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
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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.

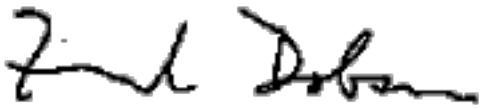
We are promoting better joint working between social services, hospitals, primary and community care so that services are moulded to meet the needs of local people and not the other way round. The close and effective joint working that coped so well during the winter was brilliantly successful and a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

on this site.

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.

on this site.

ANNEX C

National Health Service, United Kingdom by Area of Expenditure

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

							£ million
	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 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

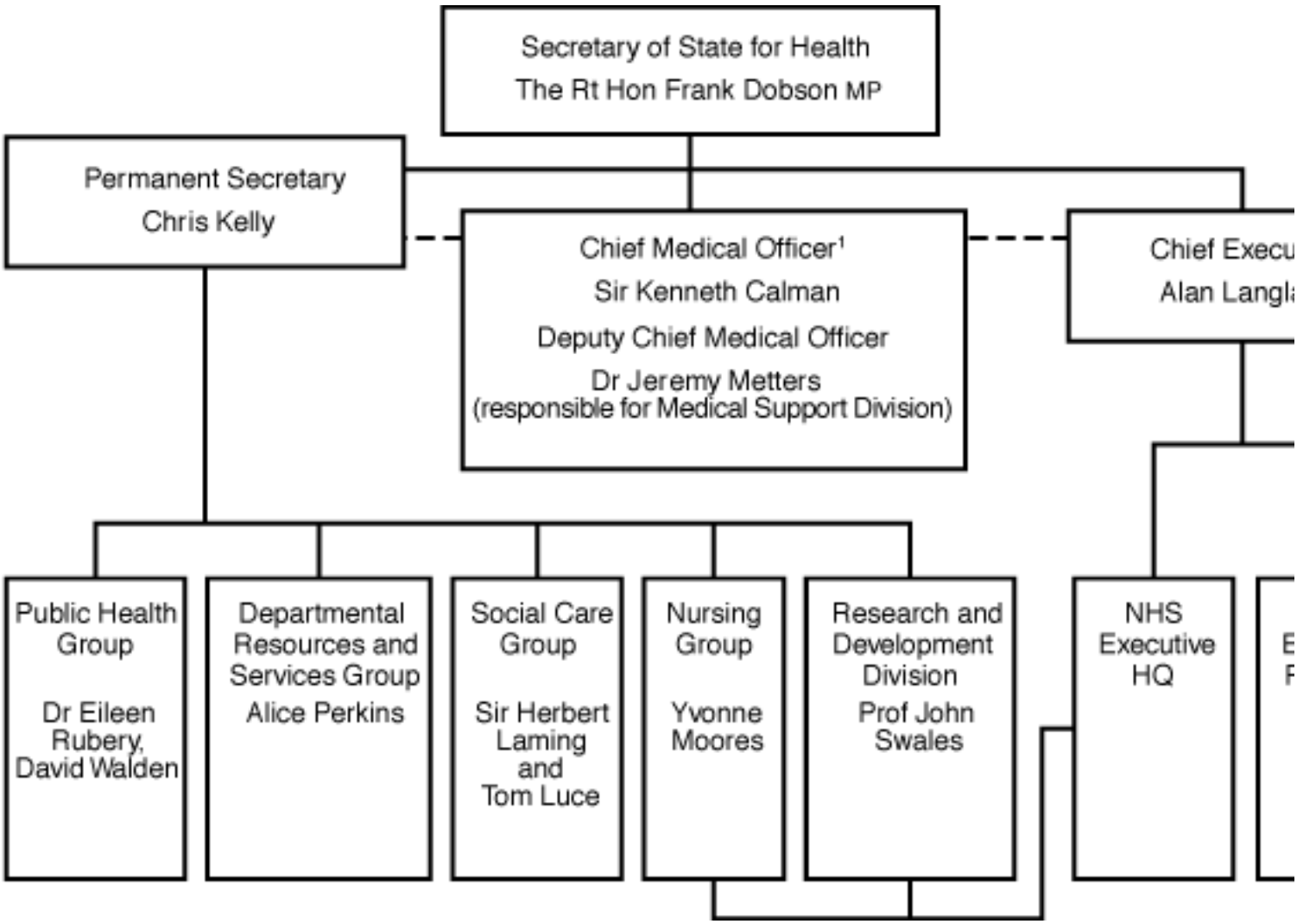
D.4 *Responsibility for:* Blood; Transplants; Cancer; Emergency services; Maternity and child health; Quality; Medicines (including licensing); Medical devices (including licensing); Pharmaceutical industry (including Pharmaceutical Price Regulation Scheme); Emergency Preparedness; All Lords Parliamentary 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



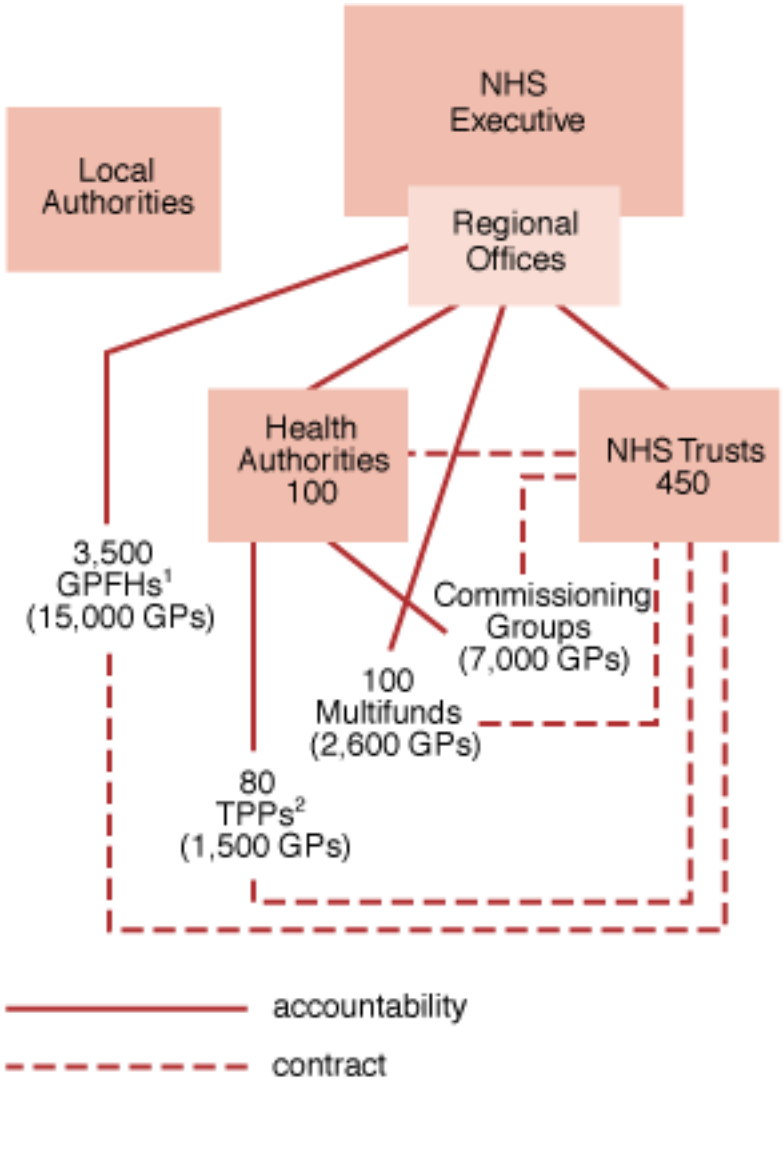
1 The Chief Medical Officer provides medical advice to the whole Department.

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

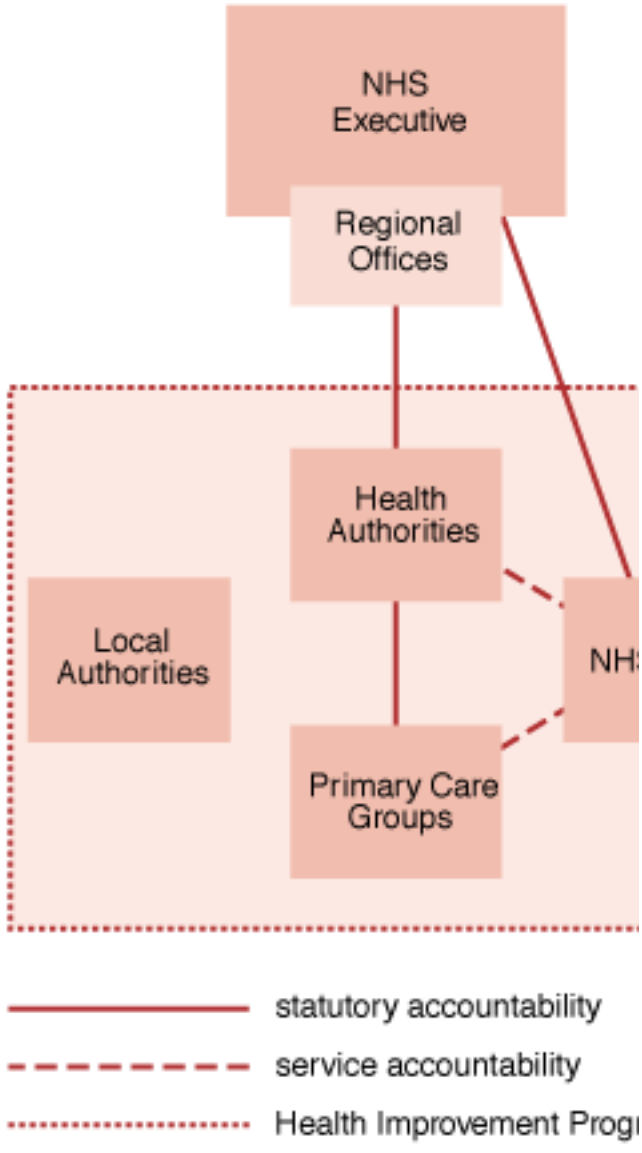
ANNEX F

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 provision for 1998-99**	**To be 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**

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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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Contents

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]

						£ million
	1992-93 outturn	**1993-94 outturn**	**1994-95 outturn**	**1995-96 outturn**	**1996-97 outturn**	**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 on this site.

