行政院及所屬各機關出國報告

（出國類別：考察）

英國國民健康服務制度改革考察報告

行政院研考會/省(市)研考會編號欄

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全民健康保險監理委員會
職　　稱：研究員
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出國類別: 考察

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內容摘要: 我國全民健保亦於2000年開始進行制度評估與檢討，2001年並依據2000的全民健保體檢報告建議，組織二代健保規劃小組，研議中、長期制度改革方案。值此全民健保改革關鍵時刻，透過實地考察英國國民健康服務制度及改革計畫，探討該國醫療照護制度問題所在、改革方案與預期效果，並瞭解推動改革的組織架構，以及如何透過預算控管達到監督NHS增進健康照護的資本投入、品質與效率等目標，以作爲全民健保監理委員會監督全民健保業務及改革措施的參考。經實地考察所得，英國NHS改革方案所涵蓋範圍從理念更新、組織變革、文化新立、預算設置、醫療法規的更新、醫療資本的投入、醫療資訊系統、到醫療品質、人力配置、教育組訓、員工薪資制度等，都訂有明確目標和實施策略。雖然改革過程繁雜，且因應現實問題的複雜性，和問題的多樣性，改革成果也將受到預算限制，然而至今，英國政府仍強調將依目標進行改革。緣提出對我國全民健保制度改革的建議如下：一、 民健保制度的基本理念：綜觀英國NHS歷次改革，由中央集權、公立服務到地方分權和自由市場競爭機制，但仍一貫堅持族群照顧的公平性。相對於我國全民健保改革，對於弱勢族群的照顧不遺餘力，全民健保仍堅持社會福利和公平性的理念。因此我國全民健保民眾滿意度高達百分之七十以上，是我國整體社會福利政策中最重要的一環。對於近年全民健保因財務狀況而調整保險費率和醫療部分負擔，以致影響健保財務負擔的公平性，未來透過二代健保規劃，希冀改進健保財務負擔和醫療照顧的公平性；且爲維持健保財務穩健和對弱勢民眾的照顧，政府應持續公部門的投資，加強對弱勢民眾的醫療保健照護，以提升全民健保制度的社會公義性。二、 加強基層照護和預防保健服務，提升全民健保醫療照護的整體服務效率：由英國NHS預算分配和提倡技術混合、強調基層和社區醫療保健服務的改革策略，英國的整體醫療保健服務費用，控制在OECD國家平均醫療費用值以下。唯其所面臨的問題與我國全民健保有顯

著不同。英國的醫療機構屬資本投入不足、設備老舊、市場缺乏競爭機制、病患等候時間過長，醫療體系亟待更多人力、設備和預算投入；而我國則醫療資源已高度擴張，醫療服務市場競爭激烈，民眾就醫可近性和方便性，居於世界領先地位，然而醫療費用快速成長。雖然我國全民健保已實施醫療費用總額支付制度，但未來更應致力於改善醫療資源配置偏重三級醫療的頭重腳輕的現象，適度分化不同醫療層級的功能，強化基層預防保健體系，以提升醫療資源分配的整體和個別效率。三、 全民健保組織再造的優先性：英國NHS改革首重組織再造，強調政策與執行二元化，並且加強人力的增雇、教育訓練和技術混合、定期進行改革方案的評估，和持續監督實施方案的過程和結果。相對於我國全民健保對於各項給付和醫療費用支付制度改革的靈活性，全民健保組織體制的改革，則顯遲滯不前，亟待二代健保進一步規劃。四、 改革基於明確的目標和可量性指標：英國衛生部和NHS部門訂有明確的改革目標，並且針對不同目標，訂定具體的可量指標，定期評估和修正，並且對民眾發布NHS改革具體成果。相對我國全民健保對於重大健保政策往往僅訂財務衝擊評估，但對於其他如醫療效率、品質和資訊服務等項目，可以參考NHS改革訂定具體可量性評估指標，並且定期發布各項指標改進成果。五、 加強全民教育與公共宣導：英國NHS改革，由衛生部長透過公共電視BBC向全體國民進行一系列的高峰談話、政策宣示、策略說明等，並且建立熱線溝通管道，廣徵各界意見，衛生部企劃部門並且進行員工教育訓練，加強員工和媒體溝通的技能，將媒體溝通視爲衛生政策和改革計劃成功的元素之一，均是我國二代健保改革足堪借境之處。

摘　要

我國全民健保亦於 2000 年開始進行制度評估與檢討，2001 年並依據 2000 的全民健保體檢報告建議，組織二代健保規劃小組，研議中、長期制度改革方案。值此全民健保改革關鍵時刻，透過實地考察英國國民健康服務制度及改革計畫，探討該國醫療照護制度問題所在、改革方案與預期效果，並瞭解推動改革的組織架構，以及如何透過預算控管達到監督 NHS 增進健康照護的資本投入、品質與效率等目標，以作為全民健保監理委員會監督全民健保業務及改革措施的參考。

經實地考察所得，英國 NHS 改革方案所涵蓋範圍從理念更新、組織變革、文化新立、預算設置、醫療法規的更新、醫療資本的投入、醫療資訊系統、到醫療品質、人力配置、教育組訓、員工薪資制度等，都訂有明確目標和實施策略。雖然改革過程繁雜，且因應現實問題的複雜性，和問題的多樣性，改革成果也將受到預算限制，然而至今，英國政府仍強調將依目標進行改革。緣提出對我國全民健保制度改革的建議如下：

一、 民健保制度的基本理念：綜觀英國 NHS 歷次改革，由中央集權、公立服務到地方分權和自由市場競爭機制，但仍一貫堅持族群照顧的公平性。相對於我國全民健保改革，對於弱勢族群的照顧不遺餘力，全民健保仍堅持社會福利和公平性的理念。因此我國全民健保民眾滿意度高達百分之七十以上，是我國整體社會福利政策中最重要的一環。對於近年全民健保因財務狀況而調整保險費率和醫療部分負擔，以致影響健保財務負擔的公平性，未來透過二代健保規劃，希冀改進健保財務負擔和醫療照顧的公平性；且為維持健保財務穩健和對弱勢民眾的照顧，政府應持續公部門的投資，加強對弱勢民眾的醫療保健照

護，以提升全民健保制度的社會公義性。

二、 加強基層照護和預防保健服務，提升全民健保醫療照護的整體服務效率：由英國 NHS 預算分配和提倡技術混合、強調基層和社區醫療保健服務的改革策略，英國的整體醫療保健服務費用，控制在 OECD 國家平均醫療費用值以下。唯其所面臨的問題與我國全民健保有顯著不同。英國的醫療機構屬資本投入不足、設備老舊、市場缺乏競爭機制、病患等候時間過長，醫療體系亟待更多人力、設備和預算投入；而我國則醫療資源已高度擴張，醫療服務市場競爭激烈，民眾就醫可近性和方便性，居於世界領先地位，然而醫療費用快速成長。雖然我國全民健保已實施醫療費用總額支付制度，但未來更應致力於改善醫療資源配置偏重三級醫療的頭重腳輕的現象，適度分化不同醫療層級的功能，強化基層預防保健體系，以提升醫療資源分配的整體和個別效率。

三、 全民健保組織再造的優先性：英國 NHS 改革首重組織再造，強調政策與執行二元化，並且加強人力的增雇、教育訓練和技術混合、定期進行改革方案的評估，和持續監督實施方案的過程和結果。相對於我國全民健保對於各項給付和醫療費用支付制度改革的靈活性，全民健保組織體制的改革，則顯遲滯不前，亟待二代健保進一步規劃。

四、 改革基於明確的目標和可量性指標：英國衛生部和 NHS 部門訂有明確的改革目標，並且針對不同目標，訂定具體的可量指標，定期評估和修正，並且對民眾發布 NHS 改革具體成果。相對我國全民健保對於重大健保政策往往僅訂財務衝擊評估，但對於其他如醫療效率、品質和資訊服務等項目，可以參考 NHS 改革訂定具體可量性評估指標，並且定期發布各項指標改進成果。

五、 加強全民教育與公共宣導：英國 NHS 改革，由衛生部長透過公共電視 BBC 向全體國民進行一系列的高峰談話、政策宣示、策略說明等，並且建立熱線溝通管道，廣徵各界意見，衛生部企劃部門並且進行員工教育訓練，加強員工和媒體溝通的技能，將媒體溝通視為衛生政策和改革計劃成功的元素之一，均是我國二代健保改革足堪借境之處。

目　錄

壹、考察目的

英國國民健康服務制度（National Health Services, NHS）實施迄今已逾 50 年，根據 2003 年 OECD 資料顯示，英國國民醫療保健支出占國內生產毛額（GDP）百分比，在 1990 年前長達十五年的時間維持在百分之六以內，1990 年以後，英國衛生部進行醫療制度改革，利用醫療市場機制，提升 NHS 的服務效率，醫療費用因而大幅上漲；至工黨主政後，1997 年起國民醫療保健支出占 GDP 比率快速成長詳附圖一。2000 年英國衛生部為提升醫療服務品質，提出五年改革計畫，大幅增加對醫療服務部門的投資，預計至 2004 年醫療費用年增率為 6.3%，國民醫療保健支出占 GDP 比率，至 2003 年已達到 7.7%。

我國全民健保亦於 2000 年開始進行制度評估與檢討，2001 年並依據 2000 的全民健保體檢報告建議，組織二代健保規劃小組，研議中、長期制度改革方案。值此全民健保改革關鍵時刻，透過實地考察英國國民健康服務制度及改革計畫，探討該國醫療照護制度問題所在、改革方案與預期效果，並瞭解推動改革的組織架構，以及如何透過預算控管達到監督 NHS 增進健康照護的資本投入、品質與效率等目標，以作為全民健保監理委員會監督全民健保業務及改革措施的參考。

具體而言，本次考察的目的為：

- 瞭解英國國民健康照護基本理念和經營管理模式的歷史脈絡；
- 瞭解英國衛生部健康發展目標和國民健康服務改革計畫與成效；
- 瞭解英國衛生組織、經費及醫療體系執行績效；
- 考察英國醫療體系改良計畫及實施方法和監督機制；

■ 英國國民健康服務制度改革對我國全民健保的借鏡；

貳、考察內容

本次考察行程為期九天，行前透過我國外交部和行政院新聞局外館，以及醫師公會全國聯合會的協助安排，並於行前擬訂訪問議題，經由電傳或電子郵件事先與參訪單位溝通。共計拜會英國衛生部國民健康服務部門主管 Mr. John Bacon、國際合作部門主管 Mr. Huge Taylor、企劃部門主管 Mr. Andy Mckeon、以及 Ms. Dhesi Rukwinder，並由 Ms. Rukwinder 安排前往參觀 St. Thomas 醫院，以及愛丁堡衛生局和醫院改革委員會。經由實際參訪，瞭解英國國民健康照護服務制度現況與問題、改革的目標、改革方案、所遭遇困難及改革成效評估，並前往政府出版社 The Stationery Office(TSO)和世界知名的出版社總部如 Waterstones、Blackwell 等蒐集醫藥保健制度相關書籍與參考資料。

參、考察心得

一、英國國情簡介

英國是大不列顛及北愛爾蘭聯合王國的簡稱，位於大西洋中的不列顛群島上，主要包含英格蘭、威爾斯、蘇格蘭和愛爾蘭島東北部及附近許多島嶼組成的島國；東瀕北海，面對比利時、荷蘭、德國、丹麥和挪威等國；西鄰愛爾蘭，橫隔大西洋與美國、加拿大遙遙相對；北過大西洋可達冰島；南穿英吉利海峽與歐洲大陸相望，約距 33 公里就到法國。面積 241752 平方千米，約為台灣的 6.7 倍。其中以英格蘭占大不列顛島的大部分，全境面積為 13 萬平方公里；其次是威爾斯 2 萬餘平方公里，蘇格蘭和其他周圍的小島面積約 7.8 萬平方公里，全境均屬山岳地帶，中間是較平緩的丘陵；北愛爾蘭面積 1.4 萬平方公里，隔愛爾蘭海與大不列顛島遙遙相望。

英國現有人口數約六千萬人，約為台灣人口的 2.7 倍。主要由英格蘭人(占人口總數的 80%以上)、威爾斯人、蘇格蘭和愛爾蘭人組成，另外自 1990 年以來，移民人口漸增，主要來自西印度、巴基斯坦、中國、越南、以及東歐等地。全境人口密度為每平方公里 229 人，但全國人口分布不均，人口的 80% 住在城市。居民多信奉基督教新教，主要教派有英格蘭教會和蘇格蘭教會。英格蘭教會亦稱英國國教聖公會，成員占英成人的 60%。蘇格蘭教會亦稱長老會，成年教徒 79 萬。另有天主教徒 570 萬，伊斯蘭教徒 150 萬，猶太教徒約 40 萬，可以說是宗教多元和自由的國家，教會所執行的慈善事業一直是英國社會福利系統的一

環。至於本次主要考察倫敦和愛丁堡兩市，前者為英國首都，人口約700萬，後者則為蘇格蘭首都，人口約45萬人。

英國是古老的工業發達國家，在工業生產中，尤以石油和天然氣業最發達，煤、鋼鐵和汽車工業是英國工業的重要生產部門，二次世界大戰後航空、電子、化工和電氣等工業在世界居於領先地位。然而，從第二次世界大戰後到現在，英國的工業產值在世界經濟中地位不斷下降，但仍居於西方七大經濟強國之一，並且和德國、法國併列歐盟三大巨頭，主導歐盟政治和經濟的未來發展。此外，英國的首都倫敦也是世界四大金融和航空交通重鎮之一。

英國政府組織主要分為中央與地方政府兩極，中央負責決策任務的核心部門（core departments），下設執行局（executive agencies），負責執行政策，且具有強大的自主性，至於國會則僅以年度預算審查作為監督機制，內閣甚至隨時可視業務需要，以行政命令更動政府機關組織架構及職掌，調整單位業務及人員配置等，毋需經由繁複的立法程序。2000年以後NHS的現代化工程，即受惠於內閣組織變格的自主性，使得衛生部在推動NHS改革上，能借由組織再造達到權力下放地方政府，透過取消地區衛生部門，代之以直屬NHS執行局的地區衛生辦公室，以增進地方政府執行NHS業務的自主性。

英國的政府地理區劃受到政黨輪替，有很大的變動。1990年保守黨執政後，地理區劃延用至今，在英格蘭取消大部分非都會區分為兩級的區和縣市（district and county council），改為單一的地方管理局（unitary authority），至1998年為止，英格蘭共有46個地方管理局，但仍有34個非都會區延用兩級制。其餘威爾斯在1996年將所有兩級制地方政府組織全數改為22個單一的地方管理局；蘇格蘭則改為32

個一級的市鎮（council）；北愛爾蘭則早於 1973 年即已改為單一的市地理區（single-tier district councils）。因應地方組織的調整，相關的公務統計資料於 1996 年起由標準統計區（Standard Statistical Regions）改為依政府辦公室地理區畫（Government Office Regions）呈現。例如本次考察倫敦和愛丁堡，其人口和健康統計指標的地理區劃和包含人口數即有相當大的差距，顯示地方政府所必需面對的人口健康問題挑戰性亦不同。本次考察所搜集的人口和健康狀況指標，統計辦公室地理區劃如下，人口統計和相關健康指標詳附錄一。

- the United Kingdom;
- England:
  - Government Office Regions;
  - unitary authorities;
  - metropolitan counties and districts;
  - non-metropolitan counties and districts;
  - Health Regional Office areas and health authorities ;
- Wales:
  - unitary authorities;
  - health authorities;
- Scotland:
  - council areas;
  - health boards;
- Northern Ireland:
  - council districts（local government districts）;
  - health and social services boards.

