the UK, it enforces the Regulations which support the Directives; appoints and monitors Notified Bodies who ensure that manufacturers comply with certain requirements of the Regulations; and assesses applications from manufacturers for clinical investigations.

G.3 The Agency's key tasks and targets and other objectives are set out in the Agency's 1997-98 Business Plan and in its Corporate Plan. Any of the documents mentioned above can be obtained from Malcolm Ridgway on 0171 972 8133.

Medicines Control Agency

G.4 The Medicines Control Agency (MCA) was launched as an Executive Agency in July 1991 and became a trading fund in 1993. It safeguards public health by ensuring that all medicines in the UK market meet appropriate standards of safety, quality and efficacy. This is achieved through a system of licensing, inspection, enforcement and the monitoring of medicines after they have been licensed. The Agency employs about 370 staff and has gross running costs of £25 million derived from fees charged to the pharmaceutical industry. These fees wholly cover the Agency's costs.

G.5 The Agency's forward plans and targets are set out in the Annual Report and Business Plan, which can be obtained from the office of the Chief Executive, room 1628 Market Towers, 1 Nine Elms Lane, London SW8 5NQ.

NHS Pensions Agency

G.6 The NHS Pensions Agency (NHSPA) was launched in November 1992 and is responsible for the administration of the NHS Pension Scheme and NHS Injury Benefit Scheme for England and Wales. It employs 410 staff and has gross running costs of £16.1 million. The NHSPA's cash plans are shown in Annex B, figure B2.

G.7 The Agency's remit is to secure value for money, while providing a timely, accurate and helpful service to its 1.6 million customers and contributing to NHS and government pensions policy together with providing advice to interested parties about the Scheme. It is also required to make prompt and accurate collection of pension contributions from some 800 NHS employers and 10,000 general practitioner (GP) practices.

G.8 The Agency continues its drive to improve its efficiency and effectiveness and measures itself against other public sector organisations through Treasury benchmarking and through comparisons with similar organisations in the pensions industry. In addition through working in partnership with its providers of medical services, IT services, pensions administration services as well as internal developments the Agency plans continuing improvements in services and value for money for Scheme administration.

G.9 Copies of the NHSPA's Annual Report and Accounts for 1996-97, which include an outline of the forward plans, and its Business and Corporate Plans (including key tasks and targets) are available from the NHS Pensions Agency, Hesketh House, 200-220 Broadway, Fleetwood, Lancashire FY78LG; 01253 774774.

NHS Estates Agency

G.10 The Department's former Estates Directorate was launched as an Executive Agency in April 1991. The Agency's task is to support Ministers, the NHS Executive and the NHS in the management of its £23 billion estate and annual capital investment programme of over £1.69 billion. It employs about 143 staff and has gross running costs of £9.5 million.

G.11 The Agency's main objectives are to encourage effective, efficient and economical management of the property used for health care and to promote excellence of design, with value for money, in new buildings. As property advisers and consultants to the health care industry, the Agency provides advice to Government on estate policy in the NHS. It also offers professional consultancy services to all branches of the NHS, the private sector, and overseas clients.

G.12 In July 1997 the Minister for Health announced that NHS Estates would not be privatised, and would remain operating as a **Next Steps**[6.8] Agency.

G.13 Details of the Agency's key tasks and targets and more information about the Agency's activities can be found in the *Annual Report and Accounts 1996-97*. Copies of this document are available from NHS Estates, 1 Trevelyan Square, Boar Lane, Leeds LS1 6AE; 0113 254 7000.

ANNEX H

Other Bodies

(including Executive Non Departmental Public Bodies and Special Health Authorities)

Executive Non Departmental Public Bodies

Central Council for Education and Training in Social Work (CCETSW)

H.1 CCETSW was established in its current form in 1983, with a remit to promote and regulate training for all social services staff across the United Kingdom (UK). Details of its work can be found in its annual Review document (available from CCETSW 0171 278 2455). CCETSW's gross expenditure was £39.5 million in 1996-97 with a total staff of 226. The Department's net grant was £27.5 million. See also **figure H1**. For more information on the Council contact Zulma Wickenden, CCETSW, Derbyshire House, St Chad's Street, London WC1H 8AD; 0171 520 3571.

The English National Board for Nursing, Midwifery and Health Visiting (ENB)

H.2 The Board's main statutory responsibility is under the 1979 Nurses, Midwives and Health Visitors Act, for the approval of educational institutions in England to provide programmes of education and training for nurses, midwives or health visitors which meet the standards set by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). In addition the Board is required to provide advice and guidance to Local Supervising Authorities (LSAs). It also provides a careers service for the public and the professions. In July 1997, the Government announced a review of the 1997 Act, which defines the Board's duties, which is due to be completed in mid-1998. The Board's gross expenditure in 1996-97 was £8.8 million of which £6.647 million was funded by the Government. The Board employs 133 staff. See also **figure H1**. For more information on the Board contact Mr A P Smith, Chief Executive, ENB, Victory House, 170 Tottenham Court Road, London W1P 0HA.

Public Health Laboratory Service (PHLS)

H.3 The PHLS was set up in 1946. The primary function of the PHLS is to improve the health of the population through diagnosis, prevention and control of infections and communicable diseases in England and Wales. The PHLS's gross expenditure in 1996-97 was £125.5 million of which £55.4million was funded by Government. The PHLS employs 3,507 staff. It operates through a network of 49 public health laboratories together with the Communicable Disease Surveillance Centre and the Central Public Health Laboratory. It works in partnership with government departments, health authorities (HAs), NHS trusts, local government, universities and other research institutions.

H.4 Details of PHLS's corporate aims and strategy together with their performance against key targets can be found in their Annual Report. See also **figure H1**. For more information about the PHLS contact Mr W McDowall at Department of Health, Skipton House, London Road, London SE16LW; 0171 972 5013.

National Biological Standards Board (NBSB)

H.5 The NBSB was set up in 1976. The role of the NBSB is to safeguard and enhance public health by controlling and standardizing biological substances used in medicine such as vaccines, products derived from human blood, hormones and response modifiers such as cytokines and growth factors. Italso produces and makes available biological standards and reference materials and conducts research and development relevant to its control and standardisation activities. The Board operates through its management of the National Institute for Biological Standards and Control (NIBSC). NIBSC operates within the European Union as an Official Medicines Control Laboratory and ensures that high standards are maintained for products available on the European Open Market. The Board's gross expenditure in 1996-97 was £16.8 million of which £10.4 million was funded by Government. TheNBSB employs 277 staff. See also **figure H1**. A summary of the Board's

targets and objectives may be found in their Annual Report. For this and other information about the NBSB contact MrWMcDowall at Department of Health, Skipton House, London Road, London SE1 6LW; 0171972 5013.

Human Fertilisation and Embryology Authority (HFEA)

H.6 The Authority was set up in 1990, and is responsible principally for regulating and licensing NHS and private centres that provide treatment involving in-vitro fertilisation and artificial insemination by donor.

H.7 The Authority's gross expenditure in 1996-97 was £1.803 million all of which was funded by Government. The Authority employs 29 staff. Details of the authority's work in the 12 months ending 31 October 1996 together with a forward look and 1995-96 accounts, can be found in its sixth annual report, which is available from the Authority. More information about the Authority can be obtained from Mr Mike Evans, Department of Health, Room 423 Wellington House, 133-135 Waterloo Road, London SE1 8UG; 0171 972 4193.

National Radiological Protection Board (NRPB)

H.8 The NRPB was set up in 1970. The Board has a statutory duty to advance, by means of research and otherwise, the acquisition of knowledge about the protection of mankind from radiation hazards, both ionising and non-ionising, and to provide information and advice to government departments and others with responsibilities for protecting the community or sections of the community. It also provides technical services and undertakes contract research related to radiological protection for which it charges. The Board's gross expenditure in 1996-97 was £15.2 million of which £6.2 million was funded by Government. The Board employs 307 staff.

H.9 A summary of the Board's targets and objectives may be found in their Annual Report. For this and other information about the NRPB contact Mr W McDowall at Department of Health, Skipton House, London Road, London SE1 6LW; 0171 972 5013.

Medical Practices Committee (MPC)

H.10 The MPC was originally set up under the NHS Act 1946, now consolidated in section 7 of the NHS Act 1977. The principal function of the MPC is to shape the distribution of GPs in England and Wales with the ultimate aim of ensuring that there will be adequate numbers of GPs throughout the country. The Committee's gross expenditure in 1996-97 was £0.47 million all of which was funded by Government. The Committee employs 13 staff. For more information on the Committee contact David Thomas, NHS Executive, HRD-MWP, Room 2N35B, Quarry House, Quarry Hill, Leeds LS27UE; 0113 254 5875.

Special Health Authorities (SHAs)

H.11 SHAs are established by the Secretary of State for Health under Section 11 of the NHS Act 1997 for a variety of purposes. There are 13 SHAs each of which has a unique function of a national or supra-regional nature which cannot effectively be undertaken by other types of health bodies. Thefunctions of SHAs are not necessarily restricted to the NHS in England: some have UK-wide responsibilities.

Dental Vocational Training Authority (DVTA)

H.12 The DVTA is an SHA which exercises the functions of HAs by allocating vocational training numbers to dentists. It was set up in 1993. Dentists who wish to practise unsupervised in the General Dental Services of the NHS need to have a vocational training number to show that they have satisfied the Regulations by either completing vocational training or that they are exempt from the requirement to do so or that they have experience or training that can be shown to be equivalent to vocational training. The Authority's gross expenditure in 1996-97 was £0.067 million. It is funded entirely from government funds. The Authority employs two staff. Forfurther information contact Jane Verity, Secretary, Dental Vocational Training Authority, Master's House, Temple Grove, Compton Place Road, Eastbourne, East Sussex BN20 8AD; 01323 431189.

Family Health Services Appeal Authority

H.13 The Family Health Services Appeal Authority was established as an SHA on 1 April 1995. TheAuthority's gross expenditure in 1996-97 was £1.496 million of which £1.364 million was funded by Government. The Authority employs 32 staff. Its role is to perform quasi-judicial appellate and other functions, devolved to it by the Secretary of State, in connection with HA decisions on family health service issues arising under the General Medical Services Regulations, General Dental Services Regulations, General Ophthalmic Services Regulations, the Pharmaceutical Regulations, the FHS practitioners' terms of service with the NHS, and the Service Committee and Tribunal (Amendment) Regulations. For further information

contact Mr John Mann, NHS Executive, Room7E01, Quarry House, Quarry Hill, Leeds LS2 7UE; phone 0113 254 6324, fax 0113 254 6088.

Health Education Authority (HEA)

H.14 The HEA was established in 1987. It has a statutory remit to provide information and advice about health directly to the public; support health professionals and others who provide health education to the public; and advise the Secretary of State on matters relating to health education. Itdesigns and manages health education campaigns and through its research strategy contributes to the evidence base for health education. About two-thirds of its revenues are contracted out to a mix of suppliers including major advertising agencies and small specialist teams.

H.15 Since April 1996 the Department has specifically contracted with the HEA for the work it wishes it to carry out. The HEA's income derives from those specific contracts with the Department and other funders. Its gross expenditure in 1996-97 was £38.5 million of which £34.3 million was funded by Government. The Authority employs 236 staff. Details of the HEA's overall strategy can be found in their interim corporate strategy for 1997-2000. More information about the Authority can be obtained from the HEA Information Centre, Trevelyan House, 30 Great Peter Street, London SW1P2HW; 0171 413 1995.

(High Security) Hospital Authorities

H.16 The three high security hospitals are managed by the Ashworth, Broadmoor and Rampton Hospital Authorities, which are SHAs. The high security hospitals provide care, treatment and rehabilitation for mentally disordered individuals in the most secure hospital settings available in the NHS. Virtually all the patients are detained under the mental health legislation and, at the time of admission, would have been considered to present such a degree of danger that detention in conditions of high security was deemed necessary. For further information about the three authorities contact MrMikePreston, Support Services Manager, High Security Psychiatric Services Commissioning Board, Room 041, Eastbourne Terrace, London W2 3QR; 0171 725 5628.

H.17 The NHS Executive is responsible for commissioning high security psychiatric services through contracts with the hospital authorities. As well as the level and quality of patient care, the contracts stipulate the security standards the hospitals must meet.

- **Hospital Authority** manages just under 480 beds. Its gross expenditure in 1996-97 was £45.547 million of which £45.261 million was funded by Government. The authority employs 1,391 staff.
- **Hospital Authority** manages just under 450 beds. Its gross expenditure in 1996-97 was £42.334 million of which £41.736 million was funded by Government. The authority employs 1,068 staff.
- **Rampton Hospital Authority** manages just over 450 beds. Its gross expenditure in 1996-97 was £43.955 million of which £42.889 million was funded by Government. Theauthority employs 1,292 staff.

Mental Health Act Commission (MHAC)

H.18 The Commission was set up in 1983 as an SHA with responsibility under the Mental Health Act 1983 for protecting the interests of detained patients in England and Wales. Commissioners visit hospitals where there are detained patients to make sure the powers under the Act are being used properly. They also have responsibility for investigating complaints made by or about detained patients. The Commission also operates, on behalf of the Secretary of State, the provision of Second Opinion Appointed Doctors (SOAD). This is a demand-led service for which the Commission not only appoints doctors but also makes the necessary administrative arrangements when a second opinion under the Mental Health Act is requested.

H.19 Details of the Mental Health Act Commission's function together with a statement of accounts can be found in The Mental Health Act Commission's Seventh Biennial Report 1995-1997.

H.20 The Commission is directly funded by the Department of Health. Its gross expenditure in 1996-97 was £2.132 million. The Commission employs 24 staff. For further information contact MrMatthew Kinton, Personal Assistant to the Chief Executive, Mental Health Act Commission, MaidMarian House, 56 Hounds Gate, Nottingham NG1 6BG; 0115 943 7148.

Microbiological Research Authority (MRA)

H.21 The MRA was established as an SHA in April 1994 to manage the Centre for Applied Microbiology and Research (CAMR). The Authority contributes to the health of the UK population by conducting research on specified microbiological hazards with a view to the development and production of effective diagnostic prophylactic and therapeutic products. During 1996-97 the Authority entered into a collaborative venture with the Swedish company Actinova Ltd, which provided the

opportunity for the commercial development of some of its work. Its gross expenditure in 1996-97 was £17.8 million of which £4.6 million was funded by Government. TheAuthority employs 360 staff. A summary of CAMR's key targets may be found in their Annual Report. For more information about the Authority, write to MRA, c/o CAMR, Porton Down, Salisbury, Wiltshire SP4 0PJ; 01980612100.

National Blood Authority (NBA)

H.22 The NBA, is responsible for the management of the National Blood Service in England, including:

- collection of blood from voluntary donors, its processing, testing and supply to hospitals, through its network of blood centres;
- International Blood Group Reference Laboratory (IBGRL), and the Bio Products Laboratory (BPL) which makes therapeutic products from blood plasma and makes and issues diagnostic materials.

H.23 The Authority's gross expenditure in 1996-97 was £201.7 million which was largely recouped through blood handling charges to hospitals, and through sales of BPL products. The Authority employs 4,519 staff. Further information, including summary financial statements, are included in the NBA's annual report which is available from: The National Blood Authority, Oak House, Reed Crescent, Watford, Herts WD1 1QH; 01923 486800.

NHS Litigation Authority (NHSLA)

H.24 The NHSLA was established as an SHA in November 1995. It has three principal functions:

- to administer the Clinical Negligence Scheme for Trusts (CNST), covering liabilities for alleged clinical negligence in respect of NHS trusts where the original incident occurred after 1 April 1995;
- to administer the Existing Liabilities Scheme (ELS), relating to clinical negligence incidents in respect of HAs and NHS trusts which occurred before 1 April 1995; and
- to act as defendant in claims against ex-regional health authorities (RHAs) following the abolition of RHAs from April 1996.

H.25 As well as overseeing the schemes in such a way as to ensure that public money is used appropriately, the Authority is expected to promote the highest possible standards of patient care and to minimise suffering resulting from adverse incidents which do nevertheless occur.

H.26 The Authority's gross expenditure in 1996-97 was £0.815 million. This covers the NHSLA's running costs and the centrally funded ELS. Membership contributions cover the costs of payments made under the CNST. The Authority employs 9 staff. Further information about the NHSLA and its remit can be found in its Framework Document, copies of which can be obtained from the Health Literature Line; 0800 555 777.

NHS Supplies Authority

H.27 The role of the NHS Supplies Authority was established in 1991 and it became operational in 1992. Its role is to enable the NHS to obtain maximum possible benefit from the money it spends on goods and services needed for the delivery of health care. NHS Supplies influences some 50 per cent of the total annual expenditure of about £5 billion on NHS procurement and has achieved purchasing savings of more than £340million since it was set up. Its gross expenditure in 1996-97 was £618.8 million. TheAuthority employs 3,813 staff.

H.28 Further information, including summary financial statements, can be found in NHS Supplies *Annual Report 1996-97*. For this and further information on the Authority contact the Administration Section, NHS Supplies, Apex Plaza, Forbury Road, Reading RG1 1AX.

Prescription Pricing Authority (PPA)

H.29 The PPA was established under the National Health Service Act of 1977. Its main functions are:

- to calculate and make payments for amounts due for supplying drugs and appliances prescribed under the NHS (processing over 500 million prescriptions each year);
- to produce information for GPs, HAs and the Department about prescribing trends and drug usage, monthly reports showing actual spending on drugs set against predetermined amounts under the Indicative Prescribing Scheme or the GP Fundholding Scheme and the monthly Drug Tariff;
- to detect and follow up prescription fraud both by patients and contractors;

- to administer the NHS Low Income Scheme. The PPA assesses some 1.2 million claims and issues certificates for the remission of NHS charges in respect of prescription, dental and other chargeable services.

H.30 The Authority's gross expenditure in 1996-97 was £44.521 million of which £43.270 million was funded by Government. The Authority employs 1,809 staff. Rigorous performance targets have been set for the Authority's work under a Service Level Agreement which is monitored by the NHS Executive. For further information on the Authority contact Mrs P Marsh, PPA SLA and Prescription Fraud, Room 157, Richmond House, 79 Whitehall, London SW1A 2NS; 0171 210 5938.

The United Kingdom Transplant Support Service Authority (UKTSSA)

H.31 The UKTSSA was established on 1April 1991. The Authority supports organ transplantation throughout the UK and Eire. Its main objective is to facilitate the effective and equitable distribution of human organs for transplantation. The Department of Health funds the UKTSSA through a centrally held budget in Vote 1. Other UK countries contribute on the basis of agreed proportions. The Authority employs 102 staff. Its gross expenditure in 1996-97 was £6.606 million of which £5.399 million was funded by Government. The Authority also operates and maintains the NHS Organ Donor Register which is a computerised record of people who have registered their wish to be an organ donor. For further information contact Mrs Robina Balderson, Chief Executive, UKTSSA, Fox Den Road, Stoke Gifford, Bristol BS21 6RR; 0117 975 7575.

H.32 The UKTSSA's management arrangements were last reviewed in 1993. A further management and financial review will take place in 1998.

Other NHS Bodies

Dental Practice Board (DPB)

H.33 The DPB is a NHS body in its own right and was founded in 1948. Its role is to check and price some 39 million remuneration claims from dentists in the General Dental Services; authorise and make the resultant payments (of some £76 million per month) to 22,000 dentists' contracts; maintain the registration of 30 million patients; monitor dentists' activities for quality and probity and take action where necessary. Its gross expenditure in 1996-97 was £20.884 million. The Board employs 563 staff. For further information contact the Chief Executive, Dental Practice Board, Compton Place Road, Eastbourne, East Sussex BN20 8AD; 01323 417000.

Tribunals

NHS Tribunal

H.34 The Tribunal is a non departmental public body with judicial powers, supervised by the Council on Tribunals. Its purpose is to protect family health services (FHS) by deciding whether the continued inclusion of an FHS practitioner's name on a HA's medical, dental, pharmaceutical or ophthalmic list would be prejudicial to the efficiency of the service in question and bring it into disrepute. If it does, it must direct that the practitioner is disqualified from providing the service. This power makes it the ultimate NHS disciplinary body for FHS practitioners. It has no other, lesser sanction available to it.

H.35 The NHS Tribunal has one permanent employee, the Clerk to the Tribunal, who is paid an annual retainer of £1,233. In addition, the Clerk receives fees according to the number and kind of Tribunal cases in a year. The Tribunal's gross expenditure in 1996-97 was £0.077 million. For further information contact Mr John Mann, NHS Executive, Room 7E01, Quarry House, Quarry Hill, Leeds LS2 7UE; phone 0113 254 6324, fax 0113 254 6088.

Mental Health Review Tribunals (MHRT)

H.36 MHRTs are independent judicial bodies which operate under the Mental Health Act 1983. Members of the tribunal are responsible for considering whether there is a need for a patient to continue to be detained in hospital under the Mental Health Act 1983. There are eight MHRTs (one for each regional office of the NHS Executive) supported by four administrative offices. Each MHRT is accountable to the regional chairman, who is legally qualified and who carries a general responsibility for the exercise of the tribunal's functions. The secretariat is provided by staff of the Department of Health who arrange the hearings. Appointments to the MHRTs are made by the Lord Chancellor. The Tribunal's gross expenditure in 1996-97 was £2.046 million. Forfurther information contact Mrs Zena Muth, NHS Executive, Department of Health, Wellington House, 135-155 Waterloo Road, London SE1 8UG.

Registered Homes Tribunal

H.37 The Registered Homes Tribunal is a non departmental, independent judicial body. It was set up by statute in 1984 to hear appeals from independent sector residential care home, nursing home and children's home owners against a decision by the registration authority to refuse, cancel or vary the registration conditions for the home. HAs are responsible for registering nursing homes, local authorities for registering residential care homes and the Secretary of State for Health for registering children's homes.

H.38 The Tribunals operate under the Registered Homes Act 1984, the Children's Act 1989 and the Registered Homes Tribunal Rules 1984. Secretariat support for the Tribunals is provided by the Department. The Tribunal's gross expenditure in 1996-97 was £0.116 million. For further information about the Tribunal contact Miss M Haywood, Registered Homes Tribunal Secretariat, Room 625, Wellington House, 133-155 Waterloo Road, London SE1 8UG; 0171 972 4035, fax01719724525.

Miscellaneous

Voluntary Sector Support

H.39 The aim of the £52 million annual funding by the Department of Health of the voluntary sector is to support and promote Ministers' policies, priorities and objectives across the entire spectrum of health and personal social services activity. The largest of the current schemes, with a provision of £20.8 million in 1997-98, is the Section 64 General Scheme, and the Department also funds volunteering projects and some time-limited schemes which have been launched to promote specific Ministerial initiatives.

ANNEX I

Long Term Capital Projects and Analysis of Capital Assets

Figure I1: Long Term Capital Projects (non PFI) Details of Capital Projects Costing over £15million and Reconciliation with Estimates

							£ thousand at 1998-99 prices[1]
Project/Scheme[2]	**Year of start/ original estimate of year of completion[3]**	**Current estimate of year of completion[4]**	**Original estimate of expenditure[5]**	**Total**	**Spent in years past**	**Estimate for 1998-99**	**To be provision spent in future years**
Northern & Yorkshire Region							
Harrogate Rationalisation of Acute Services	1993-94/1998-99	1999-00	36,531	40,124	25,685	11,766	2,673
City Hospitals Sunderland New DGH	1996-97/1998-99	2000-01	18,508	19,346	1,791	7,881	9,674
North Thames Region							
Homerton Acute Services	1996-97/2000-01	2000-01	20,074	20,989	4,080	9,079	7,830
Ambulatory Care & Diagnostics Centre, Middlesex Hospital	1996-97/1999-00	1998-99	19,299	19,299	12,650	4,812	1,837
South Thames Region							
Medway DGH Development	1995-96/1998-99	1999-00	61,093	61,111	41,609	16,888	2,614
Royal Sussex County Hospital Development	1994-95/1997-98	2000-01	58,853	63,894	44,978	15,361	3,555
Guy's & St Thomas' Hospital Reconfiguration of services	1998-99/2003-04	2003-04	60,050	60,050	2,705	13,734	43,611
Anglia & Oxford Region							
No projects							
South & West Region							
West Dorset DGH Phase 2	1993-94/1998-99	1998-99	45,652	45,652	38,023	5,531	2,098
Royal United Hospital Bath-Redevelopment	1996-97/2000-01	2001-02	34,339	34,339	2,885	12,072	19,382
United Bristol Hospital For Sick Children	1996-97/1998-99	1999-00	23,257	23,257	10,952	6,076	6,229
West Midlands Region							
No projects							

Trent Region							
Sheffield Women's Hospital Stonegrove Development	1998-99/2000-01	2000-01	22,021	22,021	400	4,504	17,117
North West Region							
Warrington Community - Reprovision of Winnick Hospital	1996-97/1998-99	1998-99	18,750	18,750	13,733	4,222	795
Walton Neuroscience NHS Trust Hospital Relocation	1996-97/1998-99	1998-99	18,215	18,222	11,478	5,930	814
Blackpool Victoria Hospital Phase 5	1997-98/2000-01	2000-01	21,443	21,443	11,533	6,163	3,747
Rochdale Infirmary Development	1998-99/2000-01	2000-01	28,496	28,496	305	7,832	20,359
Total			**486,581**	**496,993**	**222,807**	**131,851**	**142,335**

1 The original estimates of expenditure and the current estimates of expenditure on the main contract and on fees and equipment have been brought to 1998-99 prices using the GDP deflator. The expected expenditure on the main contracts has been revalued from tender base year prices using the APSAB/FORVOP index published by DOE (Quarterly Building Cost and Price Indices), which reimburses a contractor for price fluctuations occurring between the base date for the tender and the month in which it is carried out on site.

