Department of Health

Autumn Performance Report 2008

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the Secretary of State for Health
by Command of Her Majesty
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Foreword by the Secretary of State

I am pleased to present the Department of Health's Autumn Performance Report for 2008. This is the first report on our Comprehensive Spending Review 2007 (CSR07) commitments and reports progress on our new PSAs, DSOs and efficiency target for this CSR period.

The 30 cross-government PSAs give us an opportunity to work across Whitehall on delivering better health, better care and better value for all ensuring that England has a healthy population who, if they need it, have the best possible care through the NHS and local authorities.

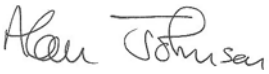
This year marks the 60th anniversary of the NHS and the celebrations, held across the country in June, reflect the major role that the NHS now plays in all of our lives. This year has also seen Lord Darzi publish the NHS Next Stage Review, which sets out a vision of a NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.

In moving towards this vision, I am pleased to announce that we have made major progress on ensuring that no one has to wait more than 18 Weeks for treatment following a GP referral unless they choose to wait longer or it is clinically appropriate for them to do so. The latest data on elective care shows that most SHAs are already meeting the commitment to ensure that patients do not wait longer than 18 weeks for treatment unless they choose to wait longer or that it is clinically appropriate for them to do so. Nine out of 10 SHAs achieved the non-admitted operational standard and seven out of 10 SHAs achieved the admitted operational standard in September 2008. Whilst this is great progress, we must ensure that 18 Weeks becomes the standard for patients everywhere. The NHS has also successfully halved the number of MRSA infections. MRSA rates have fallen by 57 per cent against the 2003/04 baseline figure. There has also been a fall in *Clostridium difficile* infections at Q1, with a 26 per cent reduction compared to the same period last year.

Our PSAs and DSOs represent the full breadth of work taking place across the department in delivering the best health and social care for patients, users, carers and taxpayers alike. We have continued to improve life expectancy for people across the country, so that a baby born tomorrow will have the highest life expectancy ever recorded and over the next three years we will improve access to psychological therapies so that everyone has the opportunity to get help if they need it.

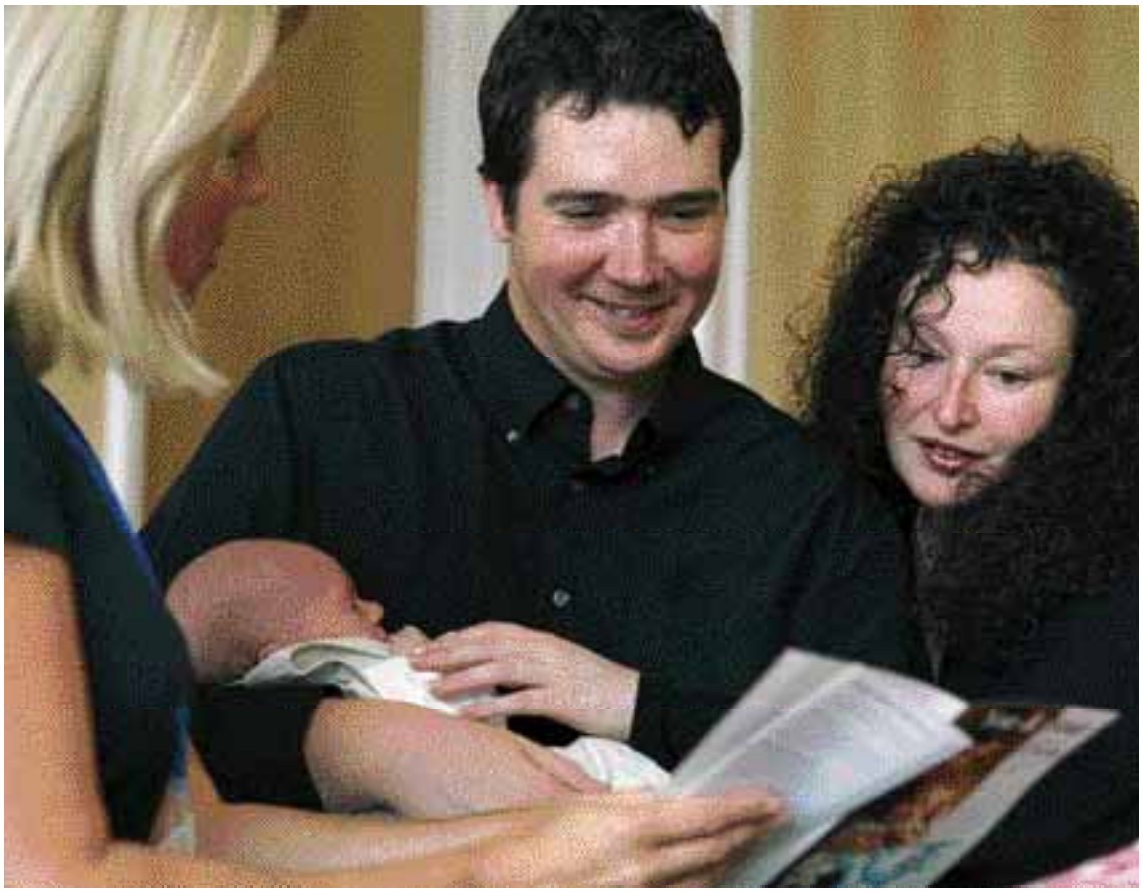
Although, we are making substantial progress on a number of our priorities there are significant challenges ahead of us during this spending review period and beyond. People living in deprived areas are still more likely to have poorer health than the rest of England. We need to give everyone the best chance of leading a healthy life through, for example, reducing smoking prevalence, halting and then turning around rises in child obesity, combating excess alcohol use and increasing the opportunity for people to direct the support they receive on social care.

These are major challenges that will require concerted effort from across government at national, regional and local level. I am pleased with the progress we have made so far and am committed to driving delivery across our PSAs and DSOs over the coming years.



Rt Hon Alan Johnson
Secretary of State for Health

1 Introduction



1.1 This is the Department's first report on progress of its Comprehensive Spending Review 2007 PSA and DSO commitments. It also covers, as required by Treasury guidance, reporting progress against our legacy PSA targets which have not been subsumed by more recent PSAs, our value for money target and any outstanding recommendations from the Public Accounts Committee (PAC), which holds departments to account for their public spending.

Background to CSR07 commitments

1.2 In October 2007, the Government published the 2007 Pre-Budget Report and Comprehensive Spending Review 'Meeting the aspirations of the British people[1].' At the same time, the Government announced 30 cross government PSAs, a Value for Money (VfM) target and DSOs for each department.

1.3 The new PSAs articulated the Government's highest priorities and outcomes for the CSR07 period (from 2008/09 -2010/11). The 30 cross-government PSAs are grouped under four headings:

- Sustainable growth and prosperity;
- Fairness and opportunity for all;
- Stronger communities and a better quality of life;
- A more secure, fair and environmentally friendly world.

1.4 The Department of Health (DH) lead on two PSAs: PSA 18 – Promote better health and well-being for all and PSA 19 – Ensure better care for all. In addition, DH contributes to a further eleven cross-government PSAs (leading on indicators for six PSAs and contributing to five PSAs through the broader work of the Department, see tables 1 and 2 below) led by other government departments.

1.5 The PSAs are a subset of our DSO indicators which track the Department's progress against its three DSOs:

- **To ensure better health and well-being for all:** helping you to stay healthy and well, empowering you to live independently and tackling health inequalities;
- **To ensure better care for all:** the best possible health and social care when and where you need help giving you choice and control; and
- **To provide better value for all.**

1.6 A full list of the Department's DSOs and PSAs is available at Annex A.

1.7 Underpinning all of this work is the CSR07 value for money programme which has three key components:

- at least 3 per cent value for money savings per year over the CSR period across central and local government;

1 Meeting the aspirations of the British people: 2007 Pre-Budget Report and Comprehensive Spending Review, HM Treasury, 2007

- 5 per cent annual real reductions in administration budgets across departments;
- the sale of financial assets for reinvestment in new infrastructure.

Partners in the delivery chain

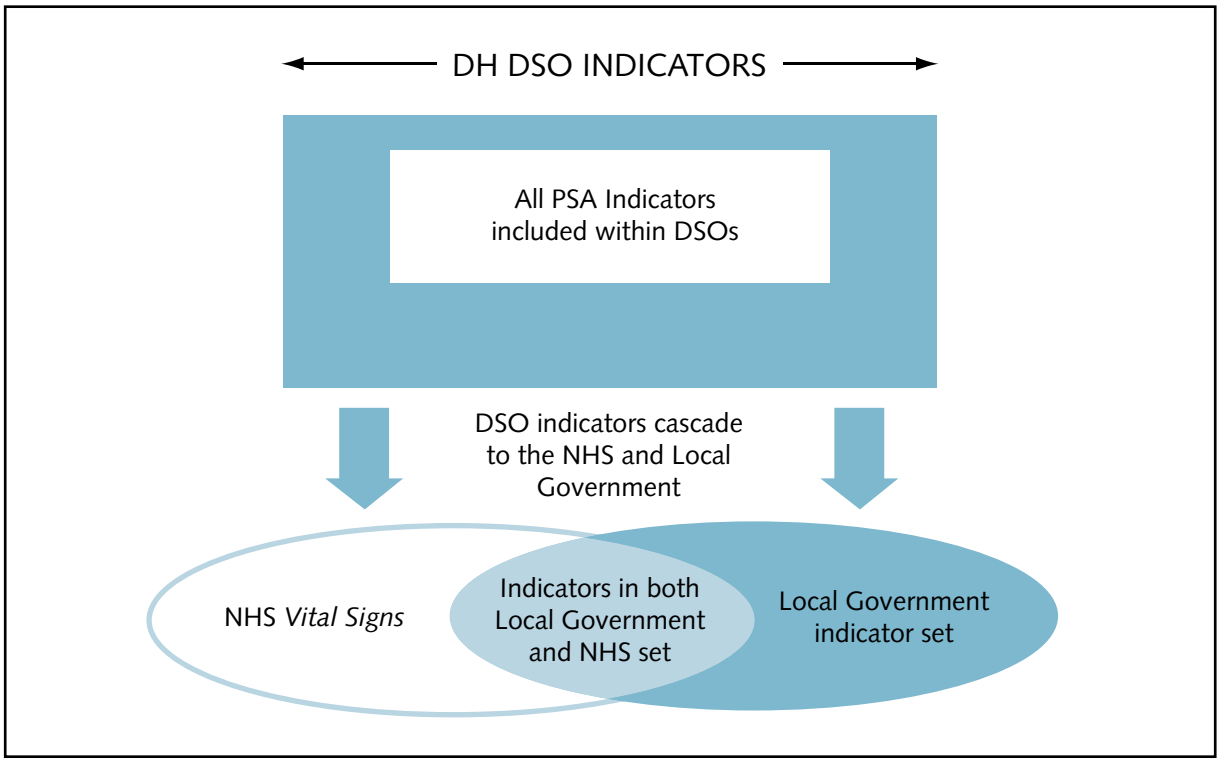
1.8 In delivering DH's PSAs and DSOs, the Department has two key delivery partners at the regional and local level: the NHS and local government. The Department's priorities for delivery are communicated through the NHS Operating Framework and Vital Signs[2] and the Local Government National Indicator Set[3].

1.9 All of DH's PSAs and DSOs, which can be delivered by its regional and local delivery partners, are reflected in the Vital Signs and/or the National Indicator Set.

1.10 Furthermore, the Department works closely with other government departments to influence and incentivise improvements where DH and/or they have a delivery role.

1.11 Diagram 1 shows the inter-relationship between DH's PSAs, DSOs, Vital Signs and indicators in the National Indicator Set.

Diagram 1:



2 The operating framework for the NHS in England 2009/10, Department of Health, 2008

3 The new local performance framework for local authorities and local authority partnerships, HM Government, 2007

Governance structure

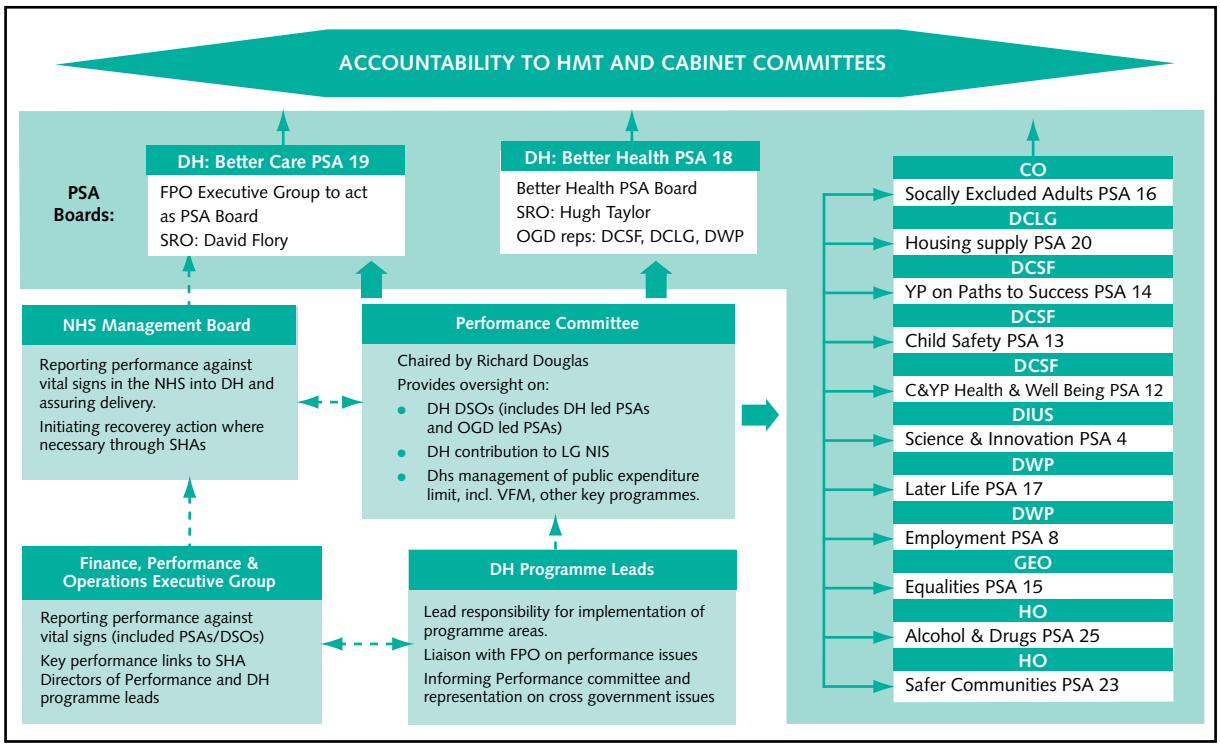
1.12 The Department has established a new governance structure (see Diagram 2) to maintain oversight over the full breadth of its CSR07 commitments.

1.13 The Departmental Board has delegated responsibility for this to a new Performance Committee, chaired by the Director General of Finance and Operations, Richard Douglas. The Senior Reporting Officers (SROs) for PSA 18 and 19 report on progress to this committee from their respective PSA Delivery Boards. The SRO for PSA 18 is Hugh Taylor, Permanent Secretary. The SRO for PSA 19 is David Flory, Director General NHS Finance, Performance and Operations. The representative SROs for the DH indicators at other government department PSA delivery boards do the same.

1.14 In addition, a sub-committee to the Performance Committee has been set up to monitor value for money work across the department.

1.15 Summary minutes for Performance Committee meetings are available online at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_089740

Diagram 2:



2 Public Service Agreements

2.1 Public Service Agreements articulate the government's highest priorities for delivery over a spending review period. They were first introduced in 1998 as an outcome-focused performance management system for public services. The new PSAs for the CSR07 period were developed in partnership with frontline professionals, the public and external experts and offer a marked change from previous years with a focus on fewer, cross-government issues.

2.2 Each PSA is communicated by a delivery agreement which is shared across all contributing departments and describe the small basket of outcome-focused performance indicators that are used to measure progress against delivery for each PSA.[4]

2.3 This chapter sets out the progress for the PSA indicators set out at Table 1 below. Further detail on the data source(s) for each indicator is contained in Annex B.