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)

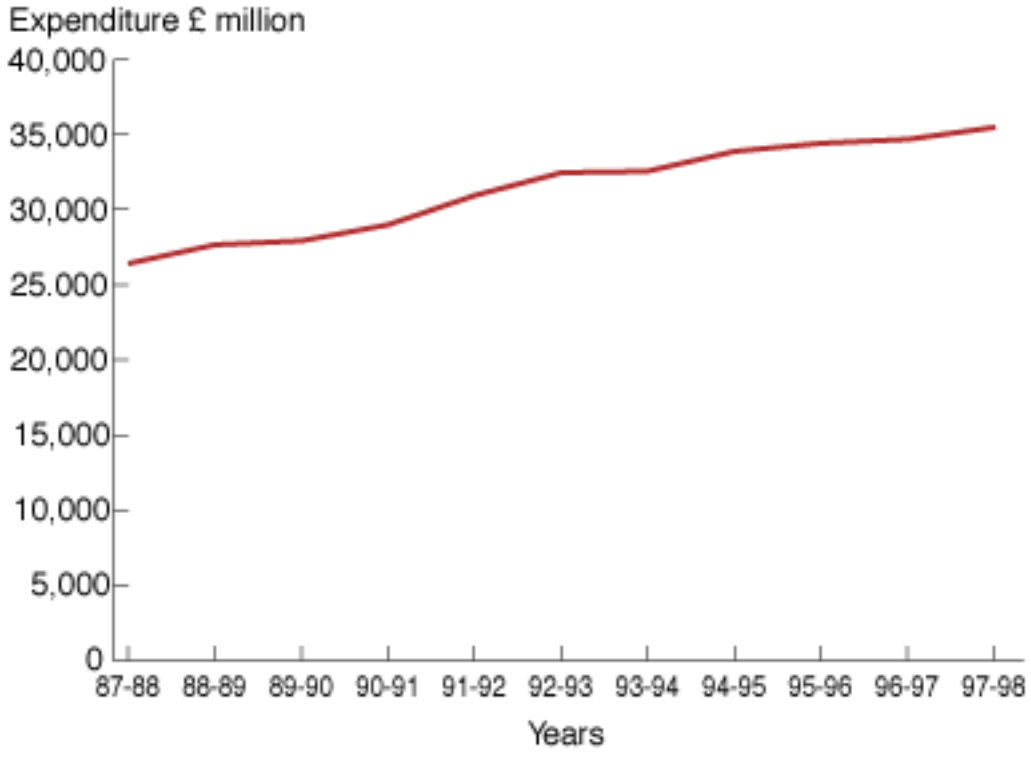

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Figure 2.5
NHS Gross Expenditure, 1997-98 (Estimated Outturn)

Total £36,438 million

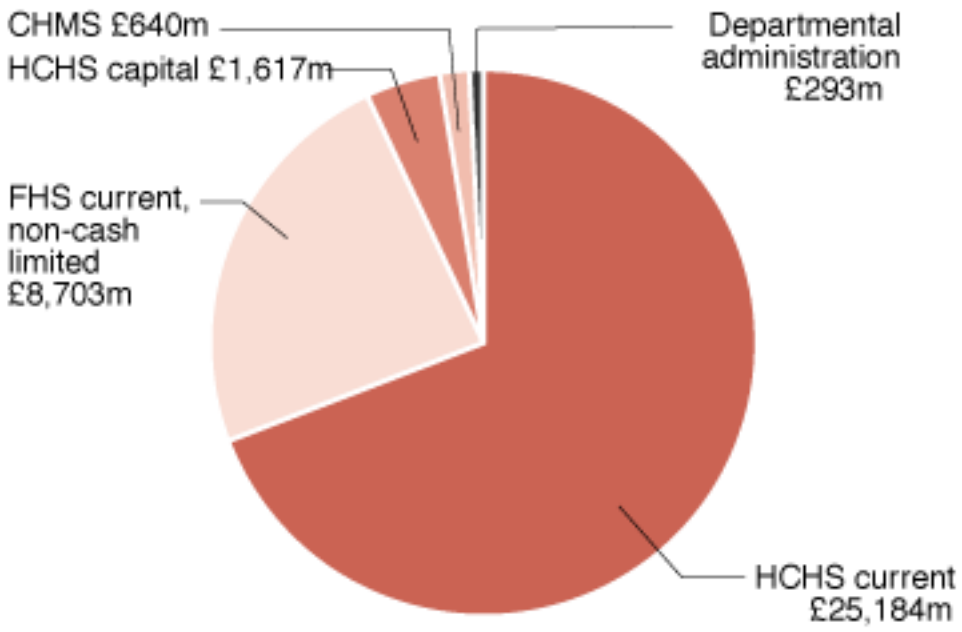

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Figure 2.6
NHS Sources of Finance, 1996-97

Total £36,330 million

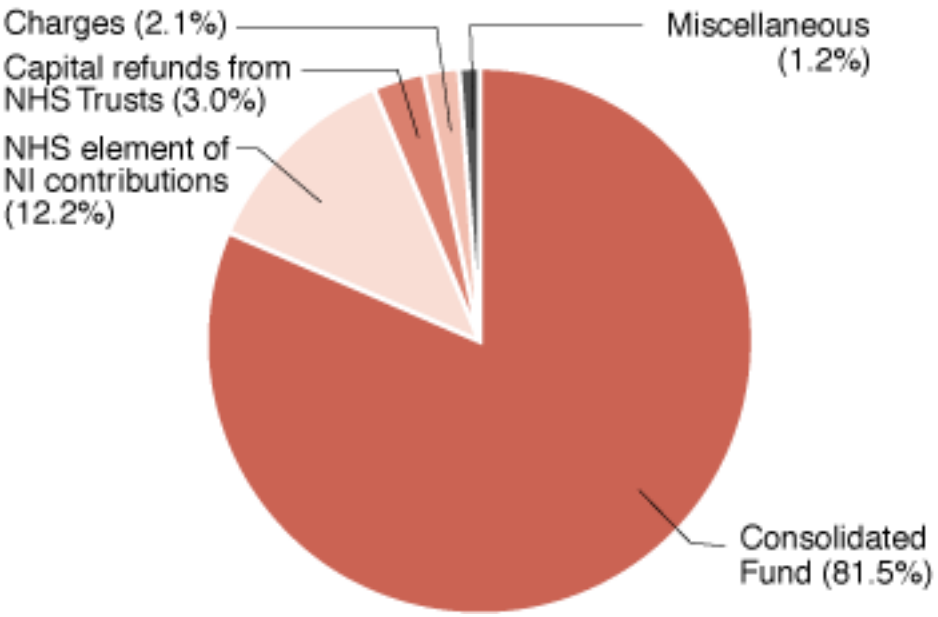

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Figure 2.7
NHS Sources of Finance[1]

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

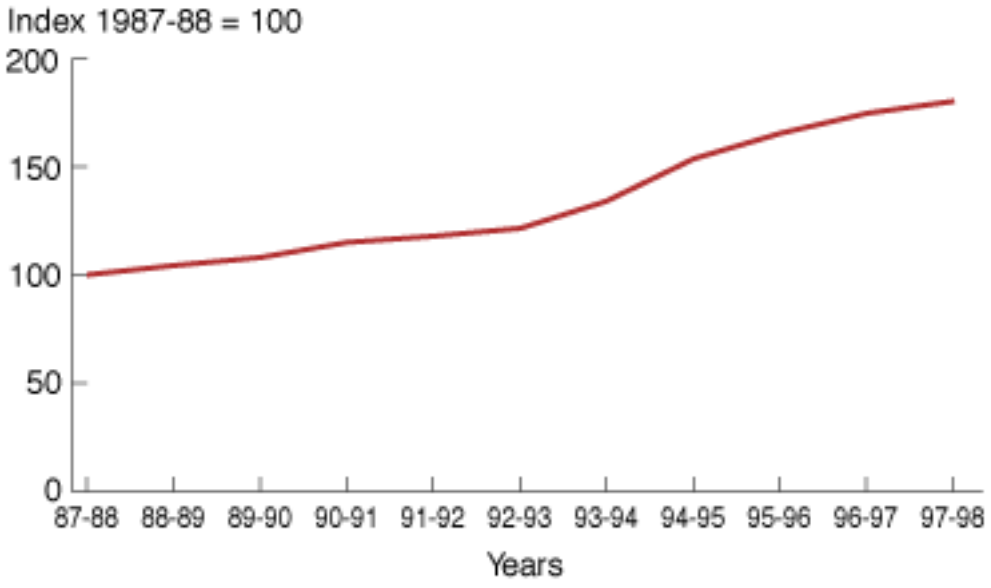

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Figure 3-1
Central Health and Miscellaneous Services Gross Expenditure, 1997-98 (Estimate)