二、NHS 的經營管理和服務理念演化及各階段改革目標

英國國民健康服務制度肇建於 1948 年，目的在國家財務可以負擔的程度內，透過稅收支付，提供全體國民身心需要的健康照護服務（need-based physical and mental health services）。五十年來，英國國民健康照護服務制度照顧該國民眾的基本醫療需求，並且控制醫療費用成長幅度，實施成果受到世界先進國家的重視，以下簡述英國 NHS 的經營管理和服務理念演化及各階段改革目標。

（一）第一階段：NHS 自 1948 年建立，其時正值二次大戰戰後，為使戰後經濟復甦和社會安定，英國政府於 1940 年開始規劃健康照護制度，以照顧全民健康。當時世界各國醫療照護制度，主要有保護全體民眾健康（protect health to the populations）和提供個別的疾病治療（provide illness services to individuals），兩大理念主軸；前者以基層保健和預防為主，後者則以急性疾病的治療為主。NHS 制度實施由預防保健和社區健康理念開始，政府採取完全控制醫療市場的方式，提供國民醫療保健服務。然而隨著醫療科技的發展，NHS 也逐漸演變為以提供治療為主的服務。

由於英國採取完全控制醫療市場發展的方式提供醫療保健服務，其和醫療機構間，是一種 command and control 的關係。此種服務模式，使英國的醫療費用獲得良好的控制，然而也影響了醫療市場的發展，無法針對不同的族群提供需要的多樣化的照護服務。

（二）第二階段：由於醫療專業和醫療科技進步，以治療為主的照護模式主導這一階段 NHS 醫療體系的發展，然而自 1960 年代起，NHS 為回應人口老化和慢性疾病盛行，且在政治上，老人、殘障和經神病患等依賴人口（dependency groups）強調醫療照護的權利，並且基於「正常化」（concept of normalization）的理念，英國政府於 1975 年提出 The Priorities Document and The Way Forward 改革方案，以「資源下放到社區」作為衛生主管機關分配資源的指導方針，改革策略主要有：

- 提供照護為主，而非以醫療為主；
- 改變 NHS 以疾病為基礎的給付內容；
- 1975 年提出 White Papers，針對不同族群，提出個別的照護方案，強調社區而非機構式的照護，並且加強地區衛生行政和社會服務行政單位的合作，共同訂定社區照護計畫；
- 強調心理健康照護服務。

英國 NHS 社區照護模式，透過社區的 Joint Consultative Committees 整合相關各方財源與服務資源，包含門診、住院服務，家庭醫師（General practitioner）、護理人員、心理醫師、公共衛生護士（health visitor），相關的醫療和社會服務工作人員、日間照護、社區圖書和教育中心、私人和志工團體等，強化 NHS 的基層醫療照護網，穩固 NHS 制度。此種特色也是世界各國衛生當局觀摩英國醫療制度的重點。

（三）第三階段： 1980 年代，英國政府評估 NHS 社區照護方案，發現 NHS 第二階段改革並未達到民眾的醫療照護需求，醫療人力資源的投入並未隨著醫療費用的上升而有明顯的成長，且個別醫

療機構的醫療效率不彰，醫師生產力低落。1989 年保守派的余契爾夫人執政時期，提出第三階段的改革方案 Working for Patients（WFP），1990 年通過 NHS and Community Care Act 立法，於 1991 年四月開始實施，1993 年四月推行社區改革，1994 年改革 NHS 行政管理組織，由原來的垂直式管理架構，由衛生部和 NHS 管理部門統轄地區衛生局和 NHS Trust，轉變為強化地方政府購買者（purchaser）和提供者（provider）的水平組合。改革前後的組織體系詳附圖一。總合這一階段的改革策略，主要為引進市場競爭機制和企業管理精神，利用經濟誘因提升醫療服務效率，使醫療提供體系由政府完全掌控，轉為以管理式醫療市場適度競爭（managed competition medical market）為主的服務體系。

此階段改革仍堅持 NHS 綜合性、普遍性、回應性與平等（comprehensiveness, universality, accountability, and equity）的基本精神，強調病人選擇的權力，並且透過競爭，有效控制醫療費用的上漲。主要的改革方案包含：改變一般開業醫師的薪水報酬、新的政府預算和財政政策，並且透過下列方法達成提升醫療保健生產效率的目標：

- 以論人計酬方式計算地區醫療保健總預算；
- 地區衛生局扮演積極的買方和合約角色，以促使醫療保健提供者提供多樣化的醫療保健服務；
- 醫療保健提供者有較大的自治權和鼓勵競爭基金預算；

（四）現階段改革：1997 年五月（新）工黨執政，首相布萊爾為適應新的經濟和政治環境，以及全球化經濟時代，修正余契爾夫人執政時期國營服務內部競爭市場和全盤私有化的改革路線，以提升醫療保健利用的公平性。布萊爾提出積極施政（progressive

governance）理念，強調介於新自由主義和社會民主主義的「第三條道路」，表明公共服務應受財政和市場約束、加強地方分權和提供多樣化的公共服務，透過預算權下放到地方政府，鼓勵私部門參與提供公共服務，以使病人有更多的選擇，同時也使得私人保險和自付醫療費用項目大幅增加。

在醫院經營方面，布萊爾主張將現行公立醫院或信託公司，改制為「醫院信託基金會」（Hospital Foundation Trusts），以使公立醫院除公共資金外，還可以接受私人捐款資助、與私營部門合資等途徑，以增長地方衛生醫療機構的自主性（empowerment）並活絡資金來源與用途，加速醫療設備更新和現代化。

由於人口老化及醫療科技發展，英國醫療費用快速成長，且醫療資源不足問題隨國民保健需求增加，愈來愈嚴重，醫院設備老舊、病人等候時間過長，以及醫療誤失頻仍，媒體輿情也大加撻伐，衛生部遂於 1998 年起提出 NHS 現代化改革方案，包含年度改革目標、實施策略，有效評估實施成果，並加強對民眾的溝通，以爭取預算投資醫療衛生照顧服務。此階段組織變革和改革方案詳細內容詳見附錄二。

2002 年英國衛生部提出預算法案，以前所未有的增幅，大量投資國民健康服務的各項軟硬體改革與更新，冀能透過改善社區醫院設備、增加醫護人力及加強醫護衛生人員訓練、以縮短看病的等候時間和增加民眾就醫的選擇性，年度目標及成果詳附錄三。

簡而言之，現階段改革具體的預算投入主要目標為：

- 減少候診時間；
- 增加服務員工人數，提升員工素質；

- 增加醫療服務能量，強化醫療服務的品質；
- 增加民眾醫療保健的選擇性；
- 建立 NHS 國家標準和監控評估系統和指標，作為改進的方向；
- 將預算權下放到地方，以提升社區的自主和權責相符；

具體可量目標例如：(1) 降低可預防生病、疾病和傷害的發生率：包含 75 歲以上的老人癌症、心臟病和中風及相關疾病的死亡率；降低意外和不良影響的死亡率、降低嚴重意外事故的發生率；(2)提升生病、疾病和傷害治療的時效：包含縮短病人等候就醫的時間、乳癌等癌症病人在兩星期內接受專科醫療、建立全國 NHS 服務電話聯絡網 (NHS Direct)，由護理人員提供 24 小時的電話諮詢服務；(3) 增加一般醫師和護理人力、合理的分布、人力素質和技術混合等。

三、英國衛生部和國民健康服務組織架構、服務現況與問題

英國在 1988 年政府組織再造，將衛生和社會保障由一分為二，自此後，英國健康照護計畫主要由中央的衛生部籌措財源、訂定總體衛生照護政策，至於醫療照護服務的提供則透過國民健康服務和一般開業醫師 (General Medical Practitioners, GPs)、牙醫、藥師等特約，提供全體國民需要的照護，並且監督各地方政府的執行績效。衛生部由六位國會議員負責，一位擔任衛生部長、兩位衛生大臣、三位副部長，分別負責醫療衛生相關業務，職掌如下：

- Secretary of State：國務卿，內閣衛生部長，負責 NHS 改革、財源籌措和資源分配、媒體和公共關係等事務；

- Minister of State：兩位國務大臣，一位負責NHS員工薪資、執行績效和基層照護方案等；另一位則負責緊急醫療照護、心理衛生醫療、醫療糾紛、慢性病及器官移植、捐贈、牙科和藥事服務等相關業務；
- Parliamentary Under-Secretary of State：三位副部長，分別負責心臟病和NHS績效評核、醫療品質管理、生技及製藥工業、研究發展等業務；癌症、慢性心臟病、香煙政策、傳染病與疫苗、健康不平等、藥物和酒精濫用、安全的性行為等；以及老人醫療和社會服務、照顧者政策、兒童健康服務、殘障服務、和長期照護服務等；各有所司。

至於衛生部組織架構，因應NHS改革需要，主要分為兩大部門，分別掌管政策、規畫和人力配置，以及服務提供、改良和監督兩大部分。此外還設有相關輔助單位如：Research Analysis and Information、Human Resources、Finance and Investment、Corporate Affairs、Policy and Planning、Strategy Unit、Communications等，提供政策規劃的參考意見、方案或評估報告。另外，衛生部下設執行管理局（Executive Agencies），以依法管理、採購與供應、NHS財產管理、和員工年金制度的執行等。衛生部組織架構圖詳如附圖二。

由於NHS有一百多萬員工，每年耗資500億英鎊，號稱是英國最龐大的機構。每週家庭醫師看診140萬人次，80多萬人在醫院門診就醫，許多醫師抱怨他們是英國工作時間最長的人，但民眾仍抱院英國是全世界等候醫院就診時間最長的國家。除了候診問題外，英國醫院的醫療設備和設施老舊，造成英國私人醫療保險日盛，出國看病的人也大幅增加。英國倫敦政經學院的中間偏左派學者Julian Le Grand即抨擊英

國公共服務改革使得富人得到最大的受益，不公平的現象更為嚴重。因此 NHS 的改革首要的是改變組織和員工教育訓練工作，包括建立信託（NHS Foundation Trust），將預算權下放，並且透過地方衛生業務自主，達到醫院更新、照護服務以病人為中心和減少等候時間的目標。

NHS 組織更新第一步是改革第一線服務的機構，汰換 health authorities 和 Regional Offices，成立地方的 Primary care trusts，聯合 NHS trusts，可以強化 NHS 對社區的服務，更加契合社區民眾的保健需求。此外，成立 Strategic Health Authorities，以確保在國家標準之下，社區醫療機構能依據社區保健的優先性，提供一定品質的醫療保健服務。

Primary care trusts 的成立，是 NHS 基層改革的重點，利用保健成果支付、增加民眾選擇和增加新的醫療保健服務提供者，如 Diagnosis and Treatment Centers 和 NHS Foundation Trusts，Primary care trusts 都扮演重要的聯繫的角色和功能。

四、NHS 計劃的預算規劃

2000 年時執政的工黨宣布 2000 到 2004 年 NHS 的預算增幅，從原有的低於五千萬英鎊，增加到七千英鎊，第一年預算實質成長率為 7.4%，其後三年每年實質預算成長率為 5.6%，四年平均的實質預算增幅為 6.1%，英國政府並保障未來五年 NHS 的預算名目成長率預算為 7.5%，英國衛生部和 NHS 預算及成長率，詳如附錄四。

英國的 NHS 實行分級保健，分為基礎醫療保健（primary health care）和醫院服務兩級。基礎醫療保健是 NHS 的主體，由一般醫師和社區診所提供服務，所需要的年度預算大約占 NHS 的百分之七十五。醫院保健僅占百分之二十五的預算，主要負責重病和手術治療，以及統籌調配社區醫療資源，有些醫學中心還另有教學和研究的經費來源。

1997 年布萊爾首相提出 NHS 改革計畫，當時主要著眼於 NHS 的預算不足和效率不彰兩大問題。2000 年七月，布萊爾發布 NHS 現代化改革的五年計畫，誓言要使 NHS 成為以病人為核心的服務體系、真正有效率的二十一世紀醫療服務。因此一方面增加國民保險稅，擴大公共投資，從 2000 年起，政府的 NHS 公部門預算計畫以每年 10%的資加幅度（但實際上至 2003 年的預算增幅僅為 6.3%），提升醫療體系的服務品質和效率，並且訂定多項品質監控指標（詳附表五）；另一方面，增加對雇主的免稅額，以鼓勵自付醫療和私部門提供多樣化的醫療服務。

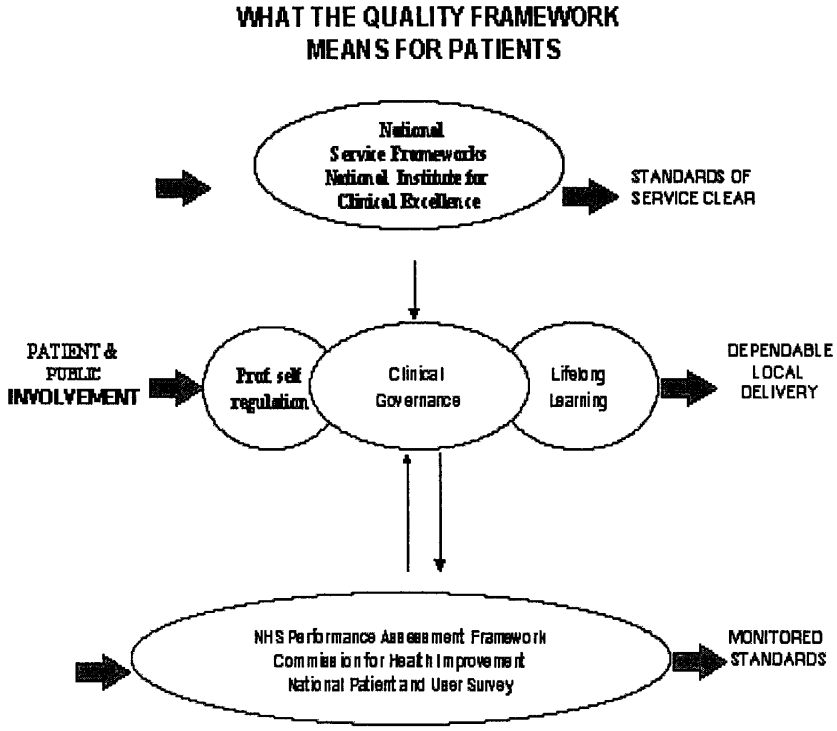
為了提升 NHS 的服務效率，衛生部和 NHS 部門進行大規模的機構重組，充實一級的基礎保健，建立快速就診中心和二十四小時醫療熱線電話，增加病人就醫的選擇性。並且透過增加 NHS 非醫療員工的薪資給付，更新一般醫師（GPs）合約條文、提供顧問醫師（consultants）的經濟誘因，以增加不同專業人員的技術混合（capacity and skills mix），達到有效提升生產效率的目的。

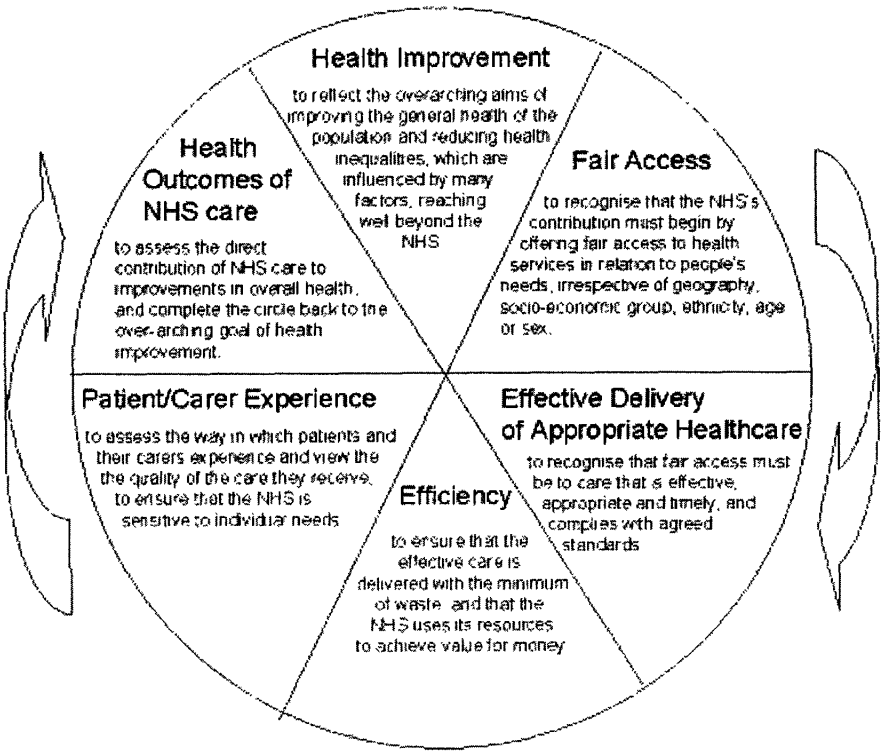
本次考察時間正逢工黨代表大會，由於工會組織的強力反對，因此 NHS 長達五年的改革前景不明，且因為預算增幅不如理想，因此改革進度緩慢。但首相布萊爾仍決心不減，加強各方面媒體的公共宣導，衛生部長 John Reid 在十月份不斷上 BBC 的訪談節目，說明 NHS 改革內容，並呼籲國民和 NHS 員工支持改革。

五、英國醫院醫療品質確保計劃

據英國衛生部統計，NHS 醫院的常規門診候診時間長達六個月，等候住院手術更長達十八個月，2003 年新加坡內閣資政李光耀的夫人在英國突發急性腦溢血，救護車送到醫院後卻發現要排隊等候，李氏只好冒險護送回國治療，並且怒斥英國醫療服務是全世界最差的。除了候診問題，英國醫院的醫療設備老舊，即連倫敦市區的聖・湯瑪士醫學中心，其護理人員不足，醫院設備陳舊、病房設備和環境衛生不佳、病人跌倒和走迷宮的情形，已成為該院提升醫療品質的最主要目標。因而，布萊爾的 NHS 五年現代化改革計劃，規劃建立以病人為核心的醫療服務體系，擴大投資的標的，主要為增加醫院服務人員、設備更新及員工訓練、改變醫療保健服務文化等。具體目標如 2004 年要達到病人能夠在 24 小時內見到醫師；在醫院急診的等候時間降到平均一小時十五分鐘；到