2 Included if current estimate costs together with other sources of funds, eg University Funding Council are £15,000,000 or more.

3 The dates shown for year of start/completion refer to the main contracts or where this is not available to a provisional estimate of contract start/completion date. Only schemes on site during 1998-99 are itemised in the first part of the table. Schemes which will reach practical completion before the start of 1998-99 or which are due to start on site after 1998-99 are not shown there, though there may be expenditure on a latter scheme in the forms of fees, equipment costs, enabling works, etc.

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

5 Comparing the above projects with previous years' Estimates tables, the trend is

	1995-96	1996-97	1997-98	1998-99	
% projects with later current completion date than original		0	0	16	33
% projects with higher current estimate of expenditure than original	34	11	11	40	
% value of the cost overrun compared to original estimate	2.61	0.70	0.07	2.14	

6 The table includes only those schemes which are publicly funded or which include a significant element of public funding. Projects currently testing for PFI are not included.

Figure I2: Capital Assets Analysis by Type of Asset (NHS Tangible Fixed Assets)

					£ million
	Land	**Buildings, installations and fittings**	**Assets under construction**	**Equipment**	**Total**
Cost or Valuation					
As at 1 April 1996	3,917	15,482	1,054	4,571	**25,024**
Net Book Value of 6th wave NHS trusts at 1 April 1996	37	89	2	32	**160**
Additions	13	382	705	277	**1,377**
Transfers	(44)	618	(763)	46	**(143)**
Indexation	76	600	34	114	**824**
Revaluation	(19)	(216)	(39)	(28)	**(302)**
Disposals	(135)	(109)	(12)	(240)	**(496)**
As at 31 March 1997	**3,845**	**16,846**	**981**	**4,772**	**26,442**
Depreciation					
As at 1 April 1996				2,792	**2,792**
Value of 6th wave NHS trusts at 1 April 1996				6	**6**
Provided during the year		604		398	**1,002**
Additions				2	**2**
Transfers				(30)	**(30)**
Indexation				69	**69**
Revaluation				(23)	**(23)**
Disposals				(213)	**(213)**
As at 31 March 1997		**604**		**3,001**	**3,604**
Net Book Value					
As at 1 April 1996	**3,917**	**15,482**	**1,054**	**1,779**	**22,232**
As at 31 March 1997	**3,845**	**16,242**	**981**	**1,771**	**22,838**

Source: NHS (England) Summarised Accounts 1996-97.

1 Total number of assets include donated assets.

2 Capital assets in the NHS are also analysed in the published NHS (England) Summarised Accounts 1996-97, however, not aggregated as in the above table.

3 Figures for the assets of the Department itself are not yet available. However, they are being prepared as part of the Resource Accounting and Budgeting initiative and will be included in a future version of this table. They will, nevertheless, be very small in comparison with the figures above.

4 Totals may not add due to rounding.

5 Opening Net Book Values (as at 1 April 1996) will not agree to closing values as shown in the corresponding table for 1995-96. This is because of the abolition of Regional Health Authorities, District Health Authorities, Family Health Service Authorities, and the creation of Health Authorities, on 1April 1996.

6 No gross depreciation figure is available for buildings, installations, and fittings. The figure as at 31 March 1997 is the charge for the year.

7 Equipment depreciation is shown gross and the figure as at 31 March 1997 is the cumulative depreciation on retained assets.

ANNEX J

Information Formerly in the *Supply Estimates*[1.7]

J.1 Since 1996-97 the *Supply Estimates*[1.7] have been presented in a condensed format aligning with the cash plans tables (see **Annex B**).

J.2 Tables J1 and J2 detail Appropriations in Aid and contingent liabilities formerly provided in the *Estimates*[1.7]. Details of Grants in Aid and Consolidated Fund Extra Receipts can still be found in the *Estimates*. Other information which is no longer available through the *Estimates* is contained in the relevant sections of this Report.

Appropriations in Aid

Figure J1 : Appropriations in Aid

Contingent Liabilities

Vote 1

J.3 A statutory contingent liability exists to meet:

i. an indemnity to water undertakers in respect of costs, damages and expenses not otherwise covered by insurance claims arising from claims or proceedings on the grounds of alleged harm to health arising solely from fluoridation; and
ii. overdraft guarantees for NHS trusts.

J.4 Non-statutory contingent liabilities exist to meet:

i. a letter which the Department sent to the Association of British Health Care Industries on 9 June 1992 may be construed as a letter of comfort in respect of contracts entered into by NHS trusts and hence result in a non-statutory liability. The letter was withdrawn on 17 August 1993, but a residual contingent liability may remain in respect of contracts entered into between the issue of the letter and its withdrawal;
ii. the Department has undertaken to meet the legal and other costs of medical and nursing staff engaged on clinical trials approved by the National Blood Authority (NBA) of new blood products manufactured by the Bio-Products Laboratory, a part of the NBA, and the costs of any claims for damages from patients arising from clinical trials of the new products;
iii. an indemnity to water undertakers in respect of costs, damages and expenses not otherwise covered by insurance claims arising from claims or proceeding on the grounds of alleged harm to health arising solely from supplying water which has been fluoridated by another water undertaker and which therefore is not covered by the statutory guarantee;
iv. an indemnity to higher education providers to cover a proportion of any redundancy costs, which may arise in respect of pre-registration nurse education which has now moved to higher education sector should a contract of education not be renewed; and
v. in the event of a nuclear emergency it would be necessary to distribute stable iodine tablets to the general public to prevent take up of radioactive iodine. The Department has undertaken to indemnify those other than qualified medical personnel distributing the tablets against any action resulting from adverse reactions.

Vote 2

J.5 A statutory liability exists to meet:

i. the Department has issued an exemption certificate to the National Radiological Protection Board in respect of any liability to its employees of the kind mentioned in Section (1) of the Employers' Liability (Compulsory Insurance) Act 1969.

J.6 Non-statutory liabilities exist to meet:

i. the Department has undertaken to meet the cost of compensation payments arising from claims for injury arising from trials of whooping cough vaccine developed by the Microbiological Research Authority;
ii. the Department has undertaken to meet the cost of compensation payments arising from claims for injury arising from the immunisation of voluntary donors with Hepatitis B Vaccine;
iii. the Department has undertaken to meet the cost of compensation payments arising from claims for injury arising from the immunisation of voluntary donors with specialised immunoglobulin subsequently harvested and used in the treatment of haemolytic diseases of newborn babies;
iv. the Government has paid £42 million to a NHS trust from which payments are made to haemophiliacs infected with HIV virus following treatment by the NHS with infected blood products. The Department has agreed to pay to the NHS trust any sums required to make payments if the funds already provided prove insufficient; and
v. to cover the costs of the Family Fund meeting its duties, under legislation, to its staff in the event of it being wound up by Government.

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Glossary

Acute Services

Medical and surgical interventions provided in hospitals.

Capital

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

Capital Charges

Capital charges are a way of recognising the costs of ownership and use of capital assets and comprise depreciation and interest/target return on capital. Capital charges are funded through a circular flow of money between HM Treasury, the NHS Executive, Health Authorities (HAs) and NHS trusts.

Cash Limited

Expenditure subject to cash limit controls.

Central Health and Miscellaneous Services

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

Community Care

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

Consolidated Fund

The Government's general account at the Bank of England. Tax revenues and other current receipts are paid into this Fund. Parliament gives statutory authority for funds to be drawn from the Consolidated Fund to meet most expenditure by Government.

Credit Approvals

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

Depreciation

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

Estimates

See *Supply Estimates*.[1.7]

European Economic Area

The European Community countries plus Norway, Iceland and Liechtenstein.

Executive Agencies

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

External Financing Limits (EFLs)

NHS trusts are subject to public expenditure controls on their spending. The control is an external financing limit (EFL) issued to each NHS trust by the NHS Executive. The EFL represents the difference between the resources a trust can generate internally (principally retained surpluses and depreciation) and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the internal resources are more than the capital spend then the money is used to meet any due repayments of debt principal on the trust's originating capital debt and Secretary of State loans, with any excess being invested.

Family Health Services (FHS)

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department following consultation with representatives of the relevant professions, and administered locally by HAs. Funding of the FHS is demand-led and not subject to in-year cash limits at HA level, though FHS expenditure has to be managed within the overall national cash limits. The exceptions to this are certain reimbursements of practice expenses payable to doctors in general practice (GMS cash limited spending), the costs of administration, and expenditure by GP fundholders on drugs. Funding for these items is included in health authorities' (HCHS) cash limited allocations.

General Medical Services (GMS)

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

General Practitioner (GP) Fundholders

Family doctors (General Practitioners) whose practices have chosen to accept an agreed budget for part of their practice activity and to manage that budget themselves. The budget covers practice staff, hospital referrals, drug costs, community nursing services and management costs. This budget is within the cash limited part of the HA's (HCHS) spending.

Gross Domestic Product (GDP) Deflator

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms. The series is produced by HM Treasury, and the one used in this report is that published at the March 1998 budget.

Gross/Net

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

Guardian Ad Litem (GAL)

A guardian ad litem provides independent social care advice and investigation to the courts in care and related proceedings.The guardian's role is to represent the child's interests and to make a recommendation on what outcome is in the best interests of the child.

Health Action Zone (HAZ)

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.

Health Authority (HA)

The health authority (HA) is responsible within the resources available for identifying the health care needs of its resident population and for securing through its contracts with providers a package of hospital and community health services to

reflect those needs. The health authority has a responsibility for ensuring satisfactory collaboration and joint planning with the local authority and other agencies.

Health Improvement Programmes

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

Hospital and Community Health Services (HCHS)

The main elements of HCHS funding are the provision of both hospital and community health services, which are mainly commissioned by health authorities and provided by NHS trusts. HCHS provision is cash limited and also includes funding for those elements of FHS spending which are cash limited (GMS cash limited expenditure). It also covers related activities such as R&D and education and training purchased centrally from central budgets.

NHS Trusts

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

National Insurance Fund

The statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid, and from which expenditure on most contributory social security benefits is met. The NHS also receives an element of funding from this.

Non-Cash Limited

Expenditure that is not subject to a cash limit, mainly "demand-led" family health services, including the remuneration and expenses of general medical practitioners, the costs of prescriptions written by them, together with all other pharmaceutical, dental and ophthalmic service costs.

Outturn

The actual year end position in cash terms.

Personal Social Services (PSS)

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

Primary Care

Family health services provided by family doctors, dentists, pharmacists, optomotrists, and ophthalmic medical practitioners.

Private Finance Initiative

The use of private finance in capital projects, particularly in relation to the design, construction and operation of buildings and support services.

Real Terms

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

Regional Offices

The eight NHS Executive Regional Offices were established on 1 April 1994. These offices are responsible for developing the commissioning function in the health service and for monitoring the financial performance of NHS trusts. The Regional Offices took on the non-statutory functions of the Regional Health Authorities following their abolition on 1 April 1996.

Revenue

Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.

Secondary Care

Care provided in hospitals.

Special Health Authority (SHA)

A special health authority is a HA which provides health services to the whole population of England, not just to a local population. Formerly the London Postgraduate Teaching Hospitals were SHAs but they are now NHS trusts. The remaining SHAs, such as the National Blood Authority, provide clinical or support services to the whole NHS.

Specific Grants

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

Supply Estimate

A request by the Executive to Parliament for funds required in the coming financial year. *Supply Estimates*[1.7] are sub-divided into groups (Classes) which contain provision (usually by a single department) covering services of a broadly similar nature. A sub-division of a Class is known as a Vote and covers a narrower range of services. The Department of Health has three Votes which form Class XI. A Supply Estimate does not of itself authorise expenditure of the sums requested. This comes through an Appropriation Act passed by Parliament.

Trading Fund

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

Vote

See *Supply Estimate*.

Weighted Capitation Formula

A formula which uses population projections for resident population which are then weighted as appropriate for the cost of care by age group, for relative need over and above that accounted for by age and to take account of unavoidable geographical variations in the cost of providing services. They are used to determine HAs' target share of available resources.

Figure 1.1
Summary Cash Plans

£ million

Vote Section		1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	1997-98 estimated outturn	1998-99 plans
	Department of Health							
	Health services							
1A	Hospital, community health, family health (cash limited) and related services and NHS trusts[1, 2, 3]	21,574	22,545	24,174	25,449	26,544	28,122	30,248
1B-H	Family health services (non-cash limited)	5,613	5,622	5,624	5,709	5,681	5,776	5,466
2A-E	Departmental administration	357	320	312	304	291	273	270
	MCA Trading Fund[4]		5					1
2F-H	Central health and miscellaneous services	427	451	460	496	528	517	523
	Total health services	**27,970**	**28,942**	**30,570**	**31,958**	**33,044**	**34,688**	**36,509**
	Other services							
2I	Personal social services	31	34	32	30	30	32	32
2J-Q	Central government grants to local authorities	83	654	831	772	638	553	576
	Credit approvals	126	132	140	145	105	69	54
	Total Department of Health	**28,211**	**29,762**	**31,574**	**32,906**	**33,816**	**35,342**	**37,170**
	Of which:							
	Central government's own expenditure	*27,779*	*28,668*	*30,012*	*31,587*	*32,971*	*34,553*	*36,418*
	Public corporations (excluding nationalised industries)	*223*	*303*	*590*	*401*	*102*	*167*	*122*
	Central government support to local authorities	*209*	*786*	*972*	*918*	*743*	*622*	*630*
	Trading funds		*5*					*1*

1 HCHS current expenditure includes provision for drugs prescribed by GP fundholders (£295 million in 1992-93, £628 million in 1993-94, £1,009 million in 1994-95, £1,296 million in 1995-96, £1,794 million in 1996-97, and £2,204 million in 1997-98 and provisional figures for 1998-99).

2 HCHS current expenditure includes that element of trust capital expenditure which they fund from their charges to health care purchasers (£363million in 1992-93, £696 million in 1993-94, £975 million in 1994-95, £1,053 million in 1995-96, £1,106 million in 1996-97 and £943 million in 1997-98, and provisional figures for 1998-99).

3 HCHS capital expenditure includes the net expenditure on Secretary of State loans and Public Dividend Capital advances used to finance trust capital expenditure (£225 million in 1992-93, £333 million in 1993-94, £577 million in 1994-95, £436 million in 1995-96, £185million in 1996-97, an estimated £244 million in 1997-98 and provisional figures for 1998-99).

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

5 The expenditure in this table relates to the 1998-99 Supply Estimates for Class XI Votes 1 and 2.

6 Totals may not sum due to rounding.

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Figure 1.2
Local Authority Expenditure [1]

	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	£ million 1997-98 estimated outturn
Department of Health						
Current spending						
Personal social services[2]	4,974	5,660	6,618	7,327	7,997	8,411
Port Health	5	5	4	4	4	4
Total current spending	**4,979**	**5,665**	**6,622**	**7,331**	**8,001**	**8,415**
Capital spending						
Personal social services	132	118	156	160	146	144
Total net capital spending	**132**	**118**	**156**	**160**	**146**	**144**
of which:						
Gross spending	*169*	*187*	*201*	*200*	*190*	*189*
Capital receipts	*38*	*69*	*45*	*40*	*44*	*45*
Total local authority expenditure	**5,111**	**5,783**	**6,778**	**7,491**	**8,147**	**8,559**

1 LA Personal Social Services expenditure did not form part of the control total until 1993-94, except for the element of central government support within it. This was described in the Statistical Supplement to the 1992 Autumn Statement (Cm 2219).

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

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4. National Health Service cont.

General Medical Services (GMS)

4.75 **Equity, quality, partnership** and **efficiency** are key themes for the General Medical Services (GMS) themselves and in respect of their contribution to the wider NHS. **Figure 4.24** presents key information about these services.

Figure 4.24: Key Statistics on General Medical Services

New Initiatives

4.76 A number of specific initiatives are in train to support these themes, with the aim of:

- tackling inequitable resource distribution, and addressing the unmet needs of specific populations;
- improving the quality, range, responsiveness and accessibility of services;
- developing new organisational models for better providing integrated care;
- improving the recruitment, retention, and skills of GPs, nurses and other clinical providers.

Equity of Access

4.77 The Medical Practices Committee (MPC, see also **Annex H**, paragraph H.10) is responsible for ensuring an even distribution of GPs. The Advisory Committee on Resource Allocation (ACRA) (see paragraph 4.185) advises on the fair distribution of NHS resources. Ministers have established a joint MPC/ACRA group to pool their expertise and consider the equitable distribution of general practice. The group will report to Ministers in the autumn of 1998. The Department is also considering ways in which more effective use of deprivation payments can be encouraged, particularly in inner city areas. Under the deprivation payments scheme, GPs with patients from deprived areas on their lists receive additional payments to reflect their workload. The Department is discussing with the profession how such resources could be better targeted to encourage improvements in the range and quality of services.

GMS Local Development Schemes

4.78 From April 1998, HAs will have the power to set up GMS local development schemes. GPs in a GMS local development scheme will be rewarded for enhancing general medical services in specified ways or to specified standards to tackle particular local health needs. These schemes have the potential to address health inequalities particularly in areas of deprivation.

Primary Care Act Pilots

4.79 The NHS (Primary Care) Act 1997[4.15] is designed to allow flexibility to explore different models for the provision of primary care that better meet local needs and circumstances. The Secretary of State has so far approved 100 pilots, to be established from April 1998. See also paragraph 4.82.

Practice Staff

4.80 General practice needs a range of high quality staff to be able to provide the best patient care. The NHS Pension Scheme was opened up to GP practice staff from September 1997. This initiative removes a barrier to free movement of staff within the NHS.

GP Premises

4.81 Four new measures will assist GPs in the provision of premises. Collectively, they will enable the GP profession as a whole to occupy premises that incorporate the wide range of facilities needed for modern general practice. In turn, a wider range of services will be accessible by patients in a primary care setting:

- a new cost rent Schedule which assists GPs towards the cost of capital used to build premises;
- revised rental arrangements for GPs in health centres and, for the first time, access to the Improvement Grant scheme;
- new arrangements to assist GPs in unsuitable leasehold property to move to better alternative premises;
- planned guidance for GPs, property developers, HAs and NHS trusts on developing primary care premises using private sector capital.

Current Issues and Recent Trends

Salaried GPs

4.82 As one of a series of measures to strengthen GP recruitment and retention, the Department has introduced salaried options for GPs who cannot, or do not wish to, become GP principals. The first is a salaried doctors' scheme which was introduced in November 1997, and £4 million from the "winter pressures" money (see paragraph 2.9) was added to HAs' GMS cash limited budgets to help pump prime the scheme. A second option for salaried service as a GP is being offered from April 1998 by Primary Care Act Pilots. The retainer scheme will be further strengthened by allowing GPs who wish to take a career break to keep in touch by undertaking up to four sessions per week with appropriate educational input and supervision. This improved scheme will be aimed at meeting the needs of individuals who wish to return to general practice after a career break.

Pharmaceutical Services

4.83 Pharmaceutical services, mainly provided by community pharmacies, consist primarily of the supply to patients of drugs and appliances prescribed by GPs. The drugs bill" (see paragraph 4.37 *etseq*.) accounts for over 80 per cent of the gross cost of the services. Fees to contractors for dispensing prescriptions and to doctors for personally administering some drugs (such as influenza injections) make up most of the remainder. Income from prescription charges collected from patients is offset against these costs (see also paragraph 4.40). Key statistics on pharmaceutical services are shown in **figure4.25**.

Figure 4.25: Family Health Services Key Statistics on Pharmaceutical Services

New Initiatives

Effective Prescribing

4.84 The White Paper *The new NHS: modern, dependable*[4.1] announced that budgets for GP prescribing would be merged with budgets for hospital and community health services and cash limited funding for GP practice staff at local level from April 1999. This will bring greater financial flexibility. The methodology used to allocate funds to HAs for GP prescribing has also been enhanced.

Community Pharmacists' Role

4.85 The Department is exploring the value of extending the role of community pharmacists to make better use of their skills. Two series of pilot projects have been funded. The first phase of projects, costing £1 million, began in 1995-96 and focused on prescribing advice to GPs. Partly as a result, HAs have been allowed to vire money from GP prescribing allocations to fund pharmacists to work with GPs on repeat prescribing. The second phase, also costing £1 million, has two main themes: repeat and instalment dispensing, which has the potential to reduce GP paperwork and drug waste; and schemes where pharmacists provide specific support for patients with medication-related problems, such as complex regimes or difficulties in taking medication effectively.

4.86 Provisions under the Primary Care Act 1997[4.15] will give HAs more flexibility in providing additional pharmaceutical services.

Current Issues and Recent Trends

Prescribing

4.87 The Department has continued to support the research project "PRODIGY" to test the acceptability of computer-aided decision support to GPs and to assess its potential to improve the quality and cost-effectiveness of prescribing.

4.88 The National Prescribing Centre (NPC) and the Prescribing Support Unit (PSU) have continued to provide support to medical and pharmaceutical advisers via bulletins and through the provision of an analytical service.

4.89 Further pilots of nurse prescribing took place from April 1997. The aim is to provide patients in the community with more convenient care by giving nurses powers to prescribe from a limited formulary. A Review of Prescribing, Supply and Administration of Medicines was set up in March 1997 to develop a framework to determine in what circumstances health professionals might undertake new roles in this area, taking account of patient safety and the implications for legislation and professional training. A final report is due in summer 1998.

Pharmaceutical Services: Remuneration Costs

4.90 **Figure 4.25** gives information on the level of activity and on the gross cost of the pharmaceutical services per prescription broken down to show the drug and remuneration costs separately. It shows that the downward trend in the remuneration for pharmaceutical services assessed on a per prescription basis has stabilised at the level of 1995-96. It has fallen by 20 per cent in real terms since its high point in 1986-87. Some 90 per cent of all prescriptions are dispensed in community pharmacies.

General Dental Services

4.91 The Government's aim is to improve the oral health of the whole population. For primary care dental services, this entails the provision of accessible, cost effective and evidence based clinical care.

New Initiatives

Investing in Dentistry

4.92 The Government is committed to reducing inequalities in dental health status or difficulties with access to NHS dental services. It launched the Investing in Dentistry initiative in September 1997 to help improve dental care in areas of poor availability and oral health. Assistance includes grants to dentists to help expand or set up new practices in return for long term commitments to the NHS, and support for newly qualified dentists and women returning from a career break. Up to £9 million (including treatment costs for new patients) has been made available in 1997-98 and a further £10million will be available in 1998-99. A number of imaginative local proposals have already been approved. The Government will monitor their effectiveness.

Personal Dental Services

4.93 The NHS (Primary Care) Act 1997[4.15] provides the legislative framework for piloting Personal Dental Services (PDS) as well as new models of medical care. PDS offers dentists, NHS trusts and HAs the opportunity to develop new ways of delivering dental services which address local problems and target local oral health priorities. 101 initial expressions of interest to pilot PDS were received. Twenty-five of these were given funding to develop their proposals further. The deadline for submission of full proposals was the end of March 1998, and the first approved pilots will come into operation from October 1998.