Total £619 million

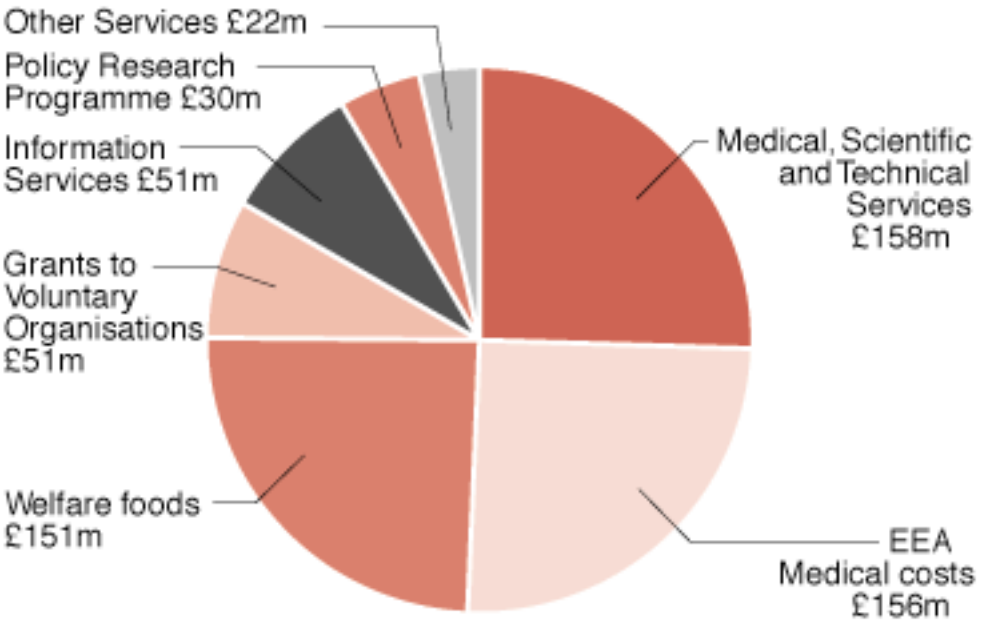

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Figure 6-7
Departmental Spending on Publicity and Advertising, 199798

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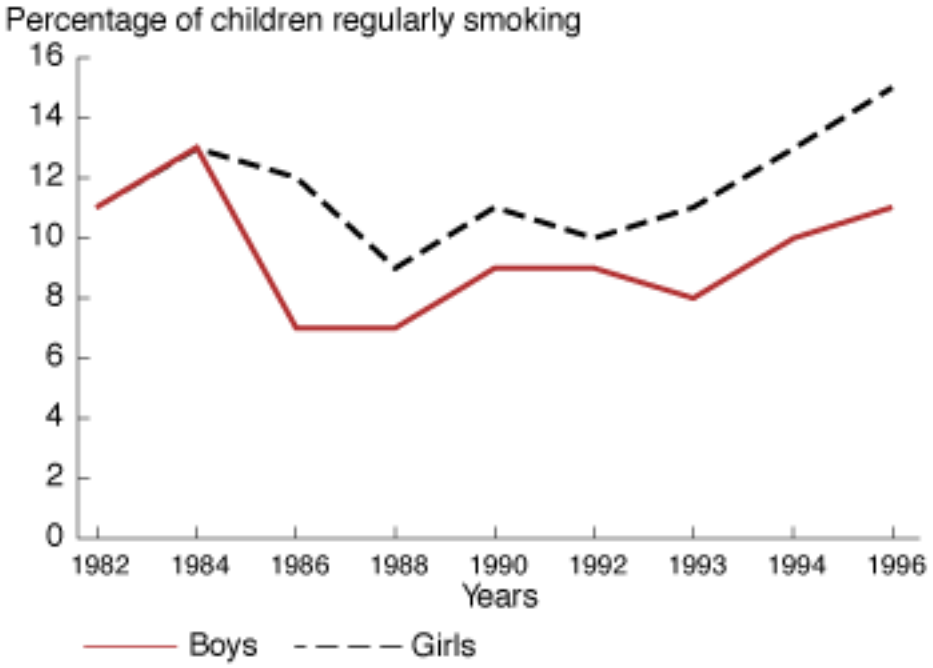
Figure 3-2
Prevalence of Regular Cigarette Smoking in Children Aged 11-15 Years, by Sex, England 1982-1996



Source: ONS smoking among secondary school children survey.

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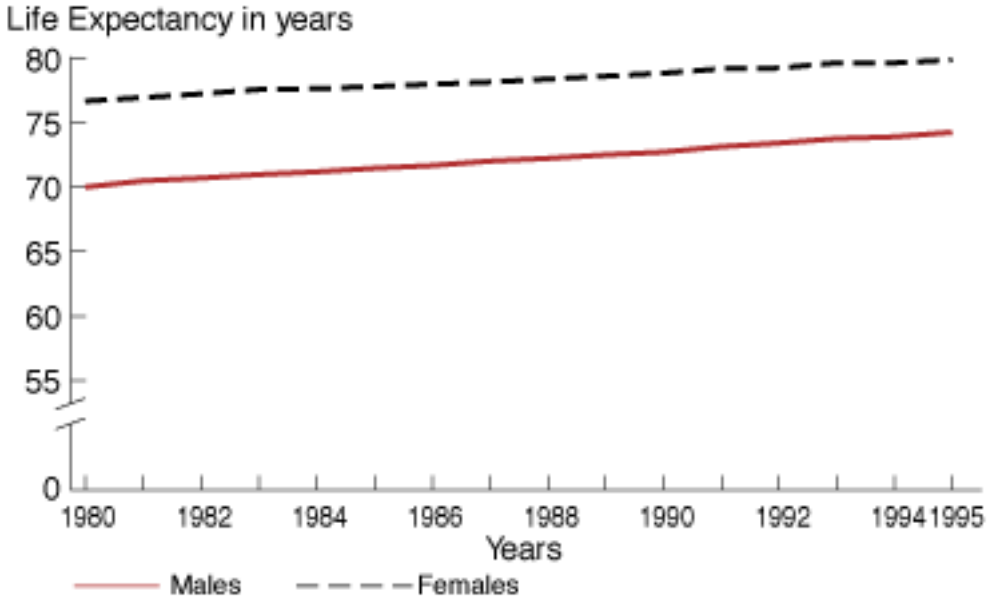
Figure 3-4
Life Expectancy at Birth in England, 1979-1996[1]



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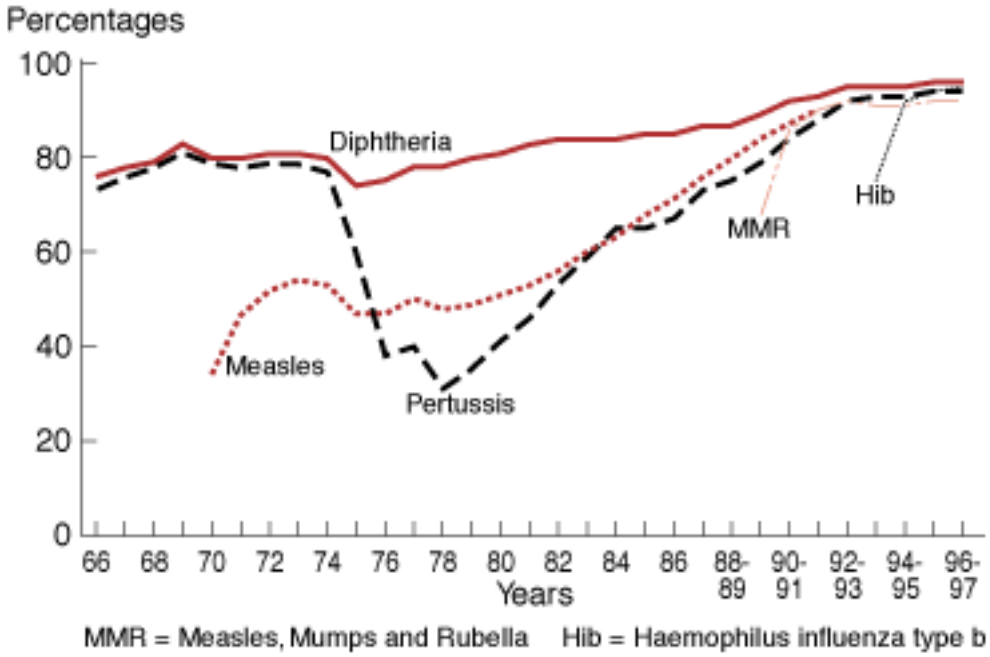
Figure 3-5
Immunisation: Percentage of Children Completing Selected Immunisations by their Second Birthday, England, 1966 1996-97