Table 1: Provides a complete list of the Department's contribution to the delivery of specific PSA indicators including the two we lead on:

PSA	Lead Department	Indicators that DH lead on
18 – Promote better health and well-being for all	DH	All Age All Cause Mortality (AAACM) rate
		Gap in AAACM rate in disadvantaged areas
		Smoking prevalence among people aged 16 and over, and aged 16 or over in routine and manual groups
		Proportion of people supported directly through social care to live independently at home
		Improving access to psychological therapies
19 – Ensure better care for all	DH	Self-reported experience of patients and users
		NHS-reported referral-to-treatment times for admitted patients
		NHS-reported referral-to-treatment times for non-admitted patients
		The percentage of women who have seen a midwife or maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks of their pregnancy
		People with long term conditions supported to be independent and in control of their condition
		Patient-reported experience of GP access
		Healthcare associated infection (HCAI) figures – MRSA
		HCAI figures – *Clostridium difficile*

4 Available at http://www.hm-treasury.gov.uk/pbr_csr/psa/pbr_csr07_psaindex.cfm

PSA	Lead Department	Indicators that DH lead on
12 – Improve the health and well-being of children and young people	Department of Children, Schools and Families (DCSF)	Prevalence of breastfeeding at 6-8 weeks
		Levels of childhood obesity
		Emotional health and wellbeing and CAMHS
		Parents' experience of services for disabled children and the 'core offer'
13 – Improve children and young people's safety	DCSF	Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people
14 – Increase the number of children and young people on the path to success	DCSF	Under-18 conception rate
16 – Increase the proportion of socially excluded adults in settled accommodation and employment, education or training	Cabinet Office	Adults in contact with secondary mental health services in settled accommodation
		Adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation
		Adults in contact with secondary mental health services in employment
		Adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment
17 – Tackle poverty and promote greater independence and well-being in later life	Department for Work and Pensions (DWP)	Healthy life expectancy at age 65
		Over 65s receiving the support they need to live independently at home
25 – Reduce the harm caused by alcohol and drugs	Home Office (HO)	The number of drug users recorded as being in effective treatment
		The number of alcohol-related hospital admissions

Table 2: Provides a list of the 5 PSAs to which the Department contributes through its broader work

PSA	Lead Department
4 – Promote world-class science and innovation in the UK	Department of Innovation, Universities and Skills
8 – Maximise employment opportunity for all	DWP
15 – Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief	Government Equalities Office
20 – Increase long-term housing supply and affordability	Communities and Local Government
23 – Make communities safer	HO

PSA 18 – Promote better health and well-being for all

PSA 18 sets out the Government's commitment to deliver the best possible health and well-being outcomes for everyone, helping people to live healthier lives, empowering them to stay independent for longer and tackling inequalities. The PSA is closely linked with the Departmental Strategic Objective to ensure better health and well-being for all. Five key indicators have been chosen to monitor progress against this PSA. Progress against the indicators is set out below.

PSA 18: Some progress – Improvement against 2 out of 5 indicators

18.1 – All Age All Cause Mortality (AAACM) rate

Indicator	Measure/data	Progress
All-age all-cause mortality (AAACM) rate Linked to SR2004 target: By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women (For reporting against this target please see legacy SR section below) Current estimate is that this is equivalent to AAACM in England decreasing to 649 deaths per 100,000 for men and 467 deaths per 100,000 for women by 2009-11 – precise numbers will change as age distribution of deaths changes (current estimate is based on 2005-07 age distribution of deaths) (Ultimate success will be measured by the life expectancy at birth measure but AAACM is used as a proxy to measure progress, particularly relevant at local level) **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.120	**Data source:** Death rate from all causes at all ages for England, for males and females separately (rates calculated by DH based on ONS death registrations and mid-year population estimates). **Baseline**: 1995-97 AAACM rates – 931.1 deaths per 100,000 population (males); 606.4 deaths per 100,000 population (females). (Note: 1995-97 selected as baseline for consistency with PSA18.2 gap in AAACM.) (Note also that the target level does not depend on the baseline value.)	**Latest data:** 2005-07 AAACM rates – 710.1 deaths per 100,000 population (males) (24% below the baseline rate); 500.2 deaths per 100,000 population (females) (18% below the baseline rate). Further progress will result from continued delivery of a range of measures in relevant National Service Frameworks (NSFs) including strategies for cancer[5] and stroke[6] services published in 2007. These measures will include: starting phased roll out of the vascular checks programme from April 2009, completing the initial rollout of bowel cancer screening, start extending the age group for the breast cancer screening programme, the establishment of stroke care networks and extending the waiting times standards for cancer treatment.

5 Cancer Reform Strategy, DH, 2007

6 National Stroke Strategy, DH, 2007

All-age all-cause mortality rates, England: 1995-97 to 2005-07

	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
Death rate per 100,000, males	931.1	911.0	891.6	869.6	844.8	822.3	807.3	786.3	761.5	732.0	710.1
Death rate per 100,000, females	606.4	598.5	591.7	580.1	567.9	556.0	552.9	543.5	531.9	512.2	500.2

18.2 – Difference in AAACM between England average and spearhead areas

Indicator	Measure/data	Progress
Gap in all-age all-cause mortality (AAACM) rate, between Spearhead group and national average Linked to SR2004 target: Reduce health inequalities by 10% by 2010 as measured by life expectancy at birth (For reporting against this target please see legacy SR section below) Current estimate is that this is equivalent to the AAACM gap decreasing to 98 deaths per 100,000 for men and 58 deaths per 100,000 for women by 2009-11 – precise numbers will change as age distribution of deaths and England life expectancy change (current estimate is based on 2005-07 age distribution of deaths and current England life expectancy trend) (Ultimate success will be measured by the life expectancy at birth measure but AAACM is used as a proxy to measure progress, particularly relevant at local level) **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.120	**Data source:** Absolute gap (i.e. difference) in death rates from all causes at all ages between Spearhead group and England, for males and females separately (rates calculated by DH based on ONS death registrations and mid-year population estimates). **Baseline:** 1995-97 gap in AAACM rates – 142.3 deaths per 100,000 population (males); 75.5 deaths per 100,000 population (females).	**Latest data:** 2005-07 gap in AAACM rates – 124.1 deaths per 100,000 population (males); 76.1 deaths per 100,000 population (females). *Health Inequalities: Progress & Next Steps*[7] sets out a renewed commitment to achieving the health inequalities target, including targeted investment and increased support for primary care trusts (PCTs) and local authorities through National Support Teams (NSTs) (including new Infant Mortality and Alcohol NSTs) and the Health Inequalities Intervention Tool.

Absolute gap (i.e. difference) in all-age all-cause mortality rates between Spearhead group and England: 1995-97 to 2005-07

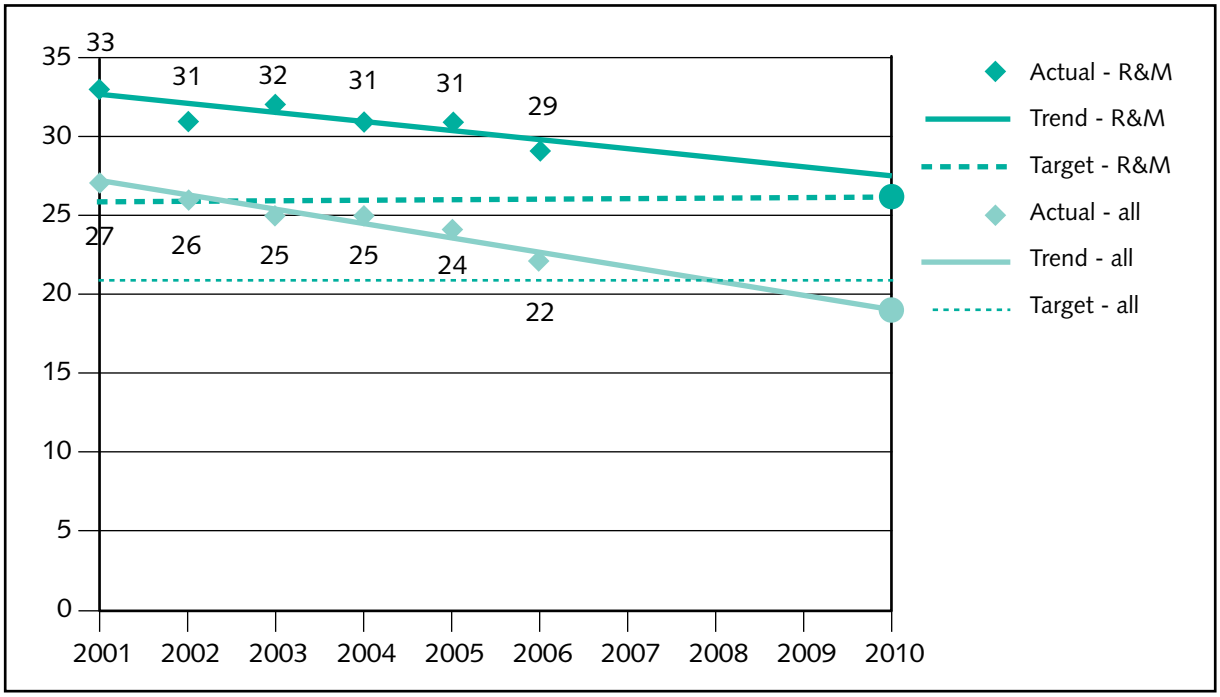
	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
Absolute gap between Spearhead Group and England (deaths per 100,000), males	142.3	141.8	142.3	136.9	133.8	129.0	130.5	128.3	126.1	123.7	124.1
Absolute gap between Spearhead Group and England (deaths per 100,000), females	75.5	78.1	78.0	76.9	74.5	73.8	75.8	76.9	77.1	77.4	76.1

7 Health Inequalities: Progress and Next Steps, DH, 2008

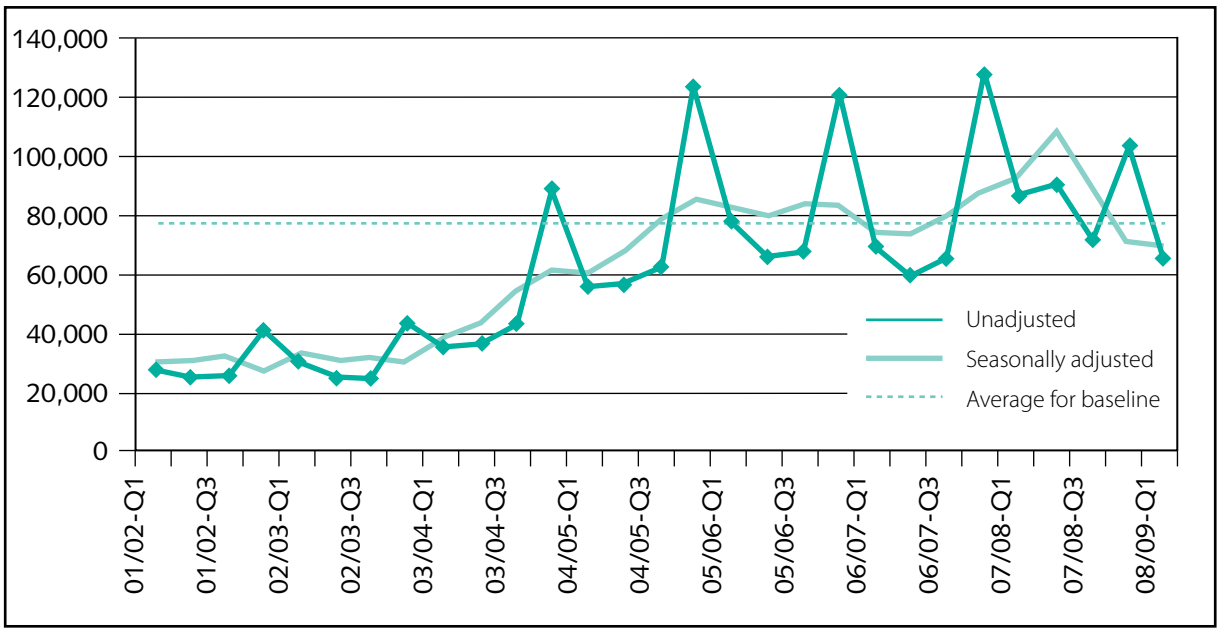
18.3 – Smoking prevalence

Indicator	Measure/data	Progress
Smoking prevalence Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less Set as PSA indicator in SR 2004 **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.123	**Data source:** General Household Survey (GHS). **Baseline:** The percentage of the overall population in 2005, aged 16 or over, who smoked was 24% and in the routine and manual occupations was 31%. Progress against this indicator is also tracked using a proxy through the number of successful quits through NHS Stop Smoking Services: Numerator: NHS Stop Smoking Services return, Information Centre. Denominator: Resident based mid-year population estimates, Office for National Statistics. **Baseline:** Baseline is the average annual number of 4-week quitters per 100,000 population achieved in the period 2004/5 – 2006/07.	**Latest data:** The percentage of the overall population in 2006, aged 16 or over, who smoked was 22% and in the routine and manual occupations is 29%. *Number of successful quits:* There were 65 thousand quitters in the first quarter of 2008/09 (70 thousand seasonally adjusted). This is 10% below the average for the baseline period 2004/05-2006/07. Successful quits through the NHS Stop Smoking Services (at 12 months) constitutes approximately 25% of what is needed to deliver the reduction in prevalence targets. Delivery of the remainder will be through DH's award winning marketing campaign, smokefree legislation, increased age-of-sale and picture warnings on tobacco packets. The more challenging R&M target will be a focus in all activity and action will be taken to reduce variations in the effectiveness of local services by establishing a NHS Smoking Cessation Training Centre and through professional accreditation for all NHS Stop Smoking staff. A new focus on reducing levels of smuggled tobacco is being developed with the UK Border Agency and HM Revenue & Customs. A new Tobacco Control Strategy will build on the successes to date to reduce smoking prevalence.

Smoking prevalence



Number of successful quits through NHS Stop Smoking Services



18.4 – Proportion of people supported to live independently (all ages)[8]

Indicator	Measure/data	Progress
Proportion of adults (18 and over) supported directly through social care to live independently at home **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.136	**Data source:** Statistical returns of the number of adults 18-64/65+ from Referrals, Assessment and Package of Care (RAP) data and Grant Funded Services (GFS1) data provided by local authorities. **Baseline:** 3143 adults (18+) receiving community-based services per 100,000 adult population in 2007/08 (based on provisional 2007/08 RAP and GFS data).	The Independent Living Strategy[8] set out the Government's commitment to give disabled people increased choice and control over the support they need in their daily lives. The transformation of adult social care (over the next three years) to a more personalised care system, as signalled in *Putting People First*[9] will help facilitate increased independent living for all in the community leading to an increased focus on access to universal services (such as information and advice) to facilitate choice and control, early intervention and community support.

18.5 – Improving access to psychological therapies (IAPT)

Indicator	Measure/data	Progress
Access to psychological therapies: proportion of people with depression and/or anxiety disorders who are offered psychological therapies **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3	**Data source:** Baseline assessment of need will be derived from the Psychiatric Morbidity Survey (fixed); the number of people offered treatment will be derived from primary care data systems (based on the relevant clinical measures). **Baseline:** The PSA indicator will apply to all PCTs and reporting will commence in Q3 2008/09. This will provide a baseline position.	The IAPT programme will be rolled out to 35 sites (PCTs) in Year 1 who will be performance managed by strategic health authorities (SHAs). Training and support will continue to be provided by the Department of Health, including guidance for PCT Mental Health Commissioners 'Commissioning for the Whole Community.'

8 Independent Living: A cross-government strategy about independent living for disabled people, HM Government, 2008

9 *Putting People First*: A shared vision and commitment to the transformation of adult social care services, HM Government, 2007

PSA 19 – Ensure better care for all

PSA 19 sets out the Government's commitment to ensure that people have high quality, safe and accessible care that is sensitive to their individual health and adult social care needs and their particular lifestyles and aspirations. The PSA is closely linked with the Departmental Strategic Objective to ensure better care for all. Eight key indicators have been chosen to monitor progress against this PSA.

PSA 19: Strong progress – Improvement against 6 out of 8 indicators

19.1 – The self-reported experience of patients and users

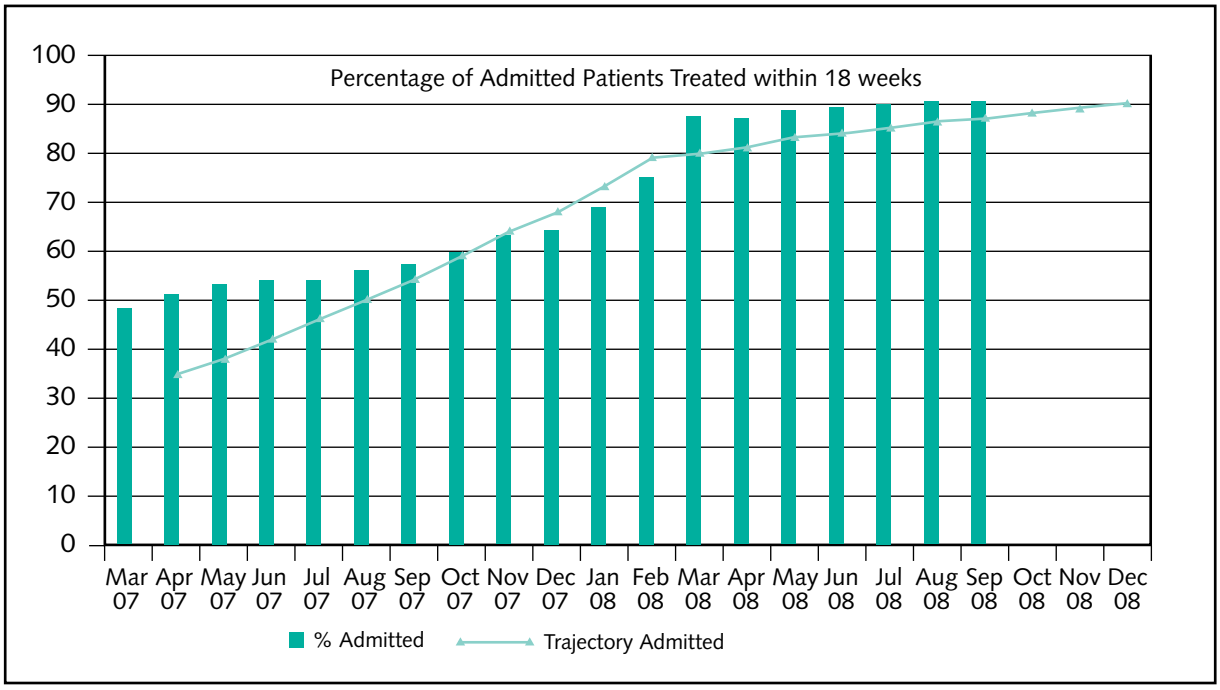
Indicator	Measure/data	Progress
Self-reported experience of patients and users This is the third consecutive SR period that this indicator has contributed towards a DH Public Service Agreement **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.127	**Data source:** The national patient survey programme, under the administration of the Healthcare Commission (HC) gathers structured feedback from patients/users on different aspects of their experience of treatment/care[10]. Progress against the PSA is calculated using a methodology that is different to that employed by HC when they publish detailed results for each survey soon after completion. Confirmation of this methodology is available on the DH website[11]. In summary, PSA scores are an average score calculated out of a maximum of 100 – calculated by aggregating scores from 5 domains of patient experience: • Improving access and waiting; • Building closer relationships; • Better information more choice; • Safe, high quality coordinated care; • Clean, friendly comfortable place to be. **Baseline[11]:** Results of surveys conducted in 2007/08 (or earlier if a more recent survey has not been conducted) form the baseline for this indictor: • Adult inpatient survey – 75.3 in 2007/08; • Primary care trust survey – 77.5 in 2007/08; • Community mental health services (CPA) survey – 75.6 in 2007/08; • Accidents and emergency survey – 75.8 in 2004/05; • Outpatients survey – 76.7 in 2004/05.	**Latest data:** Performance will be measured via repeat surveys conducted across the SR 2008-11 period, and regular updates will be published on the DH website[11]. DH and the Healthcare Commission will be developing further validated instruments/ methodologies covering different services, settings and patient groups. Not all of these will be included in the nationally coordinated programme, but all will be made available for organisations to use locally on a voluntarily basis. Where surveys are part of the nationally coordinated programme, and where baseline and subsequent performance measures are available, scores will be calculated and published[11]. The agreed future survey programme is as follows: **2008/09:** • Accident & emergency services survey; • Adult inpatient survey; • Ambulance services (category C) survey; • Mental health inpatient survey. **2009/10** • Outpatient survey; • Adult inpatient survey; • Maternity services survey.