Current Issues and Recent Trends

Effective Dental Services

4.94 From December 1996 conditions for the provision of crowns under the GDS were tightened so that resources are targeted on the most clinically effective treatments necessary to secure and maintain oral health. Reductions in the amount of complex or advanced treatments have contributed to a decrease in the average cost of an adult course of treatment of 1.7 per cent in real terms in 1996-97 compared to 1995-96; the cost when compared to 1986-87 was down by 11.9 percent. Changes to the dental contract introduced from September 1996 mean that payments to dentists for children's dentistry now relate more closely to the disease level in each child treated. Indications for 1997-98 are that more children are being taken on for dental care.

General Dental Services Staffing

4.95 Work patterns of dentists in the NHS are changing. The number of general dental practitioners on HA lists continues to

grow, reaching a new peak of 16,336 in 1996-97, an increase of 12.5 per cent over 1986-87 (see **figure 4.26**). However, the number of courses of treatment for adults has grown over the last 10 years by just under 12 per cent, so that the average number per dentist has fallen marginally.

Figure 4.26: Family Health Services Key Statistics on General Dental Services

General Ophthalmic Services

4.96 Between 1990-91 and 1996-97 there were rises of 64 per cent in the number of sight tests paid and 63 per cent in the number of vouchers reimbursed. Growth in the number of sight tests and vouchers between 1995-96 and 1996-97 was 4.5 per cent and 4 per cent respectively. See **figure 4.27**. General Ophthalmic Services underwent substantial change in April 1989, when NHS sight tests were restricted to certain priority groups, namely children, students aged under 19 in full time education, adults on low income and people who have or are predisposed to certain eye diseases. Meaningful comparisons are therefore only possible between 1990-91 and 1996-97.

Figure 4.27: Family Health Services Key Statistics on General Ophthalmic Services

Objective

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

- **providing care according to individual need regardless of organisational boundaries.**

New Initiatives

Working at the Interface Between Health and Social Services

4.97 The Department is considering the options for breaking down the barriers between health and social services, including pooling budgets and developing indicators of outcome at the interface, to enable packages of care to be provided that better meet the needs of service users whose needs cross the boundary between health and social care. See also paragraphs 5.16 and 5.21 *et seq*. in the Social Care Chapter.

4.98 Hospital discharge marks the boundary between the responsibility of the acute, continuing and community health services of the NHS and local authorities. It is at boundaries between organisations that most breakdowns in services occur. Poor arrangements for hospital discharge result in inefficient use of resources and bad experiences for patients.

4.99 Delay in hospital discharge is an important problem, and considerable action has been taken to decrease it. In 1997-98 almost £20 million has been allocated to 95 HAs through the Continuing Care Challenge Fund, across a range of services, to alleviate delayed hospital discharges. This amount will be matched by health and/or local authorities to make a total of £60 million extra for these services in 1997-98. This is being supplemented by additional resources from the extra £159 million allocated to HAs in England in 1997-98 (see paragraph 2.9) to lay the foundations for long term stability by, for example, helping hospitals cope with medical emergencies, improving community services, and supporting Family Health Services.

Objective

- **Helping people to live independently, and supporting them wherever possible in their own homes.**

New Initiatives

Better Services for Vulnerable People

4.100 The NHS, through the 1998-99 *Priorities and planning guidance*[4.2], is required to "ensure that older people, adults with a physical or learning disability, children and other vulnerable people with continuing health care needs are enabled through the NHS contribution to their care to live as independently as possible in their own homes or in homely settings in the community". In support of this priority the Department has written to the NHS and social services[4.16] asking them to undertake development work in three areas beginning in 1998-99:

- as part of a programme of work to achieve proper joint investment plans in continuing care and mental health, NHS and social care regions will examine joint investment plans produced by health and local authorities during 1998-99, and, on the basis of best practice identified in that exercise, the Department will draw up a framework, in consultation with the field, of what authorities should be aiming to reflect in their plans for 1999-2000;
- during 1998-99 the Department will encourage further development of a range of innovative rehabilitation and recuperation schemes for older people by co-ordinating the development of best practice and raising the national profile of the overall approach. There will be a series of national and regional workshops to explore and develop a national template for the care of older people. During 1999-2000 health and local authorities will be expected to review current service provision and make joint plans to move towards the template for a continuum of care in their area;
- in 1998-99 work will begin on the development of a national framework for multi-disciplinary assessment of older people in acute and community health care settings. This will be established by the Department working with health and local authorities and other key stakeholders, particularly the voluntary organisations. It will be piloted to test its robustness. In 1999-2000 the assessment framework will be introduced and will be closely monitored.

Mental Health Services

4.101 Development of a comprehensive range of local services, caring for people in the community wherever possible, continues to be a priority for the NHS. To achieve this the Department promotes effective partnership between health and social care providers and other agencies, such as housing, education, employment and benefits agencies and those working in the criminal justice system.

4.102 The Independent Reference Group (IRG), established in September 1997 as a result of a new inclusive approach to mental health policy-making, is designed to give Ministers advice to help shape credible mental health services and build up public confidence. Members are drawn from a range of key mental health organisations, including HAs and charities. The first task undertaken by the IRG has been to vet long stay hospital closure plans to ensure that alternative care in the community is in place before closures go ahead.

4.103 The autumn 1997 Review of HA Purchasing of Mental Health Services focused on identifying the distance of HAs and local authorities from the target of fully developed comprehensive local mental health services, and provided the opportunity to put in place action plans to address defects in service plans. An announcement on the findings of the Review and future policy direction will be made later in 1998.

4.104 The Mental Health Challenge Fund (MHCF) in 1997-98 attracted a total local contribution of £12.9 million, making a combined total of £23.5 million invested in new mental health services. The MHCF supported a range of developments including 13 new crisis intervention services and 17 new assertive outreach and home support teams. For 1998-99 funding has been recurrently added to HA baselines, embedding funding for mental health services in mainstream allocations.

4.105 The Mentally Disordered Offenders Strategic Assistance Fund provided £15 million of funding to HAs for 1997-98 to help them reconfigure their services to provide a more comprehensive range of services, with the bulk of resources going to London where the problems are most acute.

Current Issues and Recent Trends

4.106 Statistics on activity in community health and cross-sector services provided by the professionals allied to medicine over the period 1988-89 to 1996-97 are set out in **figure 4.33**.

Objective

- **Giving people who need it access to effective palliative care.**

Current Issues and Recent Trends

Palliative Care

4.107 The Policy Framework for Commissioning Cancer Services[4.17] (known as the Calman-Hine Report), launched in 1995 and subsequently endorsed and strengthened by this Government, has palliative care as an integral part of the framework and of its implementation. The framework has been widely welcomed by the NHS and much has already been achieved locally as a result of the vision and commitment of managers and clinicians. The central philosophy of the framework is that there should be a consistent national approach to providing a uniformly high quality service to patients with cancer, wherever they live.

4.108 Palliative care has developed considerably over the last few years. Significant advances have been made in pain and symptom control, and in improving the overall quality of life for patients with cancer and other life-threatening diseases. The Department's aim is to ensure that the benefits of these improvements in treatment and care are available to all patients. The full spectrum of palliative care provision and support required to meet patients' and carers' needs, should be addressed throughout the patient's illness from the point of diagnosis and into the carers' bereavement. This is provided by a range of professionals working in the community, hospital and hospice settings.

Objective:

The Department is committed to making progress in a way which:

- **reduces waste and maximises efficiency, including by making full use of capital assets and working across institutional boundaries.**

New Initiatives

NHS Management Costs

4.109 The Government is taking action to ensure that over the lifetime of this Parliament, £1 billion that would otherwise have been spent on bureaucracy will be freed up for patient care. The reductions will be focused on NHS trusts and HAs with proportionately higher management costs, as well as reductions in GP fundholding management allowances. Future savings will come from changes implemented as a result of the White Paper[4.1]. See also paragraph 4.50 *et seq*. regarding the new NHS Performance Framework.

Health Authorities (HAs)

4.110 1996-97 outturn figures showed that HA costs were £450 million against a target of £451 million. HAs are planning to meet the Secretary of State's requirement for a reduction in HA costs to a target of £439 million in 1997-98.

4.111 The 1998-99 definition of HA costs excludes those functions key to the modernisation of the NHS (eg. public health) with a 2.9 per cent real terms reduction targeted at HA core costs. **Figure4.28** shows the changes in HA costs between 1995-96 and 1997-98.

Figure 4.28: Health Authority Costs[1] (plan on plan) in real terms, 1995-96 to 1997-98

NHS Trusts

4.112 1996-97 outturn figures showed that NHS trust M2 costs were £1,225 million against a target of £1,233 million. NHS trusts are planning to achieve a reduction in trust M2 costs with a target of £1,211 million in 1997-98. This is based on the definition which includes the total salary costs of all senior managers, the salary costs of all staff in corporate functions, together with the costs of management consultancy contracts. In 1998-99, a real terms reduction of 2.9 per cent will be required. A new definition will be used which will have the effect of increasing those trust costs defined as management costs. It will provide a much fairer and more comprehensive measure of NHS trust management costs and incorporate managerial costs which were not included under the old definition. **Figure 4.29** shows the changes in NHS trust management costs between 1995-96 and 1997-98.

4.113 Targets have been set for reductions in bureaucracy from NHS trust mergers, with each merger expected to release at least £$^1/_2$ million in bureaucracy savings within two years. The savings will be available locally for investment in frontline NHS services.

Figure 4.29: NHS Trust Management Costs (plan on plan) in real terms, 1995-96 to 1997-98

GP Fundholding Management Allowances

4.114 Fundholding GPs receive a management allowance, Practice Fund Management Allowance (PFMA), to meet the costs of managing their fund. The deferment of the 8th wave of the GP fundholding scheme released £20 million from planned expenditure on GP fundholders' management costs, and this was redeployed into patient care in 1997-98. An additional £9 million has subsequently been released from further management efficiency savings nationally in the fundholding scheme.

4.115 Further savings are planned to the PFMA budget, incorporating a 10 per cent real terms cut in levels of PFMA for 1998-99, saving approximately £15 million. The redeployment of PFMA following plans announced in the White Paper[4.1] will provide about £3 per head of population to support the costs of Primary Care Groups as part of overall HA/Primary Care Group costs.

Fraud in the Family Health Services

4.116 The NHS loses substantial sums each year from fraud in the FHS. A report published in June 1997[4.18] estimated that losses from theft and forgery of prescription forms and from evasion of prescription charges alone amounted to some £85-£115 million, with additional losses from prescription fraud by practitioners. Losses in the general dental and general optical services are also significant.

4.117 The Department is determined to take comprehensive and effective action to reduce the opportunities for fraud, to deter potential fraudsters, and to recover past losses. The Minister for Health announced in October 1997 his intention to appoint a fraud "supremo" who would advise ministers on a wide-ranging programme of action covering all aspects of fraud in the FHS and head up implementation. In the meantime, the Department has published a provisional action plan on prescription fraud[4.19] and has issued further guidance on preventing optical fraud[4.20]. An action plan on dental fraud is in preparation.

Current Issues and Recent Trends

Efficiency

4.118 The Government is committed to maximising the use of the resources available to the NHS, and to improving the efficiency with which resources are used.

4.119 Improvements in HCHS efficiency can be estimated retrospectively by comparing the rate of increase in activity with the rate of increase in resource inputs. A faster increase in activity than in expenditure after allowing for changes in input costs constitutes an efficiency gain.

4.120 **Figure 4.30** shows that overall activity levels have increased by some 32 per cent in the 10 year period between 1985-86 to 1995-96. Over the same period, HCHS expenditure increased at only half this rate, suggesting that efficiency not accounted for by changes in pay and prices improved by some 13 per cent over the 10 year period.

Figure 4.30: HCHS Cost Weighted Activity Index

4.121 Expenditure has increased by some 41 per cent since 1985-86 after allowing for general inflation as measured by the GDP deflator. This is of the same order as the rise in overall HCHS activity (32 per cent). It follows that HCHS output unit costs have kept pace with output unit costs in the economy as a whole, of which the GDP deflator is a measure.

4.122 The Government is committed to a new broader based approach to measuring the performance of the NHS that demonstrates how the pursuit of quality and efficiency must go together (see paragraph 4.50 *et seq*.). The new performance framework will include demanding targets on unit costs and productivity throughout the NHS, with NHS trusts required to publish and benchmark their costs on a consistent basis to promote a national schedule of "reference costs".

Unit Costs

4.123 **Figure 4.31** shows the trend in hospital unit costs by category of care since 1985-86, after allowing for movements in HCHS pay and prices. The cost per day of treating patients in the mental health and learning disabilities sectors rose, by 13 per cent and 62 per cent respectively in the period 1991-92 to 1995-96. These rises reflect the shift from hospital to community care, as those who remain in hospital tend to have a higher dependency level than those who are discharged. Costs per case in the acute, geriatric and maternity sectors have fallen over the period, largely because of decreasing length of stay. However, costs for maternity in 1995-96 have risen over the previous year albeit by less than 1percent. Prior to the introduction of the internal market in 1991, hospitals and community units (now NHS trusts) completed a different form of accounts. Unit cost figures in years prior to 1991-92 are not directly comparable with figures from 1991-92 onwards because of this.

Figure 4.31: Average Unit Costs by Category of Care, 1985-86 to 1995-96

4.124 Other key unit cost statistics:

- between 1991-92 and 1995-96 the average cost of treating an acute inpatient fell by 24percent, an average reduction of 4.8 per cent per year;
- the proportion of elective patients who are treated as day cases rose from 38 per cent in 1991-92 to 55 per cent in 1995-96, while the average length of stay for those acute patients (elective and emergency) occupying a bed overnight fell from 5.7 days to 5 days in the same period;
- between 1991-92 and 1995-96, the average cost of a birth fell by 3 per cent to £1,647;
- the average cost of a geriatric case fell by 21 per cent in the period 1991-92 to 1995-96, primarily due to shorter lengths of stay.

NHS Supplies

4.125 In 1996-97 the NHS Supplies Authority (see also **Annex H**, paragraphs H.27 and H.28) made just over £77.5 million purchasing savings on behalf of the NHS, bringing the total savings to £343 million since its establishment in 1991. For the first time they also achieved a price guarantee on 100per cent of the items in their stock catalogue; 20,000 products are now price guaranteed, an increase of 20 per cent on the previous year. The greatest savings have been in pharmaceuticals and dressings (£19.3 million) and in rehabilitation services (£15.8 million).

4.126 NHS Supplies completed a major reorganisation from six geographical divisions into three distinct operating divisions: Wholesaling, Purchasing and Customer Services plus a small headquarters. This change has enabled them to become more efficient and they have a target to reduce operating costs in 1997-98 by 2.5 per cent.

4.127 Since the publication of the Audit Commission Report *Goods for Your Health*[4.21], NHS Supplies have worked with 180 NHS trusts to review their purchasing and supply activities and this work has significantly grown in 1997-98. Further information, including summary financial statements, can be found in NHS Supplies *Annual Report 1996-97* (see **Annex H** paragraph H.28 for details).

Activity Trends

4.128 **Figure 4.32** gives details of hospital activity levels for each of the main sectors. Key points are that:

- between 1986 and 1996-97, the number of finished consultant episodes in the general and acute sector grew by an average 3.8 per cent per year;
- within this increase there is a continuing shift towards treating patients on a day case basis. Thenumber of day cases nearly trebled between 1986 and 1996-97, from 1 million to 2.9million; this is an average increase of over 11 per

cent each year.

Information on waiting times is given at paragraph 4.59 *et seq*.

Figure 4.32: Health Service Activity

4.129 **NHS trust and Health Authority (HA) Data.** The statistics included in this section report on activity carried out by NHS trusts.

4.130 Statistics on community health and services from the professions allied to medicine over the period 1988-89 to 1995-96 are shown in **figure 4.33**. Following a decline in the late 1980s, activity has increased in most areas of community and cross-sector activity.

Figure 4.33: Community Health and Cross-Sector Services Activity Statistics[1]

Financial Performance

Financial Performance of Health Authorities (HAs)

4.131 In 1997-98 there were 100 HAs responsible for assessing the health needs of their local population and commissioning health services in line with national and locally agreed priorities. Services are commissioned from trusts and other providers of health care. HAs have been required to ensure a year-on-year improvement in efficiency, as measured by the Purchaser Efficiency Index (PEI).

4.132 HAs were responsible for spending over £24 billion on patient care in 1996-97. In doing so they were expected to:

- manage their resources to live within the cash limited allocation made available to them;
- achieve an aggregate increase in efficiency of three per cent (as measured by the PEI).

4.133 1996-97 proved to be a challenging year from a financial perspective with increasing pressures being placed upon the service. While overall all HAs managed to remain within their cash limit, a number only achieved this by utilising brought forward resources. A number of HAs reported recurrent (that is, underlying) financial difficulties which will only be eliminated over a period of years and did not achieve their PEI target.

4.134 The Government has signalled its intent to replace the PEI, without letting up on the drive for genuine efficiency, with a new broader performance framework. The new performance framework is intended to provide a more rounded assessment of NHS performance than can be measured under the PEI which had inherent weaknesses and created perverse incentives. For details of the new national performance framework see paragraph 4.50 *et seq*.

Financial Performance of NHS Trusts

4.135 There were 424 operational NHS trusts in 1997-98 responsible for the provision of health care. NHS trusts aim to deliver improved health care outcomes with increasing efficiency within the resources available to the health service.

4.136 Financial pressures in the NHS in 1996-97 are reflected in the performance of the 429 NHS trusts then operational. NHS trusts have three core financial duties:

- to generate the required return (currently 6 per cent) on relevant net assets;
- to break-even on an income and expenditure basis taking one year with another;
- to meet, or come within agreed limits of flexibility, the external financing limit set by the NHS Executive.

From their audited accounts, the performance against their three financial duties in 1996-97 is shown in **figure4.34**.

Figure 4.34: Financial Performance of NHS Trusts, 1996-97

4.137 A number of the deficits and failures to make a 6 per cent return can be attributed to the accounting treatment of items such as clinical negligence and early retirements which were not caused by poor financial management. There were however more instances of real problems than reported in 1995-96. NHS trusts are required to eliminate deficits in 1997-98, unless the problems are too deep-seated and require strategic change. The NHS Executive has made it clear that NHS trusts should balance their finances in-year and not put off tackling financial pressures.

4.138 The interpretation of the statutory financial duty for NHS trusts to break-even was clarified in summer 1997, to be applied from 1997-98. This recognises that although NHS trusts are expected to achieve a balanced position on their income and expenditure account each year, there may be reasons for NHS trusts to report deficits in one year which may be offset by surpluses achieved in another year. This is particularly relevant to situations where NHS trusts must recognise costs in advance of cash outlay,for example for clinical negligence (see paragraphs 4.72 *et seq*. and H.24 *et seq*. in Annex H). A run of three years may be used to test the break-even duty, but in exceptional cases the NHS Executive may agree to a five year time scale.

4.139 The requirement for NHS trusts to make a return of 6 per cent on the average value of net assets has also been clarified for 1997-98. This is viewed as a costing rule rather than a financial duty, and with the requirement for NHS trusts to remit 6 per cent trust debt remuneration the achievement of a 6 per cent return will equate very closely with the break even duty.

Payment of Bills by NHS Trusts

4.140 All NHS trusts are expected to conform with Government Accounting regulations and the CBI Prompt Payers Code. NHS trusts should pay external suppliers within 30 days of receipt of goods, or a valid invoice, whichever is the later, unless covered by other agreed payment terms.

4.141 Performance has improved considerably since compliance has been monitored, and a large number of NHS trusts are prompt payers. The national average is about 80 per cent of bills paid on time and the NHS Executive is targeting poor performing NHS trusts, working with supplier organisations and promoting the British Standard[4.22] on achieving good payment performance to reach the target of 95 per cent set by the Treasury.

Objective

The Department is committed to making progress in a way which:

- **strengthens the scientific and research base of services through partnership with industry and universities.**

New Initiatives

NHS Research and Development Programme

4.142 In order to maintain a coherent and comprehensive approach to NHS research and development (R&D), a new programme structure is under development during the course of 1997-98. This will include Service Delivery and Organisation (SDO). The existing Health Technology Assessment (HTA) Programme focuses upon which technologies work. SDO will tell us how the NHS can best deliver what works.

4.143 A new, dedicated funding system for NHS R&D forms the basis for allocating resources from 1998-99 onwards. Any NHS provider who wanted money from 1998-99 onwards to support research had to apply in 1997-98 for funding from the R&D levy. Allocations of funding were determined against set criteria, principally the capabilities of the NHS providers to manage research and research funding.

4.144 The NHS R&D Levy for 1998-99 is £426 million. This comprises £349 million to allow NHS providers (NHS trusts and primary care practices) to host or themselves initiate R&D; and £77 million to fund the NHS R&D Programme directly from the NHS Executive both nationally and regionally on behalf of the NHS as a whole. For details of other levies see paragraph 4.22.

4.145 Guidelines[4.23] issued in May 1997 set out responsibilities whereby the patient care costs associated with R&D are to be met, for non-commercial externally funded R&D hosted by the NHS. This included a Statement of Partnership with universities and research charities, setting out mutual obligations of the NHS and its partners in this respect.

Current Issues and Recent Trends

The Scientific and Research Base

4.146 The development of collaborative partnerships with the academic science base and the industrial sector is essential if the resources available to support R&D in the NHS are to be used effectively. To this end, policies for industrial involvement in NHS R&D and for the protection and exploitation of intellectual property generated through research in the NHS are being developed. Consultation with representatives of industry, particularly the major trade associations, and with the academic science base continues.

Policy Research Programme: NHS

4.147 The Department's Policy Research Programme (PRP)[3.1] has a substantial and evolving programme of R&D to support NHS strategic development. Studies include those on primary health care, prescribing, IT, organisation and quality, human resources, health economics, maternal and infant care, mental health, cancer and cardiovascular diseases and health policies for disabled and elderly people. In addition, a number of long term programmes are funded. In the region of £14 million or 52per cent of the PRP budget is planned to be dedicated to such issues. For further information about PRP expenditure see paragraphs 3.5 and 5.19.

The Pharmaceutical Price Regulation Scheme (PPRS)

4.148 The PPRS is a voluntary agreement between government and the pharmaceutical industry which controls the profits that pharmaceutical companies make from the sales of branded pharmaceuticals to the NHS. The present agreement runs to September 1998. Its objectives are to:

- secure the provision of safe and effective medicines to the NHS at reasonable prices;
- promote a strong and profitable pharmaceutical industry in the UK capable of such sustained R&D expenditure as should lead to the future availability of new and improved medicines;
- encourage in the UK the efficient and competitive development and supply of medicines to pharmaceutical markets in this and other countries.

4.149 In December 1997 the Department submitted a second report to Parliament[4.24] which gave details of the principles and operation of the PPRS and of the context in which it is applied.

Objective

The Department is committed to making progress in a way which:

- **modernises the services, in partnership with the private sector, by ensuring that patients have access to suitable facilities and can benefit from new technologies.**

New Initiatives

New Technologies

4.150 There is a drive to invest in new technology, targeted to achieve maximum clinical benefit. The new information systems strategy will reflect the priorities outlined in the White Paper, *The new NHS: modern, dependable*[4.1], which will support the drive for quality and efficiency in the NHS by:

- making patient records electronically available when they are 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 (for example, digital television);
- developing telemedicine to ensure specialist skills are available to all parts of the country.

4.151 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 health care. In addition, the Department undertakes Horizon Scanning, the aim of which is to identify new technologies well in advance which are likely to impact on the service. Early identification facilitates the timely commissioning of research and/or guidance to the NHS, so that it can harness emerging technologies for patients.

NHSnet

4.152 *NHSnet*, the NHS's private national network, is now being used for day-to-day activity that is central to the working of the NHS. *NHSnet* is also providing the mechanism for commercial third parties to provide services directly to NHS organisations in an efficient, secure and cost effective manner. A number of applications are under development, including access to Medline and Health CD medical information resources, with others, such as Aidsline and Toxline, planned.