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

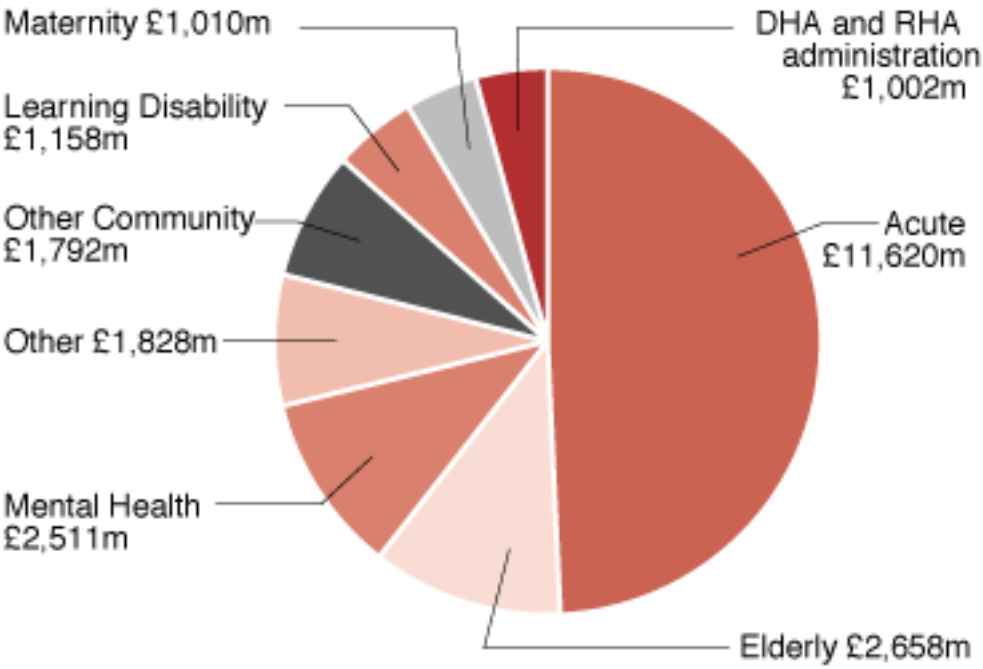

Figure 4-2
Hospital and Community Health Services Gross Current Expenditure by Age, 1995-96 (estimate)

Total £23,579 million

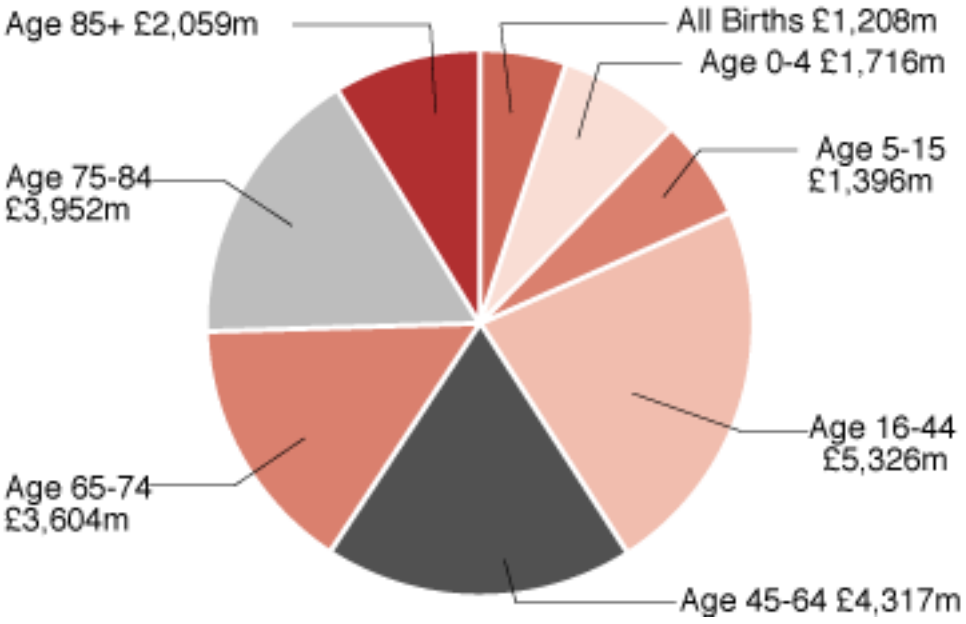

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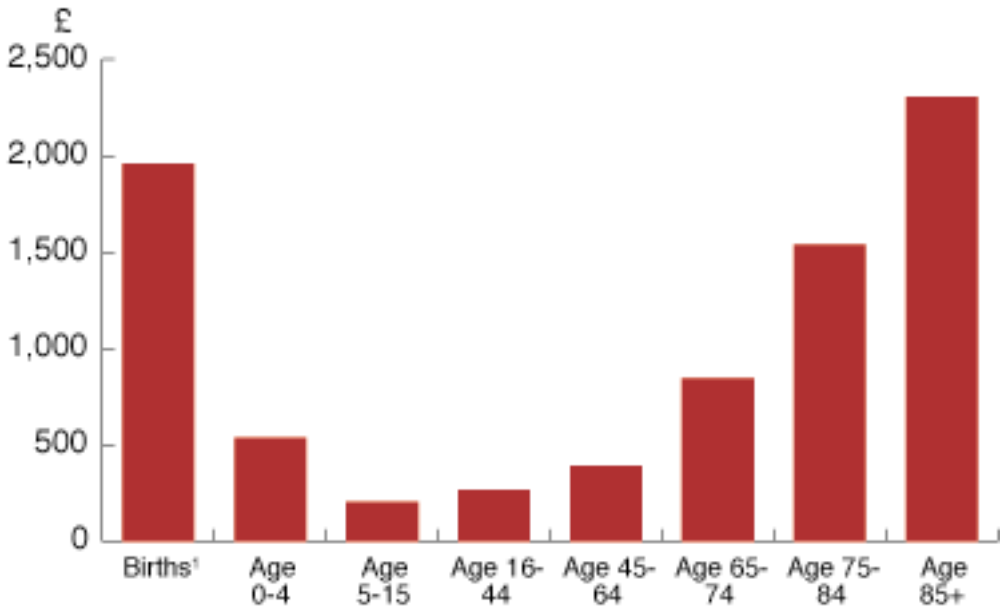
Figure 4-3
Hospital and Community Health Services Gross Current Expenditure Per Head, 1995-96 (estimate)



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

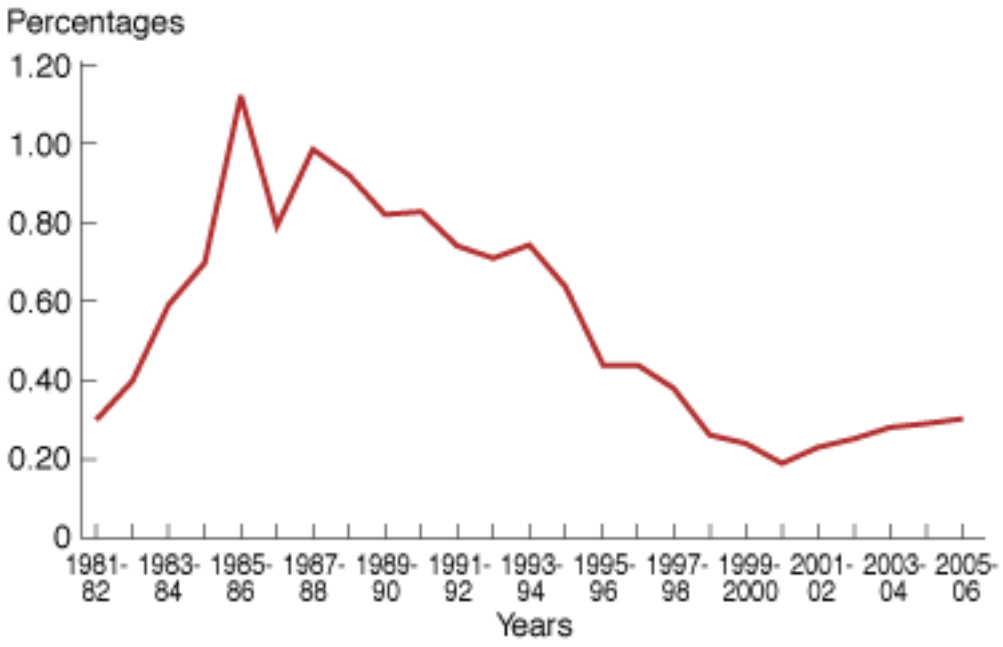

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Figure 4-5
Distribution of HCHS Resources, 1998-99