10 The Healthcare Commission (HC) publish separate and detailed results for each of their surveys on their website. soon after they have been completed. Further information is available on the their website: http://www.healthcarecommission.org.uk/yourviews/patientsurveys.cfm

11 Baseline figures for the SR 2008-11 period are obtained from the most recently conducted surveys – i.e. those conducted in 2007/08, or earlier if a more recent survey has taken place. A PSA performance report was published by DH on 24 November 2008, which describes performance at the end of the SR 2005-08 period – available via the following web link http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_087516
This report also includes some revisions to previously published figures for the 2006/07 adult inpatient survey (presented in the April 2008 PSA update and the 2008 Departmental Report). These revisions make no difference to measures of progress across the entire CSR 2005-08 period, but to this one mid-point only. Further information about the revisions are available via the DH website (see the web link above).

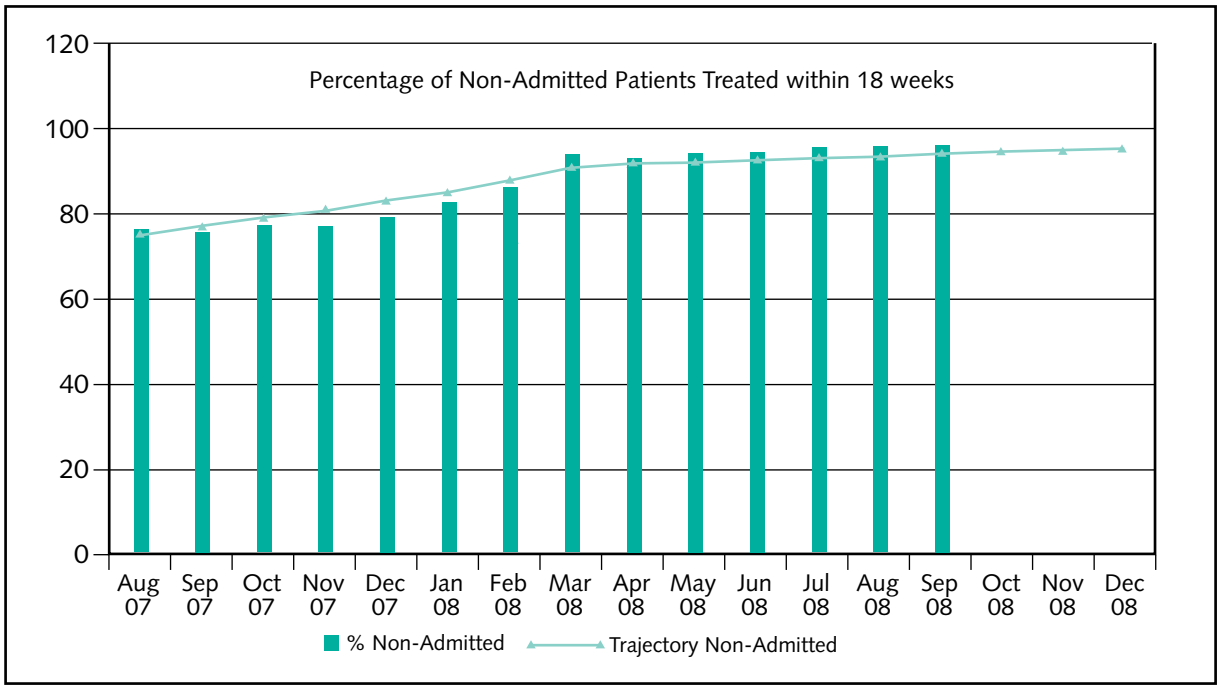
19.2 – NHS-reported referral-to-treatment times for admitted patients

Indicator	Measure/data	Progress
NHS-reported referral-to-treatment times for admitted patients To ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment (for clinically appropriate patients who choose to start their treatment within 18 weeks) Previously a SR2004 PSA **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set –** Tier 1	**Data source:** Monthly 18 Weeks Referral to Treatment data. **Baseline:** Admitted patient RTT data was first published for March 2007, when RTT performance was 48%. Monthly data is accompanied by a data completeness assessment comparing the number of completed pathways with a known clock start against the expected number of pathways. The national data completeness assessment for August was 96%.	**Latest Data:** (September 2008) 90.2% of admitted patients began treatment within 18 weeks of referral. To ensure we build on the success so far in this indicator – by September 2008 105 major acute providers and 96 PCTs had achieved the December 2008 target and the median time waited for referral-to-treatment has improved from 18.8 weeks in March 2007 to 8.3 weeks in August 2008 – the Healthcare Commission annual health check 2009 will include 18 Weeks referral-to-treatment times as a key indicator.



19.3 – NHS-reported referral-to-treatment times for non-admitted patients

Indicator	Measure/data	Progress
NHS-reported referral-to-treatment times for non-admitted patients To ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment (for clinically appropriate patients who choose to start their treatment within 18 weeks) Previously a SR2004 PSA **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set –** Tier 1	**Data source:** Monthly 18 Weeks Referral to Treatment (RTT) data. **Baseline:** Non-admitted patient RTT data was first published for August 2007, when RTT performance was 75.5%. Monthly data is accompanied by a data completeness assessment comparing the number of completed pathways with a known clock start against the expected number of pathways. The national data completeness assessment was 99%.	**Latest Data:** (September 2008) 95.7% of non-admitted patients began treatment within 18 weeks of referral. To ensure we build on the success so far in this indicator – by September 2008 125 acute providers and 111 PCTs had achieved the December 2008 target and the median time waited for referral-to-treatment has improved from 7.4 weeks in March 2007 to 4.4 weeks in September 2008 – the Healthcare Commission annual health check 2009 will include 18 Weeks referral-to-treatment times as a key indicator



19.4 – The percentage of women who have seen a midwife or maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks of their pregnancy

Indicator	Measure/data	Progress
The percentage of women who have seen a midwife or maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks of their pregnancy **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set –** Tier 2 and N.I.126	**Data source:** Vital Signs Monitoring Returns from Primary Care Trusts **Baseline:** Baseline data available in Quarter 3 of 2008-09.	**Latest data:** Q1 & Q2 data now available. Q2 return shows that 89% of PCTs returned data. Data definitions have now been amended – Q3 will provide the first data under the revised data definitions and enable the first assessment of performance to inform plans for 2009-10. An extra 4,000 midwives to be recruited by 2012 (announced in February 2008) together with additional pilot sites for the Family Nurse Partnership Programme should help drive performance on this indicator over the coming year. The National Institute for Health and Clinical Excellence (NICE) tool on health and social care needs assessment currently under development will also contribute.

19.5 – Long-term conditions

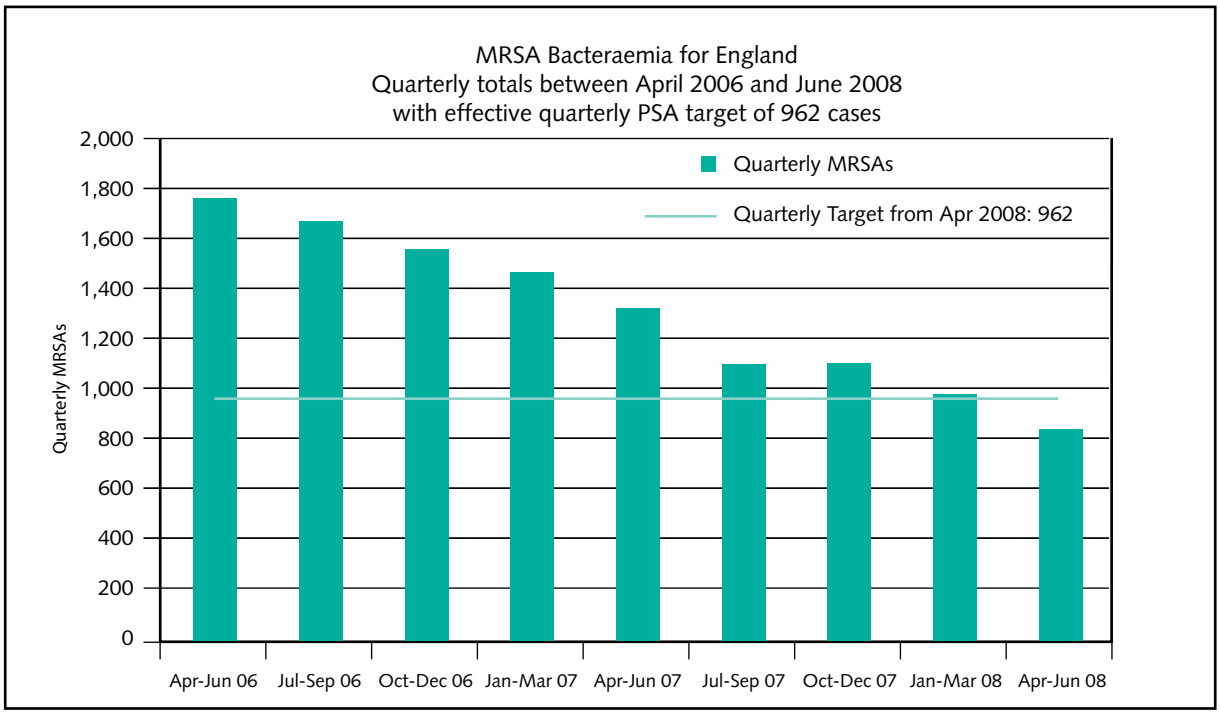
Indicator	Measure/data	Progress
People with a long-term condition supported to be independent and in control of their condition **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set –** Tier 3 and N.I. 124	**Data source:** For 2008-09, progress against delivery of the PSA is being measured by changes in emergency bed days. **Baseline:** Provisional data for 2007-08: 28.3 million emergency bed days.	From 2009-10, this indicator will be measured by a patient experience indicator "% of people with a long-term condition who feel supported to manage their condition(s)." Baseline data for 2007-08 has been published. This showed that nationally 74% of people with a long-term condition (LTC) reported feeling either fully (45%) or partially (29%) supported to manage their LTC.

19.6 – Patient-reported experience of access to GP services

Indicator	Measure/data	Progress
Patient-reported experience of access to GP services The indicator is currently made up from patient experience in five specific areas: • Getting through to the GP practice on the phone; • Getting a quick appointment with a GP; • Booking consultation with a GP more than 2 days ahead; • Booking consultation with a specific GP; • GP practice opening times. **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set –** Tier 1	**Data source:** GP Patient Survey (GPPS). **Baseline:** 2007/08 GPPS data, however, new baseline to be established using new survey questions in the 2008/09 GPPS survey.	The 2008/09 Survey to be conducted during January – March 2009 and data to be published in July 2009. The 2009/10 survey will be conducted in four quarterly tranches with the first survey going out in April 2009.

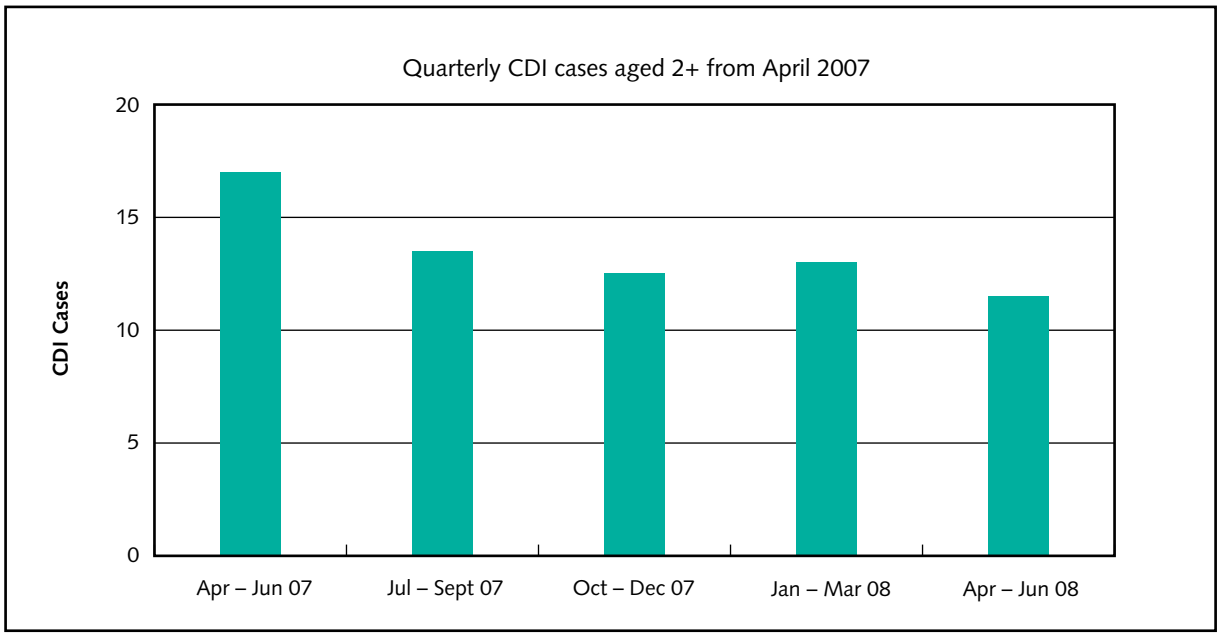
19.7 – Healthcare associated infection figures – MRSA

Indicator	Measure/data	Progress
The annual number of MRSA bacteraemias in each of the years 2008-09, 2009-10 and 2010-11 The total number of cases for each year should be below 3,850 (half the 2003-04 baseline) **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set –** Tier 1	**Data source:** Quarterly mandatory reporting results for MRSA bacteraemia. This is collected by the Health Protection Agency. **Baseline:** 7,700 cases in 2003/04.	**Latest data:** 3,978 cases for the 12 months ending June 2008. Last published quarter was 836 cases which if held at this level would equate to an annual figure of 3,344 cases. The 'Clean, Safe Care' strategy sets out ways for tackling HCAIs. Key components to sustain improvements and reduce cases further include: • Targeted support to help trusts achieve challenging reductions in MRSA cases; • MRSA screening for all routine hospital admissions by April 2009 and for emergency patients on admission by March 2011 at the latest; • Introduction of the Health and Social Care Act 2008 Code of Practice for the prevention and control of HCAIs and strengthened enforcement powers; • A national patient empowerment campaign will provide a continued focused on reducing MRSA and improving public confidence.



19.8 – Healthcare associated infection figures – (*Clostridium difficile*)

Indicator	Measure/data	Progress
The number of cases of Clostridium difficile (c.difficile) infection in 2010-11 This should be 30% less than the figure for 2007-08 **Departmental Strategic Objective 2** – Ensure better care for all **Vital Signs and National Indicator Set** – Tier 1	**Data source:** Quarterly mandatory reporting results for *Clostridium difficile* infections in all patients over 2. This is collected by the Health Protection Agency. **Baseline:** The number of cases in 2007/08, currently 55,502. The Health Protection Agency may update this figure.	**Latest data:** 10,866 cases for April to June 2008, a 35% decrease on the same quarter in 2007. Improvements will be supported by the 'Clean, Safe Care' strategy. Work to improve antibiotic prescribing is key for this infection and a new tool for improving prescribing will be published early in 2009. New *c.difficile* guidance published soon includes antibiotic prescribing and DH has re-launched its appropriate use of antibiotics awareness campaign. The Department is working with the National Patient Safety Agency to produce a new national standard for hospital cleanliness, under the auspices of the British Standards Institute.