2005 年底，常規門診等候時間從六個月縮短到三個月，住院手術等候時間從十八個月降低到六個月等。NHS 總體的醫療品質改善計畫，主軸以病人為中心，圖示如下。




Health Improvement
to reflect the overarching aims of improving the general health of the population and reducing health inequalities, which are influenced by many factors, reaching well beyond the NHS
Health Outcomes of NHS care
to assess the direct contribution of NHS care to improvements in overall health, and complete the circle back to the over-arching goal of health improvement.
Fair Access
to recognise that the NHS's contribution must begin by offering fair access to health services in relation to people's needs, irrespective of geography, socio-economic group, ethnicity, age or sex.
Patient/Carer Experience
to assess the way in which patients and their carers experience and view the the quality of the care they receive, to ensure that the NHS is sensitive to individual needs
Effective Delivery of Appropriate Healthcare
to recognise that fair access must be to care that is effective, appropriate and timely, and complies with agreed standards
Efficiency
to ensure that the effective care is delivered with the minimum of waste and that the NHS uses its resources to achieve value for money

參、結論與建議

本次考察英國 NHS 改革方案，該方案所涵蓋範圍從理念更新、組織變革、文化新立、預算設置、醫療法規的更新、醫療資本的投入、醫療資訊系統、到醫療品質、人力配置、教育組訓、員工薪資制度等，都訂有明確目標和實施策略，以符合二十一世紀醫療保健照護現代化的需求。雖然改革計畫的時程長達十年，改革過程繁雜，且因應現實問題的複雜性，和問題的多樣性，改革的時程一再延長，然而透過定期（每兩年）一次的成效評估，至今，英國政府仍強調將依目標進行改革。

由於我國全民健保正進行二代健保改革計畫，針對本次考察所得，僅提供以下建議供政策規劃和改革參考。

（一） 全民健保制度的基本理念：綜觀英國 NHS 歷次改革，由中央集權、公立服務到地方分權和自由市場競爭機制，但仍一貫堅持族群照顧的公平性。相對於我國全民健保改革，對於弱勢族群的照顧不遺餘力，全民健保仍堅持社會福利和公平性的理念。因此我國全民健保民眾滿意度高達百分之七十以上，是我國整體社會福利政策中最重要的一環。對於近年全民健保因財務狀況而調整保險費率和醫療部分負擔，以致影響健保財務負擔的公平性，未來透過二代健保規劃，希冀改進健保財務負擔和醫療照顧的公平性；且為維持健保財務穩健和對弱勢民眾的照顧，政府應持續公部門的投資，加強對弱勢民眾的醫療保健照護，以提升全民健保制度的社會公義性。

（二） 加強基層照護和預防保健服務，提升全民健保醫療照護的整體

服務效率：由英國 NHS 預算分配和提倡技術混合、強調基層和社區醫療保健服務的改革策略，英國的整體醫療保健服務費用，控制在 OECD 國家平均醫療費用值以下。唯其所面臨的問題與我國全民健保有顯著不同。英國的醫療機構屬資本投入不足、設備老舊、市場缺乏競爭機制、病患等候時間過長，醫療體系亟待更多人力、設備和預算投入；而我國則醫療資源已高度擴張，醫療服務市場競爭激烈，民眾就醫可近性和方便性，居於世界領先地位，然而醫療費用快速成長。雖然我國全民健保已實施醫療費用總額支付制度，但未來更應致力於改善醫療資源配置偏重三級醫療的頭重腳輕的現象，適度分化不同醫療層級的功能，強化基層預防保健體系，以提升醫療資源分配的整體和個別效率。

（三） 全民健保組織再造的優先性：英國 NHS 改革首重組織再造，強調政策與執行二元化，並且加強人力的增雇、教育訓練和技術混合、定期進行改革方案的評估，和持續監督實施方案的過程和結果。相對於我國全民健保對於各項給付和醫療費用支付制度改革的靈活性，全民健保組織體制的改革，則顯遲滯不前，亟待二代健保進一步規劃。

（四） 改革基於明確的目標和可量性指標：英國衛生部和 NHS 部門訂有明確的改革目標，並且針對不同目標，訂定具體的可量指標，定期評估和修正，並且對民眾發布 NHS 改革具體成果。相對我國全民健保對於重大健保政策往往僅訂財務衝擊評估，但對於其他如醫療效率、品質和資訊服務等項目，可以參考 NHS 改革訂定具體可量性評估指標，並且定期發布各項指標改進成果。

（五） 加強全民教育與公共宣導：英國 NHS 改革，由衛生部長透過

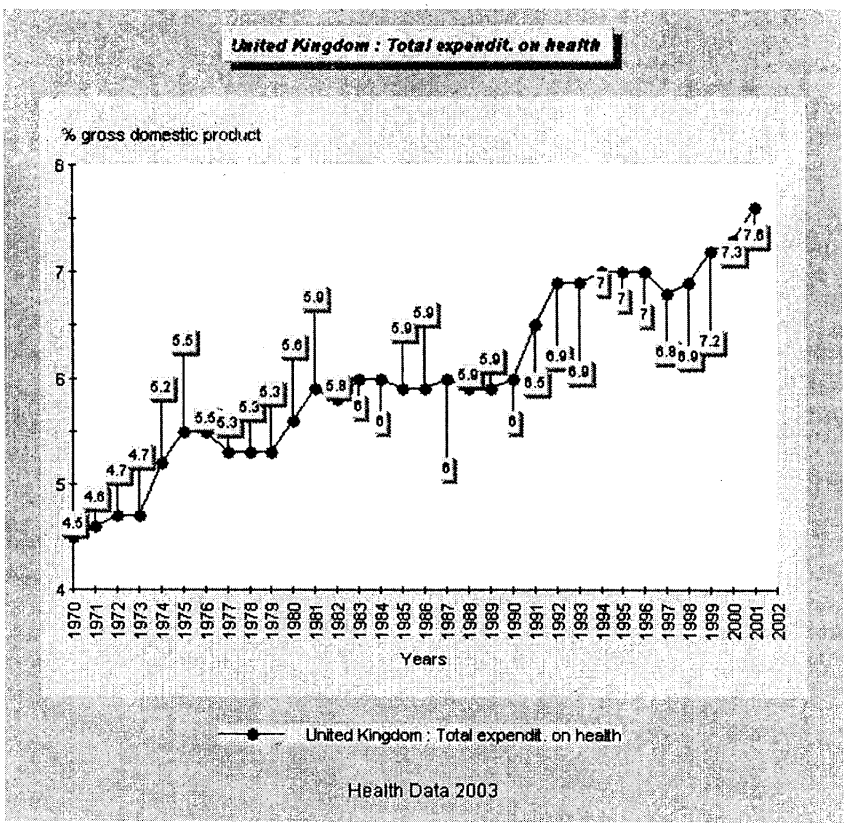
公共電視 BBC 向全體國民進行一系列的高峰談話、政策宣示、策略說明等，並且建立熱線溝通管道，廣徵各界意見，衛生部企劃部門並且進行員工教育訓練，加強員工和媒體溝通的技能，將媒體溝通視為衛生政策和改革計劃成功的元素之一，均是我國二代健保改革足堪借境之處。

（六） 以證據為基礎的政策規畫：英國衛生部每年發表大量的研究報告，從細胞複製到衛生部預算和費用統計分析，NHS 醫療服務品質等都有詳實的資料分析，並且定期發表報告（report）和研究成果（paper or statement），以做為製訂相關衛生政策的參考。相對於我國衛生統計和全民健保統計，大多為報告形式，雖然呈現大量的數據，但相關的研究成果且能做為政策製訂參考者較少，許多研究成果所提出的建議大多存參，真正參採者較少。為加強政策品質，實有必要加強政策研究及以證據為基礎的政策規劃，並且加強政策研究成果的發表，以達到資訊透明和政策溝通的目的。

肆、參考文獻

1. Commission on Taxation and Citizenship(2000). Paying for Progress: A New Politics of Tax for Public Spending. London, Fabian Society.
2. OECD(2003). OECD Health Data 2003.
3. Robinson R. et al. (1999). United Kingdom Health care systems in transition. At website: http://www.euro.who.int/document/e68283.pdf
4. Department of Health (2003). Department Report 2003. The Health and Personal Social Services Programmes.
5. Department of Health (2003). Department Report 2003. The Government's Expenditure Plans.
6. The Stationery Office (2001). Key population and vital statistics:

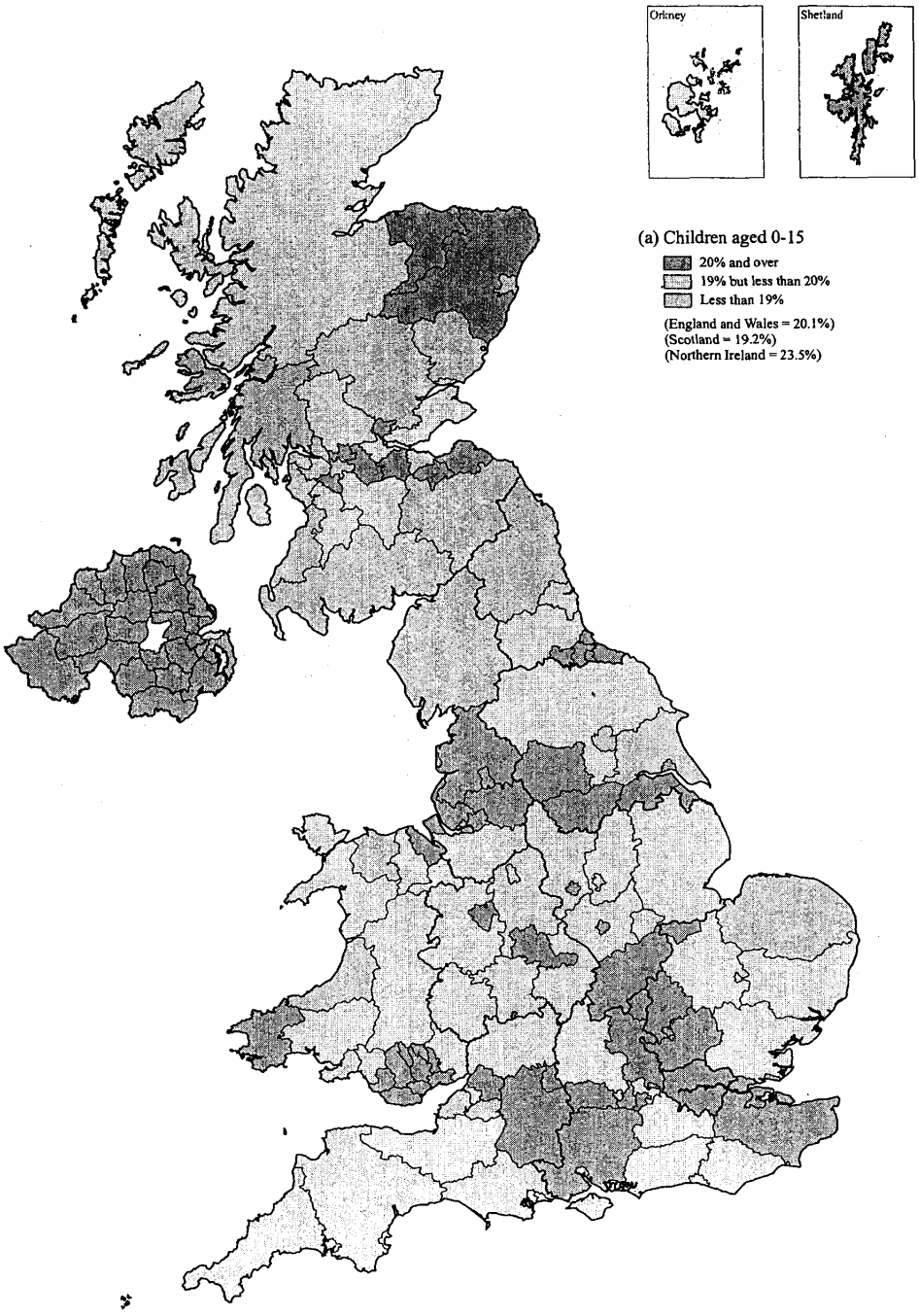
Local and health authority areas.
7. Anna Dixon, Ray Robinson (2002). Health care systems in eight countries: trends and challenges. European Observatory on Health Care Systems.
8. Sir Donald Acheson (1998). Independent Inquiry into Inequalities in Health Report. The Stationery Office.



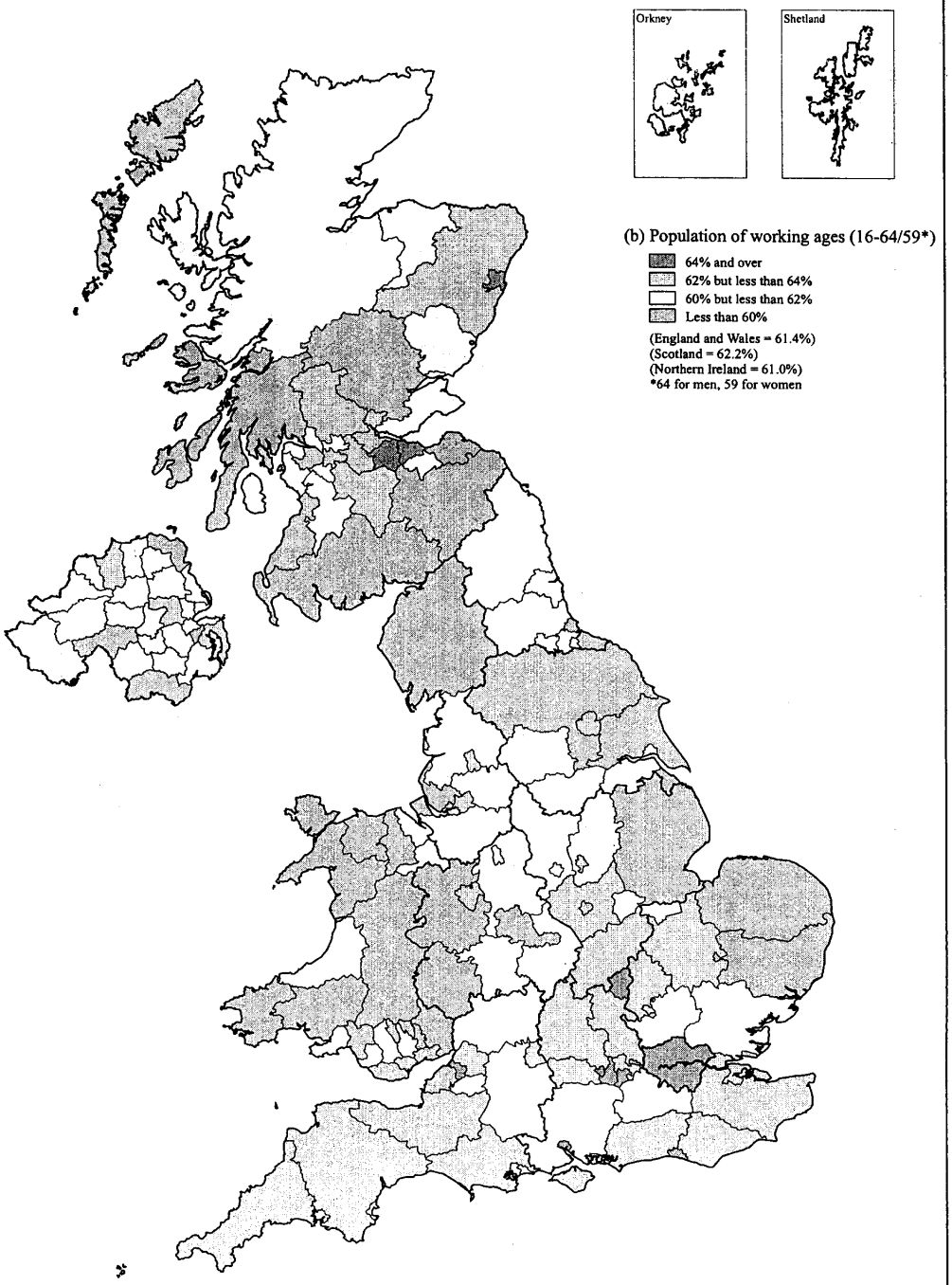
附圖一 **A simple illustration of the key elements of the NHS quality strategy(from *A First Class Service*)**

Map 1 Counties and unitary authorities in England, Wales and Scotland, and Northern Irish district council areas 1 April 2001

Map 2a **Proportion of the population at mid-2001 in certain age groups: counties/unitary authorities of England, Wales and Scotland, and Northern Irish district council areas: children 0-15**



Map 2b **Proportion of the population at mid-2001 in certain age groups: counties/unitary authorities of England, Wales and Scotland, and Northern Irish district council areas: working ages**



Map 2c **Proportion of the population at mid-2001 in certain age groups: counties/unitary authorities of England, Wales and Scotland, and Northern Irish district council areas: retirement ages**