	£ 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

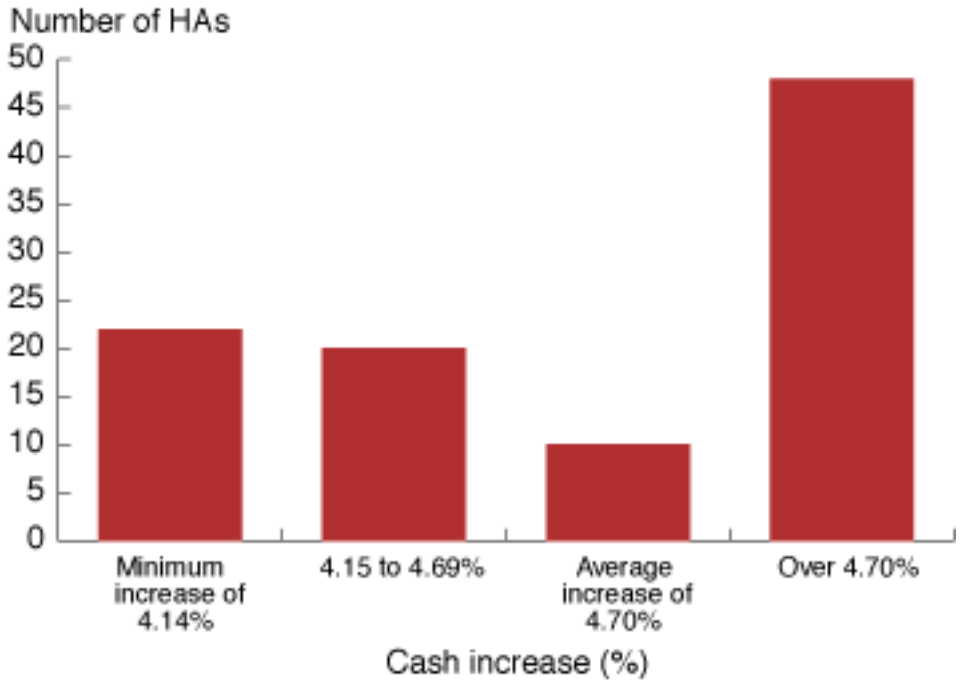

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Figure 4-10
Health Authorities' Distance from Target (DFT), 1997-98 and 1998-99

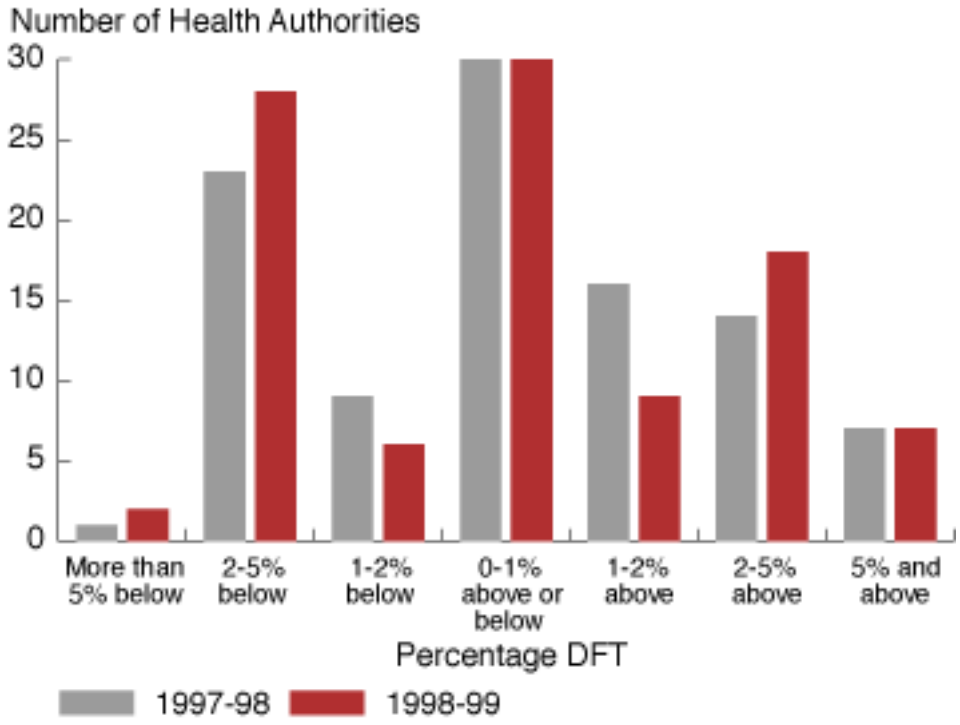

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Figure 4-11
NHS Capital Spending, 1997-98 and 1998-99

		£ 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

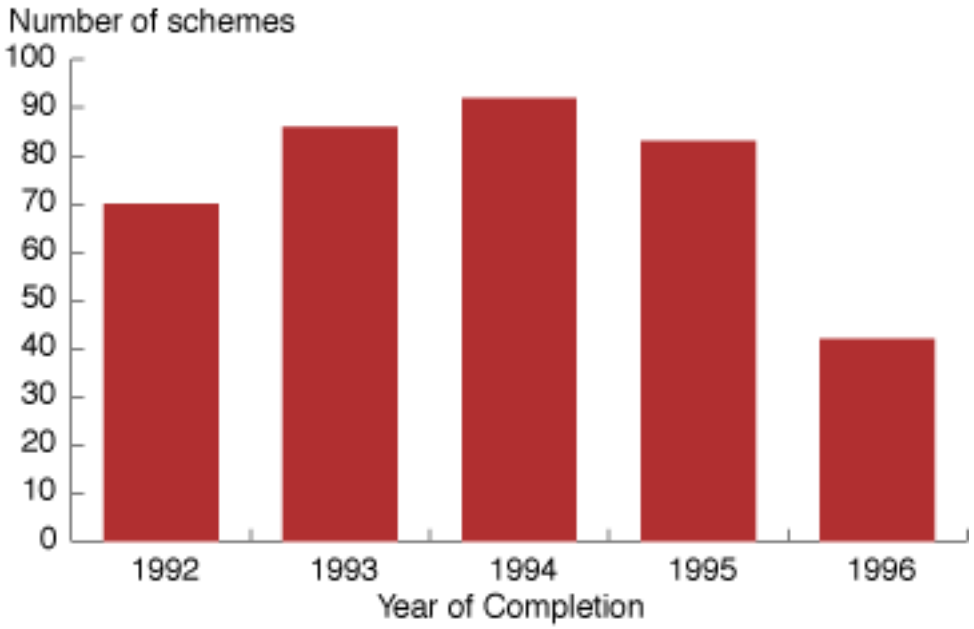

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Figure 4-15
NHS Backlog Maintenance Costs, 1992-93 to 1996-97

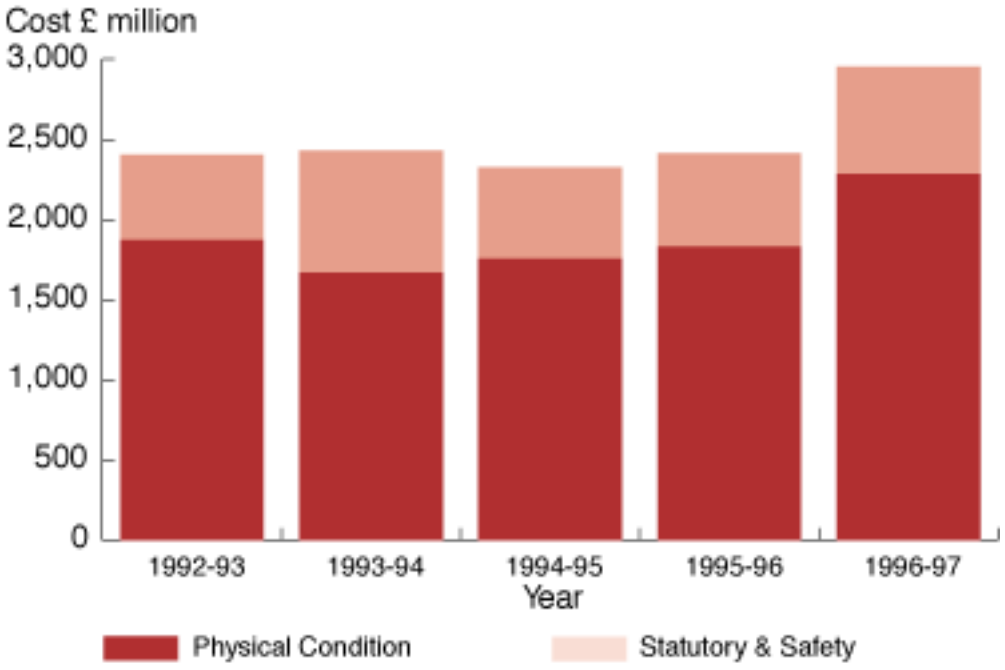

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Figure 4.16
Projects Involving Private Finance