PSA 12 – Improve the health and well-being of children and young people

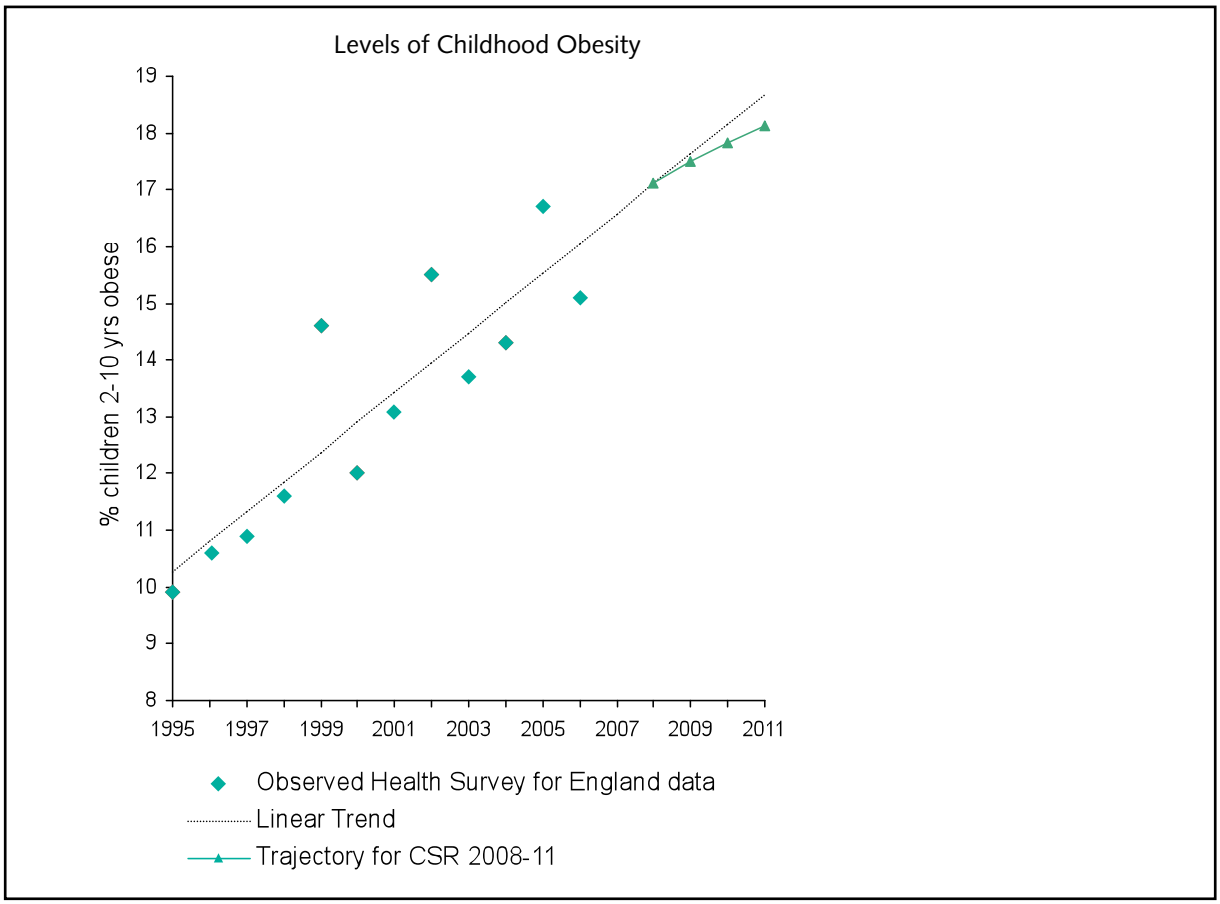
PSA 12 sets out the Government's commitment to improving the physical, mental and emotional health and well-being of children and young people from conception to adulthood – for children who are in relatively good health, those particularly vulnerable to poor health outcomes, and those who are disabled, as well as those who are ill. This PSA is led by the Department for Children, Schools and Families and the Department of Health contributes to four of the five key indicators chosen to monitor progress against this PSA.

12.1 – Prevalence of breastfeeding at 6-8 weeks

Indicator	Measure/data	Progress
Prevalence of breastfeeding at 6-8 weeks **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.53	**Data source:** Local PCT returns for prevalence of breastfeeding at 6-8 weeks. **Baseline:** Will be established in Q4 2008/09. **Supporting data** Breastfeeding prevalence at 6-8 weeks not yet assessed. However, two related indicators provide proxy information on progress: Data on initiation of breastfeeding from local PCTs shows a steady increase in levels from 2005-06 as 66.2%, 2006-07 as 68.1%, and 2007-08 as 69.9%. Data coverage on breastfeeding prevalence of infants due for 6-8 week check**.** PCTs are required to cover at least 85% of infants to meet data quality in Q4 of 2008-09. In the first quarter, 45 of 152 PCTs achieved at least 85% coverage. Among PCTs breastfeeding prevalence ranged from 81% to 12%. Data quality is being ensured by asking PCTs to re-submit quarterly data for quarters one and two after further checks and reminders of the data quality threshold.	Additional funding of £4m is being distributed to successful PCTs in 2008/09 to promote breastfeeding by implementing the NICE guidance both in hospitals and in the community by means of the Baby Friendly Initiative (which includes the training of midwives and health visitors to promote breastfeeding), working in partnership with SHAs and LAs via established networks. Regional Infant Feeding Co-ordinators are being/have been appointed to develop regional and local networks (aim to get all 9 appointed by the end of 2008). Clear and consistent support materials, including a DVD on "Bump to Breastfeeding" for frontline staff to help mothers to overcome difficulties often encountered in early years is being provided. Every mother will receive a copy of the DVD. A national breastfeeding helpline was launched in February 2008 linking up two other helplines. Children's centres are continuing to promote and support mothers to breastfeed. The Department is using evidence from the Infant Feeding Survey and consumer research to drive service design and delivery. A review of Infant Formula regulations has started with the aim to review the need for stricter controls on advertising of infant formula.

12.3 – Levels of childhood obesity

Indicator	Measure/data	Progress
Success will mean holding the rate of obesity amongst children under 11 to a maximum of 18.1% by 2011, as the first step in the Government's ambition "to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to maintain a healthy weight. Our initial focus is on children: *by 2020, we aim to reduce to proportion of overweight and obese children to 2000 levels."* This supersedes the SR2004 PSA to "halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole." **Departmental Strategic Objective 1** – Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.55 and N.I.56	**Data source:** The Health Survey for England (HSE). **Baseline:** 17.1% in 2008 (estimated as data is available 12-14 months after the end of the year).	The Child Health Promotion Programme was updated in March and prioritises obesity prevention. This complements the additional commitments on breastfeeding (see above). In schools, figures published in July 2008 show that over 3 million children are eating school dinners daily. To improve upon this the Government has made £150m available so that all schools have the opportunity to build or improve kitchen and dining facilities. Also in schools, the National Child Measurement Programme achieved its 2006/2007 target of 80% participation rate. From September 2008, many PCTs will automatically feed back a child's results to parents. More broadly, the Government recently launched Change4Life, a new movement which aims to improve children's diet and activity levels, leading to better health. The Government is inviting all parts of society to join the Change4Life coalition. This already includes some of the biggest and most respected companies in the country who have signed up to play their part to deliver commitments to change, including ASDA, Pepsico, Kelloggs and Tesco.



12.4 – Emotional health and well-being, and child and adolescent mental health services (CAMHS)

Indicator	Measure/data	Progress
Emotional health and well-being, and child and adolescent mental health services (CAMHS) This indicator has two sub-indicators a: Emotional health and wellbeing b: CAMHS **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.50 and N.I.51	**Sub-indicator a:** Emotional health and well-being **Data source:** Annual TellUs Survey. **Baseline:** To be established by the end of 2008. **Subindicator b**: CAMHS **Data source:** Quarterly PCT data through the Local Delivery Plan Returns & local authorities provide annual data at the end of the year. **Baseline:** See table below for PCTs. The baseline for local authorities will be established at the end of calendar year 2008.	A new NHS Mental Health Contract and work following the review of the CAMHS measure will support the drive towards delivery of this indicator over the coming year.

Sub indicator b: CAMHS: The table provides summary data from 2008-09 Q1 self-assessments from the 152 PCTs in England, showing the percentage of PCTs scoring one to four against each sub-measure. Percentages may not sum to 100 because of rounding. At Q1, 14% score the maximum of 16. The table shows numbered and abbreviated sub-measures that correspond to the full descriptions in the text set out underneath the table.

	1. Full range of CAMHS	2. Access for 16-17s	3. 24-hour cover	4. Full range of universal services by LA/PCT
Score of 1	0%	0%	0%	1%
Score of 2	1%	1%	0%	17%
Score of 3	70%	47%	44%	57%
Score of 4	30%	52%	56%	25%

The complete description of the sub-measures are as follows:

1. Has a full range of CAMH services for children and young people with learning disabilities been commissioned for the local authority/PCT area?
2. Do 16 and 17 year olds from the local authority/PCT area who require mental health services have access to services and accommodation appropriate to their age and level of maturity?
3. Are arrangements in place for the local authority/PCT area to ensure that 24 hour cover is available to meet urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated?
4. Is a full range of early intervention support services delivered in universal settings and through targeted services for children experiencing mental health problems commissioned by the local authority and PCT in partnership?

Local authorities and PCTs are asked to rate the service under each indicator on a scale of 1 to 4 as follows:

1 – no aspects or service or strategic plans in place

2 – protocols and plans are in place, services have yet to be put in place

3 – protocols and plans are in place but are only partially implemented

4 – protocols and plans are in place and are fully implemented.

12.5 – Parents' experience of services for disabled children and the 'core offer'

Indicator	Measure/data	Progress
Parents' experience of services for disabled children and the 'core offer' The Aiming High For Disabled Children (AHDC) report[12] made a commitment to introduce an indicator on the provision of services for disabled children as part of the comprehensive spending review **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.54	**Data source:** Annual postal survey of parents of disabled children. **Baseline:** To be available in spring 2009.	New investment in short breaks over the CSR period, together with a new core offer has shown the Government's commitment to delivery on this indicator. Improvements to the service through extra support for transition, taking forward the key recommendations from the Bercow Review for speech, language and communication needs and national children's services mapping and research on information systems will build on this over the next year.

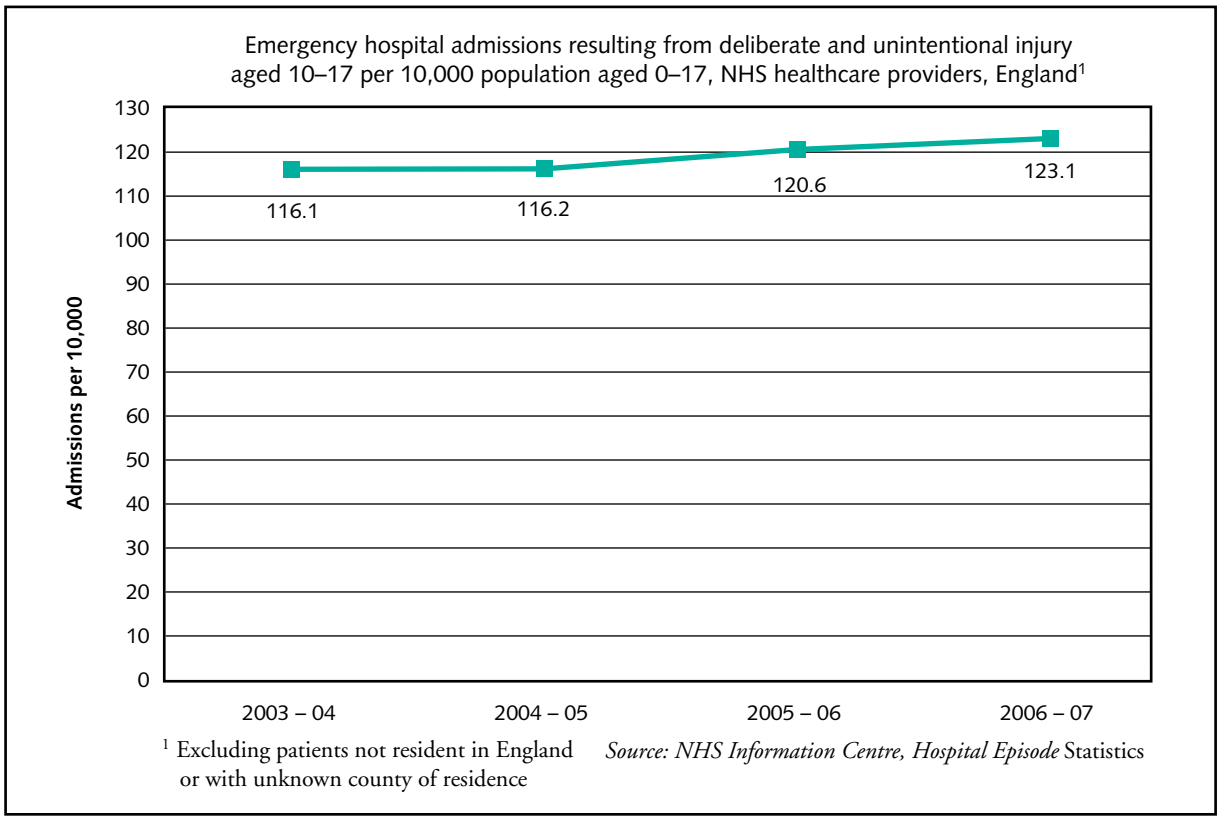
PSA 13 – Improve children and young people's safety

PSA 13 sets out the Government's commitment to improving safety of the children and young people in this country. This PSA is led by the Department for Children, Schools and Families and the Department of Health contributes to one of the four key indicators chosen to monitor progress against this PSA.

13.3 – Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people

Indicator	Measure/data	Progress
Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people aged 0-17 (per 10,000 population) **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3	**Data source:** NHS Information Centre, Hospital Episode Statistics. **Baseline:** 123.1 admissions per 10,000 in 2006-07.	A number of initiatives are supporting progress, including an advertising campaign in Child Safety Week 2008, a new Home Safety Equipment Scheme for Vulnerable Families, improved access to practical child safety education and a new Think! road safety campaign.

12 Aiming high for disabled children: better support for families, HM Treasury and the Department for Education and Skills, 2007



[1] Excluding patients not resident in England or with unknown county of residence

Source: NHS Information Centre, Hospital Episode Statistics

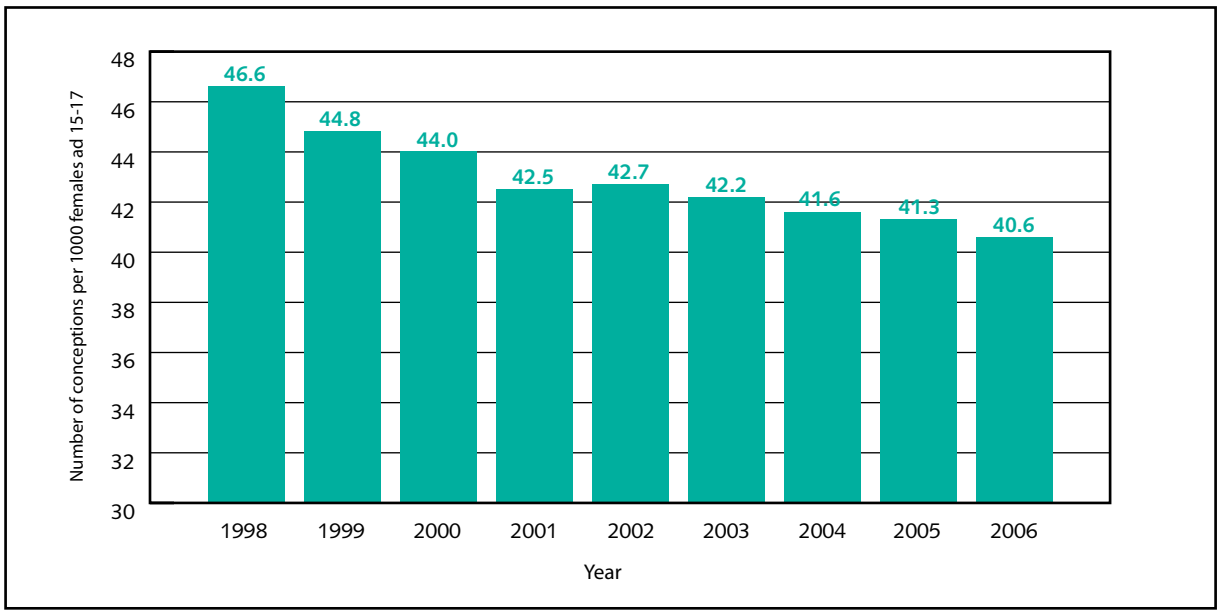
PSA 14 – Increase the number of children and young people on the paths to success

PSA 14 sets out the Government's commitment to increasing the number of children and young people on the paths to success. This PSA is led by the Department for Children, Schools and Families and the Department of Health contributes to one of the five key indicators chosen to monitor progress against this PSA.