Telemedicine

4.153 The Government gave a manifesto[1,2] commitment to promote new developments in telemedicine, bringing expert advice from regional centres to neighbourhood level using new technology. Telemedicine is the provision of care and advice by clinicians to their patients using the developing information and communication systems, in particular telephone, videoconferencing and data exchange. It allows local access to a range of high quality clinical services no matter where these are located. Telemedicine is also being used by the professions to access specialist advice for patients, making the most effective use of high cost resources, and taking advantage of educational programmes from a distance.

4.154 Developments in telemedicine could have wide implications for NHS care over the next decade, especially in the areas of care at home and in the community, bringing specialist expertise out of the hospital into the primary care sector, improving access to the support services as well as making sure specialist skills are available to all parts of the country. Telemedicine also has implications in combating professional isolation in peripheral hospitals, in supporting clinicians to develop new specialist skills, and in developing more effective networks of clinical care.

4.155 Over 30 research projects are currently in progress around the country, including a number funded by the Department and the NHS. A review of these projects has suggested the feasibility of delivering more and better care at local level using telemedicine, in particular:

- avoiding outpatient visits;
- improving access to specialist and expensive services sited at departments distant from patients;
- supporting hospital at home schemes; and
- monitoring the care of vulnerable patients in the community.

4.156 The Government will further promote research in telemedicine and, in particular, will encourage evaluation of telemedical services. The Department will also ensure that emerging findings are widely disseminated to inform Health Improvement Programmes (see paragraphs 4.47 to 4.49), local service development and reconfiguration.

Current Issues and Recent Trends

Year 2000 Problem

4.157 The "Year 2000" problem (which could cause computer systems to fail at the start of the year 2000) could cause serious disruption to the NHS, and potentially could have a serious impact on patients. Comprehensive guidance[4.25] has been issued to the NHS, and the NHS Executive has invested heavily in providing effective central support and advice, including a helpdesk, a website and an expanding database about the Year 2000 status of products, suppliers and users. NHS agencies and other central organisations are expected to have developed detailed plans by 31 March 1998. By 31December 1998 all critical systems should be ready and fully tested, or detailed plans made for coping with those systems or equipment that

cannot be repaired or replaced in time.

The Private Finance Initiative (PFI)

4.158 Partnership with the private sector is key to the success of the Private Finance Initiative, details of which are at paragraph 4.29 *et seq*.

Objective

The Department is committed to making progress in a way which:

- **is responsive to the views and preferences of patients, clients and their carers.**

4.159 There is evidence[4.26] that the public and patients want improved quality from the NHS. The Government is committed to achieving high quality standards in the provision of care, and ensuring that performance management focuses on the need to give greater attention to the quality of services being delivered, including the provision of good quality information about patients' conditions, treatment choices and outcomes. The NHS remains committed to providing quality services that are responsive to the needs and reasonable expectations of patients. The greater involvement of patients in their own care can mean better outcomes and satisfaction with treatment.

New Initiatives

4.160 In 1998 the NHS Executive will:

- replace the existing Patient's Charter[4.7] with a new NHS Charter which will concentrate on the quality and success of treatment, and provide a better balance between the rights of patients and their responsibilities towards the NHS;
- develop and introduce in the NHS a national survey of patient and user experience, the results of which shall be published annually and at HA level;
- work towards the stabilisation and eventual reduction of waiting times for outpatient appointments and inpatient admissions with special consideration for the early treatment of cancer patients (see paragraph 4.59 *et seq*.);
- continue through the Patient Partnership Strategy[4.27] to encourage greater involvement within the NHS of service users and their carers in their own care and in the development of services;
- continue work aimed at the eventual elimination of mixed sex hospital accommodation.

4.161 Key to achieving these aims will be the identification and dissemination of best practice to level-up standards and bring all services up to the achievements of the best.

Current Issues and Recent Trends

Centre for Health Information Quality

4.162 To assist in providing patients with good quality information, the NHS Executive is providing funding of £200,000 per year over three years for a Centre for Health Information Quality. It is to become a source for and will disseminate to the NHS good practice and guidance on information for patients, particularly on treatment choices and outcomes.

Objective

The Department is committed to making progress in a way which:

- **improves the quality of care by investing in the education and**

training of NHS staff, and makes best use of their skills.

New Initiatives

Managing Human Resources in the NHS

4.163 A consultation exercise on a new strategic service-wide approach was launched in September 1997. The key points are:

- to improve local involvement in national policy development;
- to give higher priority to human resources management;
- to develop capability;
- to improve communications between local and national human resources managers;
- to make better use of research and development;
- to performance-manage human resources outcomes; and
- to ensure that NHS trusts and HAs understand the importance of human resources policies and strategies to the achievement of business objectives.
- Ministers also launched an intermediate five point plan:
- to ensure the freedom of speech of NHS staff to speak out about bad practice;
- to develop family friendly employment practices;
- to combat racism;
- to improve the health of the NHS workforce; and
- to provide reasonable standards of food and accommodation for NHS staff on call.

NHS Pay

4.165 For 1997-98 the previous Government accepted the pay recommendations of the Review Body for Nursing staff, Midwives, Health Visitors, and Professions Allied to Medicine and of the Review Body for Doctors' and Dentists' Remuneration, but decided to introduce them in stages. The incoming Government agreed a staged pay increase for non-Review Body staff which gave parity with nurses and the Professions Allied to Medicine (PAMs). In 1998-99 pay awards will be determined nationally, although NHS trusts retain the freedom to set local rates for staff on NHS trust contracts, or to top-up national rates for staff on national contracts.

4.166 On coming into office, the new Government initiated exploratory talks with staff organisations and employers about options for a new national pay system for the NHS. The objective is national pay matched by meaningful local flexibility. Ministers are considering next steps.

Equal Opportunities

4.167 In 1997 the Department signed up to the Commission for Racial Equality's Leadership Challenge, and the Secretary of State launched the Challenge in the NHS and announced the start of the Inner London Black and Ethnic Minority Leadership Programme. The NHS Executive commissioned independent research to identify the real issues around racial harassment in the NHS, and what needs to be done, leading up to a day of action in January 1998 to launch a national programme of activities.

4.168 To ensure that carers can remain in, or return to, NHS employment, the NHS Executive is also developing family friendly policies for people whose domestic responsibilities may not fit traditional work patterns. The NHS Executive is piloting Timecare, a self rostering system which allows staff much greater control over the hours they work, while covering peaks and troughs in the workload across 19sites in 11 NHS trusts. A childcare survey across a sample of NHS trusts is also being undertaken.

Personal and Organisational Development

4.169 The NHS Executive is working to establish a new NHS Chief Executive Development Programme from 1998 for HAs and NHS trusts. In addition to a range of established National and Regional initiatives, a new Career Development Service

for senior managers was launched in September 1997 to provide support for individuals, in a range of target groups, who aspire to Board or equivalent posts.

4.170 Progress is being made to establish a UK-wide employment-led National Training Organisation for the health sector in early 1998. This will support new government priorities on staff competence, employability and lifelong learning. When established, the new National Training Organisation will work jointly with a parallel body for the personal social services.

Summative Assessment

4.171 From January 1998, summative assessment of vocational training for General Medical Practice became compulsory. Summative Assessment is designed to assess trainees at the end of the general practice element of vocational training for general practice. These arrangements are seen as necessary to:

- guarantee the competence of those joining the profession;
- reassure the public and protect patients from doctors whose performance is not adequate;
- confirm to individual doctors that they have achieved an agreed minimum standard of competence; and
- to identify those doctors who are not ready for independent practice and who require further training or need to reconsider their career options.

Work is also in hand to improve continuing medical education and professional development to ensure that the knowledge and skills of existing practitioners keep pace with medical and technical advances.

Current Issues and Recent Trends

Hospital and Community Health Services (HCHS) Staffing

4.172 There were 940,600 people directly employed by the HCHS in England at September 1996, equivalent to 763,800 whole-time staff. **Figure 4.35** shows these staff by the main staff groups. Direct comparison with earlier years is not possible because of changes to the way non-medical staff are classified.

Figure 4.35: NHS Hospital and Community Health Services (HCHS) Staff by Main Staff Groups

4.173 Other characteristics of the NHS HCHS workforce are that:

- it is predominantly female (76 per cent) although the proportion is smaller for some staff groups, for example 32 per cent for medical and dental staff;
- 5 per cent of non-medical staff are from ethnic minority groups, broadly in line with the working population of England; and
- over 40 per cent of the people directly employed work part-time.

Medical Workforce

4.174 Medical education and training forms a continuum across undergraduate, postgraduate, and continuing medical education and professional development. The NHS Executive aims to ensure an adequate supply of appropriately trained doctors to provide cost effective, high quality patient care; and has continued to invest substantial resources, some £592 million in 1997-98, in medical and dental education (see**figure 4.7**).

4.175 The supply of doctors to meet the expected future growth in demand depends on intake to undergraduate medical courses, improved retention of UK-qualified doctors and overseas recruitment. The Department helped to fund the 1997 Audit Commission report *Finders Keepers*[4.28], which offers practical advice on improving retention in NHS trusts and has been widely distributed to local NHS employers. Good recruitment and retention practice in NHS trusts is being identified for sharing with the service. Annual planning guidance issued to the NHS, stresses the need for employers to improve retention for all staff.

4.176 The Third Report of the Medical Workforce Standing Advisory Committee (MWSAC)[4.29] recommended an increase in the annual intake to UK medical schools. The Government will announce its decisions on all of MWSAC's recommendations during 1998 in the light of the Comprehensive Spending Review (see paragraph 2.3 *et seq*.). The Specialty Workforce Advisory Group advises annually on the required numbers of training grade doctors and dentists in each specialty in England and Wales, in order to ensure sufficient doctors are eligible for future consultant appointments. (The Group's

remit has also recently been extended to cover general practitioners.) The reforms to postgraduate medical training coupled with the availability of flexible training arrangements for doctors in the Specialist Registrar and Senior House Officer grades should help to improve retention.

4.177 In 1997 progress was made in developing a more strategic approach to medical education and training through better dialogue with professional and regulatory bodies on priorities, and with completion of the introduction of the new Specialist Registrar grade. Opportunities for overseas doctors to train and work in the NHS have been increased through improving the immigration arrangements.

Non-Medical Workforce

4.178 Since April 1996, HAs and NHS trusts have worked together in consortia to determine the nature of training for non-medical professions, giving those engaged in the delivery of patient services greater influence on the training provided. Consortia are taking increasing, direct responsibility for the planning and management of non-medical education and training in readiness for full devolution of contracting and funding responsibilities from April 1998. The NHS Executive undertakes workforce analyses and modelling and issues guidance on priorities for education and training.

Junior Doctors' Hours

4.179 The New Deal[4.30] has made significant gains in reducing junior doctors' hours since its introduction in 1991. However, progress has slowed as more complex and difficult to solve problems have been encountered. The NHS Executive will continue to implement and monitor the New Deal in 1998-99 and beyond.

Objective

The Department is committed to making progress in a way which:

- **is fair, excluding no part of the community, and directing action and resources to areas of greatest need.**

4.180 This objective is central to initiatives throughout the NHS. It underpinned the White Paper, *The new NHS: modern, dependable*[4.1] (see paragraph 4.41 *et seq*.), in which the Government committed itself to guaranteeing fair access to consistently high quality, prompt and accessible services right across the country. This will be pursued by a variety of means, including national service frameworks, resource allocation systems, standards of care which all must reach, and monitoring of fair access to health services.

4.181 Health Action Zones (HAZs) (see paragraph 4.54 *et seq*.) will include areas of pronounced deprivation and poor health, focusing on those whose needs are greatest, and implementing plans to reduce inequalities in health and in access to services. For example, HAZs will co-ordinate targeted initiatives to address the health needs of particular groups, such as children and young people in deprived communities, older people, users of mental health services, and areas identified as being priorities for action locally.

4.182 The consultation document *The new NHS: a national framework for assessing performance*[4.5] (see paragraph 4.50 *et seq*.), included in its proposals the monitoring of fair access to services, recognising that fair access must be to care that is effective, appropriate and timely, and complies with agreed standards.

4.183 Action to improve equity of access to hospital services is described at paragraph 4.57. In addition, the Government took early action to promote financial equity between fundholding and non-fundholding GP practices. New regulations and directions[4.31] require GP fundholders to meet any overspend from their savings or from a subsequent year's budget; and in-year variations in fundholder budgets are permitted, if necessary, to prevent inequalities in access to health care where there is an unforeseen surge in emergency admissions across a HA.

4.184 There is evidence of considerable inequity in access to general medical services and primary care, and the Department is addressing this issue in a number of ways, see paragraphs 4.79 and 4.92 *etseq*. There are now a number of levers to address local deficits in primary care provision.

4.185 In addition, a new Advisory Committee on Resource Allocation (ACRA) was set up in September 1997. The Committee has been asked to look at how resources are distributed across both secondary and primary care to ensure that these fully reflect local population needs, and function as fairly as possible. Health service need is also to be a factor in the prioritisation of major capital schemes (see paragraph 4.35).

4.186 New technology is also being harnessed to increase fairness. NHS Direct, access to nurse triage over the telephone (paragraph 4.44), and telemedicine (4.153), by its potential to bring sophisticated monitoring and clinical care closer to patients, will be powerful drivers towards equity in health care within the NHS, and in ensuring a fairer share of services for all.

Figure 2.1
National Health Service, England By Area of Expenditure

							£ million and percentages
	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	1997-98 estimated outturn	1998-99 plans
Central government expenditure							
National Health Service Hospitals community health, family health (cash limited) and related services and NHS trusts[1]							
Current expenditure							
Gross	20,117	20,841	21,731	22,873	23,877	25,184	26,667
Charges and receipts[2]	539	494	407	435	464	458	491
Net	19,579	20,347	21,324	22,439	23,412	24,726	26,175
Net percentage real terms change		1.0%	3.2%	2.4%	1.4%	2.8%	2.9%
Capital expenditure[3, 4]							
Gross	1,815	1,783	2,049	1,996	1,730	1,617	1,527
Charges and receipts[2]	115	213	208	282	393	425	349
Net	1,700	1,570	1,840	1,714	1,338	1,192	1,178
Net percentage real terms change		-10.3%	15.5%	-9.4%	-24.2%	-13.2%	-4.0%
Total							
Gross	21,932	22,624	23,780	24,870	25,607	26,802	28,194
Charges and receipts[2]	654	707	615	717	857	883	840
Net	21,279	21,917	23,165	24,153	24,750	25,919	27,353
National Health Service family health services (non-cash limited)[5]							
Current expenditure							
Gross	6,558	6,914	7,329	7,700	8,192	8,703	9,084
Charges and receipts	650	664	696	694	717	723	722
Net	5,908	6,250	6,633	7,005	7,475	7,980	8,361
Net percentage real terms change		2.8%	4.6%	2.8%	3.7%	3.9%	1.8%
Departmental administration							
Current expenditure							
Gross	341	320	312	305	292	280	279
Charges and receipts	27	16	17	15	14	20	17
Net	313	304	295	290	277	260	262

Capital expenditure							
Gross	43	16	17	14	13	13	8
Charges and receipts	0	0	0	0	0	-1	0
Net	43	16	17	14	13	13	8
Total							
Gross	384	336	329	319	305	293	287
Charges and receipts	27	16	17	15	14	20	17
Net	357	320	312	304	291	273	270
MCA trading fund[6]							
Current expenditure							
Gross		5	0	0	0	0	0
Charges and receipts		0	0	0	0	0	0
Net		5	0	0	0	0	0
Capital expenditure							
Gross		0	0	0	0	0	1
Charges and receipts		0	0	0	0	0	0
Net		0	0	0	0	0	1
Total							
Gross		5	0	0	0	0	1
Charges and receipts		0	0	0	0	0	0
Net		5	0	0	0	0	1
Central health and miscellaneous services							
Current expenditure							
Gross	488	509	529	578	614	632	628
Charges and receipts	71	66	76	90	96	123	112
Net	417	443	453	488	519	509	516
Capital expenditure							
Gross	10	8	7	8	9	8	7
Charges and receipts	0	0	0	0	0	0	0
Net	10	8	7	8	9	8	7
Total							
Gross	498	517	537	586	624	640	636
Charges and receipts	71	66	76	90	96	123	112
Net	427	451	460	496	528	517	523
Total National Health Service							
Current expenditure							
Gross	27,504	28,588	29,901	31,456	32,974	34,800	36,657
Charges and receipts[2]	1,287	1,240	1,196	1,234	1,291	1,324	1,342
Net	26,217	27,348	28,706	30,222	31,683	33,476	35,315
Capital expenditure							
Gross	1,868	1,807	2,073	2,018	1,753	1,638	1,543
Charges and receipts[2]	115	213	208	282	393	426	349
Net	1,753	1,594	1,865	1,736	1,360	1,213	1,194
Total							

Gross	29,372	30,395	31,974	33,474	34,727	36,438	38,200
Charges and receipts[2]	1,402	1,453	1,404	1,516	1,684	1,750	1,692
Net	27,970	28,942	30,570	31,958	33,044	34,688	36,509
Net percentage real terms change		0.6%	4.1%	1.7%	0.5%	2.2%	2.3%

1 Funding for that element of trusts' capital expenditure which they fund from their charges to health care purchasers (£363 million in 1992-93, £696million for 1993-94, £975 million for 1994-95, £1,053 million for 1995-96, £1,106 million in 1996-97, an estimated £943 million in 1997-98, and provisional figures in 1998-99), included within HCHS capital here, is included within HCHS current in Annex B (cash plans).

2 Includes trust receipts/charges (for current, £88 million in 1992-93, £165 million in 1993-94, £300 million in 1994-95, £331 million for 1995-96, £388 million for 1996-97 and an estimated £331 million for 1997-98; for capital, £6 million in 1992-93, £37 million in 1993-94, £51 million for 1994-95, £72 million for 1995-96, £122 million for 1996-97, and an estimated £135 million for 1997-98). Figures for receipts and charges for 1998-99 are provisional estimates.

3 Provision for capital spending within GMS cash limited expenditure (£23 million in 1992-93 and £21 million in 1993-94), included in HCHS capital here, is included in HCHS current in Annex B (cash plans).

4 HCHS capital includes all NHS trust capital expenditure, ie that funded from charges to health care purchasers (see Note 1) and that financed from their EFLs (£223 million in 1992-93, £303 million in 1993-94, £590 million in 1994-95, £401 million in 1995-96, £102million in 1996-97, an estimated £167 million in 1997-98 and provisional figures in 1998-99). Capital investment under the Private Finance Initiative is not included in this table, which details central government's own expenditure only.

5 Expenditure on drugs prescribed by GP fundholders (£295 million in 1992-93, £628 million in 1993-94, £1,009 million in 1994-95, £1,296million in 1995-96, £1,794 million in 1996-97, and £2,204 million in 1997-98), included here in FHS non-cash limited current, is included in HCHS Current in Annex B (cash plans) for those years. The final distribution between cash limited and non-cash limited provision of the funding for FHS drug costs for 1998-99 has not yet been determined and the full budget for 1998-99 is included in the non-cash limited provision.

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

7 Totals may not sum due to rounding.

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Figure 2.2
Comparison of Expenditure Plans for 1997-98 and 1998-99 with those in last year's Departmental Report (Cm 3612)

£ million

	1997-98			1998-99		
	Cm 3612	**difference**	**Figure 2.1**	**Cm 3612**	**difference**	**Figure 2.1**
HCHS current	24,368	358	24,726	24,891	1,284	26,175
HCHS capital	1,315	-123	1,192	1,350	-172	1,178
FHS current	7,873	107	7,980	8,085	276	8,361
Departmental administration[1]	287	-14	273	287	-16	271
CHMS	526	-9	517	531	-8	523
NHS Total	**34,368**	**320**	**34,688**	**35,143**	**1,366**	[2]**36,509**

1 For consistency includes MCA.

2 This figure differs from the £1,417 million referred to in pragraphs 2.6 and 2.7 because of transfers to other government departments. See figure 2.3.

3 Totals may not sum due to rounding.

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Figure 2.4
Growth in Real Terms in NHS Gross Expenditure (1996-97 prices)

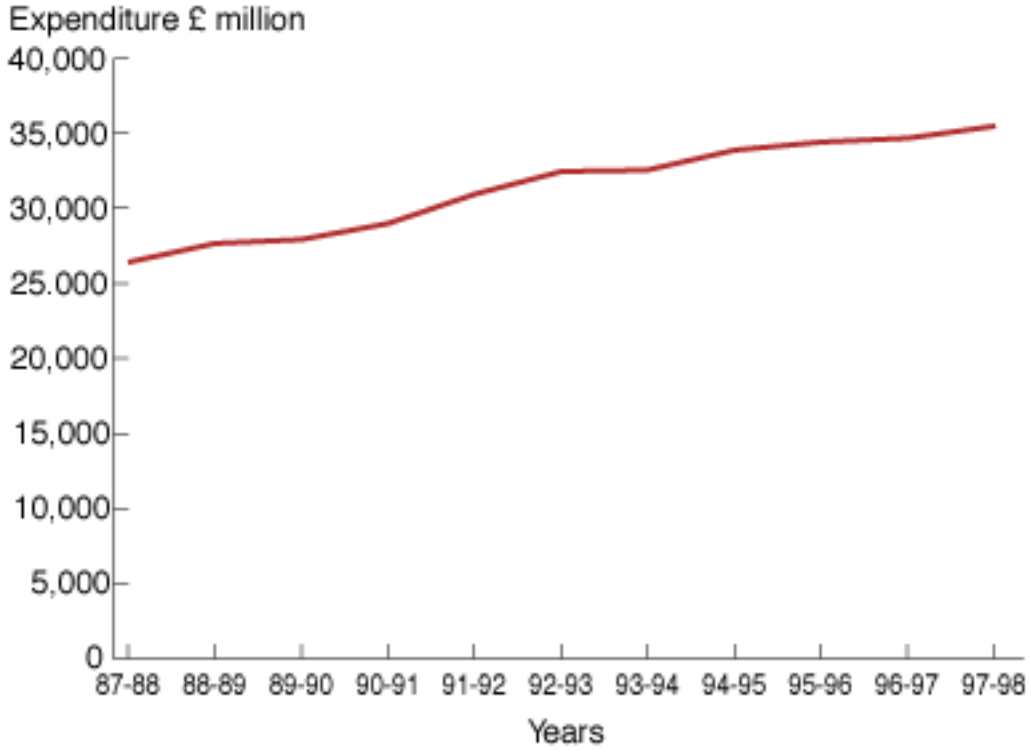

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Figure 2.5
NHS Gross Expenditure, 1997-98 (Estimated Outturn)

Total £36,438 million

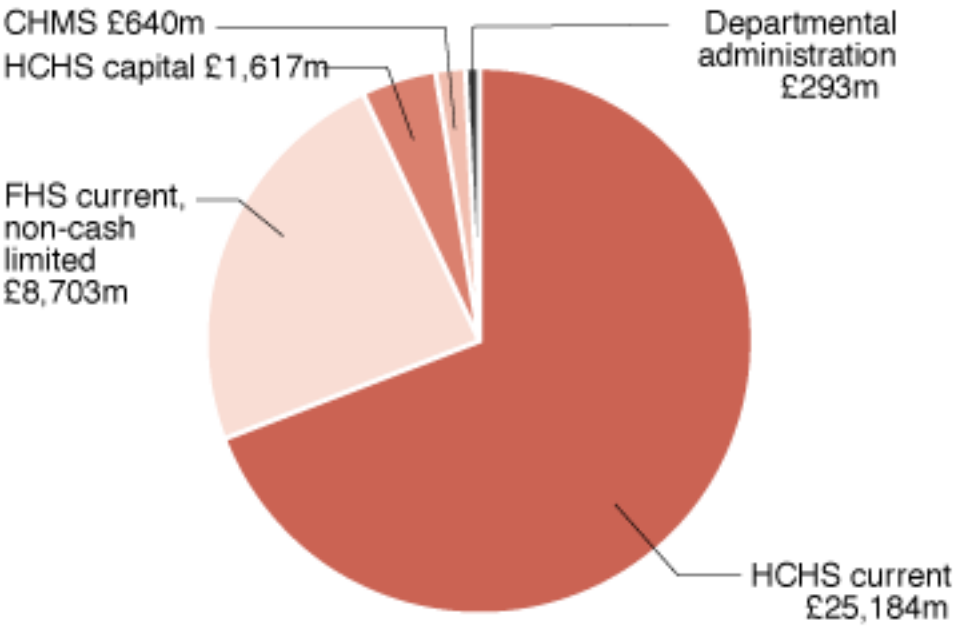

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Figure 2.6
NHS Sources of Finance, 1996-97