		£ 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

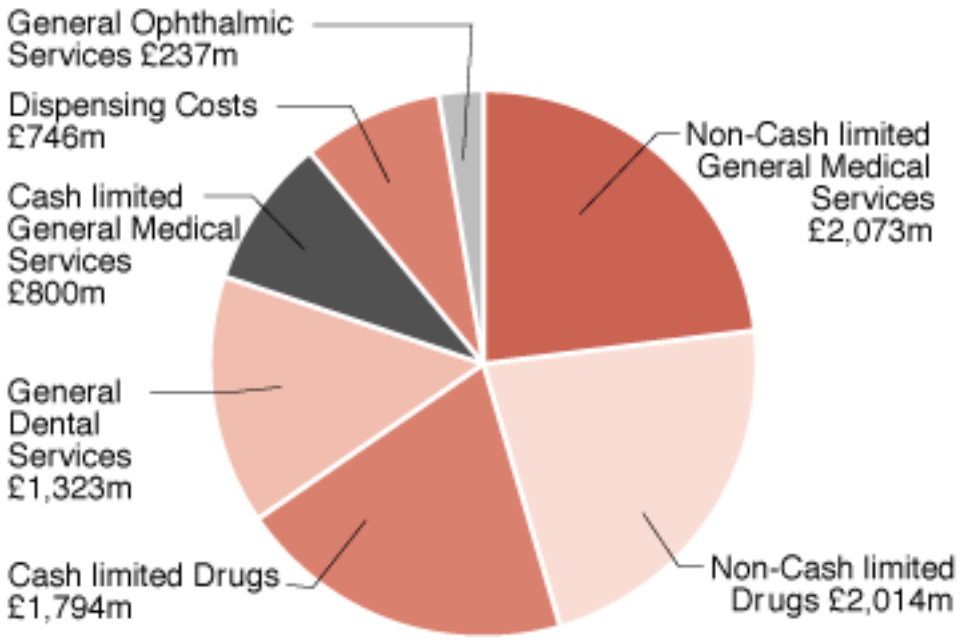

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Figure 4-18
Family Health Services Drugs Bill (Cash), 1987-88 to 1996-97

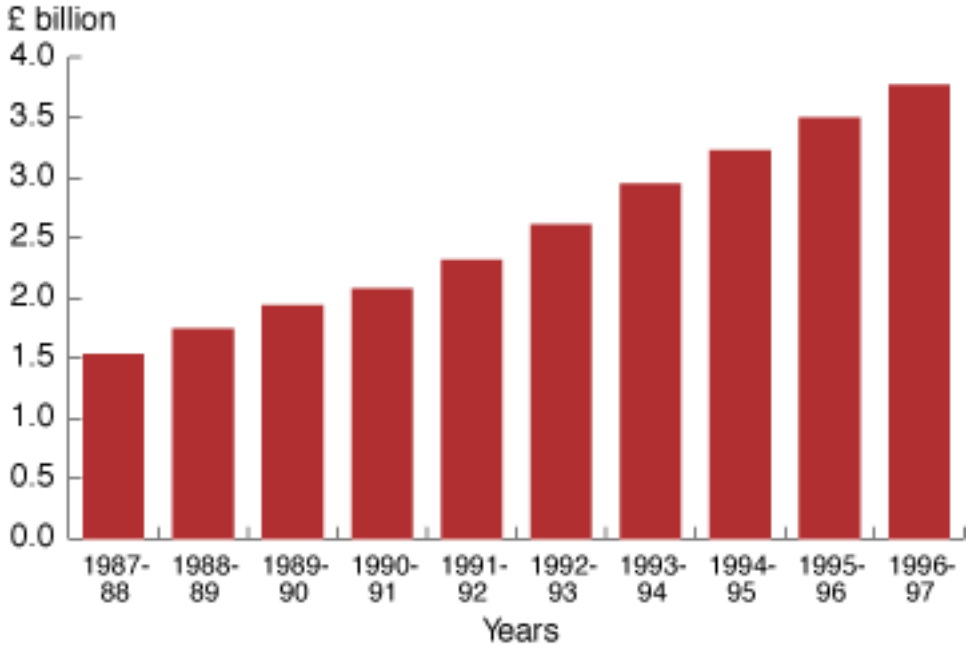

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Figure 4-19
Family Health Services Drugs Bill Percentage Growth (Cash), 1987-88 to 1996-97

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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

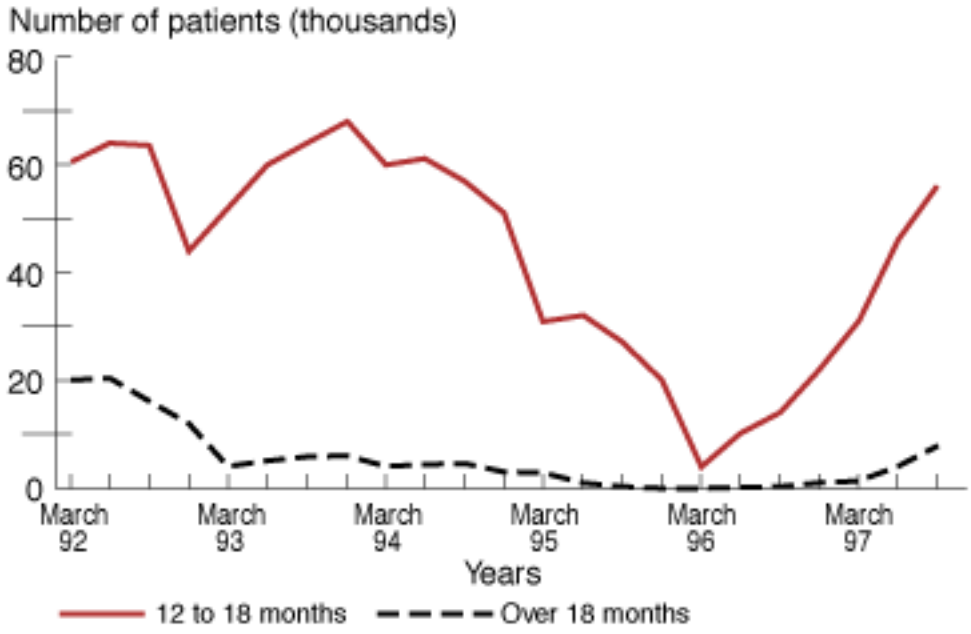

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Figure 4-22
Average Waiting Times, 1992 to 1997

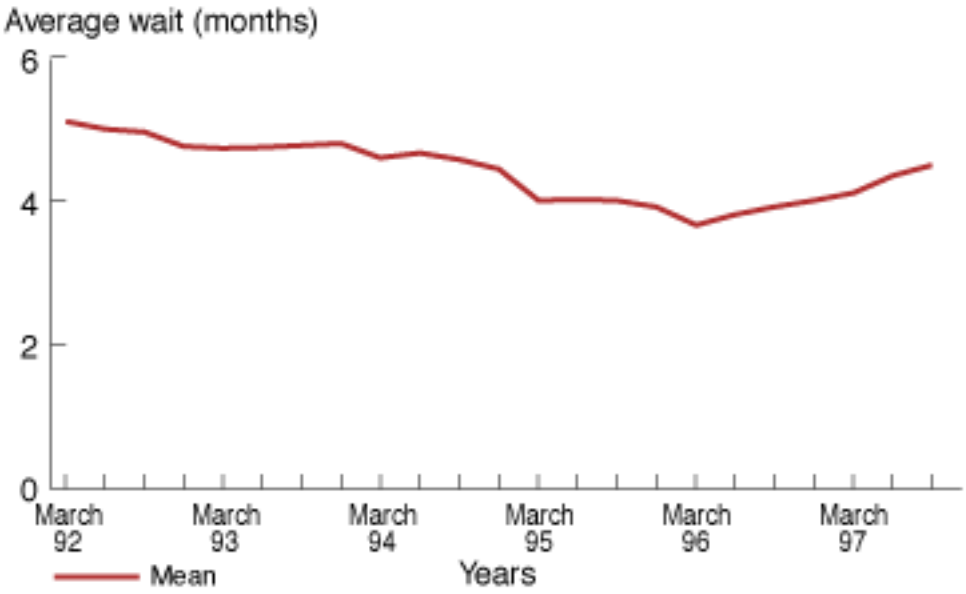

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Figure 4-23
Emergency Calls Resulting in an Ambulance Arriving on Scene, England, 1992-93 to 1996-97

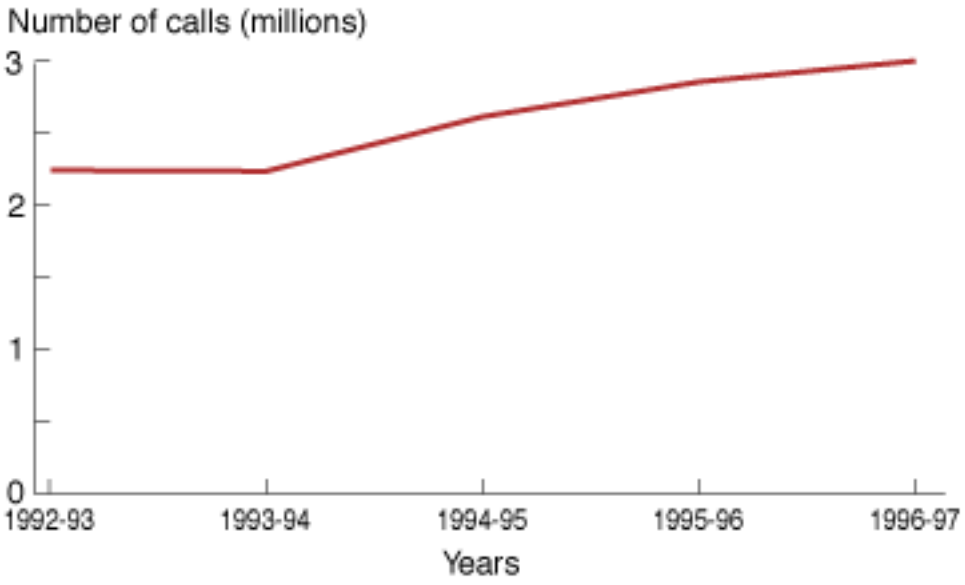

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Figure 5-2
Client Group Related Personal Social Services Gross and Net Expenditure, 1995-96