14.4 – Reduce the under-18 conception rate

Indicator	Measure/ data	Progress
Reduce the under-18 conception rate Reduce the under-18 conception rate by 50 per cent by 2010 as part of a broader strategy to improve sexual health Linked to SR2004 target **Departmental Strategic Objective 1** – Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.112	**Data source:** ONS **Baseline:** 1998 – 46.6 conceptions per 1,000 females aged 15-17	**Latest data:** England's under-18 conception rate fell overall by 12.9% between 1998 and 2006. The greater decline has been in births (23%) while the abortion rate has remained stable. Evidence has identified the following factors that need to be in place to successfully reduce teenage pregnancy rates: engagement of delivery partners; selection of a senior champion; effective sexual health advice service; prioritisation of sex and relationships education; focus on targeted interventions; training on sex and relationships education for partner organisations; and a well-resourced youth service. All areas are being asked to implement these activities. Funding to improve access to contraception together with a new contraception choices campaign will seek to help reduce the under-18 conception rate. Professionals will be supported through the publication of a new commissioning framework for contraception and abortion services and through the implementation of new Quality and Outcomes Framework indicators for contraception. Two national media campaigns – RU Thinking and Want Respect – continue to promote messages on delaying sex and on condom use, and a further support is offered to parents in talking to their children about sex and relationships.

Under 18 Teenage Conception Rates



PSA 16 – Increase the proportion of socially excluded adults in settled accommodation and employment, education or training

PSA 16 sets out the Government's commitment to ensuring that the most vulnerable adults are offered the chance to get back on a path to a more successful life, by increasing the proportion of socially excluded adults in settled accommodation and in employment, education or training.

This PSA is led by the Cabinet Office and the Department of Health contributes to four of the eight key indicators chosen to monitor progress against this PSA.

16.3 – The proportion of adults in contact with secondary mental health services in settled accommodation

Indicator	Measure/data	Progress
The proportion of adults in contact with secondary mental health services in settled accommodation **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.149	**Data source:** Mental Health Minimum Dataset. **Baseline:** To be established by end of 2009.	This is a new indicator and the first financial year baseline will be established in 2008/09. The first data report for the PSA period is expected in December 2009. This will cover the period March to July 2009.

16.4 – The proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation

Indicator	Measure/data	Progress
The proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.145	**Data source:** NHS Information Centre Key Statistics 1. **Baseline:** To be established by end of 2009.	This is a new indicator and the first financial year baseline will be established in 2008/09. The first annual data report for the PSA period will be available September 2009. This will cover the 2008/09 financial year.

16.7 – The proportion of adults in contact with secondary mental health services in employment

Indicator	Measure/data	Progress
The proportion of adults in contact with secondary mental health services in employment **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.150	**Data source:** Mental Health Minimum Dataset. **Baseline:** To be established by end of 2009.	This is a new indicator and the first financial year baseline will be established in 2008/09. The first data report for the PSA period is expected December 2009. This will cover the period March to July 2009.

16.8 – The proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment

Indicator	Measure/data	Progress
The proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.150	**Data source:** NHS Information Centre Key Statistics 1. **Baseline:** To be established by end of 2009.	This is a new indicator and the first financial year baseline will be established in 2008/09. The first annual data report for the PSA period will be available September 2009. This will cover the 2008/09 financial year.

PSA 17 – Tackle poverty and promote greater independence and well-being in later life

PSA 17 sets out the Government's focus on the quality of later life in the UK, seeking to make the most of the opportunities offered by longer life, and driving forward the necessary cultural and behavioural changes. This PSA is led by the Department for Work and Pensions and the Department of Health contributes to two of the five key indicators chosen to monitor progress against this PSA.

17.3 – Healthy life expectancy at age 65

Indicator	Measure/data	Progress
Healthy life expectancy at age 65 (self-reported) **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.137	**Data source:** ONS mortality data by age and data on self-reported health by age from the General Household Survey/ Integrated Household Survey. **Baseline:** 2007 General Household Survey; actual data to be confirmed.	The key drivers for this indicator are lifestyle choices, local health and social care services and prevention and early intervention. Work is underway to identify the key policies under each of these drivers that will contribute to this indicator.

17.5 – The extent to which people over 65 receive the support they need to live independently at home

Indicator	Measure/data	Progress
The extent to which people over 65 receive the support they need to live independently at home This is a shared indicator with CLG and DWP **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – N.I.139 (No equivalent vital sign)	**Data source:** NatCen Omnibus Survey and Place Survey. **Baseline:** Using Natcen Omnibus (end 2008).	Drivers to deliver this will rely on other services that impact on every aspect of support to live at home such as environment, community and transport. Further analysis to understand what social determinants affect the way people respond to the survey questions is underway. This will help Government, in turn, to identify the drivers, e.g. Supporting People, most likely to impact upon the PSA indicator and enable a better cross-government approach to deliver this.

PSA 25 – Reduce the harm caused by alcohol and drugs

PSA 25 sets out the Government's commitment to produce a long-term sustainable reduction in the harms associated with alcohol and drugs. This PSA is led by the Home Office and the Department of Health contributes to two of the five key indicators chosen to monitor progress against this PSA.

25.1 – The number of drugs users recorded as being in effective treatment

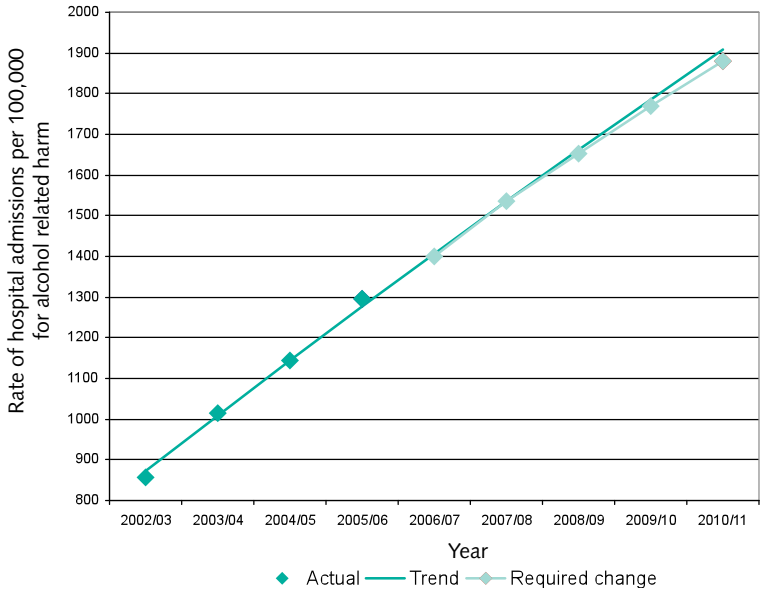
Indicator	Measure/data	Progress
Percentage change in the numbers of drug users recorded as being in effective treatment Success: The PSA delivery agreement notes a minimum 1% improvement is required for performance appraisal. This has been agreed as a sustained 3% by 2010/11 **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.40	**Data source:** National Drug Treatment Monitoring System (NDTMS). **Baseline:** 2007/08, 156,387 persons recorded as in effective treatment.	**Latest data:** July 2007-June 2008 – 158,595 persons recorded as in effective treatment, a 1.4% increase on the baseline. The new ten-year drugs strategy, Drugs: protecting families and communities[13] sets out the government's 10-year vision and a raft of new measures to enforce, educate and intervene on drugs, and to support those who need it in and out of treatment. The new strategy emphasises the key role drug treatment has and sets out the government's ambition for improving the personalisation of treatment towards meeting an individual's needs.

25.2 – The number of alcohol-related admissions

Indicator	Measure/data	Progress
Rate of hospital admissions per 100,000 for alcohol related harm Success: A minimum statistically significant reduction of 1.4% on the forecast trend is required by 2010/11. This equates to a rate of admission of 1,881 per 100,000 by 2010/11. **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 3 and N.I.39	**Data source:** IC Hospital Episode Statistics/ ONS mid-year population estimates. **Baseline:** The baseline rate of 1,400 per 100,000 in 2006/07.	**Latest data:** Figures for 2007/08 are expected to be available by January 2009. The publication of the new Alcohol Strategy – *Safe. Sensible. Social*[14] specifically focuses on the minority of drinkers who cause the most harm to themselves. A new £10m campaign to raise public awareness of units and challenge the public acceptability of drunkenness will be launched in the coming year and a new Alcohol National Support Team will provide support to PCTs in delivering on this indicator.

13 Drugs: protecting families and communities, HM Government, 2008

14 Safe. Sensible. Social – The next steps of the National Alcohol Strategy. HM Government, 2007



Legacy Spending Review Targets

In addition to our CSR07 PSA indicators the Department has a number of legacy PSA targets from previous spending reviews. The current PSA indicators have subsumed the majority of these. For indicators where this is not the case, reports on progress are set out below.

Spending Review 2004 targets:

1. Health of the population – encouraging progress

By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women – encouraging progress

Indicator	Measure/data	Progress
By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women (See also PSA18.1 All-age all-cause mortality rate indicator – used as proxy to measure progress on the life expectancy target, particularly relevant at local level) **Departmental Strategic Objective** – Ensure better health and well-being for all **Vital Signs and National Indicator Set –** Tier 2 and N.I.120	**Data source:** Period of life expectancy at birth for England, males and females separately. (Source: ONS, from National Interim Life Tables). **Baseline:** Three-year averages for the period 1995-97 – 74.5 years for males; 79.6 years for females. (Note: baseline has been moved to 1995-97 from 1997-99 for consistency with SR2004 target on inequalities in life expectancy. Assessment of progress is unaffected.)	**Latest data:** Three-year averages for the period 2005-07 – 77.5 years for males; 81.7 years for females.

2. Substantially reduce mortality rates by 2010 – on course

Reduce mortality rates from suicide and injury of undetermined intent by at least 20% by 2010 – on course

Indicator	Measure/data	Progress
Reduce mortality rates from suicide and injury of undetermined intent by at least 20% by 2010 **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2	**Data source:** Death rate from intentional self-harm and injury of undetermined intent amongst people of all ages for England (Rates calculated by DH based on ONS death registrations and mid-year population estimates. Rates are age standardised to allow for changes in the age structure of the population). **Baseline:** Three-year average rate for the period 1995-97 – 9.2 deaths per 100,000 population.	**Latest data:** Three-year average for the period 2005-07 – 7.9 deaths per 100,000 population. Over the coming year a toolkit will be launched for acute in-patient staff to help reduce the number of patients that go missing from wards who may be at risk of suicide or self harm. In addition, an amendment to the Suicide Act will be laid before Parliament to simplify the act and to reflect the new ways of communicating and accessing information to restrict the number of internet sites that promote or encourage suicidal acts.

Intentional self-harm and injury of undetermined intent (excluding verdict pending) mortality rates, all ages, England: 1995-97 to 2005-07

	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
Death rate per 100,000	9.2	9.3	9.6	9.7	9.3	8.9	8.6	8.6	8.5	8.3	7.9

Under 75 CVD mortality rate – overall – met early, inequalities element – on course

Indicator	Measure/data	Progress
Reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.121	**Data source:** Death rate from heart disease, stroke and related diseases amongst people aged under 75 for England, and absolute gap (i.e. difference) in death rates between Spearhead group and England (Rates calculated by DH based on ONS death registrations and mid-year population estimates. Rates are age standardised to allow for changes in the age structure of the population). **Baseline:** Three-year averages for the period 1995-97 – England rate: 141.3 deaths per 100,000 population; gap between Spearhead Group and England: 36.7 deaths per 100,000 population. (Note: baseline for England has been revised by 0.3, due to revised method for ensuring comparable time series following change to codes used to record cause of death in 2001.)	**Latest data:** Three-year averages for the period 2005-07 – England rate: 79.1 deaths per 100,000 population (44.0% below the baseline); gap between Spearhead Group and England: 23.5 deaths per 100,000 population (35.9% below the baseline). Further progress will result from continued delivery of a range of measures set out in the Coronary Heart Disease NSF together with measures in the stroke strategy and plans for the vascular checks programme. These measures will include starting the phased rollout of vascular checks for those aged 40-74, a stroke awareness campaign and the establishment of stroke care networks. An early priority for these networks will be to reorganise the response to acute stroke, ensuring people get to a stroke unit on day 1 and thrombolysis is given to those who will benefit.

All circulatory diseases mortality rates, ages under 75: 1995-97 to 2005-07
(Note: minor revisions have been made to some historic figures for England, including the baseline, due to revised method for ensuring comparable time series following change to codes used to record cause of death in 2001)

	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
England death rate per 100,000	141.3	135.4	128.5	121.8	114.5	108.2	102.8	96.7	90.5	84.2	79.1
Absolute gap between Spearhead Group and England (deaths per 100,000)	36.7	36.4	35.2	32.7	30.8	29.0	28.7	27.6	26.4	24.9	23.5

Under 75 Cancer mortality rate – overall (on course), inequalities element (ahead)

Indicator	Measure/data	Progress
Reduce mortality rates by 2010 from cancer by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole **Departmental Strategic Objective 1 –** Ensure better health and well-being for all **Vital Signs and National Indicator Set** – Tier 2 and N.I.122	**Data source:** Death rate from cancer amongst people aged under 75 for England, and absolute gap (i.e. difference) in death rates between Spearhead group and England (Rates calculated by DH based on ONS death registrations and mid-year population estimates. Rates are age standardised to allow for changes in the age structure of the population). **Baseline:** Three-year averages for the period 1995-97 – England rate: 141.2 deaths per 100,000 population; gap between Spearhead Group and England: 20.7 deaths per 100,000 population.	**Latest data:** Three-year averages for the period 2005-07 – England rate: 115.5 deaths per 100,000 population (18.2% below the baseline). Further progress will result from the delivery of a range of measures set out on the Cancer Reform Strategy published in late 2007. These measures will include the continued implementation of NICE's Improving Outcomes Guidance, implementation of new cancer waiting time standards, and completing the initial rollout of bowel cancer screening to those aged 60-69, starting to extend breast cancer screening and improving early detection of cancers through raising awareness and improving GP diagnosis.

Cancer mortality rates, ages under 75: 1995-97 to 2005-07
(Note: minor revisions have been made to some historic figures for England, due to revised method for ensuring comparable time series following change to codes used to record cause of death in 2001)

	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
England death rate per 100,000	141.2	138.5	134.9	132.0	128.7	126.5	124.1	121.6	119.0	117.1	115.5
Absolute gap between Spearhead Group and England (deaths per 100,000)	20.7	21.0	20.8	20.3	19.9	19.6	19.1	18.8	18.1	18.4	18.0

3. Reduce health inequalities – slippage

Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth – infant mortality – slippage and life expectancy – slippage

Indicator	Measure/data	Progress
Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth (See also PSA18.2 Gap in all-age all-cause mortality rate indicator – used as proxy to measure progress on the life expectancy target, particularly relevant at local level)	Infant mortality **Data source:** The relative gap (i.e. percentage difference) in the infant mortality rate between the "routine and manual" group and the population as a whole (Source: ONS). The target is measured using an indicator of socio-economic groups defined only through the father's occupation because there are limited occupational data associated with sole registration by mothers. The current approach has remained consistent since the target was set. **Baseline:** Three-year average for the period 1997-99 – the infant mortality rate among the "routine and manual" group was 13% higher than in the total population.	Infant mortality **Latest data:** Three-year average for the period 2005-07 – infant mortality rate among the "routine and manual" group is now 16% higher than in the total population.
(See also PSA18.2 Gap in all-age all-cause mortality rate indicator – used as proxy to measure progress on the life expectancy target, particularly relevant at local level)	Life expectancy **Data source:** The relative gap (i.e. percentage difference) in period life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole, for males and females separately. (Source: ONS, from sub-national life expectancy results). **Baseline:** Three-year average for the period 1995-97 – the relative gap in life expectancy was 2.57% for males and 1.77% for females.	Life expectancy **Latest data:** For men, in the period 2005-07 the relative gap in life expectancy between England and the Spearhead group was 4% wider than the baseline gap, compared with 2% wider in 2004-06. For women, in the period 2005-07 the relative gap in life expectancy between England and the Spearhead group was 11% wider than the baseline gap, the same as in 2004-06.

Spending Review 2002 targets:

By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth – infant mortality (see under SR2004 targets); life expectancy – slippage

Indicator	Measure/data	Progress
Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth	Infant mortality See under SR2004 targets	Infant mortality See under SR2004 targets
	Life expectancy **Data source:** The relative gap (i.e. percentage difference) in period life expectancy at birth between the fifth of local authority areas with the lowest life expectancy at birth and the population as a whole, for males and females separately (Source: ONS, from sub-national life expectancy results). **Baseline:** Three-year average for the period 1997-99 – the relative gap in life expectancy was 2.67% for males, and 1.92% for females.	Life expectancy **Latest data:** For men, in the period 2005-07 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 2% wider than the baseline gap, compared with 1% wider in 2004-06. For women, in the period 2005-07 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 12% wider than the baseline gap, compared with 11% wider in 2004-06. In addition, for health inequalities in life expectancy please see progress report under SR2004 targets.