Total £36,330 million

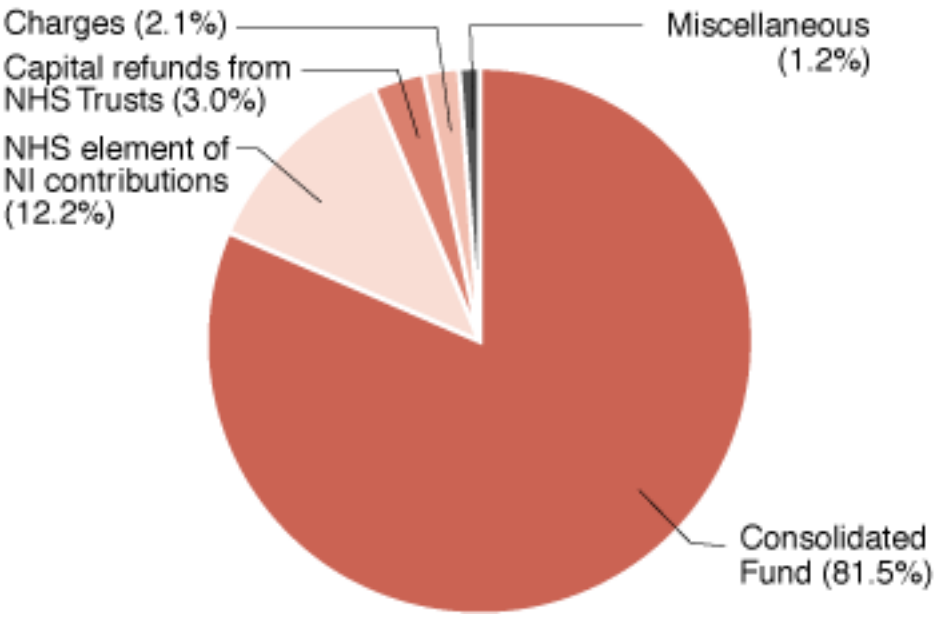

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Figure 2.7
NHS Sources of Finance[1]

Percentages unless otherwise shown

Financial Year	**Total Funding (£m)**	**Total Public**	Consolidated Fund expenditure	NHS element ofNI contributions	**Total from other sources**	Charges[2]	Capital refunds from NHS trusts[3]	Miscellaneous[4]
1988-89	**19,317**	**95.2**	80.1	15.1	**4.8**	3.1		1.7
1989-90	**21,088**	**94.1**	77.5	16.6	**5.9**	4.5		1.4
1990-91	**23,632**	**94.5**	78.8	15.7	**5.6**	4.5		1.1
1991-92	**26,954**	**94.7**	80.7	14.0	**5.6**	4.1		1.1
1992-93	**29,856**	**95.0**	81.8	13.2	**5.2**	3.7		1.5
1993-94	**31,275**	**94.7**	82.0	12.7	**5.4**	3.1	1.2	1.1
1994-95	**33,266**	**94.5**	82.4	12.1	**5.6**	2.4	2.2	1.0
1995-96	**34,878**	**94.3**	82.1	12.2	**5.8**	2.3	2.5	1.0
1996-97	**36,330**	**93.7**	81.5	12.2	**6.3**	2.1	3.0	1.2
1997-98[5]	**36,765**	**93.6**	80.8	12.8	**6.4**	2.3	3.2	0.9
1998-99[5]	**40,823**	**89.1**	76.9	12.2	**10.9**	2.0	8.0	0.9

1 Figures for 1997-98 to 1998-99 are based upon Main Estimate *provision. Figures for earlier years are based on Appropriation Accounts.*

2 Mainly Family Health Services receipts in respect of prescription and dental charges. Pay bed and similar revenue income collected centrally by health authorities is also included. Pay bed and similar income collected locally by NHS trusts is ***not*** *included.*

3 Capital refunds from NHS trusts are repayments of principal on NHS trust interest-bearing debt. They were not identified separately prior to 1993-94.

4 Mainly health authority capital receipts.

5 Estimates.

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Figure 2.8
Expenditure on Local Authority Personal Social Services

£ million

	1987-88 outturn	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 provisional outturn	1997-98 budget
Current expenditure							
Gross[1]	3,423	5,470	6,278	7,503	8,393		
Charges[1]	430	502	621	886	1,079		
Net[2]							
Cash	2,993	4,968	5,657	6,617	7,314	7,917	8,373
Real terms[3]	4,641	5,637	6,238	7,189	7,732	8,131	8,373
Capital expenditure							
Gross	150	169	185	201	200	190	189
Income	56	38	69	45	40	44	45
Net	94	131	116	156	160	146	144
Total local authority expenditure							
Gross	3,573	5,639	6,463	7,704	8,593		
Charges/income	486	540	690	931	1,119		
Net	3,087	5,099	5,773	6,773	7,474	8,063	8,517

Source: RO and RA LAs' Returns

1 Gross expenditure and income from charges figures are not yet available for 1996-97 and 1997-98.

2 The net figures quoted in this table exclude capitalised redundancies, which are included in Figure 1.2 in the introduction.

3 At 1997-98 prices.

4 Figures may not sum due to rounding.

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Figure 2.9
Growth in Real Terms in Net Current Expenditure on Personal Social Services, 1987-88 to 1997-98

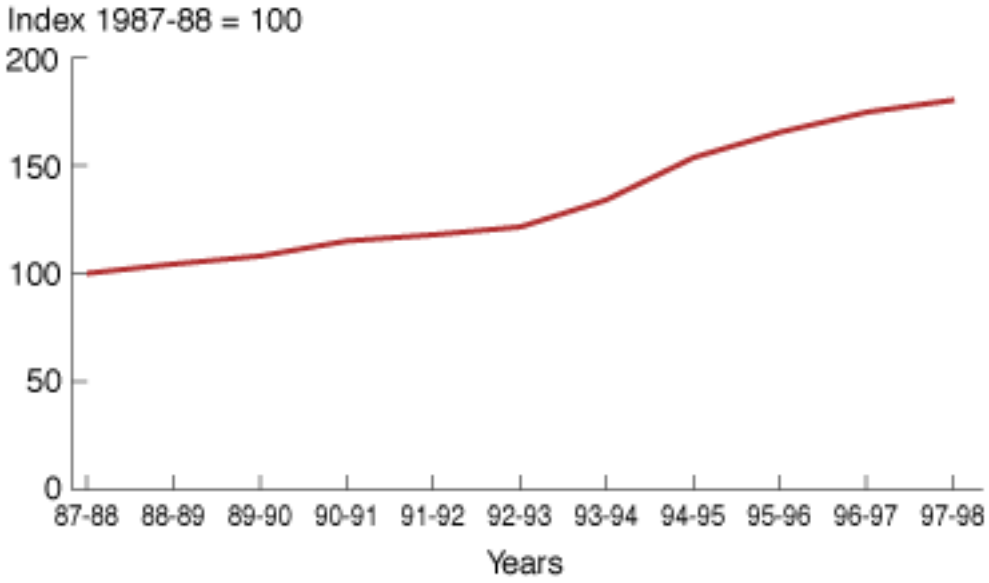

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Figure 3-1
Central Health and Miscellaneous Services Gross Expenditure, 1997-98 (Estimate)

Total £619 million

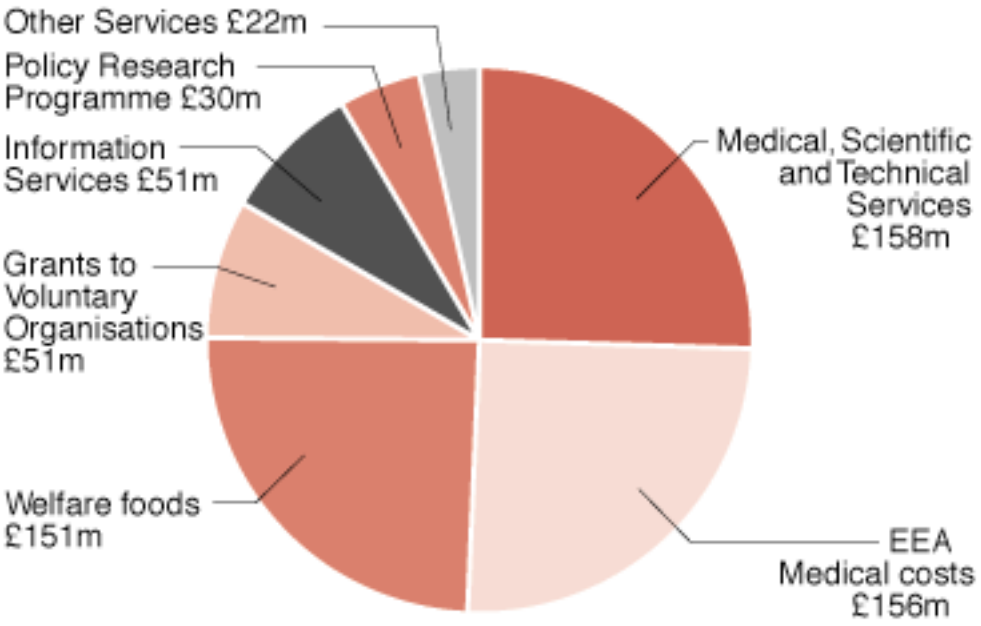

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Figure 6-7
Departmental Spending on Publicity and Advertising, 199798

Campaigns run by the Department	**£ million**
Our Healthier Nation	2.6
Health Service Professional Recruitment	2.1
Blood Donor Publicity	1.2
Organ Donation	0.5
Reciprocal Health Care Leaflet T6	1.0
Help with NHS Health Costs	0.5
Keep Warm Keep Well/Elderly Health	0.5
Emergency Services Helpline	0.4
NHS Performance Tables/Patient Response	0.4
Health Care Industry Sponsorship	0.4
Total	**9.5**
Campaigns run by the HEA and other organisations	
Anti smoking campaigns	6.2
Drugs	4.7
Physical activity	2.8
HIV/AIDS	3.0
Vaccination and Immunisation	1.6
Contraceptive Education/Unwanted conceptions	1.3
Alcohol	0.8
Nutrition	0.7
Total	**21.1**

1 Totals may not sum due to rounding.

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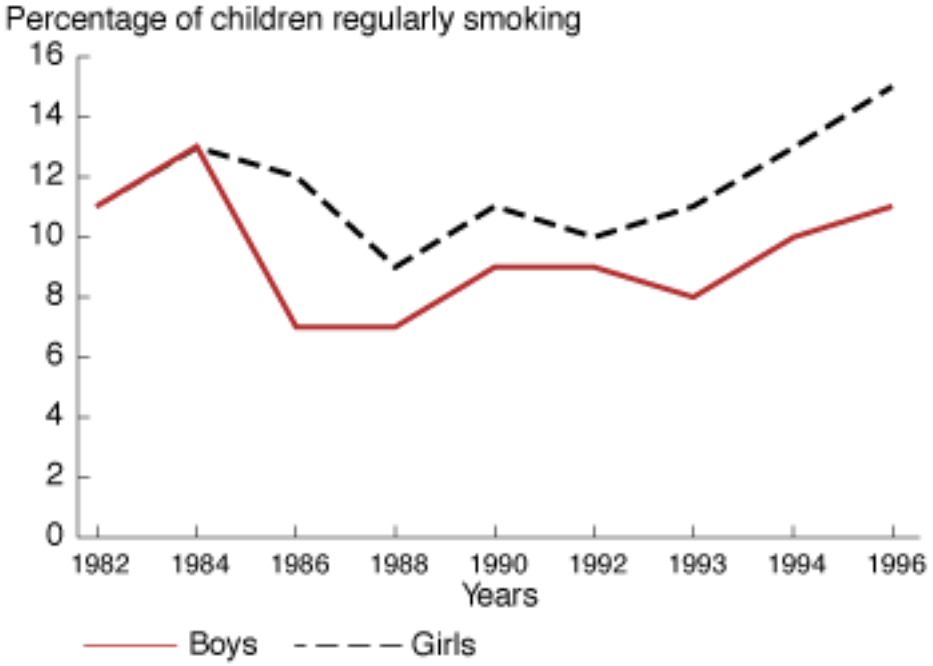
Figure 3-2
Prevalence of Regular Cigarette Smoking in Children Aged 11-15 Years, by Sex, England 1982-1996



Source: ONS smoking among secondary school children survey.

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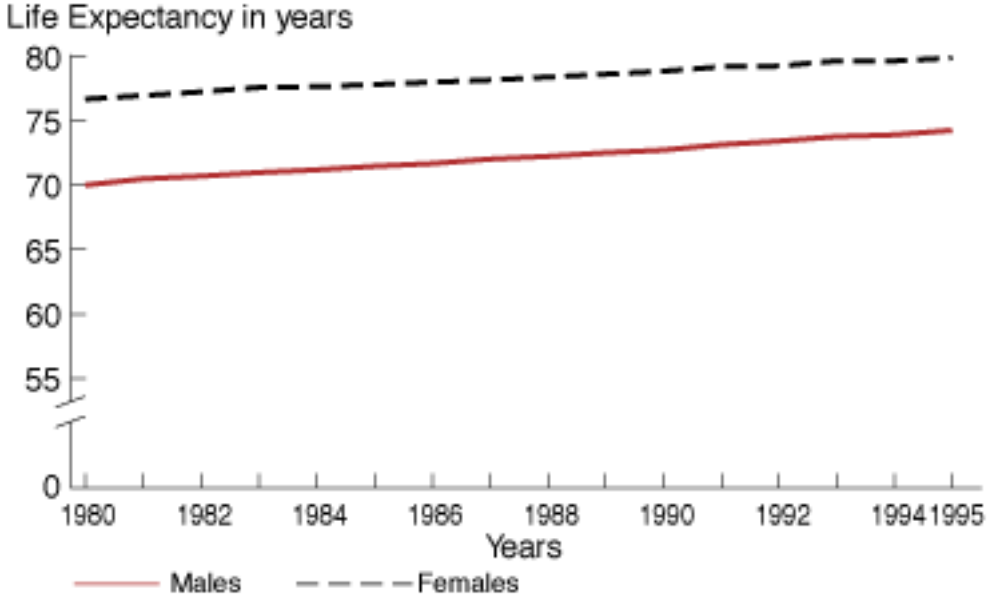
Figure 3-4
Life Expectancy at Birth in England, 1979-1996[1]



1 Figures are 3 year averages which means that the figure for 1985, for example, is the average of the years 1984/1985/1986.

2 Source: Government Actuary's Department

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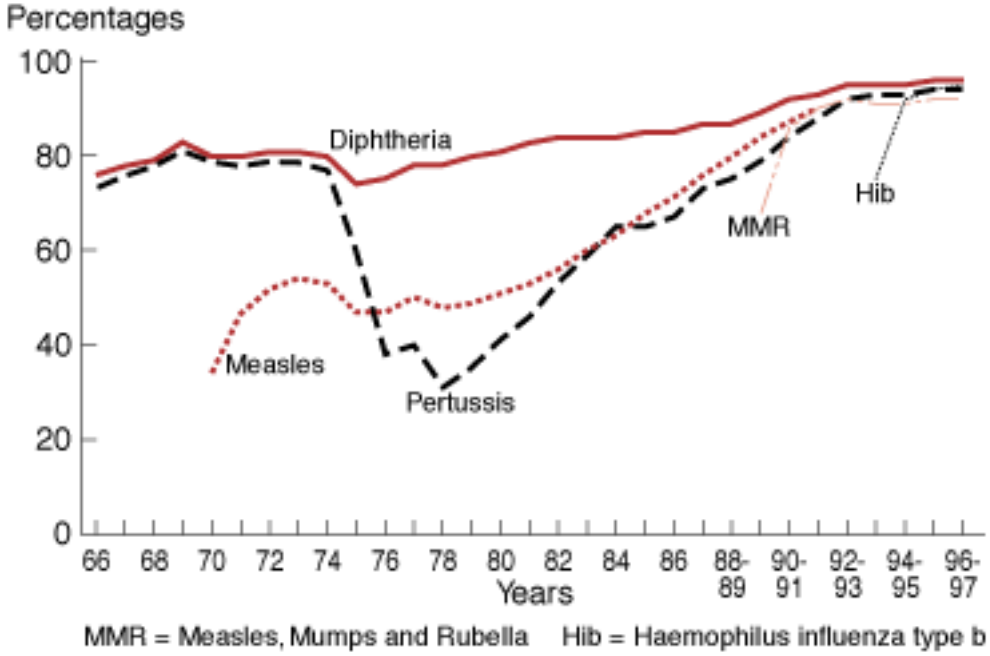
Figure 3-5
Immunisation: Percentage of Children Completing Selected Immunisations by their Second Birthday, England, 1966 1996-97



Source: Form KC50.

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Figure 4-1
Hospital and Community Health Services Gross Current Expenditure by Sector, 1995-96

Total £23,579 million

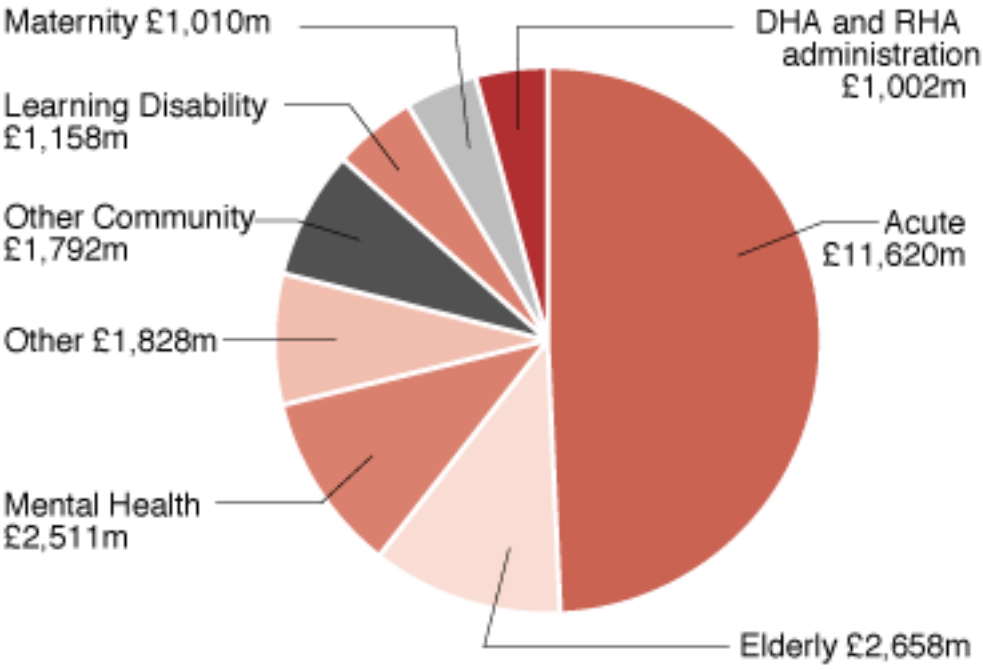

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Figure 4-2
Hospital and Community Health Services Gross Current Expenditure by Age, 1995-96 (estimate)

Total £23,579 million

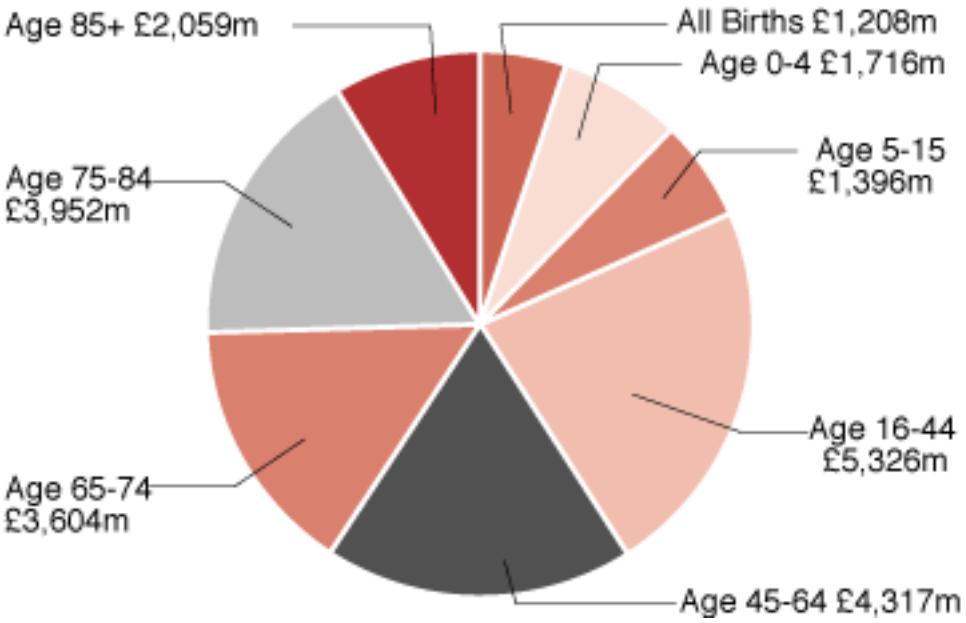

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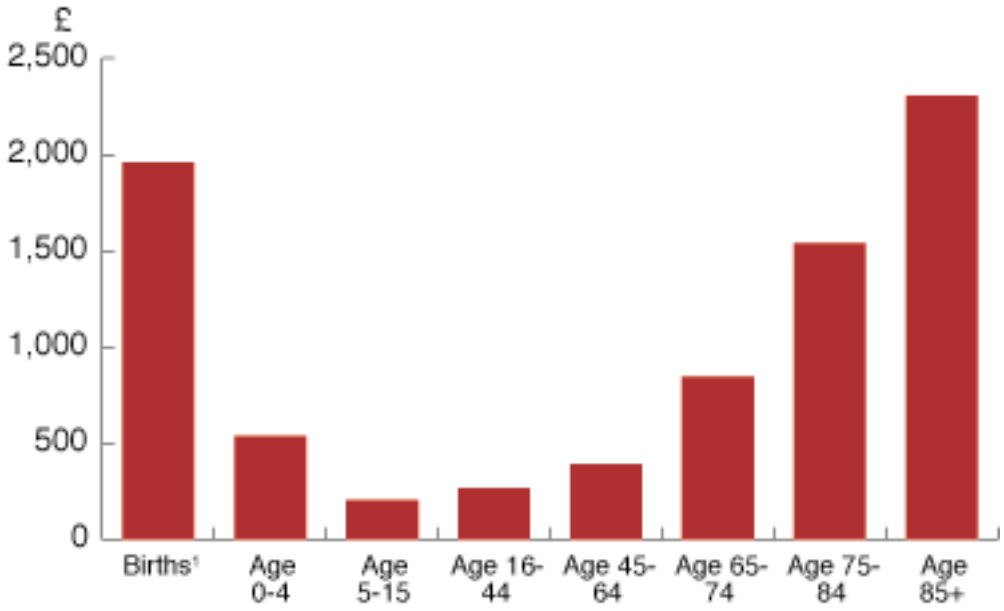
Figure 4-3
Hospital and Community Health Services Gross Current Expenditure Per Head, 1995-96 (estimate)



1 This figure is for all births, including still births.

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Figure 4-4
Estimated Growth in HCHS Expenditure Required due to Demographic Changes: Year on Year Percentage Increases