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

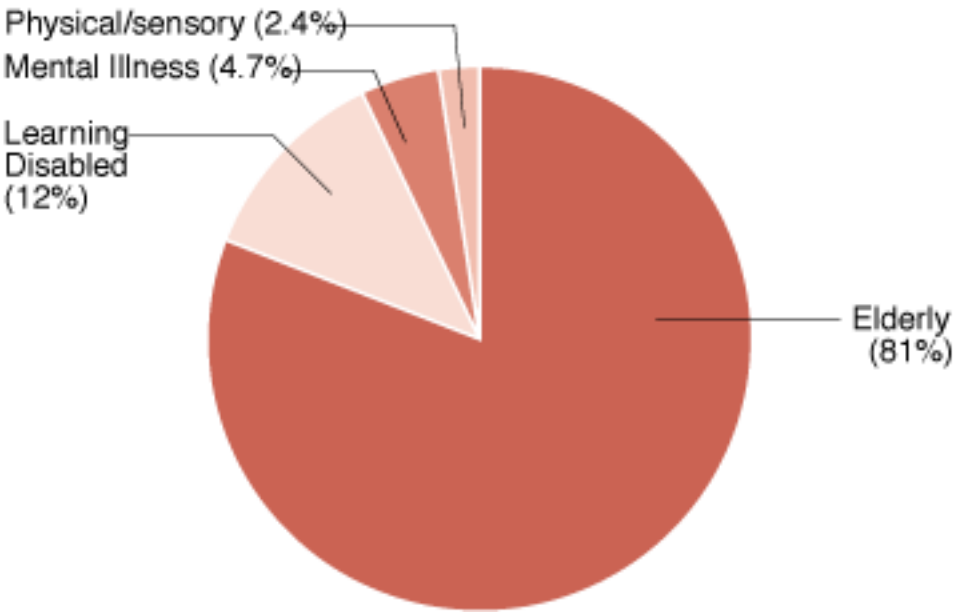

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Figure 5-6
Local Authority Funded Day Care Centre Places by Client Group, 199697

Total = 601,900 places

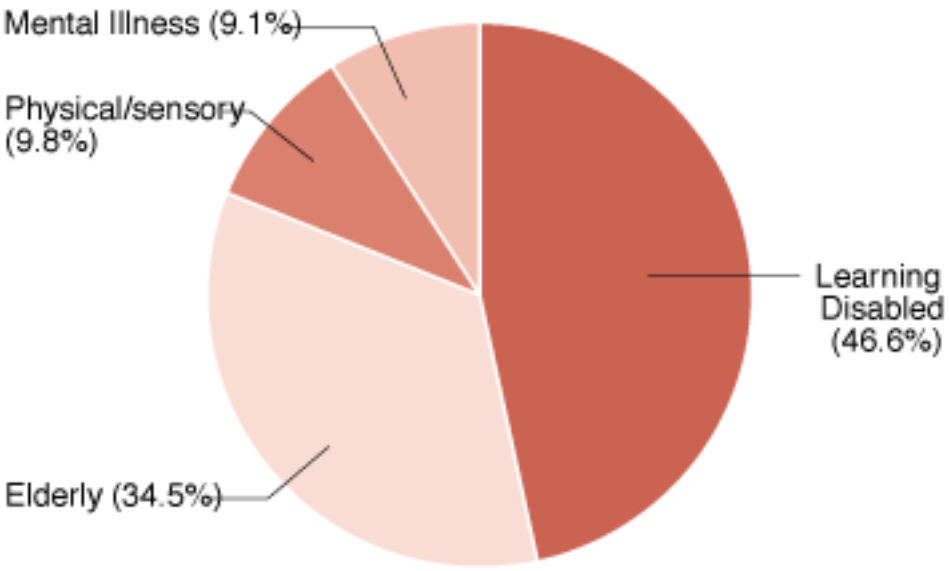

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Figure 5-7
Residential Places by Type of Accommodation, 1990-91 to 1996-97

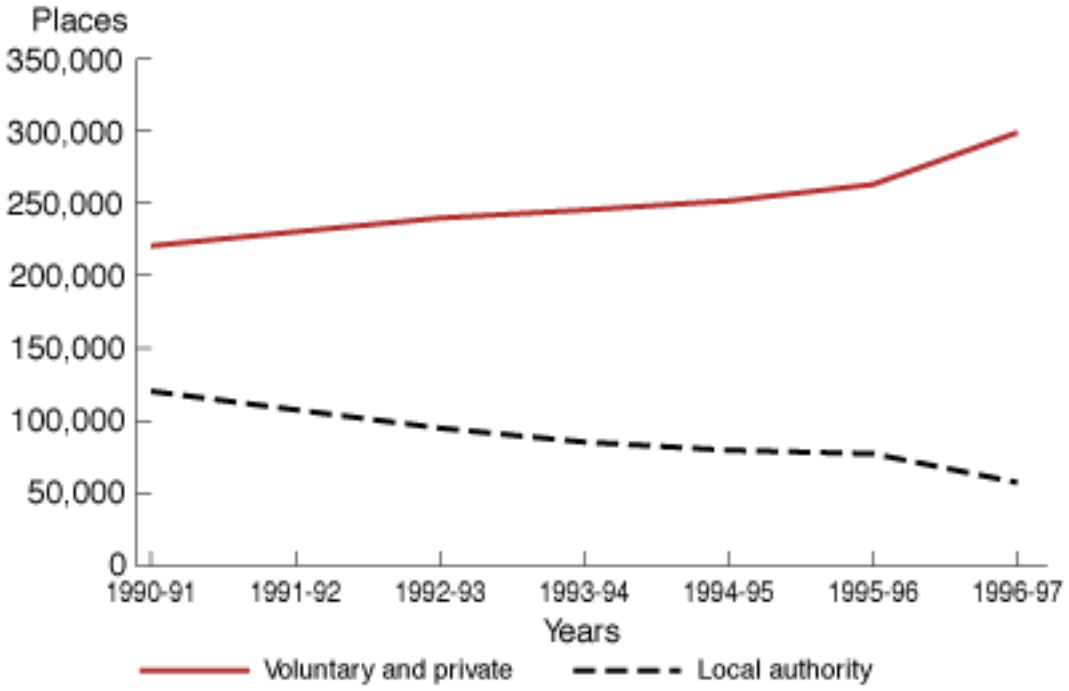

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Figure 5-8
Numbers of Children Receiving Selected Local Authority Services

					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

	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 outturn	1996-97 outturn	£. million 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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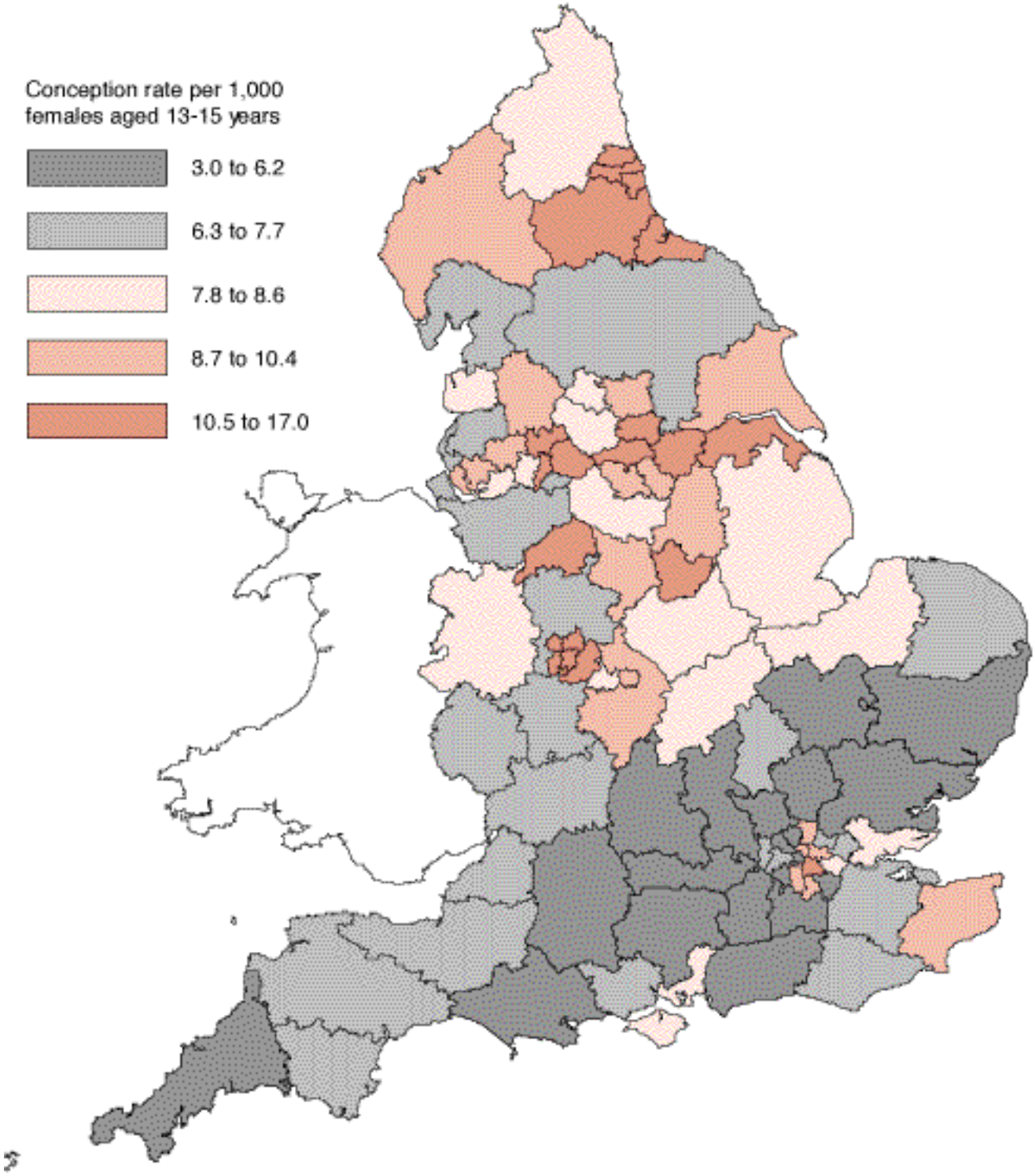
Figure 3-6
Inequalities in Conception Rates Below Age 16, by District Health Authority, 1993-1995