Spending Review 1998:

Reduction in the rate of hospital admission for serious accidental injury by at least 10% by 2010, from a baseline estimate of 315.9 admissions per 100,000 population for the financial year 1995/96 – slippage

Reduction in the death rate from accidents by at least 20% by 2010, from a baseline of 15.8 per 100,000 population for the 3 years 1995-97 – slippage

Indicator	Measure/data	Progress
Reduction in the rate of hospital admission for serious accidental injury by at least 10% by 2010	**Data source:** Rate of hospital admission for serious accidental injury requiring a hospital stay of four or more days, amongst people of all ages for England (Rates calculated by DH based on Hospital Episode Statistics from the Information Centre and ONS mid-year population estimates. Rates are age standardised to allow for changes in the age structure of the population). **Baseline:** 315.9 admissions per 100,000 population in financial year 1995/96.	**Latest data:** 325.8 admissions per 100,000 population in 2006/07. Single year data for financial year 2006/07 shows an increase of 3.1% from the 1995/96 baseline estimate. Death and serious injury are decreasing in children and young people under-15 and in the 15-24 age range. Initiatives being taken forward under PSA 13 and the DCSF's Staying Safe Action Plan, plus the Children's NSF and Early Year's Lifecheck information will contribute to reducing this further. The public in general also benefit from Government transport safety policies and initiatives. Slippage on the two targets is mainly related to accidents to older people over 65 years, particularly from falls. The Prevention Package for Older People will provide improved preventative care for older people with health and social care providers working together to support independent living. This will build upon existing recent work to prevent falls and include developing a commissioning framework around falls, fractures and osteoporosis.

Indicator	Measure/data	Progress
Reduction in the death rate from accidents by at least 20% by 2010	**Data source:** Death rate from accidents amongst people of all ages for England (Rates calculated by DH based on ONS death registrations and mid-year population estimates. Rates are age standardised to allow for changes in the age structure of the population). **Baseline:** Three-year average for the period 1995-97: 15.8 deaths per 100,000 population.	**Latest data:** Three-year average for the period 2005-07: 15.8 deaths per 100,000 population. Three-year average mortality rates are broadly flat since the baseline period, with small fluctuations above the baseline in intervening years.

3. Departmental Strategic Objectives:

3.1 The Department of Health has three Departmental Strategic Objectives (DSOs) which enshrine the core business of the department. The DSOs bring together the wider span of departmental business with the Government's highest priorities represented by the PSAs. DH's DSOs are:

- **To ensure better health and well-being for all** – this covers the Department's objectives to help people stay healthy and well, empowering them to live independently, and tackle health inequalities;
- **To ensure better care for all** – this covers the Department's objectives to provide the best possible health and social care services, offering safe and effective care, when and where people need help and empowering them in their choices; and
- **To provide better value for all** – this covers the Department's objectives to deliver affordable, efficient and sustainable services contributing to the wider economy and nation.

3.2 Two of these DSOs are also PSAs on which the Department lead and there is large overlap between the indicators. All of the Department's PSA indicators (including those in PSAs led by other government departments) are also indicators for DH's DSOs. Progress against the DSOs is measured by a set of 44 indicators. This chapter sets out the progress made on each DSO (some of which are still under development), providing updates on each indicator in turn. Where there is crossover between the DSO indicator and PSA indicator, reporting of progress on that indicator can be found in the PSA section. Further detail on the data sources for each indicator is contained at Annex B.

DSO 1: To ensure better health and well-being for all

To ensure better health and well-being for all DSO indicators
Improving access to psychological therapies
Suicide & injury of undetermined intent mortality rate
Emotional health and wellbeing and CAMHS
All-age all cause mortality rate per 100,000 (and gap between Spearhead group and national average)
<75 CVD Mortality Rate
<75 Cancer Mortality Rate
Preparedness against pandemic influenza
Healthy life expectancy at age 65
Proportion of adults (18 and over) supported directly through social care to live independently at home
Proportion of people achieving independence 3 months after entering care/re-hab

Smoking prevalence among people aged 16 and over, and aged 16 and over in routine and manual groups
Self-reported measure of people's overall health
Levels of childhood obesity
The number of alcohol-related hospital admissions
The number of drug users recorded as being in effective treatment
Prevalence of breastfeeding at 6-8 weeks
Emergency hospital admissions caused by unintended and deliberate injuries
Under-18 conception rate
Prevalence of chlamydia in under 25 year olds
Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation
Proportion of adults in contact with secondary mental health services in employment
Proportion of adults in contact with secondary mental health services in settled accommodation
Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment

Preparedness against pandemic influenza:

Indicator	Measure/data	Progress
Preparedness against pandemic influenza	All NHS organisations to have robust plans in place to respond to a flu pandemic by December 2008. Plan to increase existing stocks of antivirals to treat up to 50% of the population and to establish a stockpile of antibiotics. Plan to establish a National Pandemic Flu Line Service to operate during a pandemic.	Procurement of antivirals is set to increase in 2009. The first release of the National Pandemic Flu Line Service is due to be in place by spring 2009.

Proportion of older people achieving independence 3 months after entering care/re-hab

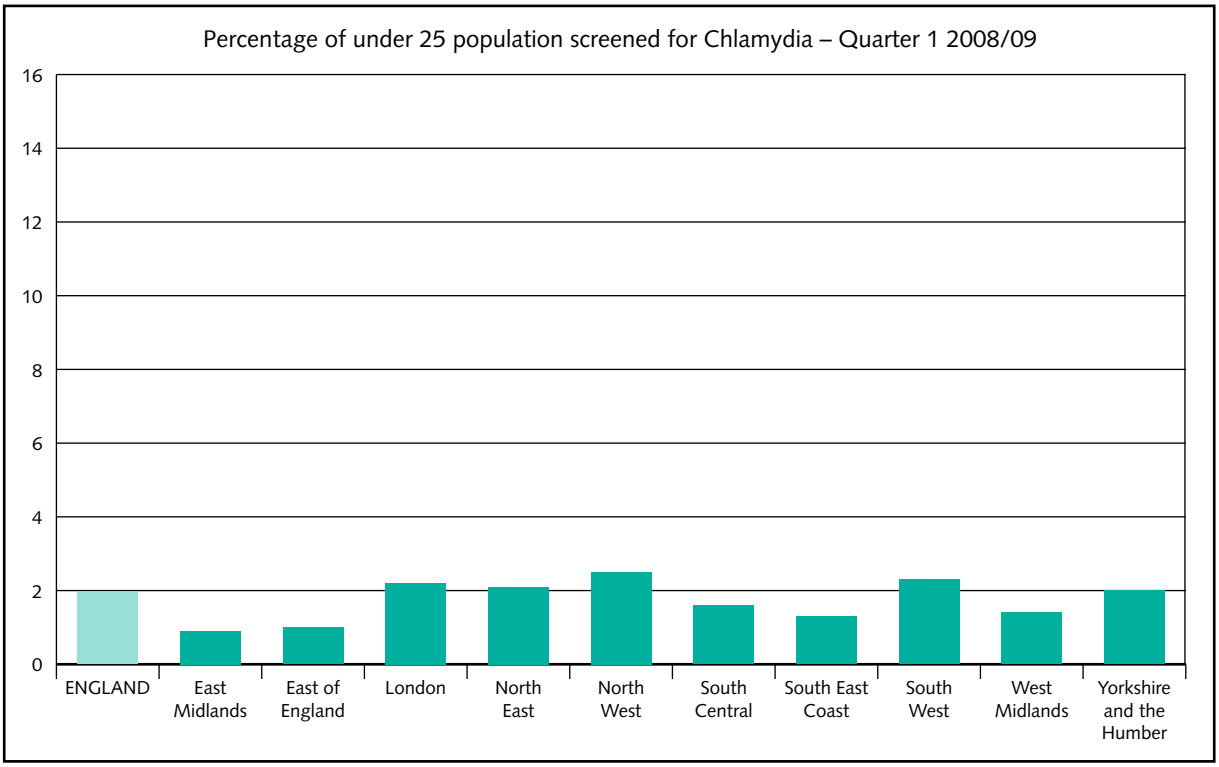
Indicator	Measure/data	Progress
The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation who are at home or in extra care housing or an adult placement scheme three months after the date of their discharge from hospital **Vital Signs and National Indicator Set** – Tier 3 and N.I.125	**Data source:** Social Care Keystats Collection (KS1); NHS Collection still being finalised. **Baseline:** Data and baseline information will be available in autumn 2009.	With the focus on rehabilitation and re-enablement, this indicator is closely aligned with the focus on preventative services set out in the Government's vision for adult social care *Putting People First*. A prevention package, which will include updated guidance on intermediate care and a discharge workbook, is due to be published in spring 2009. In addition, the new Dementia Strategy will include specific guidance on the use of intermediate care for people with dementia. Both of these activities will help contribute to the delivery of this indicator.

Self-reported measure of people's overall health

Indicator	Measure/Data	Progress
Self-reported measure of people's overall health **Vital Signs and National Indicator Set** – Tier 3 and N.I.119	**Data source:** Places Survey (CLG). **Baseline:** Data will be available in spring 2009.	This indicator will no longer be informed by an EQ5D Proms style measure in the place survey but a general health question in the same survey.

Prevalence of chlamydia in under 25 year olds

Indicator	Measure/data	Progress
Prevalence of chlamydia in under 25s: "The percentage of the population aged 15-24 accepting a test/screen for chlamydia" **Vital Signs and National Indicator Set** – Tier 2 and N.I.113	**Data Source:** Health Protection Agency (HPA). **Baseline:** 4.9% of the 15-24 population were screened in 2007/8. Progress is currently measured through a proxy using screening numbers.	**Latest data:** Data is updated and monitored on a quarterly basis. For 2007/08 4.9% of the target population were screened. Data available at www.chlamydiascreening.nhs The Health Protection Agency (HPA) National Chlamydia Screening Programme team is implementing a support package for the PCTs to accelerate delivery of the programme. In addition, the DH Sexual Health National Support Team will prioritise chlamydia screening in their PCT and SHA visits to support delivery of the target.



DSO 2: To ensure better care for all

To ensure better care for all DSO indicators
Healthcare associated infection figures – MRSA
Healthcare associated infection figures – *Clostridium difficile*
Number of delayed transfers of care per 100,000 population (aged 18 and over)
The proportion of people with long-term conditions supported to be independent and in control of their condition
NHS-reported referral-to-treatment times for admitted patients
NHS-reported referral-to-treatment times for non-admitted patients
Patient-reported experience of access to GP services
Timeliness of social care assessment
Timeliness of social care packages
Proportion of all deaths that occur at home
Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)
Percentage of women who have seen a midwife or a maternity health professional for an assessment of health and social care needs, risk, and choices by 12 weeks of their pregnancy
Self-reported experience of patients and users

Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community based services
Patient and user-reported measure of respect and dignity in their treatment
Parents' experience of services for disabled children and the 'core offer'

The number of delayed transfers of care per 100,000 population (aged 18 and over)

Indicator	Measure/data	Progress
Number of delayed transfers of care from all NHS hospitals, both acute and non-acute, per 100,000 population aged 18+ **Vital Signs and National Indicator Set** – Tier 3 and N.I.131	**Data source:** Department of Health form Weekly Situation Reports, ONS 2006 and 2007 mid year populations. **Baseline:** 14.9 per 100,000 population aged 18+ in 2006/07. The number of patients with delayed discharge is collected weekly as a snapshot at midnight on a Thursday. This data represents an average week in the year.	**Latest data:** 13.8 per 100,000 population aged 18+ in 2007/08. Local councils and their NHS partners have already made significant progress in reducing the number of cases of patients with delayed discharges from acute hospitals. In March 2007, the Care Service Improvement Partnership produced a good practice toolkit to improve discharge from inpatient mental health care settings which should help improve delivery on this indicator. Progress against this indicator is also closely associated to activity around the DSO 1 supporting indicator, achieving independence for older people through rehabilitation and intermediate care.

Timeliness of social care assessment

Indicator	Measure/Data	Progress
For new clients (aged 18+), the percentage from where the time from first contact to completion of assessment is less than or equal to four weeks **Vital Signs and National Indicator Set** – Tier 3 and N.I.132	**Data source:** Referrals, Assessment and Package of Care (RAP) data. **Baseline:** 76% in 2006/07.	**Latest data:** A national figure will be available in December 2008. Some councils did not provide the necessary 2007/08 data and, consequently, the missing cases need to be estimated to calculate a national figure. Service users report that timeliness of assessment and delivering support in a timely manner is a key part of supporting them to live independently. Providing timely support is important to deliver the preventative approach set out in the Government's vision for adult social care, *Putting People First.* This indicator gives the Department headline monitoring of whether the social care system is working well.

Timeliness of social care packages

Indicator	Measure/Data	Progress
For new clients (aged 65+ for 2008/09 and all ages from 2009/10), the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks **Vital Signs and National Indicator Set** – Tier 3 and N.I.133	**Data source:** Referrals, Assessment and Package of Care (RAP) data. **Baseline:** 89.3% in 2006/07.	**Latest data:** 90.9% in 2007/08 (provisional). Service users report that timeliness of assessment and delivering support in a timely manner is a key part of supporting them to live independently. Providing timely support is important to deliver the preventative approach set out in the Government's vision for adult social care, *Putting People First*. This indicator gives the Department headline monitoring of whether the social care system is working well.

Proportion of all deaths that occur at home

Indicator	Measure/data	Progress
Proportion of all deaths that occur at home **Vital Signs and National Indicator Set** – Tier 3 and N.I.129	**Data source:** ONS death registration data. **Baseline:** 18.4% in 2005.	**Latest data:** 19.5% in 2007 A national End of Life Care Strategy[15] has been published to improve care for adults, providing greater choice about how they are cared for and where they die. National initiatives set out in the strategy include the development of quality markers to support the commissioning, provision and assessment of end of life care services and are currently being consulted.

Year	2002	2003	2004	2005	2006	2007
Proportion of deaths that occur at home	18.3%	18.0%	18.3%	18.4%	19.0%	19.5%

15 End of Life Care Strategy – Providing high quality care for all adults at the end of life, DH, 2008

Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)

Indicator	Measure/data	Progress
Social care clients receiving self-directed support **Vital Signs and National Indicator Set** – Tier 3 and N.I.130	**Data source:** Referrals, Assessment and Packages of Care (RAP) data and Personal Social Services Expenditure (PSSEX1) data. **Baseline:** 2006/07 – 122.0 per 100,000 population.	**Latest data:** A national figure will be available in December 2008. Some councils did not provide the necessary 2007/08 data and, consequently, these missing cases need to be estimated for calculating a national figure. A revised definition of this indicator which will better reflect local authorities' progress and performance in moving towards a system of self-directed support and the wider introduction of personal budgets over the period 2008-11 that were set out in *Putting People First* will be introduced in April 2009. In addition, the extension of direct payments to people who lack capacity (due to come into force in spring 2009) will also help improve performance on this indicator.

Proportion of carers receiving a 'carer's break' or a specific service or advice and information for carers as a percentage of clients receiving community based services

Indicator	Measure/data	Progress
Proportion of carers receiving a 'carer's break' or a specific service, or advice and information for carers as a percentage of clients receiving community based services **Vital Signs and National Indicator Set** – Tier 3 and N.I.135	**Data source:** Referrals, Assessment and Packages of Care (RAP) data. **Baseline:** 20.7% in 2006/07.	**Latest data:** A national figure will be available in December 2008. Some councils did not provide the necessary 2007/08 data and, consequently, the missing cases need to be estimated to calculate a national figure. The publication of the new Carers Strategy[16] will see an increased focus on and additional funding for providing services for carers. Breaks pilots will begin looking at innovative approaches to providing personalised cost-effective breaks.

16 Carers at the heart of 21st century families and communities, Department of Health, 2008

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

Indicator	Measure/data	Progress
Patient and user-reported measure of respect and dignity in their treatment **Vital Signs and National Indicator Set** – Tier 3 and N.I.128	**Data source:** Healthcare Commission National Patients Survey 2007. **Baseline:** 2002 – see data below.	**Latest data:** 2007 – see data below. The profile of dignity in care will continue to be raised over the coming year through a public facing Dignity Award as part of the Health and Social Care Awards and the publication of the new Dignity Ambassador's, Michael Parkinson, report as part of the Dignity in Care campaign. This follows on from a National Ministerial Dignity tour which raised the profile of the campaign and shared best practice across the country.

Q66: Overall, did you feel you were treated with respect and dignity while you were in the hospital?