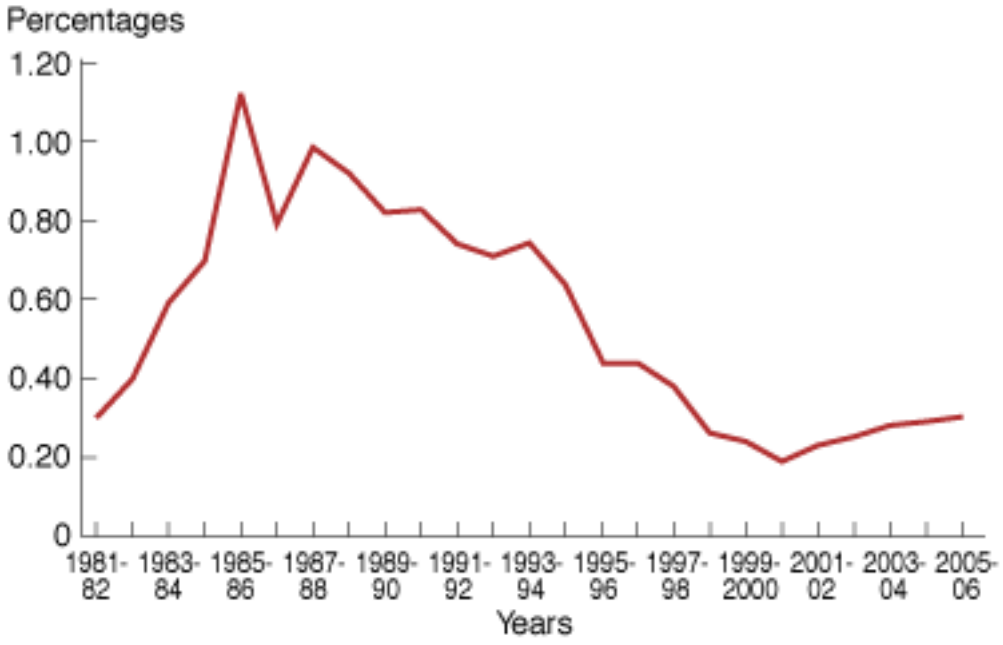

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Figure 4-5
Distribution of HCHS Resources, 1998-99

	£ million	Percentage increase
HCHS revenue	**25,652**	**5.27**
Capital charges and other adjustments	2,579	
Total available	**28,231**	**4.78**
Less top slicing	258	
Less national levies	2,957	
Allocated to HAs	**25,016**	**4.65**
Comprising:		
Special allocations	2,120	
General Allocations	**22,895**	**4.70**

1 Figures in the above table may not sum due to rounding.

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Figure 4-6
Top-sliced Funding over £10 million, 1998-99

		£ million
Budget	**1997-98**	**1998-99**
Community Health Councils	22	22
Dental Practice Board[1]	20	20
Prescription Pricing Authority[1]	42	45
High Security Psychiatric Services Commissioning Board[1]	131	134
National Blood Authority	11	13
All other budgets	21	24
Total	247[2]	258[3]

1 Net of receipts.

2 This is the latest available figure for the level of budgets for 1997-98.

3 Provisional figures for these budgets in 1998-99.

4 For further details of Non Departmental Public Bodies and Special Health Authorities see Annex H.

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Figure 4-7
National Levies, 1998-99

		£ million
	1997-98	**1998-99**
Services Specific Levies:		
Medical and Dental Education Levy (MADEL)	592	622
Non-Medical Education and Training (NMET)	749	800
Service Increment For Teaching (SIFT)	458	479
Research and Development (R & D)	425	426
Total 4 major levies	**2,224**	**2,327**
Other Centrally Funded Initiatives and Services:		
Budgets over £10 million		
Clinical Negligence	93	100
Injury Allowances	23	24
Information Management Group	22	21
Distinction Awards	87	93
London Implementation Group	61	63
Charge Exempt Overseas Visitors	23	26
National Specialist Commissioning Group	56	61
Purchase of Vaccines	38	42
Special Assistance	51	55
Mentally Disordered Offenders	15	15
Primary Care Act Pilots	5	10
All other budgets	88	120
Total	**562**	**630**
Total levies	**2,786**[1]	**2,957**[2]

1 This is the latest available figure for the level of budgets for 1997-98.

2 Provisional figures for these budgets in 1998-99.

3 Figures may not sum exactly due to rounding.

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Figure 4-8
Special Allocations, 1998-99

		£ million
Special allocation	**1997-98**	**1998-99**
General Medical Services (cash limited)	804	848
Out of hours development fund	39	39
Joint finance	155	155
Drug misuse	37	41
AIDS prevention	52	53
AIDS treatment and care	199[1]	228
Old long stay patients[2]	590	607
Practice fund management allowance	161[3]	148
Total	**2,038**[4]	**2,120**[5]

1 Figure has been adjusted since the publication of the 1997 Departmental Report, reflecting movement between special allocation and general allocation.

2 Patients who were in hospitals for people with learning disabilities or mental illness in 1971. These count as residents of the host HA and not the HA where they resided prior to admission.

3 This figure has been adjusted since the publication of the 1997 Departmental Report.

4 This is the latest available figure for the level of budgets for 1997-98.

5 Provisional figures for these budgets in 1998-99.

6 Figures may not sum exactly due to rounding.

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Figure 4-9
HCHS General Allocations Distribution of Cash Increase, 1997-98

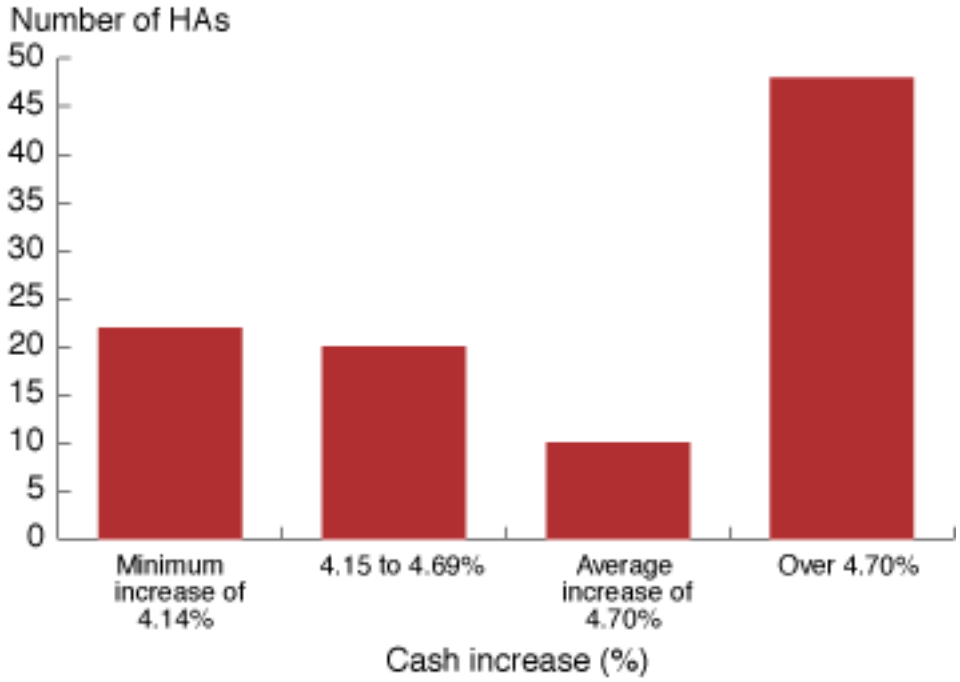

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Figure 4-10
Health Authorities' Distance from Target (DFT), 1997-98 and 1998-99

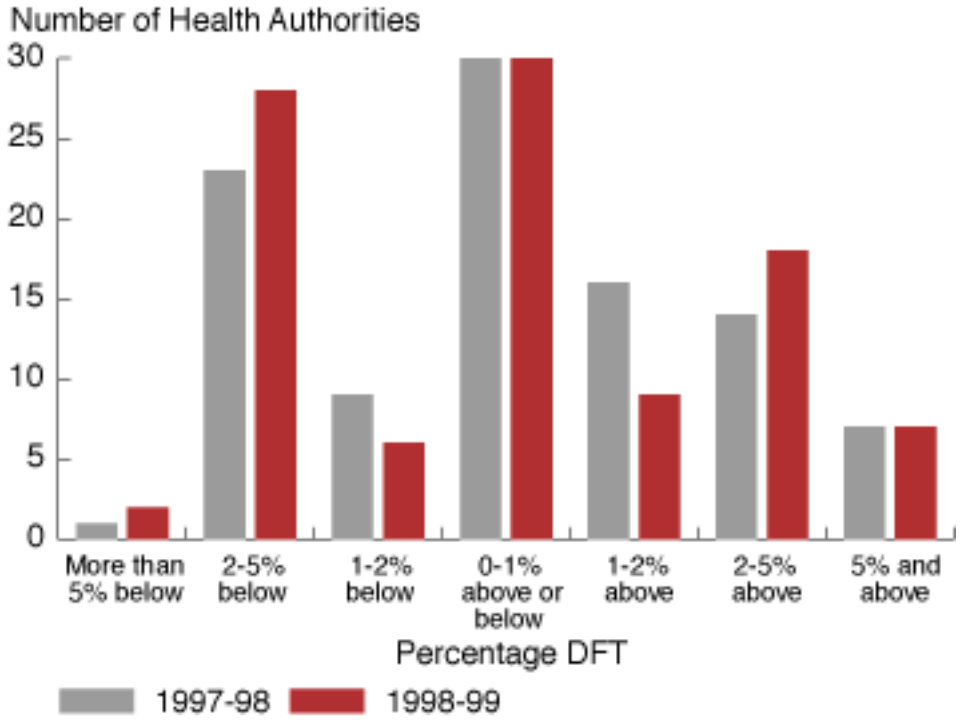

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Figure 4-11
NHS Capital Spending, 1997-98 and 1998-99

£ million

	Estimated outturn 1997-98	Plan 1998-99
Hospital and Community Health Services		
Government spending	1,192	1,178
percentage real growth		4%
Receipts from land sales[1]	425	349
percentage real growth		20%
PFI investment[1]	55	321
percentage real growth		467%
Other NHS spending[2]	21	16
percentage real growth		26%
Total	**1,693**	**1,864**
percentage real growth		7%

1 Estimated.

2 Central Health and Miscellaneous Services and Departmental Administration.

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Figure 4-12
Sources and Applications of HCHS Capital; Plans[1], 1997-98 and 1998-99

		£ million
	1997-98 Plan	**1998-99 Plan**
Sources:		
Net Capital HCHS Expenditure	**1,315**	**1,216**
Plus:		
NHS trust capital receipts	45	58
Retained estate receipts	244	214
Total capital receipts	**289**	**272**
Gross HCHS Capital Expenditure	**1,604**	**1,488**
Applications:		
Retained estate costs[2]	33	49
NHS trust capital receipts[3]	45	58
Centrally financed capital[4]	78	91
Transfers to revenue[5]	194	200
NHS trust voted capital	1,253	1,088
Total Capital	**1,604**	**1,488**
Financing of NHS trust capital:		
Depreciation[6]	943	966
External Financing Limit (EFL)	310	122
Total NHS trust voted capital	**1,253**	**1,088**
Plus:		
NHS trust capital receipts	45	58
Total capital available to NHS trusts	**1,298**	**1,146**
Financing of EFL:		
Net borrowing from Secretary of State voted in *Estimates*[7]	362	22
Change in market borrowing (non-voted)[8]	52	100
EFL	**310**	**122**

1 The table shows the planned position for 1997-98 and 1998-99 HCHS capital. It does not reflect adjustments to plan at Main Estimates or any in-year changes. Therefore the figures do not match those in Figure 2.1.

2 These are the costs associated with the maintenance and disposal of the NHS retained estate.

3 These are the capital receipts generated from the sale of NHS trust assets. These receipts can be spent in addition to those

voted in Estimates.

4 This is capital which is retained centrally for Special Health Authorities such as the National Blood Authority and the Prescription Pricing Authority and to central initiatives such as the Making London Better (MLB) programme.

5 This is to cover:

(i) the higher capital theshold in the NHS;
(ii) capital expenditure on Joint Finance and GMS which are recorded as revenue as they are spent by a third party.

6 The element of capital charges included in HCHS revenue but earned by NHS trusts in prices and used to finance capital expenditure and/or repayment of principal on debt.

7 Net lending from voted monies to support NHS trust capital expenditure and short term cash flow needs.

8 The movements in borrowing cash and investments outside the public sector of monies not voted in Estimates in the financial year.

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Figure 4-13
Completions on Site of Publicly Funded Major Capital Schemes, 1992-1996

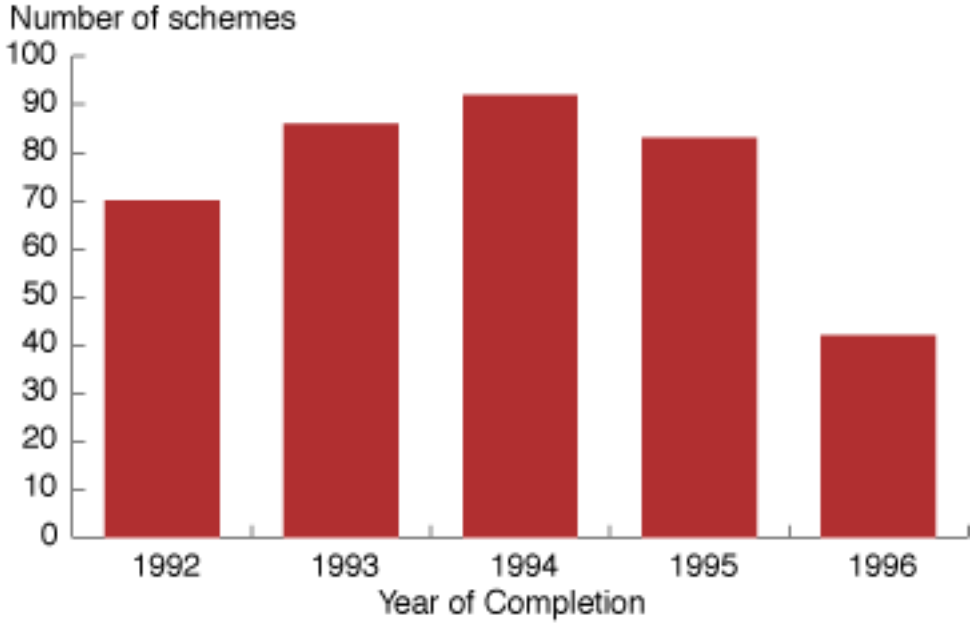

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Figure 4-15
NHS Backlog Maintenance Costs, 1992-93 to 1996-97

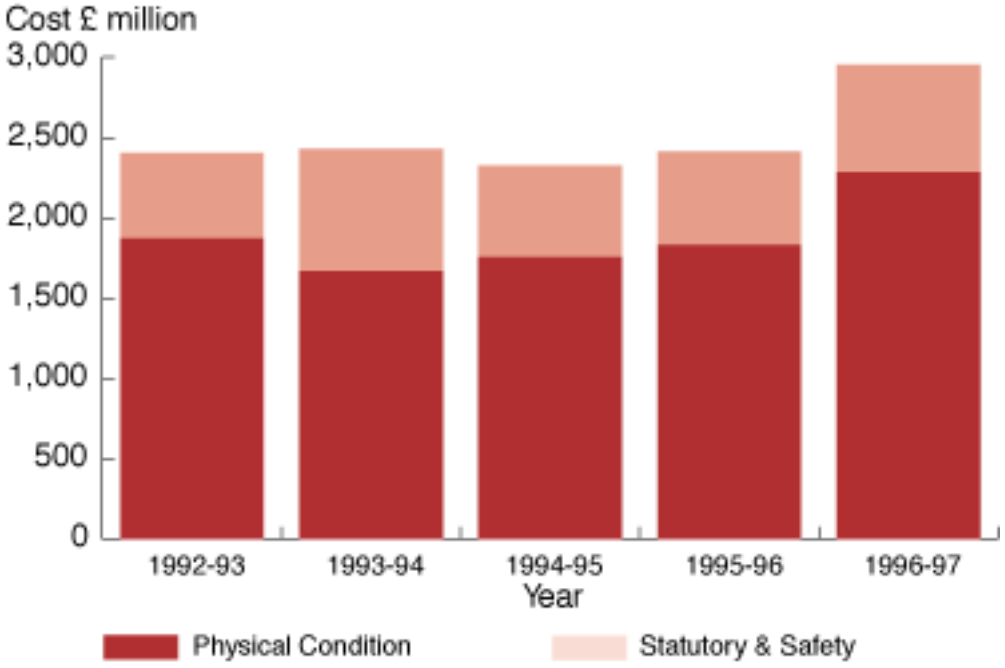

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Figure 4.16
Projects Involving Private Finance

£ million

		Estimated Outturn 1997-98	Projections 1998-99
A	Gross publicly sponsored capital	1,775	1,926
	Of which:		
	B[1] Capital spending (by private sector) on PFI projects	55	321
	C Capital spending by public sector by conventional procurement	1,720	1,605
D	Central government	528	455
E	Local government (PSS)	82	62
F	Public corporations (NHS trusts)	1,165	1,409
G	PFI revenue consequences	5	12

1 Estimates as at March 1998, and subject to change.

Key

Row A = B + C
Row B = PFI expenditure
Row C = Gross HCHS capital + gross other NHS + E
Row D = A (E + F)
Row E = PSS capital (total credit approvals plus capital grant)
Row F = Trust publicly funded and PFI capital expenditure
Row G = PFI revenue consequences

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Figure 4-17

Family Health Services Gross Expenditure, 1996-97

Total £8,987 million

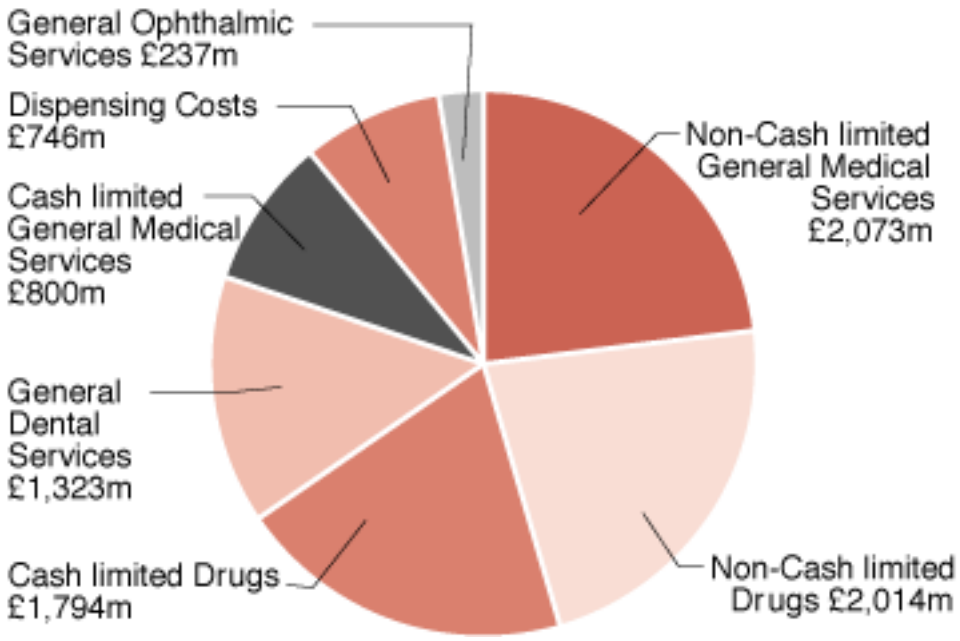

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Figure 4-18
Family Health Services Drugs Bill (Cash), 1987-88 to 1996-97

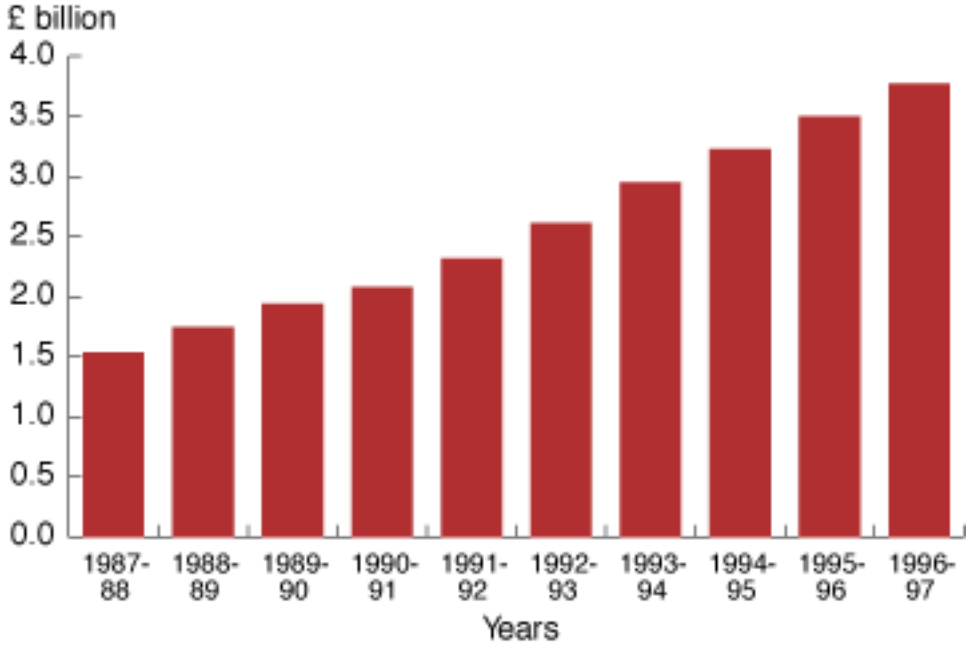

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Figure 4-19
Family Health Services Drugs Bill Percentage Growth (Cash), 1987-88 to 1996-97

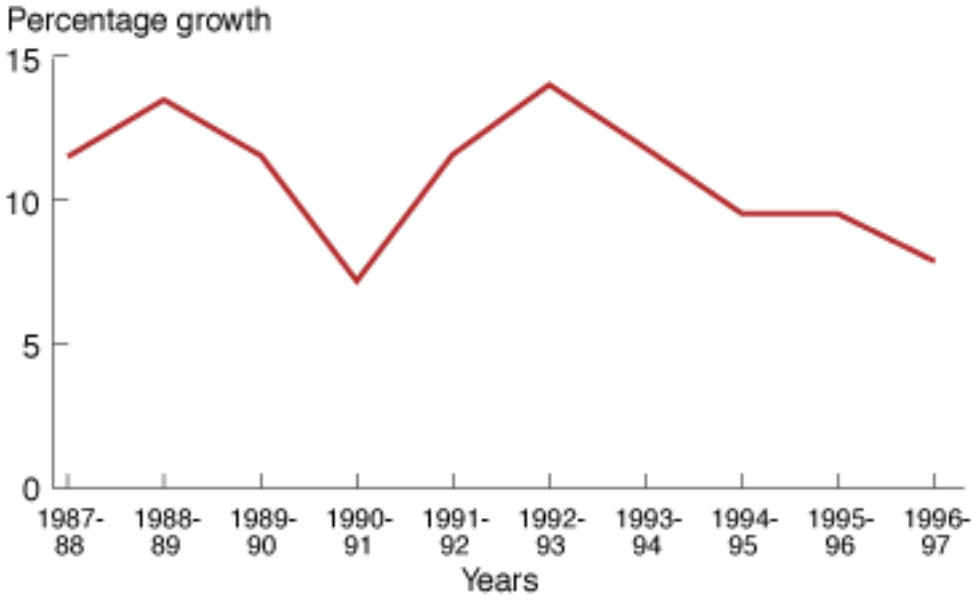

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Figure 4-20
Family Health Services Gross Expenditure, 1989-90 to 1997-98

									£ million	
									% real terms growth	
									1997-98	1989-90 to
	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	Allocation	1997-98
Drugs non-cash limited	1,952	2,091	2,210	2,356	2,352	2,243	2,210	2,014	1,920	n/a
Drugs cash limited	0	0	125	295	628	1,009	1,296	1,794	2,203	n/a
Drugs Total	**1,952**	**2,091**	**2,335**	**2,651**	**2,980**	**3,252**	**3,506**	**3,808**	**4,123**	**55.5**
General Medical Services non-cash limited	1,569	1,484	1,656	1,768	1,840	1,902	1,965	2,073	2,208	3.6
General Medical Services cash limited	0	464	600	686	715	723	754	[1] 800	847	n/a
Total General Medical Services	**1,569**	**1,948**	**2,256**	**2,454**	**2,555**	**2,625**	**1,965**	**2,873**	**3,055**	**43.3**
General Dental Services	948	1,040	1,246	1,306	1,222	1,279	1,290	1,323	1,336	3.7
Dispensing Costs	518	561	603	658	677	679	706	746	770	9.3
General Ophthalmic Services	108	111	141	172	192	213	223	237	244	65.9