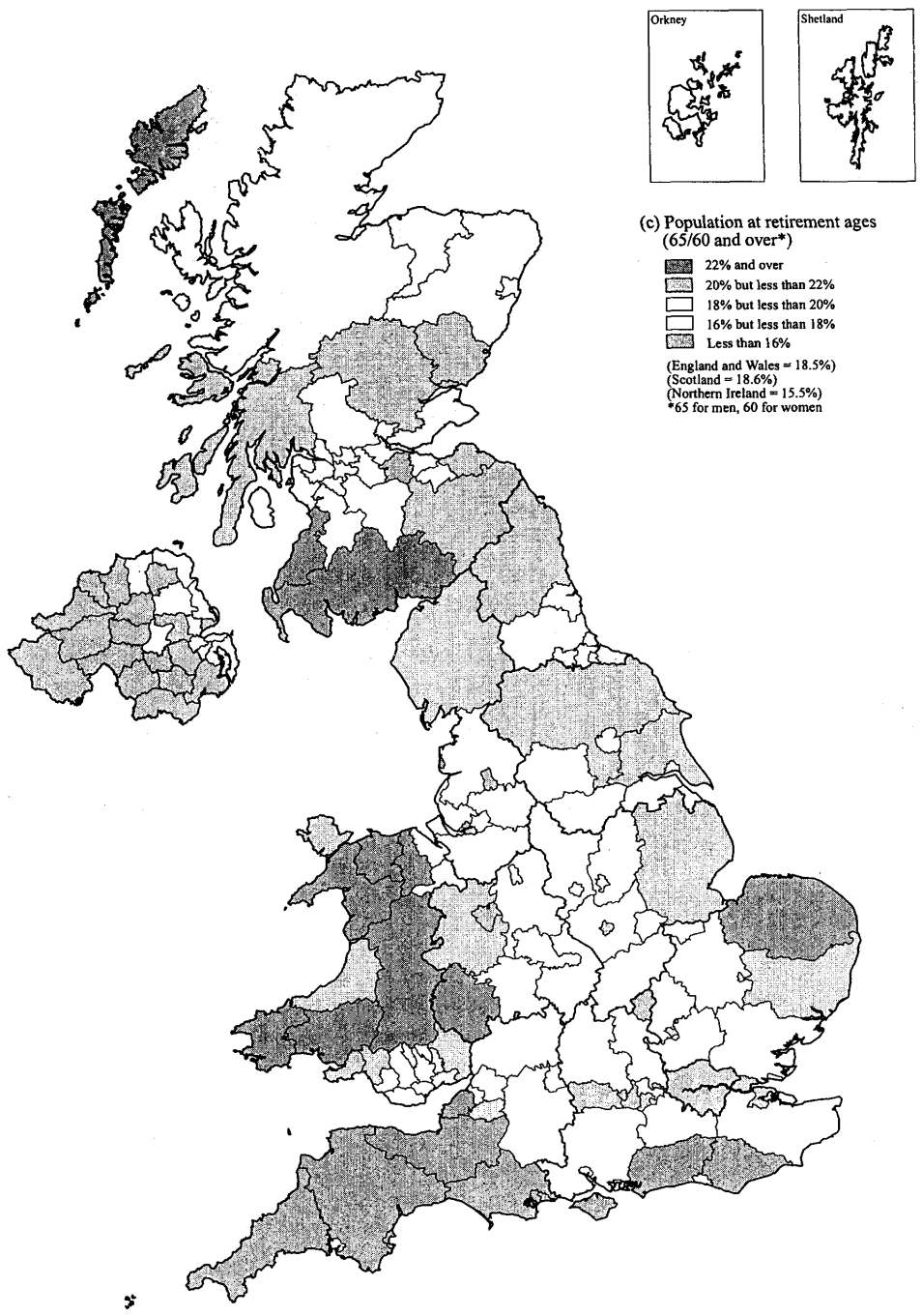


Table 1. Health and population indicators

Population	59 008 700
% over 65 years	15.71
Life expectancy at birth	77.40
Infant mortality rate	5.86
Total fertility rate	1.72
Crude birth rate per 1000 population	12.30
Crude death rate per 1000 population	10.67

Source: WHO health for all database.
Note: All figures for 1997.

Table 2. Causes of death (deaths per 100 000 population) in the United Kingdom, 1970–1995

	1970	1975	1980	1985	1990	1995
All causes	1 099.2	1 042.2	984.3	917.9	820.8	770.7
Circulatory system diseases	557.6	529.5	483.0	434.9	363.6	317.2
Neoplasm	216.9	217.4	220.3	224.8	220.4	206.5
Respiratory system diseases	160.0	138.7	134.3	97.4	84.3	109.2
External causes	46.7	43.6	41.1	36.1	33.3	28.6
Mental and behavioural disorders	14.8	15.7	17.3	33.7	32.7	25.1
Nervous system diseases	14.8	15.7	17.3	33.7	32.7	25.1
Digestive system diseases	25.5	26.7	28.0	28.2	26.9	27.4
Endocrinal/ metabolic diseases	12.6	12.5	10.9	14.3	14.1	11.7
Genito-urinary system diseases	14.9	14.1	12.8	11.7	9.7	9.0
Infectious/ parasitic diseases	7.3	6.1	4.3	4.1	4.0	4.9
Blood and immune system diseases	3.7	3.2	2.8	3.5	3.2	2.4

Source: OECD health data 1998.

Table 3. Average annual percentage change in real GDP in five-year periods

	OECD	western Europe	United Kingdom
1960–1965	5.9	5.6	3.3
1965–1970	5.2	5.0	2.7
1970–1975	4.2	3.8	2.2
1975–1980	3.6	3.5	1.9
1980–1985	2.3	1.9	2.0
1985–1990	3.3	3.5	3.6
1990–1995	1.1	1.0	1.3

Source: OECD health data 1998.
Notes: Figures for OECD and western Europe are arithmetic means for relevant countries and not weighted for population.

Table 5. NHS sources of finance (% unless otherwise shown), 1988/1989–1996/1997

Financial Year	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992	1992/ 1993	1993/ 1994	1994/ 1995	1995/ 1996	1996/ 1997
Total funding (£m)	**19 317**	**21 088**	**23 632**	**26 954**	**29 856**	**31 275**	**33 266**	**34 878**	**36 330**
Total Public	**95.2**	**94.1**	**94.5**	**94.7**	**95.0**	**94.7**	**94.5**	**94.3**	**93.7**
Consolidated fund expenditure	80.1	77.5	78.8	80.7	81.8	82.0	82.4	82.1	81.5
NHS element of NI contributions	15.1	16.6	15.7	14.0	13.2	12.7	12.1	12.2	12.2
Total from other sources	**4.8**	**5.9**	**5.6**	**5.6**	**5.2**	**5.4**	**5.6**	**5.8**	**6.3**
Charges	3.1	4.5	4.5	4.1	3.7	3.1	2.4	2.3	2.1
Capital funds from NHS Trusts	–	–	–	–	–	1.2	2.2	2.5	3.0
Miscellaneous	1.7	1.4	1.1	1.1	1.5	1.1	1.0	1.0	1.2

Source: Department of Health (1998) *The Government Expenditure Plans 1998–1999.* Departmental Report. Cm 3912. London: The Stationery Office.

Table 6. Total number of people waiting for hospital admissions in England, 1997–1999 (thousands)

	March 1997	June 1997	March 1998	December 1998	February 1999
Total	1 158	1 190	1 298	1 174	1 120
< 12 months	1 127	1 143	1 230	1 118	1 068
12–18 months	31.1	46.3	68.0	56.0	51.8

Source: Department of Health, 1999.

Table 7. Main sources of finance (as % of total expenditure on health care), 1975–1995

Source of finance	1975	1980	1985	1990	1994	1995
Public						
Taxes	89.0	89.0	86.0	79.0	82.0	84.0
Other public	7.9	7.3	8.2	14.3	11.6	9.8
Private						
Out-of-pocket	2.2	2.5	3.3	3.4	2.9	2.7
Private insurance	0.9	1.2	2.5	3.3	3.5	3.5

Population summary (Series VS no. 28, PP1 no. 24)

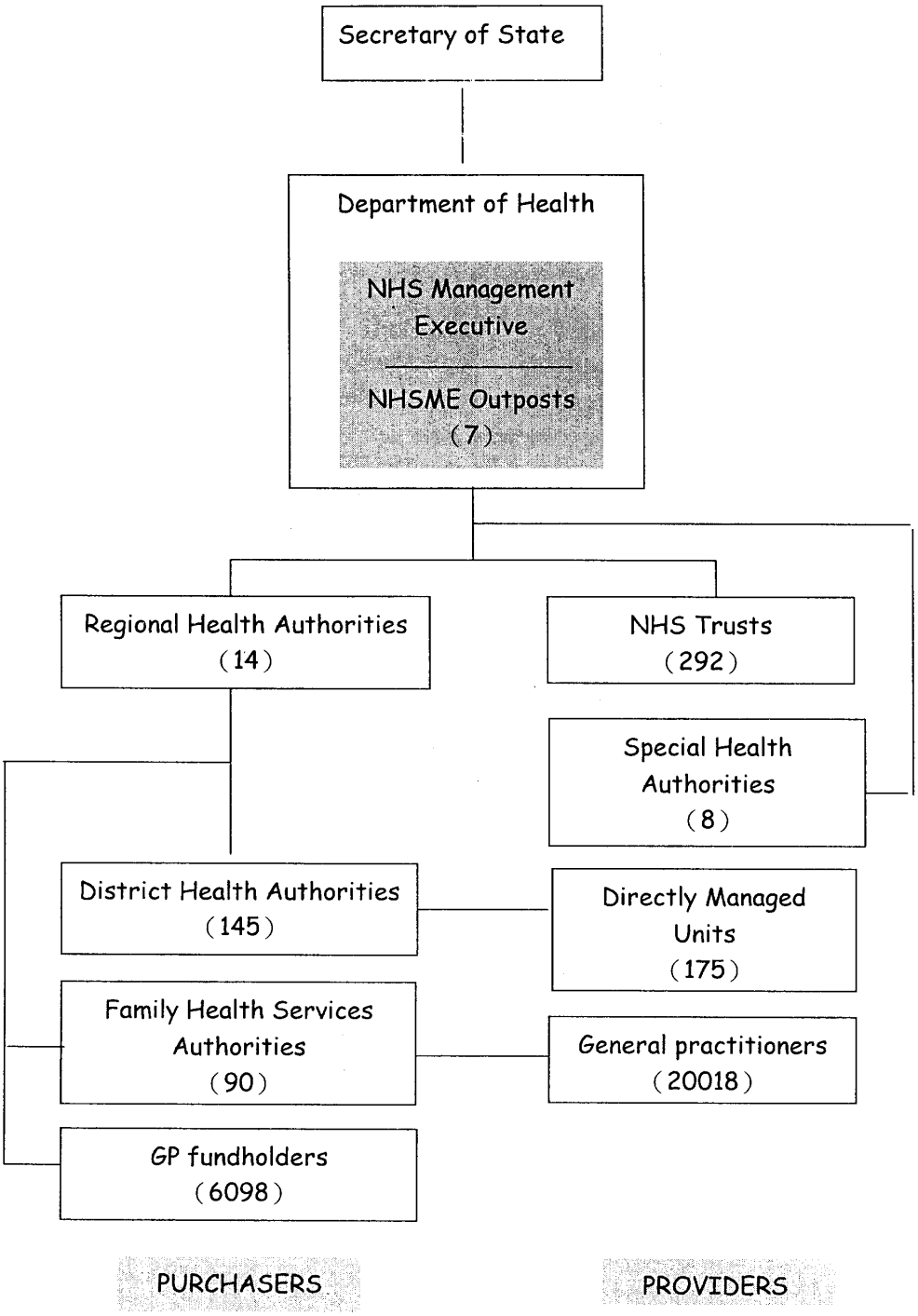
To link to Excel version ofthe table - click on the red box surrounding the table title

Table 1 Mid-2001 population estimates: estimated resident population by broad age-group and sex

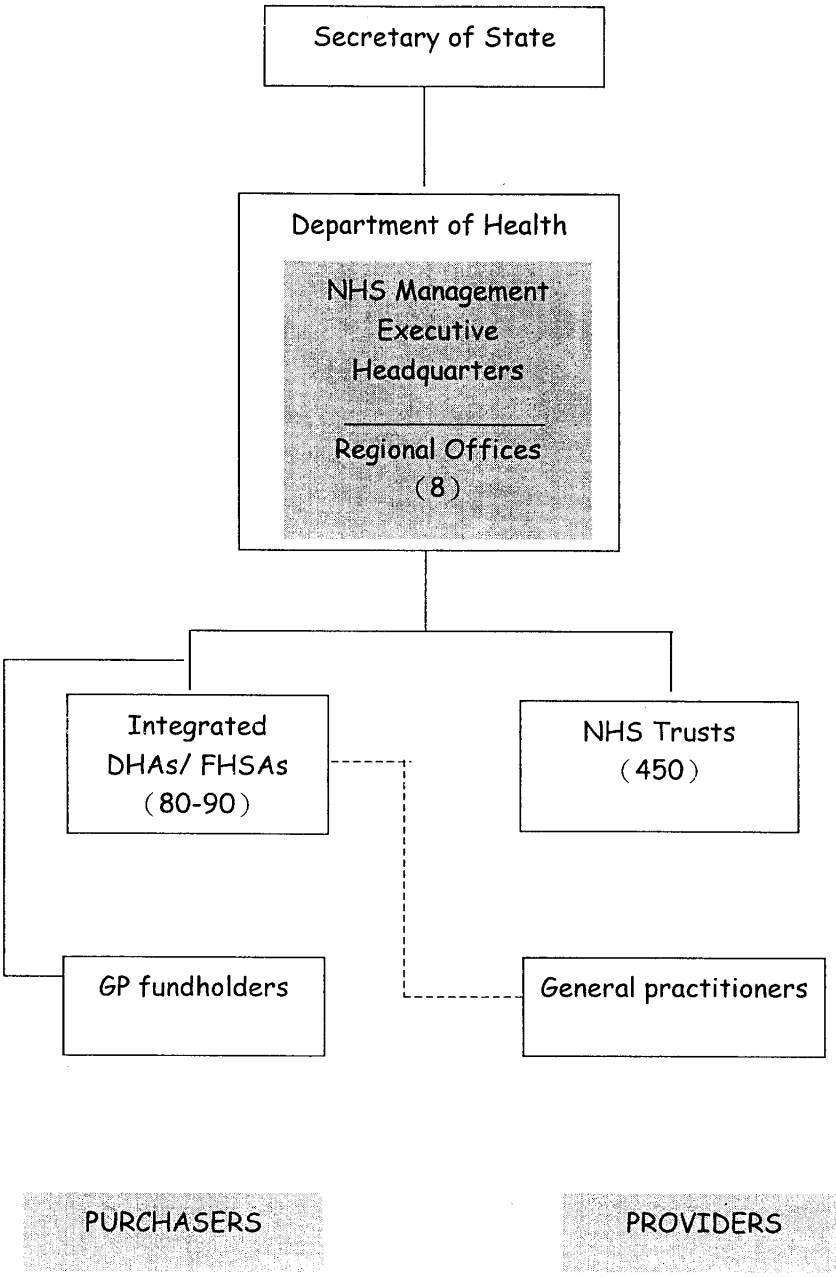
Area	All ages		Under 1		1 - 4		5 - 15		16 - 29	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
United Kingdom	**28,611.3**	**30,225.3**	**338.4**	**324.0**	**1,442.6**	**1,372.3**	**4,292.4**	**4,085.0**	**5,142.5**	**5,166.7**
England and Wales	**25,354.7**	**26,729.8**	**300.9**	**287.9**	**1,279.2**	**1,218.2**	**3,792.1**	**3,608.8**	**4,540.1**	**4,559.3**
England	**23,950.6**	**25,230.8**	**284.6**	**272.6**	**1,209.8**	**1,152.1**	**3,576.7**	**3,404.6**	**4,301.4**	**4,317.0**
Government Office Regions										
North East	1,219.3	1,297.2	13.1	12.6	57.6	54.7	183.6	174.8	212.4	215.8
North West	3,260.5	3,471.0	37.9	36.4	163.9	155.5	510.3	486.3	567.0	581.2
Yorkshire and the Humber	2,413.8	2,553.4	28.1	26.8	120.4	115.8	369.5	353.8	431.9	435.2
East Midlands	2,050.4	2,124.7	22.9	21.7	99.6	94.1	307.9	290.7	355.8	348.1
West Midlands	2,575.5	2,691.6	30.4	29.4	132.8	125.4	397.5	379.6	453.3	450.5
East	2,642.2	2,752.7	31.1	30.0	133.5	126.6	389.9	372.6	447.0	439.8
London	3,479.5	3,708.5	49.6	47.4	194.1	186.9	496.7	475.8	757.5	800.8
South East	3,909.6	4,097.3	45.8	43.7	196.0	186.1	577.4	545.4	678.9	664.8
South West	2,399.8	2,534.4	25.8	24.5	111.9	106.9	343.9	325.6	397.6	380.8
Wales	**1,404.1**	**1,499.1**	**16.3**	**15.3**	**69.4**	**66.1**	**215.4**	**204.2**	**238.7**	**242.3**
Scotland	**2,433.7**	**2,630.5**	**26.3**	**25.7**	**115.4**	**108.8**	**355.5**	**338.6**	**438.5**	**444.0**
Northern Ireland	**824.4**	**864.9**	**11.1**	**10.4**	**47.9**	**45.3**	**144.8**	**137.6**	**164.6**	**163.4**