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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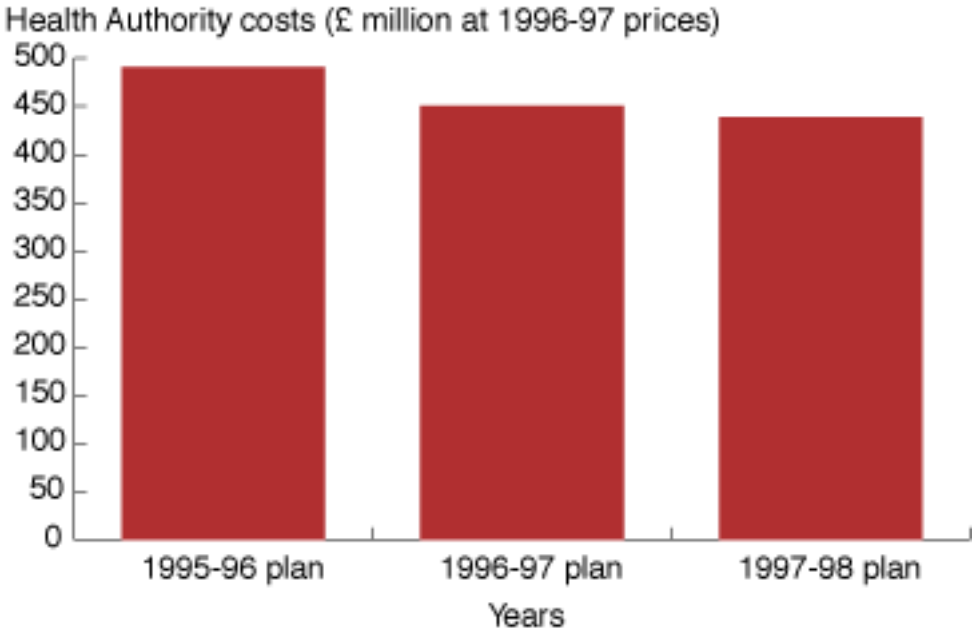
Figure 4-28
Health Authority Costs[1] **(plan on plan) in real terms, 1995-96 to 1997-98**



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

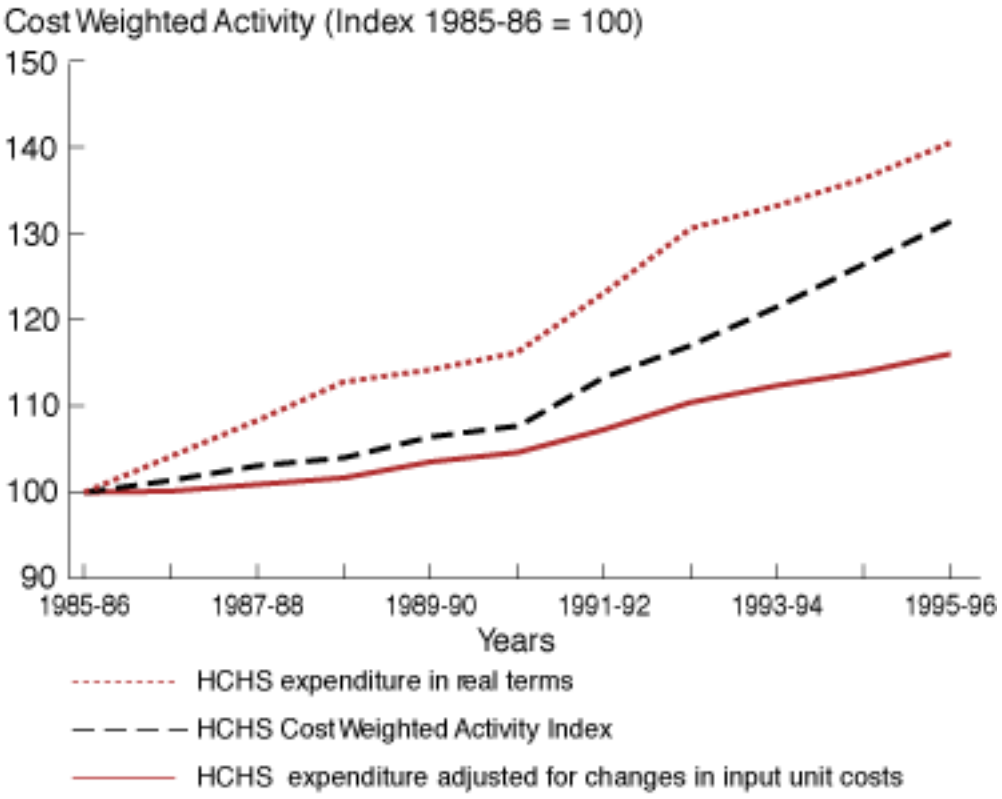

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Figure 4-31
Average Unit Costs by Category of Care, 1985-86 to 1995-96

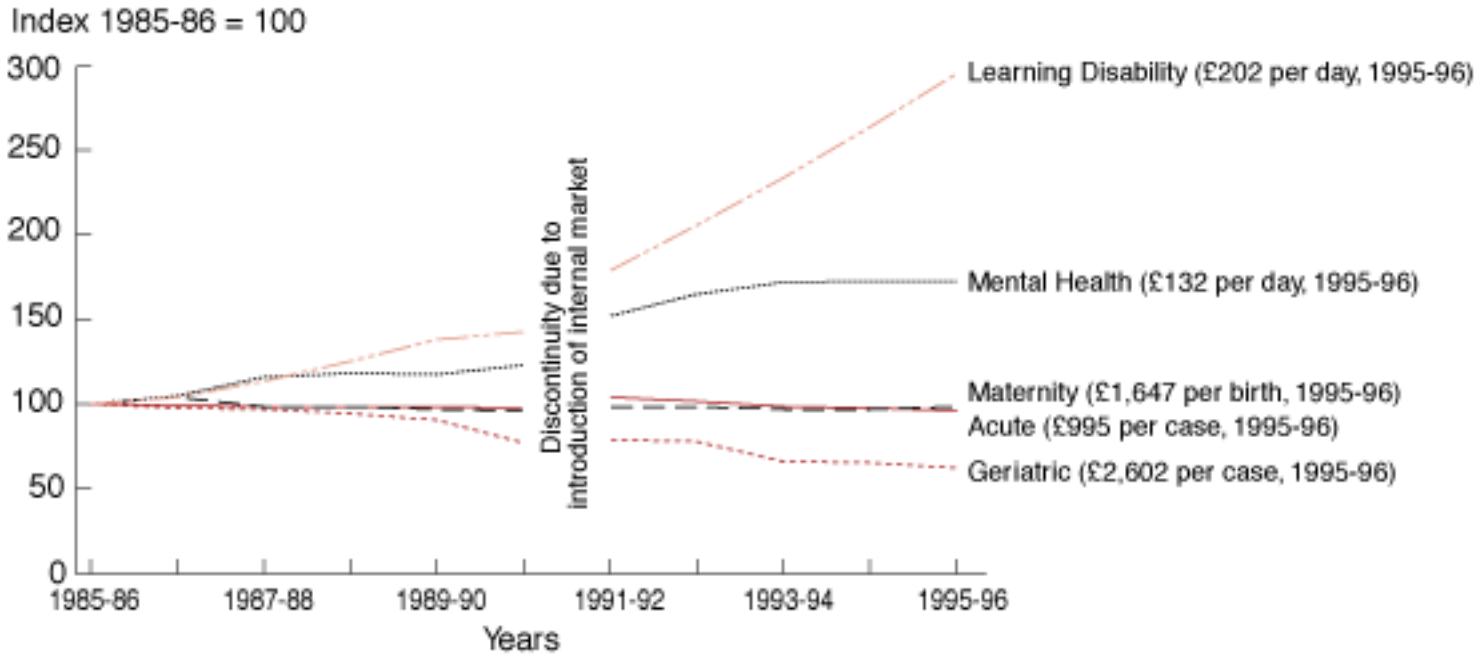

Figure 4-32
Health Service Activity

	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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