1 General Medical Services cash limited allocation from 1995-96 includes Out of Hours allocation.

2 Figures rounded to nearest £ million.

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Figure 4-21
Patients Waiting 12 Months or More, 1992 to 1997

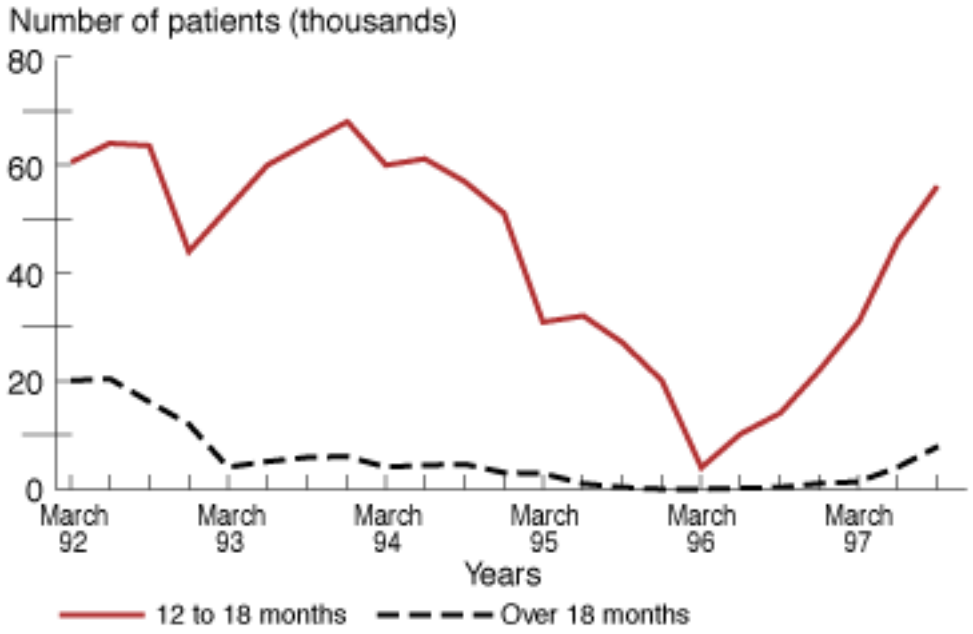

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Figure 4-22
Average Waiting Times, 1992 to 1997

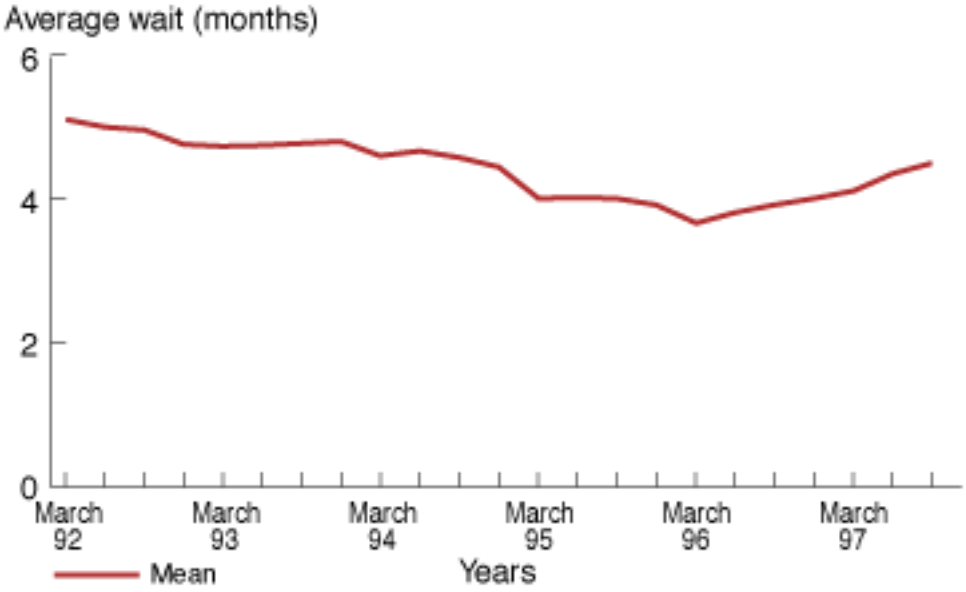

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Figure 4-23
Emergency Calls Resulting in an Ambulance Arriving on Scene, England, 1992-93 to 1996-97

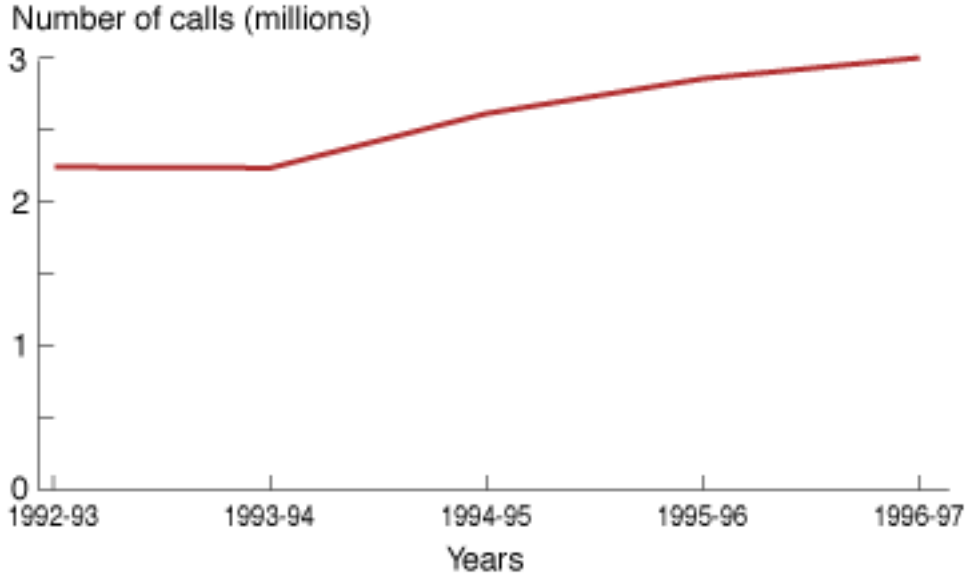

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Figure 5-2
Client Group Related Personal Social Services Gross and Net Expenditure, 1995-96

Summary of Expenditure 199596		**£ million**
England		
Client Group	**Gross**	**Net**
CHILDREN		
Senior Management and Purchasing	152	151
Care Assessment/Care Management	289	288
Non-residential	961	948
Residential	631	616
Total	**2,033**	**2,004**
ELDERLY		
Senior Management and Purchasing	99	99
Care Assessment/Care Management	221	217
Non-residential	1,467	1,330
Residential	2,282	1,605
Total	**4,070**	**3,251**
YOUNGER PHYSICALLY DISABLED		
Senior Management and Purchasing	29	29
Care Assessment/Care Management	62	61
Non-residential	352	340
Residential	153	122
Total	**596**	**553**
PEOPLE WITH LEARNING DISABILITIES		
Senior Management and Purchasing	22	22
Care Assessment/Care Management	47	44
Non-residential	450	429
Residential	561	452
Total	**1,080**	**948**
MENTALLY ILL		
Senior Management and Purchasing	23	23
Care Assessment/Care Management	69	69
Non-residential	167	164
Residential	147	111
Total	**406**	**367**
OTHER NON-CHILDREN		
Generic	55	54

Non-residential	15	15
Residential	18	15
Total	**88**	**83**
ENGLAND SUMMARY		
Central/Strategic Functions	121	109
Senior Management and Purchasing	325	324
Generic	55	54
Care Assessment/Care Management	688	680
Non-residential	3,412	3,226
Residential	3,792	2,921
Total	**8,393**	**7,314**

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Figure 5-3
Personal Social Services Provision, 1998-99

	£ million
Total PSS provision	**8,293.0**
of which:	
Standard Spending Assessments	7,814.7
Special Transitional Grant for Community Care	350.0
Special Grant for Unaccompanied Asylum Seeking Children	3.0
Specific Grants, total	125.3
of which:	
Services for the mentally ill	73.3
Training Support programme	35.5
Services for people with HIV/AIDS	13.7
Services for drug and alcohol misusers	2.5
Contribution to grants for projects to help meet the language needs of ethnic minorities	0.4

1 Figures may not sum due to rounding.

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Figure 5-4
Personal Social Services for Adults, 1990-91 to 1996-97

	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	% change 1990-91 to 1996-97
All client groups								
Local authority residential places	119,100	107,400	96,600	86,900	80,100	78,800	68,750	42
Voluntary and private residential places	219,300	230,000	239,600	246,200	251,500	263,800	298,800	36
Local authority funded day centre places	99,500	n/a	468,200	504,000	549,200	590,900	601,900	n/a
Elderly								
Local authority residential places[1]	96,200	85,100	75,400	67,400	61,400	60,400	52,600	45
Voluntary and private residential places[1]	185,100	192,700	198,500	202,800	206,300	215,600	244,800	32
Local authority funded day centre places[2]	25,900	n/a	139,100	147,600	176,400	192,600	207,700	n/a
Number of main meals served[3]	45.9m	45.8m	776,700	768,400	794,100	818,400	771,000	n/a
Learning disabilities								
Local authority residential places[4]	16,700	16,300	15,500	14,200	13,600	13,500	11,700	30
Voluntary and private residential places[4]	18,900	21,200	24,100	25,500	27,200	29,400	32,500	16
Local authority funded day centre places specific to people with learning disabilities[2]	56,700	n/a	236,200	259,200	268,800	284,300	280,500	n/a
Mental illness								
Local authority residential places	4,500	4,400	4,100	3,800	3,700	3,600	3,500	15
Voluntary and private residential places	8,400	9,200	10,000	10,700	11,100	11,700	13,600	165
Local authority funded day centre places specific to people with a mental illness[2]	7,800	n/a	39,800	45,300	50,500	53,000	54,700	n/a
Physical and/or sensory disabilities								
Local authority residential places	1,700	1,600	1,600	1,500	1,400	1,300	950	79
Voluntary and private residential places	6,900	6,900	7,000	7,200	6,900	7,100	7,900	13
Local authority funded day centre places specific to people with physical and/or sensory disabilities[2]	9,100	n/a	53,100	51,900	53,500	61,000	59,000	n/a

1 Figures include places in homes for elderly and elderly mentally infirm.

2 Figures are as at 31 March up to 1990-91 and during a sample week in September/October for subsequent years.

3 Annual estimate in millions to 1991-92; from 1992-93 onwards figures relate to a sample week in September/October.

4 Figures include places in homes for children with learning disabilities.

Small homes are excluded (ie homes with less than 4 places) from the above figures, local authority unstaffed (group) homes are included.

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Figure 5-5
Residential Places by Client Group, 199697

Total = 367,350 places

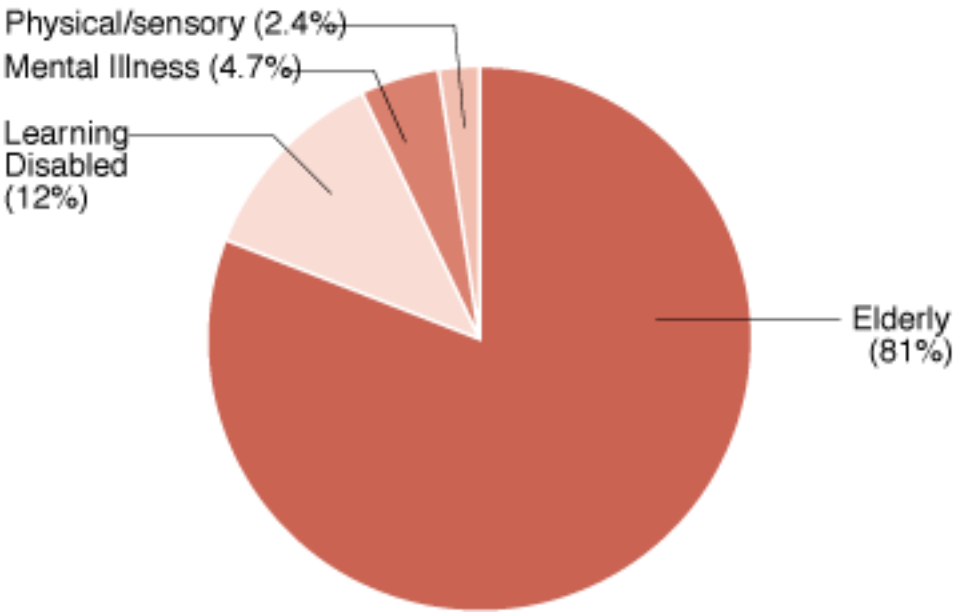

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Figure 5-6
Local Authority Funded Day Care Centre Places by Client Group, 199697

Total = 601,900 places

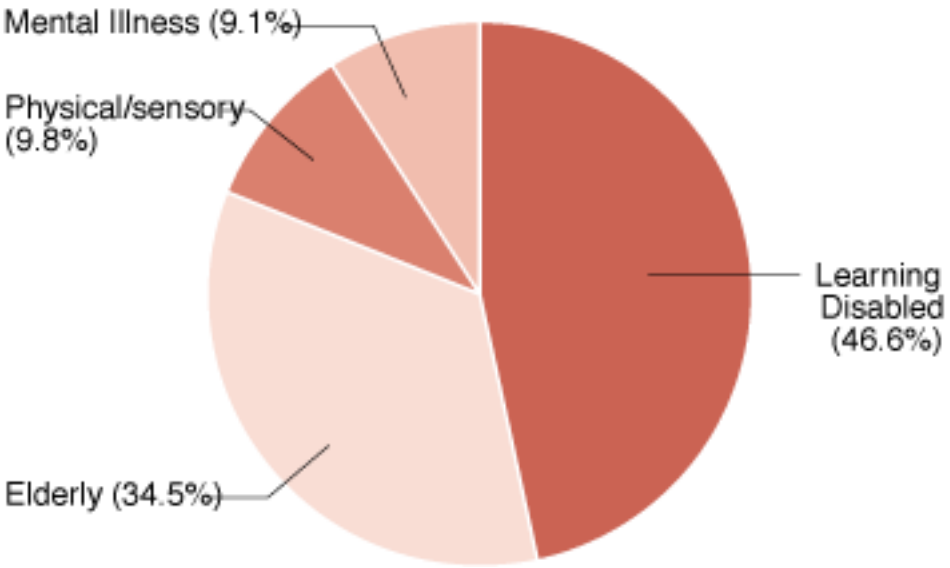

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Figure 5-7
Residential Places by Type of Accommodation, 1990-91 to 1996-97

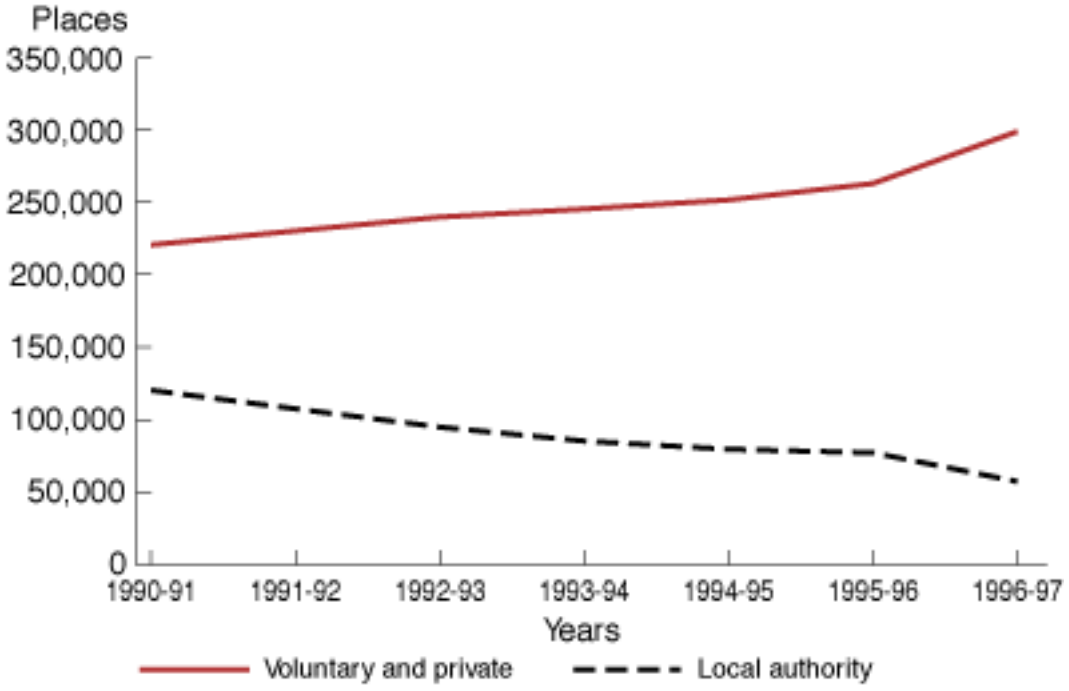

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Figure 5-8
Numbers of Children Receiving Selected Local Authority Services

					numbers of children	
England	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**
In foster placements[1]	32,700	31,900	31,800	32,600	33,200	n/a
In community homes[1]	7,900	7,000	6,400	6,100	5,500	n/a
Other looked after children[1]	15,600	13,700	12,400	12,400	12,500	n/a
In day nurseries[2, 3]	30,400	28,800	31,800	29,800	25,700	n/a
In secure units[3]	238	251	244	233	246	279
On child protection registers[3]	38,600	32,500	34,900	35,000	32,400	32,400

1 Excluding agreed series of short term placements.

2 Includes children on LA day nursery registers, and children placed and paid for in private or voluntary day care facilities.

3 Some of these children will be looked after by the local authority and therefore are also included elsewhere in the table.

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Figure 6-1
Running Costs

						£. million	
	1992-93 outturn	**1993-94 outturn**	**1994-95 outturn**	**1995-96 outturn**	**1996-97 outturn**	**1997-98 estimated outturn**	**1998-99 plans[5]**
Department of Health							
Gross running costs:[1]							
Paybill	164	155	151	148	138	141	
Other	162	149	143	141	139	124	
Total	326	304	295	290	277	265	270
Related receipts	16	13	10	12	13	15	14
Net expenditure	310	292	284	278	264	251	256
Gross Running Costs Limit[6]							258
NHS Pensions Agency[2, 4]	10	21	20	17	17	12	15
Medical Devices Agency[2, 4]	10	11	11	9	10	10	10
Running costs by control area:							
Net control areas:							
Medicines Control Agency[2, 3]							
Gross expenditure	13						
Net expenditure	7						
NHS Estates Agency[2]							
Gross expenditure	7	9	7	8	8	10	10
Net expenditure	1	1			#		

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

2 A Next Steps Executive Agency.

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

4 These figures are included in the Department of Health net expenditure figures above.

5 Running costs related receipts from within the running costs provision of other Government departments are now offset against the gross running costs limit.

6 Only the gross running costs limit for 1998-99 is shown as the basis for calculation changes from that year.

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Figure 6-2
Staff Numbers

							Staff-years
1 April31 March	**1992-93 actual**	**1993-94 actual**	**1994-95 actual**	**1995-96 actual**	**1996-97 actual**	**1997-98 estimated outturn**	**1998-99 plans**
Department of Health (Gross Control Area)							
Civil Servants (full-time equivalents)	4,413	4,412	4,325	3,801	4,309	4,087	3,990
Overtime	92	49	42	43	40	40	40
Casuals	211	177	248	239	137	114	100
Total	**4,716**	**4,638**	**4,615**	**4,083**	**4,486**	**4,241**	**4,130**
NHS Estates Agency (Net Control Area)							
Civil Servants (full-time equivalents)	135	105	103	101	138	143	142
Overtime	0	1	1	2	0	0	0
Casuals	3	0	2	1	1	2	0
Total	**138**	**106**	**106**	**104**	**139**	**145**	**142**
Medicines Control Agency							
Civil Servants (full-time equivalents)	322	349	250	356	378	411	465
Total Department of Health	**5,176**	**5,093**	**4,971**	**4,543**	**5,003**	**4,797**	**4,737**

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Figure 6-3
Salaries in the Department of Health for Senior Civil Service Staff in Post at 1 April 1997 divided into £5,000 bands

Payband (per annum)[1]	**No. of Staff**
Less than £40,000	3
£40,000£44,999	29
£45,000£49,999	73
£50,000£54,999	78
£55,000£59,999	101
£60,000£64,999	36
£65,000£69,999	26
£70,000£74,999	17
£75,000£79,999	12
£80,000£84,999	8
£85,000£89,999	4
£90,000£94,999	11
£95,000£99,999	4
Over £100,000	8

1 The figures reflect staff in post at 1 April 1997, but show1 December 1997 salaries (ie after the second stage of the Senior Civil Service pay award) and include reserved rights to London Weighting, London and NHS Geographical and other allowances.

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Figure 6-4
Payment of Bills

Year	Percentage of bills paid within agreed contract period or 30 days
1994-95	91.9%
1995-96	95.2%
1996-97 (Jun 96Mar 97)[1]	92.8%
1997-98 (Apr 97Sept 97)[2]	92.2%

1 The basis of sampling changed in June 1996.

2 Provisional, April to September 1997, subject to confirmation

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Figure 6-5
Recruitment to the Senior Civil Service in Department of Health: Successful Candidates by Sex, Ethnic Origin, and Disability (January 1997 to December 1997)

Male	Female	Ethnic Minorities[1]	Disabled[1]
10	8	0[1]	0[1]

1 Where known

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Figure 6-6
Posts at Former Unified Grade Six and Below: Successful Candidates by Sex, Ethnic Origin, and Disability (January 1997 to December 1997)

Male	Female	Ethnic Minorities[1]	Disabled[1]
115[1]	125[2]	44[3]	11[3]

1 Includes one external fast-stream appointment

2 Includes six external fast-stream appointment

3 Where known

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Figure 6-8
The Appointment of Women and People from Ethnic Minorities to NDPBs, NHS trusts and Health Authorities, as at 30 September 1997

Percentages

	Non Departmental Public Bodies	**NHS trusts and Health Authorities**
Appointments held by:		
women	30.7 (35)[1]	41.1 (43)[2]
members of ethnic minorities	4.9 (5.5)[1]	6.6 (6)[2]

1 NDPBs figures in brackets show targets for the year 2000.

2 NHS bodies figures in brackets show goals for the period ending 30 September 1998.

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Figure H1
Gross Expenditure on Administration for Larger[1] Executive Non Departmental Public Bodies (ENDPBs), 199495 to 199899

£ million

	1994-95	**1995-96**	**1996-97**	**1997-98 (estimated)**	**1998-99 (planned)**
NBSB	1.3	1.3	1.4	1.4	1.4
ENB	10.3	10.2	8.8	7.4	7.7
CCETSW	10.3	8.0	8.3	8.1	7.4
PHLS	4.7	4.7	4.3	3.9	3.8

1 Larger ENDPBs are defined as those which have 25 or more staff and where government grant/grant in aid accounts for more than 50percent of their income or trades mainly with other Government departments.