United Kingdom, by countries and, within England, Government Office Regions
thousands

30-44		45-59		60-64		65-74		75 and over		Area
Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	
6,544.1	**6,747.2**	**5,520.0**	**5,624.2**	**1,409.3**	**1,470.4**	**2,303.8**	**2,636.0**	**1,618.2**	**2,799.6**	**United Kingdom**
5,797.0	**5,955.7**	**4,892.6**	**4,981.8**	**1,249.2**	**1,295.3**	**2,047.7**	**2,322.1**	**1,455.8**	**2,500.9**	**England and Wales**
5,502.1	**5,644.6**	**4,610.6**	**4,693.1**	**1,173.9**	**1,217.3**	**1,924.0**	**2,181.6**	**1,367.4**	**2,347.8**	**England**
										Government Office Regions
271.7	284.8	242.9	244.5	63.6	67.4	106.3	123.2	68.1	119.5	North East
728.9	759.0	638.5	646.7	167.6	174.8	268.5	310.1	177.9	321.0	North West
540.2	555.3	469.7	473.0	121.0	126.6	196.2	227.9	136.9	239.0	Yorkshire and the Humber
461.9	471.6	410.2	410.4	102.9	104.8	169.1	187.3	120.0	195.8	East Midlands
570.3	582.0	502.7	504.4	132.1	134.7	211.8	238.2	144.5	247.4	West Midlands
603.0	607.4	524.7	533.7	131.6	135.0	221.4	244.6	159.9	262.9	East
909.5	939.7	561.1	594.9	136.8	145.4	219.0	249.1	155.1	268.7	London
897.6	912.9	775.4	786.1	190.0	196.2	313.4	355.5	235.1	406.6	South East
518.9	532.0	485.3	499.5	128.2	132.5	218.4	245.6	169.9	286.9	South West
294.9	**311.1**	**282.1**	**288.6**	**75.3**	**77.9**	**123.7**	**140.5**	**88.3**	**153.0**	**Wales**
563.4	**599.9**	**483.1**	**496.1**	**124.6**	**136.9**	**200.5**	**246.1**	**126.2**	**234.3**	**Scotland**
184.5	**191.5**	**144.1**	**146.4**	**35.5**	**38.2**	**55.6**	**67.8**	**36.2**	**64.4**	**Northern Ireland**



附圖二之一　Structure of the NHS 1993



附圖二之二　Structure of the NHS 1994

Fig. 4. Structure of the 'new' NHS

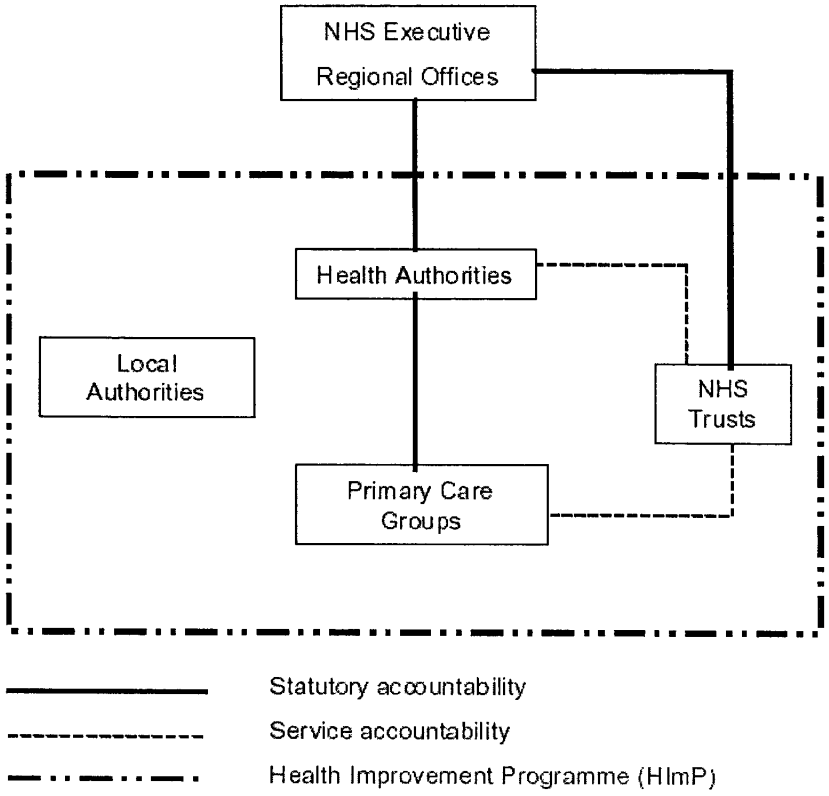
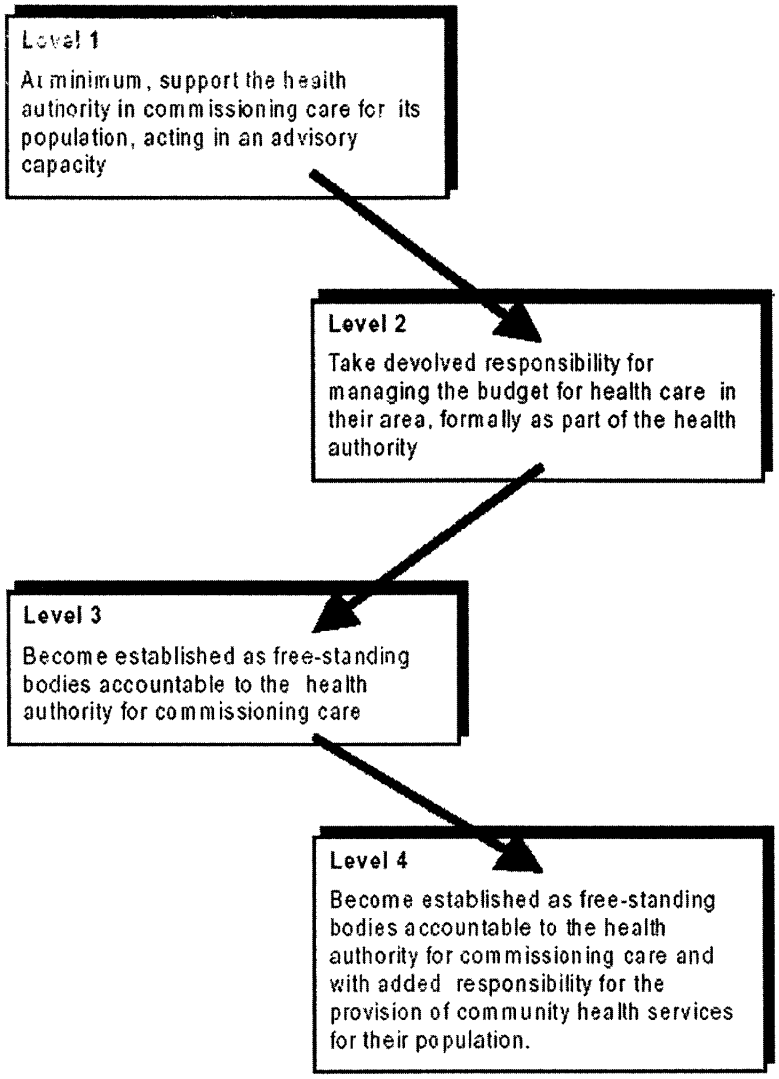
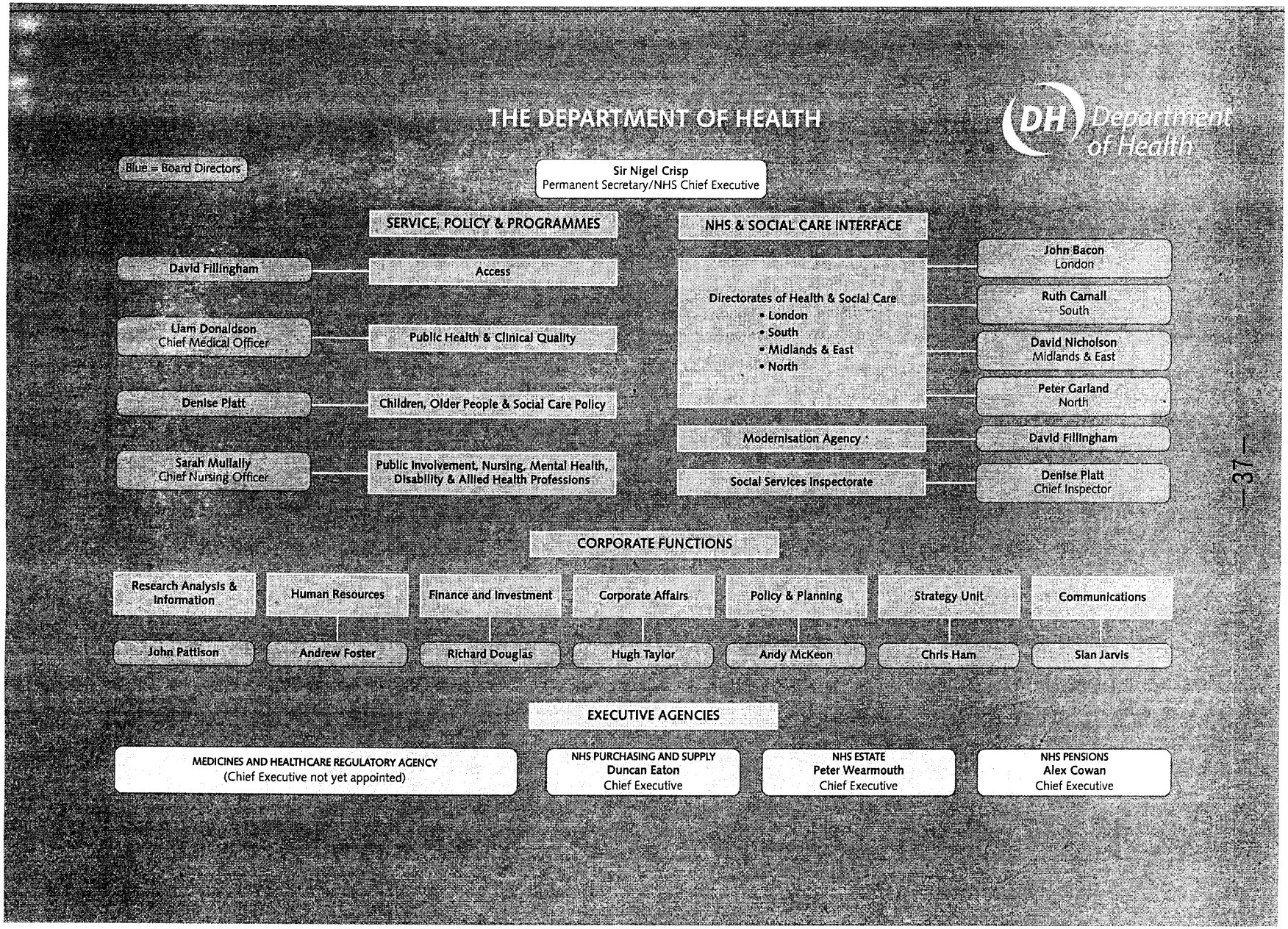


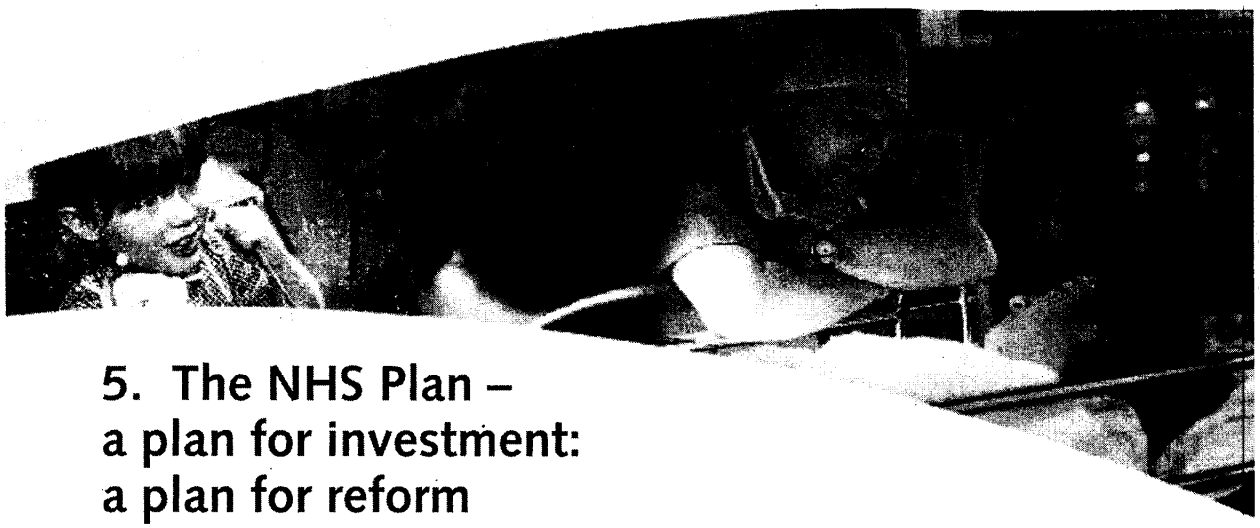
Fig. 5. The stages of development of primary care groups[5]



Source: Based on Department of Health (1998) *The new NHS: modern and dependable* London: The Stationery Office.

[5] Primary care groups will begin at whatever point on the spectrum is appropriate for them. Most of them are expected to start at level 2 and to progress so that in time all primary care groups will assume fuller responsibilities. Some primary care groups may proceed directly from level 2 to level 4.


THE DEPARTMENT OF HEALTH
Department of Health
Blue = Board Directors
Sir Nigel Crisp
Permanent Secretary/NHS Chief Executive
SERVICE, POLICY & PROGRAMMES
NHS & SOCIAL CARE INTERFACE
David Fillingham
Access
Liam Donaldson
Chief Medical Officer
Public Health & Clinical Quality
Denise Platt
Children, Older People & Social Care Policy
Sarah Mullally
Chief Nursing Officer
Public Involvement, Nursing, Mental Health, Disability & Allied Health Professions
Directorates of Health & Social Care
• London
• South
• Midlands & East
• North
Modernisation Agency
Social Services Inspectorate
John Bacon
London
Ruth Carnall
South
David Nicholson
Midlands & East
Peter Garland
North
David Fillingham
Denise Platt
Chief Inspector
CORPORATE FUNCTIONS
Research Analysis & Information
Human Resources
Finance and Investment
Corporate Affairs
Policy & Planning
Strategy Unit
Communications
John Pattison
Andrew Foster
Richard Douglas
Hugh Taylor
Andy McKeon
Chris Ham
Sian Jarvis
EXECUTIVE AGENCIES
MEDICINES AND HEALTHCARE REGULATORY AGENCY
(Chief Executive not yet appointed)
NHS PURCHASING AND SUPPLY
Duncan Eaton
Chief Executive
NHS ESTATE
Peter Wearmouth
Chief Executive
NHS PENSIONS
Alex Cowan
Chief Executive



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

THIS CHAPTER COVERS:

Summary of the NHS Plan

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

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

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

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

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

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

What does the Plan aim to achieve?

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

5.8 *Improvement Expansion and Reform – the Priorities and Planning Framework (PPF) 2003-2006*[52] was issued in October 2002 and describes the vision for services over the next three years. This takes forward the objectives of the NHS Plan and other national commitments and sets targets that the NHS and social services need to meet during the period 2003-04 to 2005-06.

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

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

5.10 The funding increase announced in the 2002 Budget will enable the Government to take forward the next phase of the NHS Plan. The next steps for investment and reform were published in *Delivering the NHS Plan* (April 2002).[53] This document outlines what the public can expect to see in improved services as the Plan is implemented, and how these improvements will be secured. It sets out how the NHS will operate to secure the best use of resources and be redesigned around the needs of the patient. The changes outlined in *Delivering the NHS Plan* centre around increasing choice for patients, introducing greater plurality of health service provision, devolving power to frontline staff, strengthening local accountability and changing the way in which money flows around the NHS.