	Survey Year			
	2002	2005	2006	2007
Yes, always	79%	79%	78%	78%
Yes, sometimes	18%	18%	18%	19%
No	3%	3%	3%	3%
Number of respondents	92961	79008	79030	74873

Source: Healthcare Commission National Patients Survey 2007

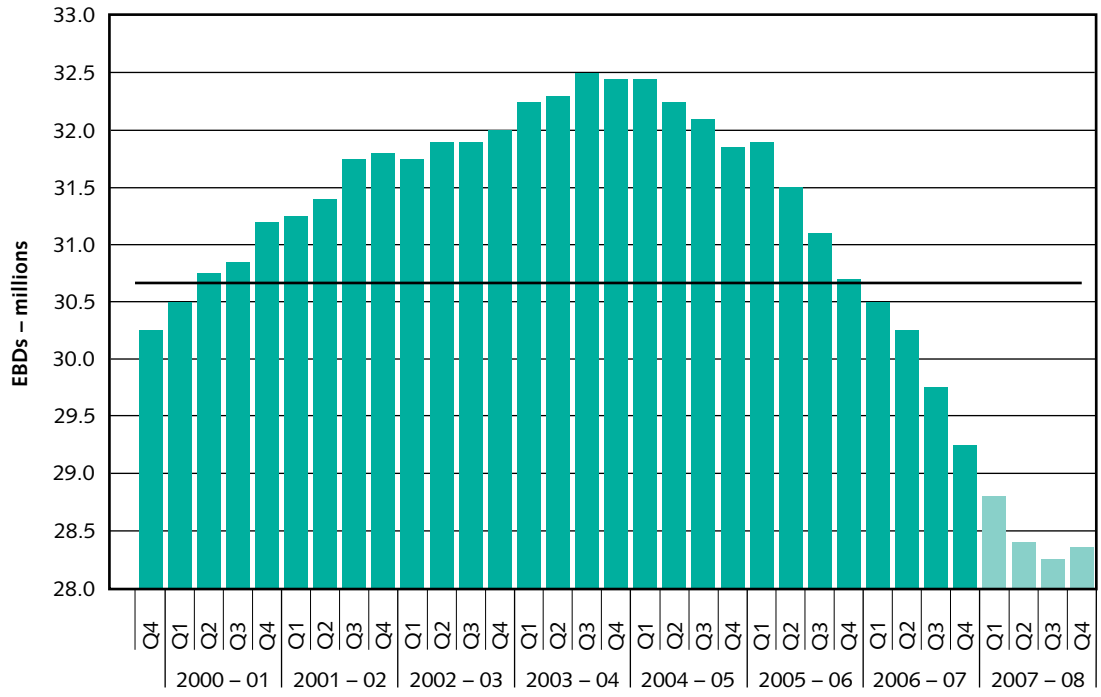
DSO 3: To provide better value for all

To provide better value for all DSO
Number of emergency bed days per head of weighted population
Financial balance (PCT)
Prescribing indicator
Public confidence in local NHS
NHS estates energy/carbon efficiency

17 Carers at the heart of 21st century families and communities, Department of Health, 2008

Number of emergency bed days per head of weighted population

Indicator	Measure/data	Progress
Number of emergency bed days per head of weighted population Target: Reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions **Vital Signs and National Indicator Set** – Tier 3 and N.I.134	**Data source:** For 2008-09, Hospital Episode Statistics. From 2009-10 Healthcare Commission PCT survey. **Baseline:** Provisional 2008-09 baseline: 28.3 million emergency bed days.	Over the next two years everyone with one or more long-term conditions will be offered personalised care plans which together with a National Patient's Prospectus on NHS Choices should help drive down the number of emergency bed days.



Source: Hospital Episode Statistics, Information Centre for Health and Social Care. Data for 2007–08

Financial balance (PCT)

Indicator	Measure/data	Progress
Financial Balance (PCT) **Vital Signs and National Indicator Set** – Tier 1	**Data source:** PCT audited Financial Monitoring & Accounts Forms 2007-08. PCT Financial Monitoring returns from Quarter 1.	The NHS ended the 2007/08 year with a net surplus in PCT accounts of £391m. At the end of the second quarter of 2008/09, PCTs are forecasting an overall surplus of £395 million. The forecast at Q2 is in accordance with the 2008/09 Operating Framework. The overall surplus allows the NHS the flexibility to respond to fluctuations in demand, whilst maintaining sufficient funds for investment in new services. It is disappointing to report that at quarter 2 there are 3 PCTs forecasting that they will end 2008/09 with an operating deficit, this compares to none at quarter 1. The three PCTs have a combined forecast gross operating deficit of £27 million. The Department is working through the strategic health authorities to ensure that the PCTs forecasting an operating deficit are developing recovery plans to return to financial balance whilst maintaining and improving services to patients.

	2007/08 Annual Accounts Surplus / (deficit) £m	2008/09 Forecast Outturn Surplus / (Deficit) £m
Gross Surplus	436	422
Gross Deficit	(45)[1]	(27)[2]
Net PCT Total	**391**	**395**

1 – at the end of 2007/08, 4 PCTs reported a year-end deficit

2 – at Q2 2008/09, 3 PCTs are forecasting a year-end deficit

Prescribing indicator

Indicator	Measure/data	Progress
Prescribing indicator (still to be defined) **Vital Signs and National Indicator Set** – Tier 3	**Data source:** To be decided.	The prescribing indicator is in its final stages of development – the aim is to introduce a basket of measures which will be used to track progress on the overall indicator. The proposed measures are still subject to discussion with interested parties.

Public confidence in local NHS

Indicator	Measure/data	Progress
Public confidence in local NHS (Indicator currently under development) **Vital Signs and National Indicator Set** – Tier 2	**Data source:** Primarily based on the national patient survey programme (under the administration of the Healthcare Commission), but this indicator will also draw on other currently available published data including KO41 complaints returns. **Baseline:** Expected in spring 2009.	Development work has taken place with a wide range of stakeholders leading to 10 broad headings which describe the full range of 'patient and public focus'. Some of these headings are closely related to those already addressed in PSA indicator 19.1 (patient experience). To complement that, the Department has therefore narrowed the focus of this indicator to three headings, and will provide a composite measure to cover: 1. indication that the organisation organises services with a focus on the individual; 2. indication that the organisation arranges services with a focus on dignity and respect for the patient; 3. indication that the organisation makes use of patient and public feedback and learns from experience. A composite indicator (based on existing, published data) needs to be agreed with NHS performance leads before data collection can begin in 2009/10.

NHS estates energy/carbon efficiency

Indicator	Measure/data	Progress
The current success measures are to: a. *reduce the overall level of primary energy consumption by 15% or 0.15 MtC (million tonnes carbon) from March 2000 to March 2010;* b. *achieve a level of 35–55 GJ/100 m3 (gigajoules per 100 m3) energy performance for all new capital developments and major redevelopments/refurbishments and 55–65 GJ/100 m3 for existing facilities.* **Vital Signs and National Indicator Set** – Tier 3	**Data source:** Estates Related Information Collection (ERIC) 2007-08. **Baseline:** ERIC 1999-2000.	**Latest data:** Initial analysis of the ERIC 2007-08 data shows the current position as: a. Energy performance has improved by 6.5% since 2000. In the same period, total energy consumption has increased by 9% as the size of the NHS has increased by 18%; b. Currently, 55% of NHS buildings meet the target for new capital development with and additional 17% meeting the existing facilities target. Annual figures are provided for all NHS organisations and can be used to judge progress.

4. Value for Money

4.1 Improving value for money (VfM) is a key priority for the Department of Health (DH) and *providing better value for all* is one of the Department's three Departmental Strategic Objectives. Building upon its significant VfM improvements recorded in recent years as part of the Gershon programme, DH has put in place an ambitious programme to further improve VfM over the next three years and to explore potential for making additional step changes in VfM in the longer-term.

4.2 Reporting of progress on value for money is separated into two sections:

- A final report of savings recorded from 2004/05 through 2007/08 under the Gershon programme;
- A first update on progress towards the VfM target for the period 2008/09 through 2010/11, set as part of the 2007 Comprehensive Spending Review (CSR07).

Gershon Efficiency Targets

4.3 The Gershon Report *Releasing Resources to the Front Line*,[17] published in March 2004, committed the Department of Health to achieving the following targets as part of the 2004 Spending Review:

- annual efficiency gains of £6.47bn by March 2008, at least half of which should be cashable;
- a reduction in whole time equivalent civil servants of 720 by March 2008;
- the relocation of 1,030 whole time equivalent posts out of London and the south east by March 2010 (reduced from previous 1110 following transfer of some agencies to the then Department for Constitutional Affairs).

Programme Structure

4.4 The programme comprised 5 main workstreams:

- **Productive Time:** Modernising the provision of front line services to be more efficient and also improving the quality of patient care, by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce;
- **Procurement:** Making better use of NHS buying power at a national level to secure better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies and other consumables and pharmaceuticals;
- **Corporate Services:** Ensuring NHS organisations can rationalise and share back office services, such as finance, information and communications technology and human resources;
- **Social Care:** Improving commissioning of social care and other cash releasing and non-cash releasing gains from the design of social care processes by local authorities;

17 Releasing Resources to the Front Line – Independent Review of Public Sector Efficiency. HM Treasury, 2004

- Public Funding and Regulation: Reducing the operating costs of the Department of Health, arms length bodies, strategic health authorities and primary care trusts through reducing processes and functions and restructuring, merging or abolishing existing organisations.

Gershon Programme – final reported gains:

4.5 The following gains have been recorded for the four years of the programme:

Workstream	2004/05 (£m)	2005/06 (£m)	2006/07 (£m)	2007/08 (£m)
Productive Time[1]	508	963	1756	3134
Procurement	333	1322	2448	3162
Corporate Services[2]	14	38	57	180
Social Care	0	179	390	785
Public Funding & Regulation	13	77	270	615
Gross Health	**868**	**2579**	**4921**	**7876**
Net Health[3]				**7057**

Notes:

1 Length of Stay final gains are now calculated against absolute 2004 baseline resulting in lower calculated savings than using formula previously agreed with NAO.

2 Final figure includes £100m of Connecting for Health previously reported as Productive Time. It does not include estimated £20m saving for Shared Services as data received too late to verify.

3 The net total excludes the calculated CSR07 over-delivery offset which is explained in the following section.

4.6 Of the total reported gains, £4,611m (59%) are cashable. Savings attributable to reducing the cost of patient stays, which would require local capacity planning changes to realise the savings as cash, are counted as non-cashable.

4.7 All of the reported gains are based on finalised data covering the operating period up to March 2008. Gains for any previously identified projects where finalised gains have not been able to be substantiated have been excluded from final reporting.

4.8 Of the total reported gains £5,474m is based on fully assured data, and the remaining £2,403m is based on substantially assured data.[18]

18 Detailed definitions of these classifications are provided in the Efficiency Technical Note: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124041

Over-delivery offset against CSR07

4.9 The original SR2004 target of £6,470m has been exceeded by almost £1,400m up to March 2008. A significant proportion of this over-delivery has been achieved in projects and initiatives for which further gains had been forecast as part of CSR07 efficiency (value for money) savings plans. This is particularly the case for productive time (service improvement), procurement and pharmaceuticals. Early delivery of these gains clearly reduces the scope to deliver during CSR07.

4.10 To ensure perverse incentives were not created for departments to artificially delay efficiency measures, HM Treasury has agreed that these additional savings would score towards the Department's CSR VfM target. The calculated carry forward of £820m has been deducted from the final reported SR2004 figure.

4.11 The net reportable efficiency gain for SR2004 (Gershon) is therefore £7,057m.

Assurance of Service Quality

4.12 For each separate efficiency project or area of gain, departments were required to demonstrate that service quality has been at least maintained. DH developed balancing quality measures appropriate to most individual workstreams and projects and these are set out in Efficiency Technical Note 12. The final position on agreed quality measures is as follows:

Workstream	Quality Measures
Procurement	Maintained or improved product quality standards are inherent in procurement contracts and specifications. NHS organisations will choose not to purchase if standards not maintained. Drug price savings are for named drugs for which quality must be unchanged.
Productive Time	• Patient satisfaction (2007) Primary Care + 0.6% Acute Care – 0.4% Mental Health + 1.4% • Inpatient waiting times improved from 12.4 to 6.9 weeks and outpatient waiting times from 7.9 weeks to 6.9 weeks (2007); • Main PSA targets delivered or on track; • Post inpatient mortality (non-elective) reduced by 6.7% (2005/06); • Hospital readmissions increased from 9.0% to 10.3% (2007)[19].
Social Care	• Quality assurance of individual projects by councils not reported to central government; • Maintained or improved performance on each of five key performance (PAF) indicators.

19 Note: Patient readmissions have been rising since 1999. Detailed analysis recently completed has confirmed that this trend is linked to changes in treatment processes and clinical protocols and also to shifting case mix, in particular the higher incidence of elderly patients with multiple long-term conditions. There is no significant causal link with length of stay. More importantly in-patient mortality is falling. This research has been published separately on the DH website - Emergency Admission Rates Further Analysis, October 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090053

Workstream	Quality Measures
Corporate Services	• NHS Jobs – voluntary opt-in to use of the system; • ESR – awaiting results of independent Gateway 5 benefits review.
Public Funding & Regulation	• Main NHS PSA targets delivered or on track (quality measure for DH and SHA restructuring as these functions support NHS delivery); • Arms length bodies are meeting service level agreements and basket of service quality indicators; • NAO report on delivery of programme substantiates level of reported gains.
(Baseline for data is 2003 or 2003/04. Latest available end-point data shown in brackets)	

Measurement Assurance

4.13 Aggregate efficiency gains are assimilated through a large number of projects and business changes. Detailed measurement and assurance processes have been developed for each resulting efficiency gain. These have been verified and agreed with HM Treasury and the Office of Government Commerce. Details are provided in an Efficiency Technical Note (ETN)[20].

4.14 The Department also identified other projects that were part of the original programme on which the £6.5 billion target was predicated, but where it was not possible to verify robust attributable financial values within a strict definition of efficiency. Therefore they have not been included within the reported Gershon savings but are recognised as contributing to improved value for money. They are identified separately in the ETN.

4.15 In its report *The Efficiency Programme: A Second Review of Progress*[21] the National Audit Office, challenged two specific measurement processes in the DH programme. The Department agreed to revise the calculation of hospital length of stay using a more statistically robust moving average calculation to resolve the issue of volatile baseline data (which would create a one-year time lag on final figures). To avoid this time lag DH has chosen to use the actual (lower) baseline which reduces the reported saving by £93m from the NAO agreed method. It also removed the declared savings relating to reduced GP bureaucracy, as it was not cost effective to undertake a new full validation survey on the savings previously agreed by a smaller group of GPs. NAO also noted within their report that some health efficiency calculations were more prudent than Gershon guidelines required, and also that the complexities of health processes and data availability can result in understated or incomplete reported efficiencies.

4.16 Additional assurance on the reported gains of arms length bodies and procurement national contracts has been provided through separate NAO reports. NHS Jobs and Electronic Staff Records (pending) have undertaken Gateway 5 Benefit Reviews.

20 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124041

21 The Efficiency Programme: A Second Review of Progress, National Audit Office, 2007

4.17 In 2008, DH internal audit completed a full review of the efficiency programme, as part of which they reviewed measurement and assurance processes. This review concluded that efficiency calculations were fully compliant with guidance provided to the department.

Delivery Highlights

1. *Productive Time*

- A reduction in average length of stay (case weighted) for hospital inpatients by over 15% since 2004 as a result of service redesign and more effective management of patient treatment pathways;
- Almost 900 Emergency Care Practitioners (ECPs) now employed by ambulance trusts. ECPs, treating emergency patients in-situ, are reducing the number of A&E admissions and saving over £20m per year;
- Over 10 million patient appointments in GP surgeries administered by Nurse Practitioners, freeing GPs to spend more time with patients suffering more urgent and complex illnesses;
- Improving medical techniques, technology and associated process redesign enabling an increasing number of treatments as day cases. Over 73% of all planned procedures are now done this way, reducing treatment costs by over £75m and enabling more patients to go home earlier;
- A reduction of over 5 million emergency bed days per year driven in particular by the strategy for treatment of long-term conditions.

2. *Procurement*

- Renegotiated national procurement contracts for NHS supplies and services have provided annualised savings of over £350m;
- Full regional procurement hubs established in all SHAs except London and South West, which both have substantive collaborative processes. Aggregate savings now exceed £200m per year;
- Price cuts of 7% for branded medicines negotiated under the Pharmaceutical Price Regulation Scheme (PPRS) of 2005, delivering savings of £380 million per year;
- Reducing the prices of generic drugs through the community pharmacy contract, delivering savings of over £1 billion per year.

3. *Corporate Services*

- The development and implementation of NHS Jobs, an internet based system for the advertising and selection process for NHS staff posts, has resulted in cost savings of over £40m per year;
- The Shared Services Joint Venture Company established in 2005 has over 100 NHS organisations contracted for functions including financial services and payroll.

4. *Public Funding & Regulation (PFR)*

- The commissioning a patient-led NHS programme reduced the number of strategic health authorities and primary care trusts by more than a half, realising operating cost reductions of over £250m per year;
- The NHS arms length bodies programme reduced the number of bodies by more than a third. Together with other internal efficiency savings, this has realised operating cost savings of nearly £300m per year.

5. *Social Care*

- Local authorities with responsibility for social services have delivered significant efficiency gains through their specific local efficiency programmes. In addition the Care Services Efficiency Delivery (CSED) team have worked closely with local authorities, regional offices and the Association of Directors of Adult Social Services (ADASS) to promote five major efficiency opportunities based on leading edge practices.

Reduced Civil Service Headcount

4.18 The Department is committed to a gross reduction of 1,400 full time equivalent civil servant posts through its change programme launched in early 2003. Just under half (680) of the overall reduction were planned transfers to other NHS bodies and 720 were net reductions as defined in the Gershon target.

4.19 The Change programme enabled a net 700 headcount reduction to be achieved by March 2004. Since 2006 reductions in central administration budgets across central government have resulted in an overall reduction of 805 from the 2003 baseline.

Lyons Relocations

4.20 The Department and its arms length bodies (ALBs) are committed to the relocation of 1,030 posts out of London & South East by March 2010 (80 out of the original target of 1,110 have transferred to the Ministry of Justice who have assumed responsibility for the Mental Health Review Tribunal).

4.21 By September 2008, 897 relocations had been completed, almost 90% of the target. Between September 2007 and September 2008 main relocations comprised the core department in Leeds, the NHS Institute in Coventry and a number of NHS PASA posts in Chester.

4.22 The department and its ALBs have plans to relocate further posts from London and the south east by 2010 and DH is therefore confident that it will meet its final target.

Value for Money in the 2007 Comprehensive Spending Review

4.23 The additional investment in the NHS announced in the 2007 Comprehensive Spending Review (CSR) settlement was accompanied by a requirement for the Department to secure VfM savings of £8.2bn by 2010/11 when compared with a baseline of 2007/08. This is in line with requirements for all Government departments. HM Treasury guidance requires that all of these savings are sustained over time, net of any costs incurred and cash-releasing.