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Figure J1
Appropriations in Aid

Based on 1998-99 provision

£ thousand

Service	Miscellaneous income mainly goods and services	Revenue from charges	Sale of assets	Capital repayments by NHS trusts	Total
Vote 1					
Hospital, community health, family health (cash limited), related services and NHS trusts	11,650	91,650	214,000	3,260,000	3,577,300
General medical services					0
Drugs	1				1
Dispensing costs					0
Prescription charge income		337,178			337,178
General dental services		388,494			388,494
General ophthalmic services		25			25
Other family health services					0
Rehousing of displaced families					0
Trust debt remuneration					0
NHS contributions	4,993,626				4,993,626
Other					0
Total	5,005,277	817,347	214,000	3,260,000	9,296,624
Vote 2					
Departmental Administration	5,367		152		5,519
NHS Estates Agency	4,790				4,790
NHS Pensions Agency	386				386
Medical Devices Agency	447				447
Youth Treatment Service	5,802				5,802
Non-departmental public bodies and special health authorities	89,850				89,850
Other services including medical, scientific and technical services, grants to voluntary bodies, research and development and information services	1,850				1,850
Welfare food and European Economic area medical costs	20,490				20,490

Personal social services	1,048	255	1,303
Central government grants to local authorities			0
Other			0
Total	130,030	407	130,437

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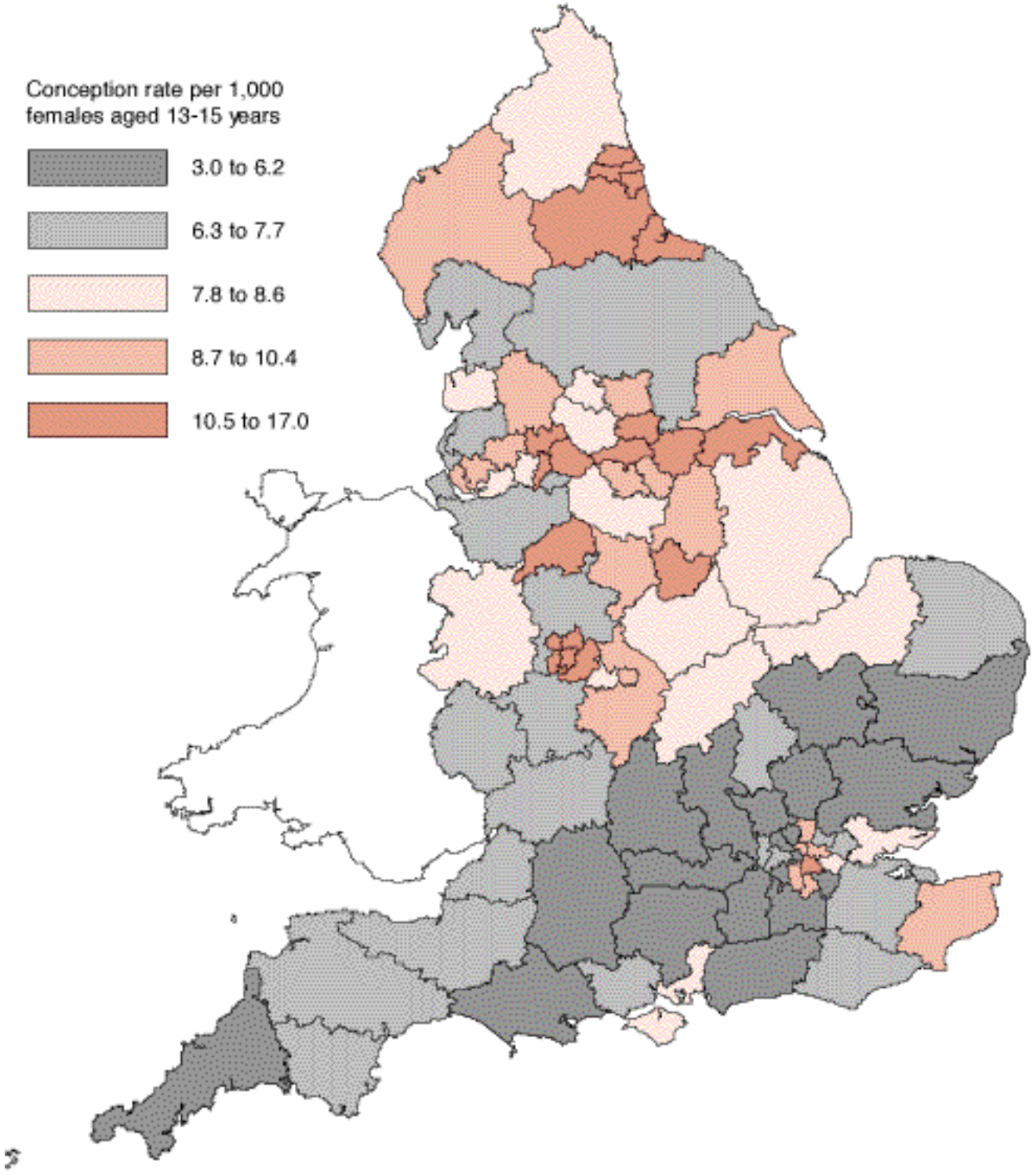
Figure 3-6
Inequalities in Conception Rates Below Age 16, by District Health Authority, 1993-1995



Source: Public Health Common Data Set 1997.

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Figure 4-24
Key Statistics on General Medical Services

	1986-87	1992-93	1993-94	1994-95	1995-96	1996-97	%change 1986-87 to 1996-97	%change 1995-96 to 1996-97
Staffing								
Number of General Medical Practitioners[1]	24,460	25,968	26,289	26,567	26,702	26,855	9.8	0.6
Number of GP practice staff (WTE)[1, 2]	29,441	51,020	53,952	51,833	59,255	59,318	101.5	0.1
Number of WTE practice nurses[1, 2] (included in GP practice staff)	2,501	9,121	9,605	9,099	9,745	9,821	292.7	0.8
Organisation								
Number of practices[1]	n/a	9,101	9,142	9,100	9,062	8,999	n/a	0.7
Average list size at 1 October each year[1]	2,042	1,922	1,902	1,900	1,887	1,885	7.7	0.1
Consultations								
Total number of consultations (millions)[3, 4, 5]	228.82	253.42	260.79	265.59	264.88	270.97	18.4	2.3
Total number of consultations per GMP[3, 4, 5]	9,355	9,759	9,920	9,997	9,920	10,090	7.9	1.7
Expenditure								
Total General Medical Services (£000s)[6]								
Cash limited[7, 8]	n/a	638	650	698	747	785	n/a	5.1
Non-cash limited	1,130	1,768	1,840	1,902	1,965	2,073	83.5	5.5
Total	1,130	2,406	2,490	2,600	2,712	2,858	152.9	5.4
Total General Medical Services per GMP (£ cash)	46,198	92,652	94,716	97,866	101,565	106,423	130.4	4.8
Total General Medical Services per GMP at real terms 1996-97 prices (£)	73,473	102,380	101,706	103,528	104,540	106,423	44.8	1.8
Cash limited expenditure per GMP (£ cash)		24,569	24,725	26,273	27,975	29,231	n/a	4.5
Cash limited expenditure per GMP at real terms 1996-97 prices (£)		27,149	26,550	27,793	28,794	29,231	n/a	1.5
Real terms expenditure per consultation (1996-97 prices)	7.85	10.49	10.25	10.36	10.54	10.55	34.3	0.1

1 Source: GMS Census 1 October. Data refers to unrestricted principals.

2 Decrease in GP practice staff whole time equivalents (WTE) in 1994-95 due to under reporting, primarily by GP fundholders.

3 Source: General Household Survey.

4 Data for 1986-95 is final, data for 1996 is provisional.

5 Consultation data is a three year moving average except 1986-87 and 1996-97 where only two years' data was available.

6 All cash information taken from Appropriation Accounts.

7 Cash limited expenditure commenced 1990-91.

8 GP fundholding IT costs are excluded from GMS cash limit.

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Figure 4-25
Family Health Services Key Statistics on Pharmaceutical Services

		1986-87	1992-93	1993-94	1994-95	1995-96	1996-97	% change 1986-87 to 1996-97	% change 1995-96 to 1996-97
Pharmaceutical Services[1]									
Prescriptions (thousands)[2]		346,497	432,366	455,318	467,793	484,937	498,285	43.8	2.8
Number of contracting pharmacies[3, 4]		9,741	9,763	9,766	9,771	9,787	9,773	0.3	0.1
Average number of prescriptions dispensed by pharmacy and appliance contractors		31,634	39,248	41,290	42,380	43,996	45,329	43.3	3.0
Cost of Pharmaceutical services per prescription (1996-97 prices) (£)[2, 5]	Gross	8.23	8.46	8.62	8.89	8.94	9.14	11.1	2.2
	Drug	6.35	6.78	7.02	7.35	7.44	7.64	20.3	2.7
	Remuneration	1.88	1.68	1.60	1.54	1.50	1.50	20.2	0.0
Cost of drugs and appliances in real terms (1996-97 prices) (£m)[2, 6]		2,191	2,919	3,168	3,417	3,601	3,774	72.3	4.8
Percentage of prescriptions chargeable[7]		23.6	19.0	17.9	17.3	16.2	14.4	39.0	11.1

1 Pharmaceutical services are mainly the supply of the proper and sufficient drugs, medicines and listed appliances which are prescribed by general practitioners.

2 Numbers relate to prescription fees; figures include prescriptions dispensed by chemists, appliance contractors, dispensing doctors and personal administration.

3 Excludes appliance contractors and dispensing doctors.

4 From 1992-93 figures are shown as at 31 March (eg. 1992-93 is a number as at 31 March 1993). Figures for earlier years refer to 31December.

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

6 Includes receipts under the Pharmaceutical Price Regulation Scheme.

7 Chargeable prescriptions based on a calendar year and including items dispensed to holders of prescription prepayment certificates. Theanalysis is based on a 1 in 20 sample of all prescriptions submitted to the Prescription Pricing Authority by community pharmacists and appliance contractors.

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Figure 4-26
Family Health Services Key Statistics on General Dental Services

General Dental Services[1]	1986-87	1992-93	1993-94	1994-95	1995-96	1996-97	% change 1986-87 to 1996-97	% change 1995-96 to 1996-97
Number of general dental practitioners (GDP)[2]	14,516	15,411	15,773	15,885	15,951	16,336	12.5	2.4
Adult courses of treatment (thousands)	21,962	25,141	24,848	24,913	24,752	24,580	11.9	0.7
Adult courses of treatment per GDP[2]	1,513	1,631	1,575	1,568	1,552	1,505	0.5	3.0
Children registered into capitation (thousands)[3, 4]	n/a	7,103	7,396	7,367	7,292	7,270	n/a	0.3
Children registered per GDP[4,5]	n/a	461	469	464	457	445	n/a	2.7
Average gross cost of adult courses of treatment								
in real terms (1996-97 prices) (£)[6]	43.11	43.22	38.85	39.68	38.65	37.98	-11.9	-1.7

1 General Dental Services are the care and treatment provided by independent high street dentists who provide services under arrangements made with the local Health Authorities.

2 Principals, assistants and vocational trainees at 30 September.

3 Number of children registered as at 30 September. Capitation registrations only began with the introduction of the new dental contract from 1 October 1990.

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

5 Average number of children registered per dentist, including principals and assistants at 30 September, although patient registrations are formally attributed to principals only.

6 From 1992-93 onwards, costs are based on items of service fees payable and adult continuing care payments. For 1986-87, the cost covers items of service fees only.

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Figure 4-27
Family Health Services Key Statistics on General Ophthalmic Services

General Ophthalmic Services	1990-91	1992-93	1993-94	1994-95	1995-96	1996-97	% change 1990-91 to 1996-97	% change 1995-96 to [2] 1996-97
NHS Sight Tests (thousands)[1]	4,154	5,528	5,935	6,383	6,512	6,808	64.0	4.5
Optical vouchers (thousands)[3]	2,432	3,185	3,485	3,741	3,815	3,967	63.1	4.0
Number of opticians[4]	6,431	6,601	6,619	6,622	6,778	6,939	7.9	2.4

1 Figures show the number of sight tests paid for by FHSAs/HAs in the year.

2 Because eligibility for sight tests was restricted to certain priority groups from 1 April 1989 meaningful comparisons can only be made back to 1990-91.

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

4 Optometrists and Ophthalmic Medical Practitioners at 31 December.

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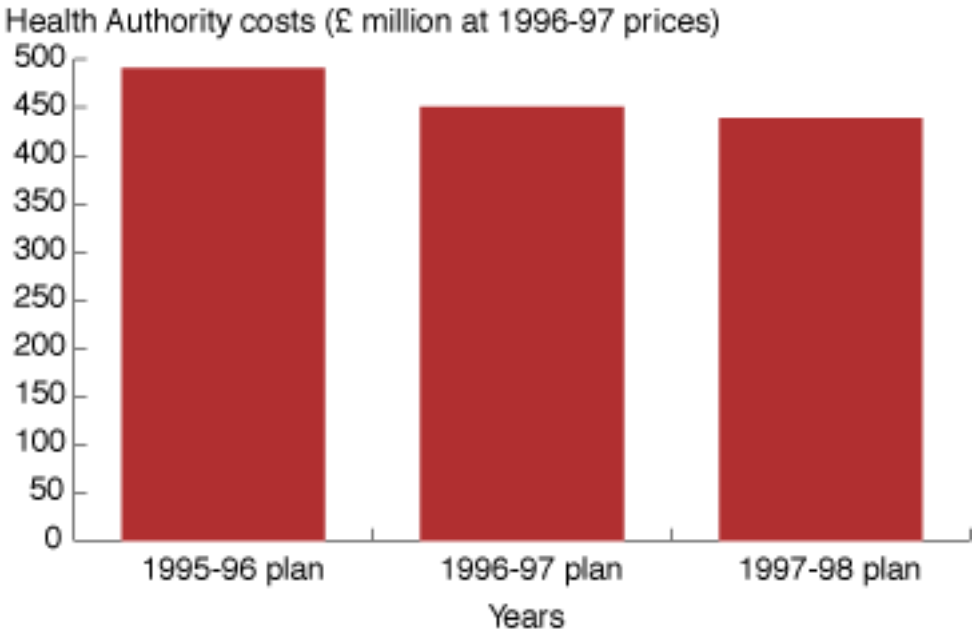
Figure 4-28
Health Authority Costs[1] (plan on plan) in real terms, 1995-96 to 1997-98



1 HA costs are shown at 1996-97 prices using the 1996-97 definition (the definition changed slightly in 1997-98). Consequently, actual targets set will vary slightly from the figures shown.

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Figure 4-30
HCHS Cost Weighted Activity Index

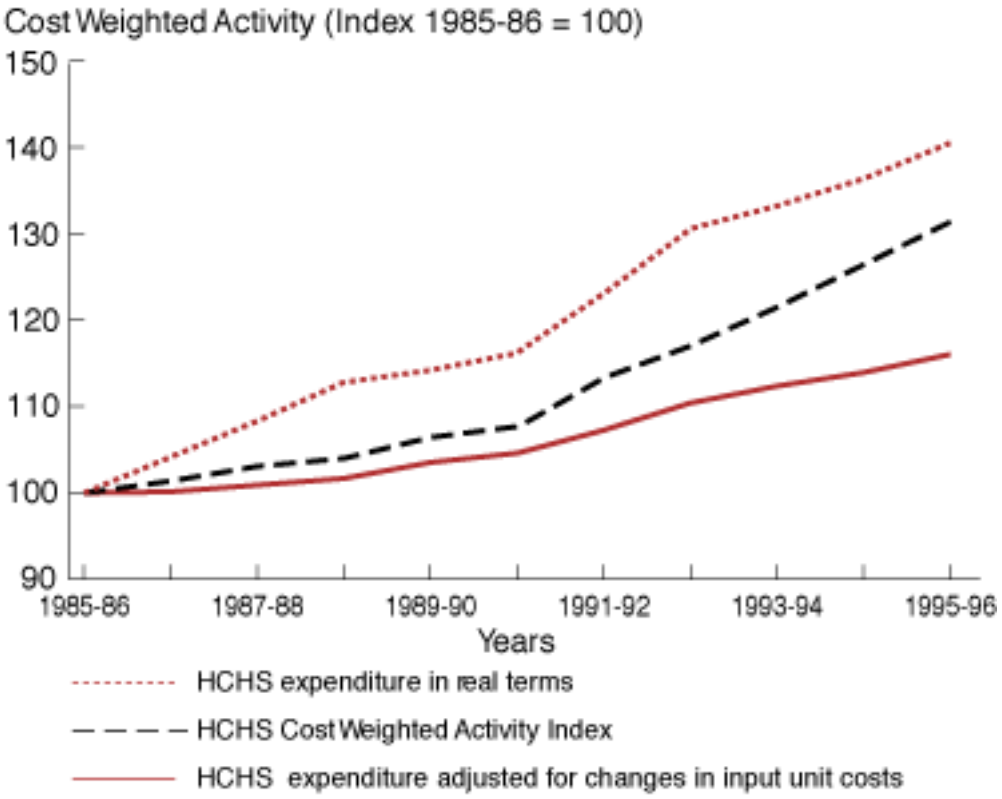

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Figure 4-31
Average Unit Costs by Category of Care, 1985-86 to 1995-96

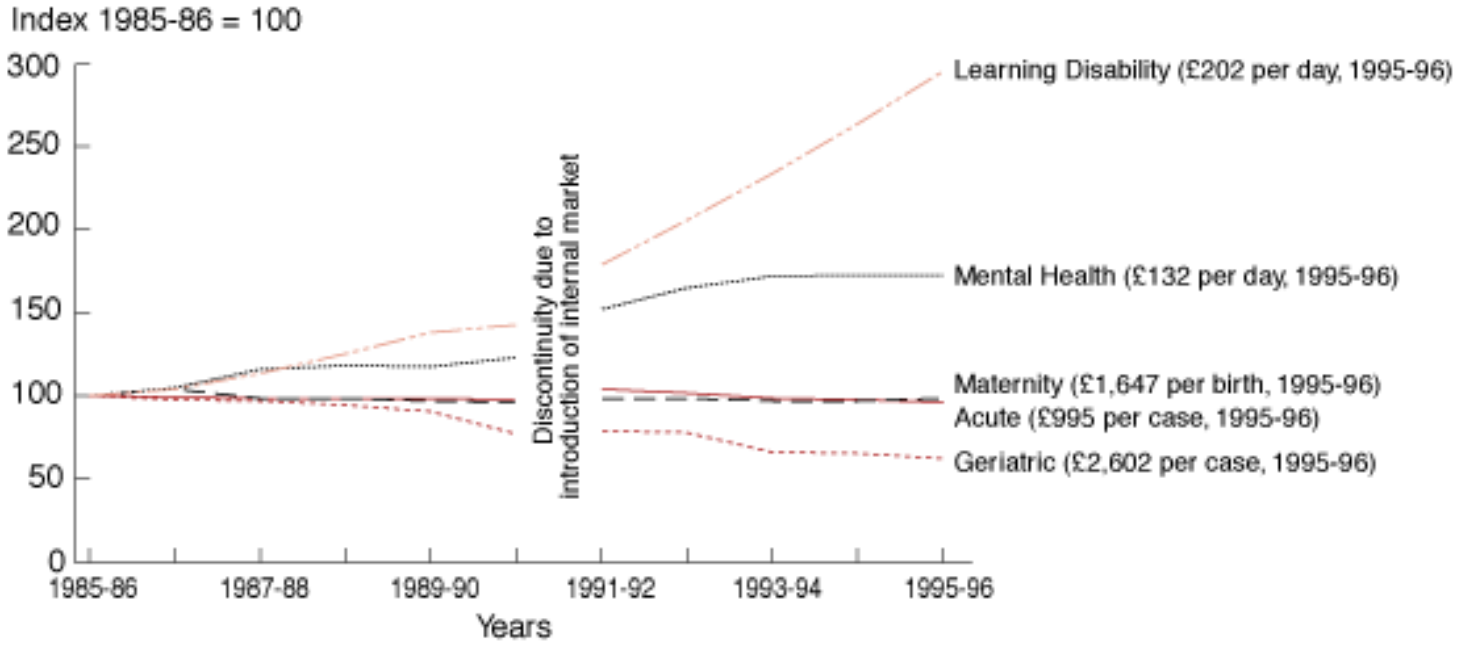

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Figure 4-32
Health Service Activity

Finished Consultant Episodes (thousands)

	1986[1]	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	Annual average % change 1986 to 1996-97	% change 1995-96 to 1996-97
Ordinary admissions[2]									
General and acute[3]	5,429	5,913	5,987	6,127	6,210	6,396	6,408	1.7	0.2
Geriatric	390	508	527	554	548	553	544	3.4	1.6
Maternity[4]	874	950	943	970	974	1,119	1,112	2.4	0.7
All specialties[5]	7,132	7,755	7,828	7,988	8,065	8,379	8,381	1.6	0.0
Day cases									
General and acute[3]	1,020	1,535	1,785	2,080	2,439	2,813	2,919	11.1	3.8
All specialties[5]	1,050	1,547	1,808	2,106	2,474	2,845	2,958	10.9	4.0
All finished consultant episodes									
General and acute[3]	6,449	7,448	7,772	8,207	8,649	9,209	9,327	3.8	1.3
All specialties[5]	8,182	9,302	9,635	10,094	10,539	11,224	11,339	3.3	1.0
New outpatients (first attendances)									
New outpatients[6]	8,768	8,942	9,342	9,683	10,363	10,989	11,298	2.6	2.8
General and acute[3]	7,835	8,036	8,488	8,832	9,513	10,128	10,419	2.9	2.9
Geriatric	59	70	77	83	94	101	108	6.3	6.3
Maternity[7]	728	684	612	600	588	585	588	2.1	0.6
Mental health	202	218	238	245	257	271	285	3.5	5.1
Learning disabilities	3	3	4	5	5	5	6	6.6	1.6
New A & E (first attenders)	10,532	11,035	10,993	11,365	11,943	12,404	12,439	1.7	0.3
Ward attenders[6]	n/a	1,008	1,029	985	980	1,013	1,027	3.2	1.4
Average length of episode (ordinary admissions) days[8]									
General and acute[3]	11.7	7.7	7.2	6.9	6.7	6.5	6.3	5.9	3.1
Geriatrics	44.8	26.8	23.5	21.2	19.8	19.2	18.6	8.2	3.1

1 The figures for 1986 are estimates based on 1986 discharges and deaths adjusted using 1988-89 data where information was collected for both discharges and deaths and finished consultant episodes.

2 The method of data collection was revised for well babies in 1995-96.

3 General and acute is the sum of geriatric and acute.

4 The maternity sector includes delivery episodes and birth episodes not resulting in well babies.

5 Well babies are included.

6 From April 1992 patients seen by medical staff on a ward are recorded as outpatients rather than ward attenders. No data is available for ward attenders for 1986: the average annual percentage change is based on 1987 to 1996-97.

7 Obstetrics and GP Maternity outpatient attendances.

8 Figures for 1986 are average length of stay for discharges and deaths (source: SH3). All figures exclude well babies. 1996-97 data are derived from provisional ungrossed Hospital Episode Statistics.

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Figure 4-33
Community Health and Cross-Sector Services Activity Statistics[1]

thousands

Number of episodes[2, 3]	**1988-89**	**1989-90**	**1990-91**	**1991-92**	**1992-93**	**1993-94**	**1994-95**	**1995-96**	**1996-97**
Health visiting	4,100	3,900	3,600	3,700	3,700	3,700	3,700	3,700	3,700
Community nursing services (total)	2,800	2,800	2,600	2,700	2,800	2,800	2,900	3,000	3,000
District nursing	2,400	2,300	2,100	2,200	2,200	2,200	2,300	2,300	2,300
Community psychiatric nursing	230	240	250	270	300	340	360	380	380
Community learning disability nursing	21	21	21	21	21	22	23	24	26
Specialist care nursing	196	200	190	220	270	270	250[4]	280	280
Chiropody services	880	920	910	940	970	1,010	980	950	980
Clinical psychology	150	150	140	150	160	170	180	190	200
Occupational therapy	770	750	740	840	880	940	1,020	1,100	1,130
Physiotherapy	3,100	3,200	3,200	3,300	3,400	3,500	3,900	4,100	4,100
Speech therapy	240	230	240	250	270	290	300	300	320
Community dental services[5]	n/a[6]	n/a[6]	1,155	1,186	1,214	1,156	1,156	1,103	1,085

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

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

3 Estimated national totals based on those NHS trusts and districts supplying data.

4 The range of staff groups included under specialist care nursing changed in 1994-95.

5 Includes a small number of discontinued episodes of care.

6 Not collected on a comparable basis.

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Figure 4-34
Financial Performance of NHS Trusts, 1996-97

Duties achieved	Number of trusts achieving duty	% of trusts achieving duty	% failing due to technicalities or immateriality	% failing for non-technical reasons
All 3 duties	155	36.1	28.7	n/a
Required return	208	48.5	20.5	31.0
Break-even on income and expenditure	292	68.1	11.4	20.5
EFL	412	96.0	2.3	1.7

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Figure 4-35
NHS Hospital and Community Health Services (HCHS) Staff by Main Staff Groups

England as at 30 September 1996	**whole-time equivalents**
All directly employed staff	**763,800**
Nursing, midwifery and health visiting staff (including learners)	335,300
Scientific, therapeutic and technical staff	99,000
Healthcare Assistants	16,800
Medical and dental staff	56,800
Support staff	70,100
Administration and estates staff	167,400
Ambulance staff	15,100
Other staff	3,200

1 Totals may not add to the sum of their components because of rounding.

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