IMPLEMENTING REFORM

Increasing Devolution – Driving extra provision locally

Planning and Priorities

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

5.12 Issued in October 2002, the *Improvement, Expansion, Reform – the Priorities and Planning Framework (PPF) 2003-2006*[54] describes how national commitments translate into targets for the NHS and social services. It also sets out a summary of the new system for planning and performance management. The new planning framework has been designed to:

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

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

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

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

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

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

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

Financial Allocations

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

NHS Foundation Trusts

5.19 *Delivering the NHS Plan*[55] set out plans to introduce NHS Foundation Trusts for NHS Trusts. In November 2002, as part of the Queen's Speech, the Department announced that it would establish Foundation Trusts as locally owned public benefit organisations, modelled on co-operative societies and mutual organisations. Their primary purpose will be to provide health and health-related services for the benefit of NHS patients and the community, on the basis of clinical need and according to national standards, and they will be subject to inspection by the Commission for Healthcare Audit and Inspection. Details on proposals are set out in *A Guide to NHS Foundation Trusts*[56] published by the Department in December 2002. This document invites preliminary applications, subject to criteria laid down by the Department, from acute and specialist NHS Trusts that were successful in gaining three stars in the July 2002 NHS Performance Ratings. Subject to legislation, the first NHS Foundation Trusts will be established from April 2004, with the first NHS Foundation Trusts existing in "shadow" form from 2003-2004.

Pay Modernisation

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

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

Patient Choice –
Redesigning NHS services around the needs of patients

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

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

5.24 Specifically, patients will be able to:

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

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

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

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

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

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

Next steps

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

Choice for People with Coronary Heart Disease

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

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

Diagnosis and Treatment Centres

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

5.30 The core objectives of the DTC programme are to:

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

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

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

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

Use of Spare Capacity in the UK Independent Sector

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

Overseas Treatment

5.34 *Delivering the NHS Plan*[57] set out the Government's intention to make greater use of overseas providers to treat NHS patients and to bring about greater diversity and pluralism in the provision of NHS services. Overseas treatment offers a means to add to the capacity of the NHS, and reduce waiting times. An overseas treatment pilot was set up between January and April 2002, with patients from three NHS pilot sites (East Kent, Portsmouth/Isle of Wight and West Sussex/East Surrey) receiving treatment in France and Germany. An independent evaluation of the pilot was conducted by the Health Economics Consortium at York University; patients' reactions were very positive.

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

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

Strengthened Accountability – Confidence in health service delivery

NHS Performance "star" Ratings

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

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

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

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

68	★★★
171	★★
53	★
12	0

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

45	★★★
77	★★
34	★
10	0

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

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

2003 Performance Ratings Indicators

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

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

2004 Performance Ratings Indicators

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

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

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

NHS Franchising

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

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

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

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

NHS Franchising Register of Expertise

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

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

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

Patient Prospectus – "Your Guide to Local Health Services"

5.56 The concept of local NHS organisations producing a 'Patient Prospectus' was first outlined in the *NHS Plan*,[58] as part of the Government's drive to strengthen local accountability, provide better information for local people about their local NHS and to place patient views at the centre of service improvement.

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

The Commission for Healthcare Audit and Inspection (CHAI)

5.58 Announced in *Delivering the NHS Plan*[59] the Commission for Healthcare Audit and Inspection (CHAI) will become the health watchdog which the public can trust as the independent commentator on the quality of NHS and independent health care and on how the additional funding announced in the Budget is being used to benefit patients. The current fragmentation in the system of NHS inspection means the same NHS organisation can face multiple uncoordinated inspection visits and demands for information from a number of different bodies. Fragmentation not only makes for unnecessary bureaucracy it also weakens the system of inspection. CHAI will help to reduce burdens and

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

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

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

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

Financial Flows –

Making sure money moves between commissioners and different healthcare providers

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

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

Next Steps:

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

NHS Bank

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

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

ACTIONS ACHIEVED TO DATE

ACCESS

Primary Care

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

At March 2003 nationally:

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

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

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

ON THE GROUND:

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

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

Secondary Care

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

Workforce –

Increase numbers of staff within the service and modernise jobs

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

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

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

ON THE GROUND:

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

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

Capital and Capacity –

Increase and improve capital and infrastructure within the system

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

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

ON THE GROUND:

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

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

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

Primary Care

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

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

Quality –

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

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

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

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

ON THE GROUND:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical Governance

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

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

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

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

ON THE GROUND:

Before patients were given automatic appointments every six to 12 weeks. But often patients felt this unnecessary and only need an appointment when problems arise.
A scheme to give diabetics the power to book their own podiatry appointments has been launched at North Tyneside General Hospital. Now the patient can choose the time and date of their next appointment.
This is not only more convenient for the patient but is also helping to ease the pressure on the service and make it more responsive to patient needs.

New consent processes

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

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

Patient Safety

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

National Clinical Audit

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

Controls Assurance

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

Modernisation Agency

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

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

ON THE GROUND:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cancer –

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

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

5.113 Significant progress is being made in cancer care including:

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

ON THE GROUND:

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

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

ON THE GROUND:

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

Prevention

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

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

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

Screening and early detection

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

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

ON THE GROUND:

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

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

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

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

Treatment

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

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

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

Palliative Care

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

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

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

Staffing

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

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

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

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

Equipment

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

ON THE GROUND:

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

Coronory Heart Disease –

Improve the care of patients with CHD and reduce mortality and morbidity of CHD

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

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

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

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

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

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

ON THE GROUND:

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

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

ON THE GROUND:

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

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

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

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

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

ON THE GROUND:

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

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

Older People's Services –

Improve the care provided to older people

5.142 The National Service Framework for Older People:

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

Wider programme

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

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

Mental Health –

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

5.143 Targets Achieved:

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

ON THE GROUND:

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

Children –
Improve children's health and social care services

Public Service Agreement (PSA) Targets

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

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

Children's NSF

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

Children's Trusts

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

Pathology Modernisation

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

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

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

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

Modernising NHS Dentistry

5.149 *NHS Dentistry – Options for Change*[5 15] was published in August 2002. The key themes and priorities that emerged were the need for:

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

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

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

Support to PCTs

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

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

Dental IT Strategy

5.154 The ideas and proposals in *Options for Change*[5 16] that will be tested need IT infrastructure support and so developing IT within dentistry is an essential component of the Options for Change programme.

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

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

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

Pharmacy in the Future

5.157 The Department's programme for pharmacy was published in *Pharmacy in the Future – Implementing the NHS Plan* (September 2000).[5 17] That set an ambitious programme for the role of pharmacy in the NHS, including measures to improve access to medicines, to promote high quality pharmacy services, and to reduce waste by promoting better use of medicines within the NHS.

5.158 During 2002-03 a new legislative framework and process for reclassifying the legal status of medicines was set in place, making it easier (where it is safe to do so) for medicines to be sold by pharmacists, rather than needing a prescription. The option of referring people to their community pharmacist for help has been rolled out nationally by NHS Direct. In 32 PCT areas repeat dispensing has begun. This means that patients will be able to get their medicines supplied in instalments from their pharmacy, without having to go back to their GP's surgery each time they need a new prescription. The Department will be considering options for rolling repeat dispensing schemes out nationwide. Three pilot schemes began under which prescriptions are transmitted electronically between GPs' surgeries, pharmacies and the Prescription Pricing Authority (PPA). The first three waves of the medicines management collaborative are helping people make better use of their medicines, a fourth wave is due to start later in the year. The community pharmacists' medicine management research project, funded by the Department, is under way where people with coronary heart disease are given advice on their medicines in community parmacists medicine. A guide to medication review – *Room for Review*[5 18] – was published. This will promote medicines partnership between patients and health professionals and support effective medicine taking. The first Local Pharmaceutical Services (LPS) pilots were approved. Eight pilots covering 17 providers are already under way with 10 further pilots due to start in the next few months. LPS provides flexibility for PCTs to contract locally for provision of pharmacy and a broad

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

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

Independent Reconfiguration Panel (IRP)

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

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

5.162 The Panel will take account of all relevant Department policy guidance in formulating its advice. In particular, *Keeping the NHS Local – A New Direction of Travel*[5.19] and the route map described in that document will be a central feature of its consideration of contested proposals. *Keeping the NHS Local* offers support to the NHS and partner organisations engaged in service change. It also stresses the importance of local stakeholder involvement from the outset. In providing advice to the Secretary of State, the IRP will take specific account of the extent of public and patient involvement.

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

Modernisation Agency

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

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

5.166 Modernising the NHS means:

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

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

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

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

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

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

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

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

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

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

IMPROVEMENT, EXPANSION AND REFORM: THE NEXT 3 YEARS

PRIORITIES AND PLANNING FRAMEWORK 2003 - 2006

Preface

The extra money coming into Health and Social Services gives us the opportunity to make real improvements. We can expand through recruiting new staff, developing new services and creating new facilities. Even more importantly we can transform the quality of services by raising standards, tackling inequality, becoming more accessible and flexible and designing our services around the needs and choices of the people we serve.

This is about both quality and growth. The real test for success will be whether people can feel the difference and believe the services they receive are truly designed around them.

These are hugely ambitious goals. They will take time to deliver. Making progress over the next three years will be demanding and difficult and require real determination and discipline. It will need us to:

- focus on priorities, we cannot make progress at the same pace in every area
- extract the maximum value from every pound
- be prepared to change old practices, be creative and take uncomfortable and difficult decisions in the drive to improve quality and respond to people using services

Local plans

This document sets out what organisations need to do over the next three years. It identifies national priorities and targets which organisations need to build into their local plans. These targets are challenging but simply achieving them will not be enough to guarantee success. Organisations need to challenge old perceptions of public service and build public confidence in new systems. Cultural change is an essential part of the transformation. Crucially the NHS at all levels needs to embrace diversity in provision and choice for patients

This cultural change can only be achieved through the increased involvement of the public, staff, service users and our partners. Each brings their own perspective. We need each of them to contribute to progress.

Developing these plans should itself involve all these different people and be part of that cultural change. In every area our staff, the people using services and the public need to understand what we are doing, what progress is being made. They need to be able to advise and share in the drive for improvement and quality.

Nigel Crisp
Chief Executive

1. Introduction

1.1 The NHS Plan will deliver for the people of the country a health service fit for the 21st century with services designed around the needs of patients and improved health outcomes, particularly for the poorest in our society. Similarly the aims for social care are to improve services, promote independence and well being, and protect and support the most vulnerable.

1.2 The vision is to offer prompt, convenient, high quality services with people exercising greater choice. It is a vision where staff are fairly treated, properly rewarded and able to use their skills to the full.

1.3 Over the next three years we need to increase the range and quality of services, and improve the service user's experience. The emphasis will be on:

- making measurable progress, particularly in the highest priority areas
- developing the capacity needed to deliver these plans: increasing staffing numbers and providing more facilities, more equipment and more providers of services and care
- changing the way the whole system works to help staff and organisations deliver on these ambitious goals particularly by ensuring patients and users have greater choice over services

1.4 It is about improvement, expansion and reform.

1.5 This paper sets out the priorities for the next three years for the NHS and social services and describes what local organisations and communities need to do to plan for and implement these improvements.

1.6 During these three years the whole health and social care system will be changing with most notably:

- more choice for patients
- payment being made for results in the NHS so increasing the incentive for delivery (a consultation document on Reforming NHS Financial Flows will be published shortly)
- new incentives for both social services and health to provide appropriate services for older people outside hospital
- increasing freedom for high performing organisations, including the establishment of the first foundation hospitals in the NHS

1.7 At the same time every organisation needs to:

- ensure the safety of its patients and users and the quality of its services, including developing clinical governance arrangements
- ensure people are fully informed and involved in their own care and in planning and reviewing services and that services are provided equitably to all who need them

- take into account in its planning the progressive implementation of the working time directive and the expected introduction of new contracts.
- take part in emergency planning and ensure that the necessary arrangements are in place
- continue to modernise the way in which services are delivered, with the learning about good practice being spread between organisations
- provide for the continuing training, re-training and development of individuals, offering new skills and competencies
- be involved in the introduction of new information and communications systems

2. *Planning framework*

2.1 Planning in the past has been done annually and constrained by time pressures and the requirement for multiple plans. For the first time ever health services are now able to plan over a three-year period with, later this autumn, local health services receiving three-year budgets. Following the completion of the Local Government Finance Review, councils will have some confidence about the distribution of resources available over the next three years, including for social services. This will allow organisations to look in-depth at their services, plan change with confidence and implement improvements year on year. Against this background planning consists of the following six steps which need to be followed through in each organisation and community:

- identifying the national and local priorities and the key targets for delivery over the next three years
- agreeing the capacity needed to deliver them
- determining the specific responsibilities of each health and social care organisation
- creating robust plans which show systematically how improvements will be made and which are based on the involvement of staff and the public
- establishing sound local arrangements for monitoring progress and NHS performance management which link into national arrangements
- improving communications and accountability to the public locally so as to demonstrate progress and the value added year on year

Each of these steps is described briefly in this paper.

3. The priorities

3.1 The priorities for this period are based on the Department of Health's Public Service Agreement which is shown at Appendix A.

3.2 The health and social care priorities are:

- improving access to all services through:
  - better emergency care
  - reduced waiting, increased booking for appointments and admission and more choice for patients
- focusing on improving services and outcomes in:
  - cancer
  - coronary heart disease
  - mental health
  - older people
  - improving life chances for children
- improving the overall experience of patients
- reducing health inequalities
- contributing to the cross-government drive to reduce drug misuse

3.3 In each of these priority areas there are key targets for the next three years. These are shown in Appendix B. They are relevant to primary care as well as hospital services and will not be achieved without close co-operation between health and social services. Indeed many rely on achieving a better balance in local service provision with a greater emphasis on community-delivered services. Every health and social care community must plan to meet each of these targets in the next three years.

3.4 There are, naturally, a very large number of important services and needs not covered by these targets:

- local communities will have local priorities related to their local populations and local circumstances
- local government has priorities in other important areas of public services
- nationally, the NHS and social services will be supporting other areas of public services including, for example, neighbourhood renewal

And the world will not stand still over the next three years. There will for example be the new National Service Frameworks for Children and Renal Services and the delivery of that for Diabetes. (Critical milestones for diabetes are included in the targets set out here.)

3.5 Other than the targets in this document, arrangements for delivery will be a matter for local determination. Local organisations and communities will set their own timescales and milestones. They will be responsible for reporting to and accounting to their local communities for improving these services where necessary.

4. Building capacity

4.1 In order to deliver in the priority areas it will be necessary in most cases to have additional capacity available in terms of staff, facilities and equipment. In some cases this may mean involving new organisations in providing services and care.

4.2 Alongside the targets in Appendix B we have set out the national assumptions about the level of capacity that will be needed to deliver targets in each priority area. Organisations will take these into account in developing their plans. Whilst the targets themselves are not negotiable, local organisations and communities can work to different assumptions where these can be justified by local circumstances.

4.3 In addition each NHS organisation, working with its local councils and other local partners, will need to develop underpinning plans which show the total increases in capacity in the three key areas of:

- physical facilities
- workforce
- information management and technology

4.4 Nationally the NHS will be looking for significant increases and developments in each of these areas. The national requirements in each area for the three years are described in Appendix C.

5. Organisational responsibilities

5.1 Implementing these plans will depend on taking a whole system approach with each organisation playing its part in delivery. It will be important that there is local sharing of performance and financial data (particularly between PCTs and providers of health care such as acute hospital trusts and GP practices) to inform local planning. The planning process itself will need to involve all the relevant organisations and, most importantly, the front line staff who must make the vision happen. For example, staff in General Practices must be actively involved through improved engagement with PCTs.

5.2 Within the new planning framework a lead agency will be responsible for ensuring that the process of developing plans is robust to take responsibility for the quality of the final product. For the priority areas the division in leadership between the NHS and social services is:

NHS lead	Joint lead	Social services lead
Access to services for emergency and planned care	Mental health	Life chances for children
Cancer	Older people	
CHD		
Patient experience		
Health inequalities		
Drug misuse		

5.3 Where the NHS is in the lead, strategic health authorities will be responsible for ensuring the process and outcome of planning is robust, and similarly councils will take responsibility for the social care lead area. Where the lead is joint, PCTs and councils should locally agree the lead arrangements at the beginning of the planning process.

5.4 Within the NHS planning will be from the bottom up:

- PCTs (and relevant Care Trusts), as the lead planners, will be responsible for creating local plans which describe health and service improvement in their area. These will be developed using local clinicians' knowledge as well as patients and the public. They will address the needs of the community as a whole and incorporate the national priorities.

- each NHS Trust will be responsible for creating its own plan which shows how it will deploy its resources to deliver on both national and local priorities and fit within the plans of its PCT commissioners

- Workforce Development Confederations will work with the other organisations to contribute to these plans and support Strategic Health Authorities to create the workforce plan as part of the Local Delivery Plan.

- Strategic Health Authorities will bring together those PCT plans, as described in the next section, into a comprehensive Local Delivery Plan for their area

- taken together these plans will make up a coherent national picture

5.4 Councils should contribute to Local Delivery Plans as necessary. In particular, where they are leading on one of the joint priority areas, the plan they produce with the NHS should be built into the Local Delivery Plan for the area. Councils' planning for their lead priority on life chances for children should follow local government requirements taking account of any special arrangements agreed for the Local Government PSA as a whole. Both NHS organisations and Councils should consider how joint activity will be reflected in local PSAs and contribute to meeting them.

6. Creating robust plans within a new planning process

6.1 A new NHS planning system has been designed to allow organisations to produce three-year plans. It is simpler and has fewer national requirements and national targets. The essence of the new system is for all the current national planning requirements for the NHS to be replaced by a single three year local delivery plan. This mirrors the recent changes for social care where there is already a reduction in the number of plans required to be submitted to the centre and further work being undertaken on simplifying local government planning requirements.

6.2 The Local Delivery Plan will be significantly different from previous plans. It will need to identify the expected progress or milestones for each priority area over the three year period (in programme management terms this means the "trajectory" of delivery). In general terms it will need to identify quarterly or annual milestones but in a small number of critical deliverables it may need to show planned progress on a month by month basis.

6.3 It will also need to be supported by a financial strategy and plan, taking account of the changes to the financial system during the period, and showing how resources will be deployed and value for money will be achieved.

6.4 The Local Delivery Plan will cover a whole Strategic Health Authority area but will be based on PCT level plans. It will need to take account of the various reforms to the systems which will be happening during this period, (eg on financial flows), and show how these will contribute to progress.

6.5 The Local Delivery Plan itself will be a "live" document which will be amended with, for example, corrective action taken if delivery goes off course or new initiatives taken when new opportunities arise. These adjustments will generally be made following quarterly and annual monitoring. There will not be an annual planning round to replace the current SaFFs process. However a new three-year plan will need to be developed within the third year.

6.6 The timetable is as follows:

- local planning started during the summer months following the briefing sessions which were organised nationally
- technical guidance on the new process will be published shortly
- a guidance and consultation document on the introduction of payment for results will be published shortly
- the national project on Configuring Hospitals will be publishing an advisory framework during the autumn. (The focus of the framework is hospital configurations but it has been developed in the context of a whole systems approach to planning and delivering care.)
- the three year financial allocations to PCTs will be announced in November, together with the national price tariff which will apply to the payment for results system. (In the meantime organisations will need to work to sensible assumptions about the amount of money available to them based on the national allocation.)
- Strategic Health Authorities have been asked to produce capacity plans in October which identify how sufficient capacity will be brought into use during the three year period. These will be incorporated into the local delivery plans which are due in March. However some aspects of the capacity plans which are time critical eg for capital projects or key appointments will need to be actioned before March.

6.7 Whilst the final plans are required in March, all NHS organisations will need immediately to design their local planning processes, where they have not already done so. In addition there will need to be constant and continuing discussion between StHAs and the Department of Health over these plans throughout the next few months to ensure that they can be agreed before the start of the next financial year.

6.8 As part of this new planning process the Department of Health has set out the key priorities for the next three years. It will do everything possible to ensure that these are maintained and to minimise any changes which may result from unforeseen risks or events and changes in local or national circumstances. The vast majority of NHS resources will be in the hands of PCTs, thereby reducing the scope over this period for new initiatives and programmes.

6.9 However the three-year period will inevitably bring about some change. Where this happens, the Department will consult with Strategic Health Authorities, councils with social services responsibilities – and where possible with the NHS more widely – about how to introduce changes to this framework.

7 Arrangements for monitoring and NHS performance management

7.1 Under the new arrangements, it will be much more important for local organisations to have good monitoring arrangements in place so that they can amend their plans and take action where necessary during the course of these three years. Wherever possible individual organisations should be taking action themselves rather than waiting for intervention to be initiated by others.

7.2 The arrangements for monitoring and performance management in the NHS are that:

- each organisation will have its own system. In addition each organisation will need to make arrangements, as described in the next section, to report to their staff and public on performance.
- PCTs will hold provider organisations to account for the delivery of services which they have commissioned
- StHAs will hold all NHS organisations to account for performance
- The Department of Health will hold StHAs to account for the performance of the NHS within their area.

7.3 Monitoring and performance management will focus on the targets for the next three years. There will be routine monitoring of national standards and past targets where appropriate to ensure they continue to be met.

7.4 During the year, SSI will track councils' progress against the local improvement plan. Monitoring information will continue to be used to contribute to the overall assessment of social services performance that leads to the award of star ratings.

7.5 As part of this system, new inspectorates are to be put in place for both health and social care. They will have the responsibility for assessing the overall performance of organisations and for the publication of performance ratings.

8 Improving NHS accountability and demonstrating added value

8.1 The NHS is transforming itself into an organisation which truly focuses on its patients, designs its services around them and offers them choice and involvement. Its success depends on the involvement of very many people and organisations and on the support of patients and the public.

8.2 PCTs have responsibility for publishing an annual Patient Prospectus which describes services and performance in their area. This will be a core document for the public. In addition, however, each organisation will continue to bear responsibility for its own communication and involvement of stakeholders. It is therefore essential that each NHS Board reviews its arrangements for involving and communicating with all its stakeholders – its patients, its public, its staff and its partners. It will need to involve these stakeholders in preparing and advising on the plans. It must also show in its plans how it will continue to involve and communicate with them and report on performance and progress for each of these groups.

8.3 The arrangements for reporting to stakeholders will, amongst other things, need to demonstrate how extra funding has been used to add value to services provided by or commissioned through the organisation, for example by investment in new facilities or in training or in extending the availability of services to people.

8.4 The precise way that an organisation demonstrates the value that is being added will depend on its activities and local circumstances. However, in every case the organisation should be able to demonstrate that it has added value at least to the level of any additional funding, that it has secured a minimum 1% increase in cost efficiency and a minimum increase in quality equivalent to 1% of its budget. Further guidance covering methodology will be issued to organisations in due course.

9 Conclusion

9.1 This document sets out the national requirements for local planning. Taken together these local delivery plans will show how the NHS, working with social services and other partners, will make visible improvements, expand and reform services over the next three years.

9.2 This national picture is very important. However, it is equally important that plans make sense locally and that they are understood and owned by all the local parties. Delivery of improvements will depend on the involvement and determination of front-line staff and the involvement of patients and the public in shaping services. PCTs, as fully inclusive organisations, must ensure that the plans produced as part of this process must be about local accountability and local action as much as being about national accountability and the delivery of national targets.

Department of Health
September 2002

APPENDIX A

DEPARTMENT OF HEALTH – PUBLIC SERVICE AGREEMENT

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

Objective I: improve service standards.

1. Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to 3 months by 2008.
2. Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004; and reduce the proportion waiting over one hour.
3. Guarantee access to a primary care professional within 24 hours and to a primary care doctor within 48 hours from 2004.
4. Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.
5. Enhance accountability to patients and the public and secure sustained national improvements in patient experience as measured by independently validated surveys.

Objective II: improve health and social care outcomes for everyone.

6. Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40 % in people under 75; from cancer by at least 20% in people under 75.
7. Improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010.
8. Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30 % of the total being supported by social services at home or in residential care.
9. Improve life chances for children, including by:
   - improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area, and at least 15% of children in care attain five good GCSEs by 2004. (The Government will review this target in the light of a Social Exclusion Unit study on improving the educational attainment of children in care.);
   - narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted; and
   - reducing the under-18 conception rate by 50% by 2010.
10. Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
11. By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

Objective III: improve value for money

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

APPENDIX B

IMPROVE ACCESS FOR BOTH EMERGENCY CARE AND PLANNED CARE

Objective

The overall objective is to provide fast, safe and high quality emergency care and fast convenient access and patient choice for planned care.

Throughout the country, there will be:

- Universally high quality primary care services which are accessible and responsive to patients' needs and preferences.
- Integrated networks of emergency care involving health and social services that link together primary care, social care, hospital care, ambulance services, voluntary services and NHS Direct all of whom will play their part.
- Increasing separation of elective and emergency capacity.
- Efficient systems for booking appointments and admissions that offer patient choice and fast access to planned care.
- Local systems to ensure that guarantees to patients are met including the NHS Plan cancelled operations guarantee. (From 1 April 2003 this will apply to patients cancelled at "the last minute" and not just those cancelled "on the day of surgery".)

Targets

For emergency care:

- Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by March 2004 for those Trusts who have completed the Emergency Services Collaborative and by the end of 2004 for all others. A target will be set relating to a reduction in the proportion of patients waiting over one hour, following consultation with the service over its precise definition.

- By December 2004 a single phone call to NHS Direct will be a one-stop gateway to out-of-hours healthcare, with callers passed on where, necessary, to the appropriate GP co-operative or deputising service.

For planned care:

- Ensure 100% of patients who wish to do so can see a primary health care professional within 1 working day and a GP within 2 working days by December 2004.

- Achieve a maximum wait of 4 months (17 weeks) for an outpatient appointment and reduce the number of over 13-week outpatient waiters by March 2004, as progress towards achieving a maximum wait of 3 months for an outpatient appointment by December 2005.

- Achieve a maximum wait of 9 months for all inpatient waiters and reduce the number of 6-month in-patient waiters by 40% by March 2004, as progress towards achieving a maximum 6 month wait for inpatients by December 2005 and a 3 month maximum wait by 2008, ensuring an overall reduction in the total list size and a reduction of at least 80% by March 2005 in the number of over 6-month in-patient waiters from the March 2003 baseline.

- Increase the level of choice in each year, offering routine choice of hospital provider at point of booking for all patients by December 2005 with 100% booking of day cases and two thirds of all first outpatient and inpatient elective admissions being pre-booked by March 2004.

National capacity assumptions

- Differential between growth in elective activity and GP referrals of 3% to ensure sufficient elective capacity to meet waiting time targets and offer choice.
- Day case rate increased to 75%
- Increased amount of activity taking place in primary and community settings to contribute to the national assumption of at least one million more outpatients appointments (around 10%) take place in the community rather than in hospital.
- Sufficient bed capacity (including critical care) to ensure that bed occupancy drops to a level consistent with admitting emergency cases without delay.
- Support and incentives for routine delivery of fast and convenient access to primary care services for all patients by increasing and targeted resources in those practices or other service providers with particular resource, management or other developmental needs.
- Increase the amount of elective activity undertaken in dedicated facilities (including DTCs) and non-NHS providers (including the private sector).

CANCER

Objective

The NHS Cancer Plan sets out a framework for services that will:

- Save more lives
- Ensure people with cancer get the right professional support and care as well as the best treatments
- Reduce inequalities
- Build for the future through investment in workforce and research for cancer

All patients should have access to prompt, high quality services for prevention, diagnosis, treatment and care for cancer as set out in the NHS Cancer Plan. Services should be developed through cancer networks (involving the Cancer Services Collaborative) and be provided in line with national cancer standards, taking full account of NICE appraisals and clinical outcomes service guidance. Providers should ensure full participation in national cancer comparative clinical audit, from 2003/04 for lung and breast cancer and from 2004 for colorectal and head and neck cancers.

Targets

- Maintain existing cancer waiting time standards and set local waiting time targets for 2003/04 and 2004/05 so that by the end of December 2005 there is a maximum of one month from diagnosis to treatment, and two months from urgent referral to treatment for all cancers.

- Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006

- Extend breast screening to all women aged 65-70 by 2004

- Set local targets to achieve compliance with forthcoming national standards on supportive and palliative care (to be derived from NICE supportive and palliative care guidance)

- Agree, implement and monitor local plans to improve the outcomes of cancer treatment, as evidenced by increasing compliance with NICE Improving Outcomes guidance and the associated national cancer standards

National capacity assumptions

- Increased investment in cancer services, to contribute to additional funding nationally of £570 million for cancer services by 2003/04 (baseline 2000/01)
- Increased access to radiotherapy and diagnostic services (including radiology, pathology and endoscopy) to enable cancer waiting times targets to be met, as demonstrated through increased staffing, improved facilities and equipment.
- Increased investment in specialist palliative care in line with NICE Supportive and Palliative Care Guidance and NHS Cancer Plan commitment, contributing to an extra £50m nationally by 2003/04 (baseline 2000/01)

CORONARY HEART DISEASE

Objective

The National Service Framework for Coronary Heart Disease set the framework for action to:

- prevent disease, save more lives and improve quality of life;
- deliver services that are responsive to the needs and choices of patients;
- reduce inequalities, through action to reduce the risk of CHD

All patients should have access to prompt, high quality care across the patient pathway, as set out in the NSF. Service development should build on the experience of the Primary Care and Coronary Heart Disease Collaborative Programmes, and should take full account of the results of comparative clinical audits. In particular all appropriate units should participate in national CHD comparative audits for paediatric and adult cardiac surgery and for myocardial infarction; and prepare to contribute to the planned national audit on angioplasty.

Targets

- Improve access to services across the patient pathway and increase patient choice by achieving the two week wait standard for Rapid Access Chest Pain Clinics; setting local targets to make progress towards the NSF goal of a 3 month maximum wait for angiography; and delivering maximum waits of 3 months for revascularisation by March 2005, or sooner if possible.

- Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.

- In primary care, update practice-based-registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.

- Improve the management of patients with heart failure in line with the NICE Clinical Guideline due in 2003, and set local targets for the consequent reduction in patients admitted to hospital with a diagnosis of heart failure

National capacity assumptions

- Increased access to diagnostic and surgical capacity to enable waiting times targets to be met.
- More defibrillators commissioned in public places, working with the New Opportunities Fund, to contribute to national target of 3,000 by 2004.

MENTAL HEALTH

Objective

The Mental Health NSF and Suicide Prevention Strategy set out a modernisation programme to:

- reduce the suicide rate and deaths by undetermined causes by 20% by 2010
- improve access to general community Mental Health services

Services should be delivered in line with the standards in the Mental Health NSF, the Mental Health Implementation Guide, national Mental Health strategies and compliance with NICE appraisals/guidance. Comparative clinical audit and information from the Mental Health Minimum Data Set (which should be implemented in all Trusts by 03/2003) should be used to develop services, and the National Institute for Mental Health England will support development work. Modernisation will be supported by a new Mental Health Legislative framework. NHS and social services joint responsibility will be delivered through Local Implementation Team partnership.

The Children's NSF and its emerging findings will set out the standards and milestones for improvement in child & adolescent mental health services (CAMHS), including year on year improvements in access.

Targets

- Reduce the duration of untreated psychosis to a service median of less than 3 months, (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis by 2004.

- Offer 24-hour crisis resolution to all eligible patients by 2005.

- By Dec 2003, deliver assertive outreach to the 20,000 adult patients with severe mental illness and complex problems who regularly disengage from services.

- Increase breaks available for carers and strengthen carer support and networks to the benefit nationally of approximately 165,000 Carers of people on CPA by 2004.

- Improve mental health care in prisons so that all prisoners with severe mental illness have a Care Plan by April 2004 (approximately 5000 prisoners nationally) and ensure appropriate use of secure and forensic facilities by 2004, contributing to the national target of moving 400 patients from high secure hospitals by 2004.

- Ensure that by April 2004 protocols are in place across all health and social care systems for the care and management of older people with mental health problems.

National capacity assumptions

- Expanded service capacity in key services, to contribute to national requirements by 2004 of 335 crisis resolution teams; 50 additional assertive outreach teams; 50 early intervention teams; 140 new secure personality disorder places.
- Reduced pressure on acute inpatient units by reduction in bed occupancy rate
- All child and adolescent mental health services to provide comprehensive service including mental health promotion and early intervention by 2006
- Increase child and adolescent mental health services by at least 10 per cent each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment)

OLDER PEOPLE

Objective

The NSF for Older People sets out the framework for health and social care services that will deliver:

- Person centred care, respecting dignity and promoting choice
- The promotion of independent living and health and active life
- User satisfaction through timely access to high quality services that meet people's needs
- Partnership with carers

Services will be developed in line with the NSF standards and milestones. They will be provided in wider partnerships where appropriate, with the right professional support and care, to meet the full range of needs. The Information Strategy for Older People will be implemented and there will be systems in place to explore user and care experience. Councils will implement the policy of offering eligible individuals the choice of direct payments during assessment for community care services.

Targets

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

- Each year there will be less than 1% growth in emergency hospital admissions and no growth in re-admissions.

- By December 2004: all assessments of older people will begin within 48 hours of first contact with social services and will be completed within four weeks, (with 70% within two weeks); following assessment, all social services will be provided within four weeks, (with 70% within two weeks); all community equipment for older people (aids and minor adaptations) will be provided by social services within seven working days.

- By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.

- By April 2004 all general hospitals caring for people with stroke to have a specialised stroke service, and all health and social care systems to have established an integrated falls service by 2005.

National capacity assumptions

- Intermediate care capacity expanded to meet the NHS Plan targets of an increase in the number of intermediate care beds by 5000 and the number of people benefiting from intermediate care by 220,000, in 2004 compared with 2000. By 2006 councils increase their intermediate care places to benefit an extra 70,000 people a year.
- Service capacity increased in other key services which support people at home so that in 2006: 30,000 more people a year receive care packages involving 5 hours or more a week of home care; 500,000 more pieces of community equipment are provided; there are 6,900 more extra care housing places. An increase of 6000 in the number of people in care homes supported by councils over the three years to 2006.
- An additional 130,000 carers a year receive services in 2006, using the increased investment in the existing carers special grant.
- As a result of investment in extra capacity and the introduction of reimbursement of the NHS by councils, delayed transfers of care reduce to a minimal level by 2006.

LIFE CHANCES FOR CHILDREN

Objective

Ensure the NHS and local government work together to improve life chances for children by:

- promoting the secure attachment of children to carers capable of providing safe and effective care for the duration of their childhood;
- enabling looked after children to gain maximum life chance benefit from educational opportunities, health care, social care and other services;
- addressing issues identified in the Kennedy Report including preparation for and implementation of the first module of the Children's NSF once this is published; and
- engaging fully with the ongoing development of cross-agency preventive work to support children and families, including local prevention strategies, and the continued development of Sure Start and Children's Centres.

Targets

- Improve the educational attainment of children and young people in care by increasing to 15 per cent by 2003-04 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*-C, and maintain this level up to 2006. (N.B. The Government will review this target by the end of 2002 in the light of a Social Exclusion Unit study on improving the education attainment of children in care.)

- Improve the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004, and maintain this level up to 2006.

- Reduce by 2004, the proportion of children aged 10-17 and looked after continuously for at least a year who have received a final warning or conviction, by one third from September 2000 position. (Reduce the proportion from the 2000 national figure of 10.8 per cent to a local maximum of 7.2 per cent.) Maintain this reduction up to 2006.

- Maintain current levels of adoption placement stability (as measured by the proportion of placements for adoption ending with the making of an adoption order) so that quality is not compromised whilst increasing the use of adoption as follows:
  - By 2004-05 increase by 40 per cent the number of looked after children who are adopted, and aim to exceed this by achieving, if possible, a 50 per cent increase by 2006, up from 2,700 in 1999-2000. All councils will bring their practice up to the current level of the best performers (band 4 or 5 on PSS PAF indicator C23).
  - By 2004-05 increase to 95 per cent the proportion of looked after children placed for adoption within 12 months of the decision that adoption is in the child's best interests, up from 81 per cent in 2000-01, and maintain this level (95%) up to 2006, by locally applying the timescales in the National Adoption Standards, taking account of the individual child's needs.

National Capacity Assumptions

- All Local Authorities to have in place robust mechanisms for partnership working with relevant agencies to achieve targets.
- Improvement in the stability and quality of placements for looked after children including through recruitment/retention and support to foster carers over this period to support targets in line with the Choice Protects Review.

IMPROVING THE PATIENT EXPERIENCE

Objective

The NHS will be transformed through better engagement with patients, the public and staff. By regularly seeking out and acting on local feedback, the NHS will create patient responsive services that people perceive to be improving.

The 5 key dimensions for a good patient experience are:
- Improving access and waiting
- More information, more choice
- Building closer relationships
- Safe, high quality, co-ordinated care
- A clean, comfortable, friendly environment

Patients and the public will hold their local NHS to full and proper account for delivering improvements. They will expect updates on progress through formal patient and public involvement structures, and an annual guide to local health services.

Targets

- Improve the 5 key dimensions of the patient's experience as evidenced by increasingly positive local annual survey results, and other patient focused performance indicators, including those developed for the star ratings system. Agree, implement and jointly monitor local improvement plans as a result of surveys, with Patient Forums, as they come on stream during 2003.

- Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient & Public Involvement in Health, and annual publication of a patient prospectus covering local health services.

- Set local targets to contribute to national target of reducing the value of NHS building backlog maintenance by 25% by 2004.

- Introduce bedside TV and telephone systems in every major hospital by December 2003.

- Eliminate Nightingale wards for older people by April 2004.

- Introduce ward housekeepers in hospitals by 2004 and appoint modern matrons to all remaining posts by April 2004.

National capacity assumptions

- Active Patient Advisory & Liaison Service
- Regular and systematic approach to obtaining, analysing and responding to local patient and public feedback about services
- Partnership working with Patient Forums

REDUCING HEALTH INEQUALITIES

Objective

To reduce inequalities in health outcomes across different groups and areas in the country. Initially the focus is on reducing the gap in infant mortality and life expectancy at birth, and on reducing teenage pregnancies.

NHS improvement, expansion and reform should narrow the health gap by:

- ensuring that the distribution of health benefit from service expansion and development consistently favours individuals and communities that have been traditionally under-served,
- ensuring that service planning is informed by an equity audit and supported by an annual public health report by the Director of Public Health
- tackling the wider determinants of health - agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and neighbourhood renewal programmes, and ensuring the NHS makes a full contribution to support the *Sure Start* programme
- building capacity for public health improvement and protection in PCTs

Targets

- Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year.

- Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups.

- Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets.

- Contribute to a national reduction in death rates from CHD of at least 25% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of CHD.

- Contribute to a national reduction in cancer death rates of at least 12% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of cancer.

- Achieve the target of 70% uptake in influenza immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy.

National capacity assumptions

- Improved access to services for disadvantaged groups and areas, particularly:
  - Early antenatal service booking
  - Antenatal and child health screening services
  - Sexual health services, and breast/cervical screening.
  - Strengthened primary care services through increased numbers of health professionals and improved facilities in under-served and deprived areas.

DRUG MISUSE

Objective

To contribute to delivery of the National Drugs Strategy by reducing the harmful effects of substance misuse.

This will be achieved through expansion and improvement of drug treatment services, and by contributing to the Strategy target to reduce the use of Class A drugs, and frequent use of any illicit drug by young people.

This will include:

- Agreement through the local DAT of arrangements for commissioning integrated drug treatment and prevention programmes jointly with other partners.
- Implementation of the NTA guidance on maximum waiting times for drug treatment, Models of Care, prescribing guidance and action plan on drug-related deaths.

Targets

- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 (against 1998 baseline), and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

- Reduce drug-related deaths by 20% by 2004 (against 1999 baseline).

National Capacity Assumptions

- An increase in access to general medical services for all problem drug users (irrespective of prescribing needs), and GP participation in training programmes on treatment of drug users.

APPENDIX C

PHYSICAL FACILITIES

Objective

To create a clean, comfortable, well-maintained physical environment which is fit to deliver modern, convenient care. This includes delivering sufficient physical capacity in the right place to implement the NHS's key priorities, increasing diversity of provision through use of non-NHS providers where appropriate, and ensuring that physical facilities are modernised in line with the vision set out in the NHS Plan.

National capacity requirements

- Introduce new providers from the independent sector and overseas to offer patients a greater choice over where they obtain diagnosis and treatment.
- Trusts with major capital schemes: achieve financial close on 29 schemes for new hospitals announced in February 2001 by June 2005, or sooner if possible.
- Improve GP premises, to contribute to national target of 3000 GP premises refurbished or replaced by the end of 2004.
- Establish new one-stop primary care centres, to contribute to national target of 500 centres by the end of 2004, 125 more by 2006, and a further 125 by 2008.
- Establish additional inpatient beds and hospital capacity to meet access and clinical priority targets.
- Establish new Diagnosis and Treatment Centres operational in time to make a contribution to meeting 2005 waiting targets.
- Plan for at least 40% of the total value of the NHS estate to be less than 15 years old by 2010.

WORKFORCE

Objective

To support delivery of NHS priorities by ensuring there are sufficient numbers of appropriately trained, motivated staff working in the right locations. The HR Strategy for the NHS sets out a managed programme for a rapid expansion in the NHS workforce, introduction of more flexible ways of working and improving the working lives of staff. Delivery of this strategy is absolutely central to the achievement of other NHS Plan priorities. Workforce Development Confederations will need to work on behalf of Strategic Health Authorities to develop a local delivery plan for workforce which:

- ensures sufficient increases in workforce to meet delivery priorities
- makes optimum use of the new contractual arrangements
- delivers the changes set out in *"HR in the NHS Plan"*
- addresses critical issues, particularly implementation of the Working Time Directive

National capacity requirements

- Increase the number of nurses employed by the NHS by 20,000 by 2005 (from a 2000 baseline), and plan to achieve increase of 35,000 by 2008 (from a 2001 baseline).

- Increase the number of consultants by 7,500 and the numbers of GPs by 2,000 by 2004 (from a 1999 baseline); increase the number of GPs and Consultants employed by the NHS by 10,000 by 2005 (from a 2000 baseline); plan to achieve increase of 15,000 doctors by 2008 (from a 2001 baseline). This will include: 1,000 cancer consultants by 2005; and increasing total numbers of cardiologists to 685 and cardiothoracic surgeons to 217 by 2004, (enabling single handed cardiologist posts to be eliminated).[1]

- Increase the number of therapists and scientists employed by the NHS by 6,500 by 2004 (from a 1999 baseline), and plan to achieve an increase of 30,000 by 2008 (from a 2001 baseline).

- Increase the number of health care assistants employed by the NHS by 27,000 by 2005 (from a 2002 baseline).

- By 2004 expand the mental health workforce by: 1,000 new graduate workers in primary care; 500 community mental health "Gateway" workers; 700 more staff to support carers; 300 prison in-reach staff to ensure prisoners with severe mental illness have an appropriate care plan and care co-ordinator on release; 400 staff to support secure step-down.

- By 2006 expand the mental health workforce by: 300 extra prison in-reach staff, 500 community development workers for black and minority ethnic communities; 200 staff and 6 outreach teams for personality disorder and training of 3000 Support, Time and Recovery Workers (STR).

- Increase workforce capacity and productivity through skill mix and continuing professional development; moving work from doctors to other healthcare professionals and from healthcare professionals to the support workforce, supported by pay modernisation, and service redesign.

[1] Further explanation of these baselines and national requirements for increasing the number of doctors will be issued with the technical guidance

IM&T

Objective

To provide information management and technology to support deliver of fast, seamless and convenient care to patients. IM&T will facilitate greater patient choice, giving patients better information about options for their care. At the same time it will improve working lives for staff by reducing paper-based bureaucracy, enabling more effective communications between professionals and provide support for clinical and management decision-making. There will be a nationally-led programme for IM&T and all NHS organisations as part their Local Delivery Plans will need to implement the National Strategic Programme, (described in the document "Delivering 21st Century IT Support for the NHS"). In the years 2003-06 the elements to be delivered involve infrastructure, records, prescribing and booking.

National Programmes

- infrastructure - deliver broadband access to NHS net for NHS clinicians and support staff by April 2004. This will be a single national procurement of a new NHS network. StHAs and trusts should be aware of the national procurement and make arrangements for local networks.

- booking - implement electronic booking by December 2005. The chosen architecture is decided upon and early adopters (enterprise communities) are developing. Local communities should respond to the national roll out programme.

- national prescriptions service - this will be 50% implemented by December 2005 and 100% by December 2007 with full clinician and patient functionality. Pilots are being conducted in order to define a specification for a national programme. Local communities will need to respond to the national programme.

- electronic records - implement key elements of electronic records by December 2005. There will be a national health records infrastructure accessible nationally for out-of-hours reference and an electronic staff record. Existing systems and new procurements will need to be made part of the Integrated Care Records Service, the specification of which is out to consultation. A central advisory group is being set up to evaluate and answer questions about current procurements.

TABLE E1 Expenditure

NHS Expenditure (Estimated Outturn) 2002-03 (stage 2 resource budgeting)

England **?millions**

	Hospital Community & Family Health (discretionary) Services (HCFHS) and related services and Trusts	Family Health Services (non discretionary)	Central Health and Miscellaneous Services (CHMS) (including Departmental Admin)	NHS Total
Current expenditure				
Gross	51,033	5,986	1,225	58,245
Charges & receipts	-2,378	-919	-172	-3,470
Net	48,655	5,067	1,053	54,775
Capital expenditure				
Gross	2,331	0	30	2,361
Charges & receipts	-402	0	-6	-408
Net	1,929	0	24	1,953

Total				
Gross	53,364	5,986	1,255	60,605
Charges & receipts	-2,781	-919	-178	-3,877
Net	50,583	5,067	1,077	56,728

Source: Departmental of Health. Figures are consistent to those shown in table 3.3b of the Departmental Report 2003 (CM 5904)

Net NHS Expenditure, 2002-03 to 2005-06 (stage 2 resource budgeting)

England **?millions**

	2002-03 estimated outturn	2003-04 outturn	2004-05 outturn	2005-06 outturn
NHS Total	56,728	63,294	69,374	76,390
Hospital Community & Family Health (discretionary) Services (HCFHS) and related services and Trusts (revenue)	48,655	53,679	58,680	63,993
Family Health Services (non-discretionary) (revenue)	5,067	5,475	6,070	6,738
Central Health and Miscellaneous Services (CHMS) (including Departmental Admin) (revenue)	1,053	1,248	1,242	1,296
Total NHS Capital	1,953	2,892	3,383	4,363

Source: Departmental of Health. Figures are consistent to those in table 3.3b of the Departmental Report 2003 (CM 5904)

Analysis of health authority, NHS trust and primary care trust expenditure (year end 31 March)

England **?millions**

	1998	1999	2000	2001	2002
Revenue expenditure	25,329	27,329	30,622	34,009	37,229
of which:					
Salaries and wages	16,099	17,081	18,708	20,532	23,212
Supplies and services - clinical	2,849	3,157	3,433	3,885	4,305
Supplies and services - general	634	706	755	803	874
Establishment expenses	869	904	956	1,079	1,195
Premises and fixed plant	1,560	1,557	1,549	1,780	1,864
Miscellaneous expenditure	1,009	1,483	2,151	3,107	2,559
Cost of use of capital assets	1,065	1,073	1,639	1,125	1,218
Purchase of health care from non-NHS bodies	1,108	1,246	1,301	1,549	1,793
External contract staff	136	121	128	149	209

Historical trend in local authority personal social services expenditure

England **?billions**

Year	Gross		Net	
	Cash terms	2000-2001 Prices (GDP)	Cash terms	2000-2001 Prices (GDP)
1990-91	4.7	6.3	4.2	5.6
1991-92	5.1	6.4	4.6	5.8
1992-93	5.5	6.7	5.0	6.0
1993-94	6.3	7.5	5.7	6.7
1994-95	7.5	8.8	6.6	7.8
1995-96	8.4	9.6	7.3	8.3
1996-97	9.3	10.2	7.9	8.8
1997-98	10.0	10.7	8.5	9.1
1998-99	10.8	11.3	9.1	9.4
1999-2000	12.0	12.3	10.1	10.2
2000-2001	12.8	12.8	10.7	10.7

TABLE E5 Expenditure

Local authority personal social services gross expenditure by type of provision, 2000-2001

England **?millions**

	Older people	Children	Learning disability	Physical disability	Mental health	Other	Total
Total	5,899	2,865	1,752	859	677	785	12,837
Service strategy	-	-	-	-	-	126	126
Assessment and care management	498	789	105	153	192	-	1,737
Residential provision	3,592	780	1,015	258	260	-	5,905
Non -residential provision	1,810	1,296	632	448	226	-	4,412
Ayslum seekers	-	-	-	-	-	557	557
Other	-	-	-	-	-	112	112

In accordance with CIPFA guidance, a number of Support Management costs are reallocated to individual client groups.

Table 1:

Written complaints about Hospital and Community Health Services: performance against targets for Local Resolution and Independent Review, England, 1996-97 to 2000-01

		Number and percentage				
		2000-01	1999-00	1998-99	1997-98	1996-97
Total Written complaints received	**No.**	**95,994**	**86,536**	**86,013**	**88,757**	**92,974**
Local resolution:						
Local resolution concluded within performance target	No.	53,365	51,597	53,797	58,002	62,007
	%	55.6	59.6	62.5	65.3	66.7
Local resolution concluded outside performance target	No.	36,396	30,120	28,309	27,210	26,992
	%	37.9	34.8	32.9	30.7	29.0
Local resolution still being pursued at end of year	No.	6,233	4,819	3,907	3,545	3,975
	%	6.5	5.6	4.5	4.0	4.3
Requests for independent review:						
Cases requesting independent review	No.	2,243	2,061	1,838	1,871	1,612
	%	2.3	2.4	2.1	2.1	1.7
Cases still being considered	No.	446	394	336	370	283
	%	0.5	0.5	0.4	0.4	0.3
Cases referred to independent review panel	No.	312	296	285	348	373
	%	0.3	0.3	0.3	0.4	0.4
Independent review:						
Cases referred to independent review panel	**No.**	**312**	**296**	**285**	**348**	**373**
Independent review concluded within performance target	No.	72	80	64	88	131
	%	23.1	27.0	22.5	25.3	35.1
Independent review concluded outside performance target	No.	120	99	112	96	67
	%	38.5	33.4	39.3	27.6	18.0
Independent review still being pursued at end of year	No.	120	117	109	164	175
	%	38.5	39.5	38.2	47.1	46.9

(1) 2000-01 saw the introduction of the first Primary Care Trusts (PCTs). Figures for 2000-01 include information about written complaints received by the 40 PCTs which became operational during the year.