4.24 This is an ambitious target that aims to build upon the success of the Gershon programme by going further and faster. The department's approach to delivering this target was described in the DH Value for Money Delivery Agreement, published in December 2007[22].

4.25 DH has been working closely with HM Treasury to explore potential for unlocking further VfM in the longer term. The Pre-Budget Report[23], published in November 2008, announced that the cross-Government VfM target would be increased from £30bn to £35bn in 2010/11. Individual departments' shares of this additional £5bn will be announced in the 2009 Budget.

General Approach

4.26 DH's approach to securing VfM improvements in the NHS reflects the movement away from centrally determined targets towards more devolved priority setting and delivery. Nevertheless, the Department has several key roles to play in ensuring that Government's national VfM target is met.

4.27 Firstly, the Department has set the overall level of VfM savings required from the NHS, which equates to 3% per year. This requirement has been fully incorporated in setting tariff prices- the prices at which hospitals are paid for providing NHS services – under Payment by Results[24].

4.28 Local NHS organisations are therefore responsible for ensuring that they live within this tariff income and for identifying and delivering detailed local actions to deliver the VfM improvements that are necessary for them to do so.

4.29 Secondly, the Department is responsible for key central actions that will contribute towards local delivery of VfM improvements. For example:

- DH has negotiated a new Pharmaceutical Price Regulation Scheme (PPRS)[25], announced in November 2008, that will deliver significant reductions in the prices of branded prescription drugs over the coming years;

22 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081547

23 Pre-Budget Report – facing global challenges: supporting people through difficult times, HM Treasury, 2008

24 Further details can be found at http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHS-FinancialReforms/index.htm

25 The PPRS is the voluntary agreement between government and industry on prices of branded drugs in the UK. Further details are available at the following link: http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS/index.htm

- The NHS Purchasing and Supplies Agency (PASA) harnesses the purchasing power of the NHS by negotiating national framework contracts for purchasing a wide range of goods and services. These contracts are utilised widely by local NHS organisations to secure VfM savings in their procurement.

4.30 Thirdly, the Department has identified a number of key opportunities for VfM savings that will offer potential for most or all local NHS organisations to benefit. These were described in detail in its Value for Money Delivery Agreement. Areas include better commissioning and provision of mental health services, improved management of patients with long-term health conditions, more appropriate urgent and emergency care and improved productivity and reduced variations in areas including average length of hospital stay, hospital admission rates and outpatient appointment rates.

4.31 It is anticipated that local NHS organisations will address at least some of these key opportunities, based upon analysis of their local performance and conditions, but that these will be supplemented with other actions that are more specific to local delivery.

4.32 To support local adoption and delivery of key common opportunities, the Department has worked with the NHS Institute for Innovation and Improvement to develop a range of Better Care Better Value indicators which allow local NHS organisations to benchmark their current performance against other organisations and to estimate the potential scope of local savings[26].

4.33 In addition, the Department has developed, wherever possible, national indicators (key performance indicators or KPIs) to track progress against key components of VfM savings. These indicators are not targets, at either a national or a local level, but will be used in combination to track overall national progress towards our VfM target and to provide assurance that savings are being made. Further detail on these KPIs was included in the Value for Money Delivery Agreement[27].

4.34 Given the devolved approach that the Government has taken towards the NHS, it is not feasible that all VfM savings identified and delivered locally will be captured in these national indicators. Therefore, while these indicators will be used to track and assure overall progress nationally, they will not necessarily capture the totality of VfM savings delivered locally. DH recognises, however, that only measurable savings can be reported as VfM savings under CSR 2007.

Governance and assurance arrangements

4.35 As described above, the Performance Committee of the Department of Health oversees progress against, and delivery of, the overall VfM target, alongside oversight of progress against PSAs, DSOs and financial performance.

26 Further detail and data are available at http://www.productivity.nhs.uk/

27 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081547

4.36 In addition to the oversight and challenge provided by the Performance Committee, the Department has also commissioned DH internal audit to undertake a review of the governance, reporting and measurement processes associated with the DH VfM programme. Additionally, the National Audit Office will provide independent scrutiny of departments' reported VfM savings through the CSR 2007 period and DH is currently working with them to develop their approach. Finally, public scrutiny will be facilitated through regular public reporting of progress in the DH Autumn Performance Reports and Departmental Reports, both published annually.

Progress so far

4.37 Delivery of DH's VfM programme for the 2007 CSR period (April 2008- March 2011) is at an early stage. Given time lags in the collection and collation of data, there are currently only limited data available with which to measure progress towards our VfM target. On the basis of currently available provisional in-year data, savings of over £200m have already been made in 2008/09. These are detailed below, along with a report on progress so far in the three major VfM delivery programmes: pharmaceuticals, procurement and patient pathways.

4.38 *Pharmaceuticals:* The Government announced in November 2008 that agreement had been reached with industry for a new Pharmaceutical Price Regulation Scheme (PPRS). This will be effective from 2009 for a minimum of five years and includes a 3.9% reduction in the prices of branded pharmaceuticals from February 2009 with a further price cut of 1.9% from January 2010 combined with the introduction of generic substitution. This new agreement is expected to deliver VfM savings in the UK of around £350m in 2009/10 and approximately £550m per year thereafter. This builds upon savings of £1.8bn achieved under the five years of the previous PPRS agreement. As outlined above, significant savings were achieved under the Gershon programme by reducing the prices of generic drugs through the terms of the community pharmacy contract. DH will continue to monitor pharmacy margins and make further price reductions if and when they are warranted under the terms of the contract.

4.39 Separately, the Department has continued to make further VfM savings as a result of encouraging more switching within the same class of drugs from more expensive branded products to cheaper generic alternatives. More than £7m was saved in the first quarter of 2008-09 through such switching on statins alone.

4.40 *Procurement:* Building upon significant achievements under the Gershon programme, additional savings of over £170m have been delivered in the first six months of 2008-09 through new national framework contracts negotiated by the NHS Purchasing and Supplies Agency (PASA) and through regional collaborative procurement hubs, which have both secured continued improvements in the prices paid by the NHS for goods and services.

4.41 *Patient pathways:* Savings in the first quarter of 2008/09 of £18m and £8m have been made by reducing A&E attendances and non-elective admissions respectively. These reductions and savings are calculated by comparing actual activity levels with "counterfactual" growth in activity. In other words, the growth in activity that would have been expected in the absence of any VfM initiatives.

Gershon over-delivery:

4.42 As described above, in addition to the £7,057 million of net savings achieved as part of the SR04 Efficiency Programme, the Department of Health delivered a further £820 million of net, cash-releasing savings by March 2008 which will be counted towards its CSR07 target.

5. PAC recommendations

5.1 The Public Accounts Committee (PAC) is a committee of the House of Commons, which examines the accounting for and the regularity and propriety of government expenditure. It also examines the economy, efficiency and effectiveness of expenditure. Since the passage of the National Audit Act in 1983, the committee's main function has been to examine the reports issued by the Comptroller & Auditor General (C&AG).

5.2 In addition, to the formal responses to PAC reports in Treasury Minutes, presented to Parliament by a Treasury Minister, the Department has reported on PAC reports annually in the Departmental Report. These are available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/index.htm

5.3 There are five outstanding PAC reports, listed below, on which we have not reported progress in previous Departmental Reports are and progress on the recommendations in these PAC reports can be found at Annex C:

- Prescribing costs in Primary Care;
- Improving services and support for people with dementia;
- Improving corporate functions using shared services;
- Report on NHS Summarised Accounts 2006-07 – achieving financial balance;
- Caring for vulnerable babies: the reorganisation of neonatal services in England.

Annex A: List of indicators

Indicator	PSA	DSO	Vital Signs	National Indicator Set
Improving access to psychological therapies	18.5	BH	Tier 3	
Suicide & injury of undetermined intent mortality rate	SR04	BH	Tier 2	
Emotional health and wellbeing and CAMHS	12.4	BH	Tier 2	51
All-age all cause mortality rate per 100,000 (and gap between spearhead group and national average)	18.1 &18.2	BH	Tier 2	120
<75 CVD Mortality Rate	SR04	BH	Tier 2	121
<75 Cancer Mortality Rate	SR04	BH	Tier 2	122
Preparedness against pandemic influenza		BH		
Healthy life expectancy at age 65	17.3	BH	Tier 3	137
Proportion of adults (18 and over) supported directly through social care to live independently at home	18.4 & 17.5	BH	Tier 3	136
Proportion of people achieving independence 3 months after entering care/re-hab		BH	Tier 3	125
Smoking prevalence among people aged 16 and over, and aged 16 and over in routine and manual groups	18.3	BH	Tier 2	123
Self-reported measure of people's overall health		BH	Tier 3	119
Levels of childhood obesity	12.3	BH	Tier 2	55 & 56
The number of alcohol-related hospital admissions	25.2	BH	Tier 3	39
The number of drug users recorded as being in effective treatment	25.1	BH	Tier 2	40
Prevalence of breastfeeding at 6-8 weeks	12.1	BH	Tier 2	53
Emergency hospital admissions caused by unintended and deliberate injuries	13.3	BH	Tier 3	
Under-18 conception rate	14.4	BH	Tier 2	112
Prevalence of chlamydia in under 25 year olds		BH	Tier 2	113
Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation	16.4	BH	Tier 3	145
Proportion of adults in contact with secondary mental health services in employment	16.7	BH	Tier 3	150
Proportion of adults in contact with secondary mental health services in settled accommodation	16.3	BH	Tier 3	149

Indicator	PSA	DSO	Vital Signs	National Indicator Set
Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment	16.8	BH	Tier 3	146
Healthcare associated infection figures – MRSA	19.7	BC	Tier 1	
Healthcare associated infection figures – *Clostridium difficile*	19.8	BC	Tier 1	
Number of delayed transfers of care per 100,000 population (aged 18 and over)		BC	Tier 3	131
The proportion of people with long-term conditions supported to be independent and in control of their condition	19.5	BC	Tier 3	124
NHS-reported referral-to-treatment times for admitted patients	19.2	BC	Tier 1	
NHS-reported referral-to-treatment times for non-admitted patients	19.3	BC	Tier 1	
Patient-reported experience of access to GP services	19.6	BC	Tier 1	
Timeliness of social care assessment		BC	Tier 3	132
Timeliness of social care packages		BC	Tier 3	133
Proportion of all deaths that occur at home		BC	Tier 3	129
Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)		BC	Tier 3	130
Percentage of women who have seen a midwife or a maternity health professional for an assessment of health and social care needs, risk, and choices by 12 weeks of their pregnancy	19.4	BC	Tier 2	126
Self-reported experience of patients and users	19.1	BC	Tier 3	127
Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community based services		BC	Tier 3	135
Patient and user reported measure of respect and dignity in their treatment		BC	Tier 3	128
Parents' experience of services for disabled children and the 'core offer'	12.5	BC	Tier 3	54
Number of emergency bed days per head of weighted population		BV	Tier 3	134

Indicator	PSA	DSO	Vital Signs	National Indicator Set
Financial balance (PCT)		BV	Tier 1	
Prescribing indicator		BV	Tier 3	
Public confidence in local NHS		BV	Tier 2	
NHS estates energy/carbon efficiency		BV	Tier 3	

Annex B: Data Sources

To ensure better health and well-being for all DSO	Data Source(s)
Improving access to psychological therapies	No data has been collected as yet. However, it is expected to be sufficiently robust – formal sign off on quarterly reporting is required from all PCT Directors of Performance and IAPT Key Performance Indicators Technical Guidance sets out the requirements for the data.
Suicide & injury of undetermined intent mortality rate	The data, death registrations and mid-year population estimates, are National Statistics produced by the Office of National Statistics so the quality is rigorously assured.
Emotional health and wellbeing and CAMHS	The data is self-reported on a scale of 1-4. Guidance indicates what would be expected in order to achieve a certain score and so limits the possibility for inconsistency between areas.
All-age all cause mortality rate per 100,000 (and gap between spearhead group and national average)	The data, death registrations and mid-year population estimates, are National Statistics produced by the Office of National Statistics so the quality is rigorously assured.
<75 CVD Mortality Rate	The data, death registrations and mid-year population estimates, are National Statistics produced by the Office of National Statistics so the quality is rigorously assured.
<75 Cancer Mortality Rate	The data, death registrations and mid-year population estimates, are National Statistics produced by the Office of National Statistics so the quality is rigorously assured.
Preparedness against pandemic influenza	All NHS organisations must have robust pandemic flu plans in place as stated in the 2008/09 Operating Framework; a self-assessment was carried out in spring 2008 and will be repeated in 2009. Data from the self-assessment relies on the integrity of the NHS organisations, but is quality assured by the respective SHA.
Healthy life expectancy at age 65	ONS produce estimates for this indicator at national level using mortality data and data on health state from the General/ Integrated Household Survey. The latter data are subject to confidence intervals. DWP will produce local estimates using ONS mortality data and data from the 2001 and 2011 Censuses.
Proportion of adults (18 and over) supported directly through social care to live independently at home	The indicator uses Referrals, Assessments and Packages of Care (RAP) data which are National Statistics, and is combined with Grant Funded Services (GFS1) data that are Official Statistics. There is the possibility of double counting as some people are probably included in the two datasets used (RAP and GFS). However, using both datasets gives a broader picture of overall services.

To ensure better health and well-being for all DSO	Data Source(s)
Proportion of people achieving independence 3 months after entering care/re-hab	Baseline data is not available until Autumn 2009 but it is expected to be sufficiently accurate (taking into consideration that this is a new data collection and so data will not be as robust in the first year as future years). The Information Centre (IC) will manage a new data collection from 1 October 2008 onwards and have robust checks in place to ensure data quality.
Smoking prevalence among people aged 16 and over, and aged 16 and over in routine and manual groups	*Prevalence* The General Household Survey figures are based on the self-reported smoking status of a sample of the population and, like results from all surveys, are subject to sampling and measurement error. The results are weighted to take account of different response rates between sections of the population. We can be confident of achievement if the recorded levels are below 20.3 per cent and 24.6 per cent for all adults and the routine and manual group respectively (at the 95% one-tailed level). Conversely, we can be confident that they have not been met if the recorded levels are above 21.7 per cent and 27.4 per cent respectively.
	Quitters The figures are based on clients' self-reported smoking status at the four-week follow-up. Over two-thirds of these are confirmed by testing carbon monoxide (CO) levels. Services have been challenged with increasing CO validation rates to 85%. Other developments will drive up quality further, including 'real time' referrals from central support mechanisms, central data capture of potential quitters and gold-standard training related to data management. Some clients who have successfully quit at four-weeks start smoking again at a later point. There is strong evidence about the degree of 'attrition'.
Self-reported measure of people's overall health	The Place survey has been piloted in 4 local authority areas and cognitively tested by IpsosMORI. Changes have been made following this which should ensure the response rates required and comparable data across local authority areas.
Levels of childhood obesity	The baseline for 2008 is estimated because Health Survey of England (HSE) results are available about 12-14 months after the end of the year in which the survey is undertaken. HSE data from 1995 to 2006 is used to calculate a linear trend for child obesity over the period and forecast a baseline trajectory for the CSR period 2008-11.

To ensure better health and well-being for all DSO	Data Source(s)
The number of alcohol-related hospital admissions	The data set used, referred to as Hospital Episode Statistics (HES), is a record of all hospital inpatient spells. HES data has around 98% coverage. It is mandatory for the NHS to submit data in a standardised format on a monthly basis. NHS trusts may have their data assessed by their internal management before it is submitted. After submission, the data are cleaned to remove the duplicates and improve data quality. The HES data quality team confirm trusts are happy with the data they have submitted, in a consultation exercise, on an annual basis. Where issues are identified during processing, these are communicated with the trust to drive future improvements. Any data quality issues are highlighted in data quality notes and publications that are made available with HES. The data are derived from administrative systems and, whilst subject to detailed standards and quality assurance, are still dependent to some extent on healthcare providers' practices. In particular, the recorded change in alcohol-related hospital admissions is affected by the depth of diagnostic coding undertaken by providers.
The number of drug users recorded as being in effective treatment	National Drug Treatment Monitoring System (NDTMS) collects client activity data from drug and alcohol treatment services in England. The data collected is used to produce National Statistics and performance monitoring information. NDTMS is a robust data system and quality assurance processes are in place. This target has been developed in line with data available in NDTMS.
Prevalence of breastfeeding at 6-8 weeks	Data collection commenced in Q1 of 2008/09. PCTs have been challenged with increasing data coverage to 85% by Q4 of 2008/09. At Q1, all but 5 PCTs submitted data, 45 PCTs achieved 85% coverage and a further 65 achieved 50% coverage. Among PCTs breastfeeding prevalence ranged from 81% to 12%. PCTs are supplied with detailed definitional guidance and the data are subject to quality assurance. Data quality is being ensured by asking PCTs to re-submit quarterly data for quarters one and two after further checks and reminders of the data quarterly threshold.

To ensure better health and well-being for all DSO	Data Source(s)
Emergency hospital admissions caused by unintended and deliberate injuries	The data set used, referred to as Hospital Episode Statistics (HES), is a record of all hospital inpatient spells. HES data has around 98% coverage. It is mandatory for the NHS to submit data in a standardised format on a monthly basis. NHS trusts may have their data assessed by their internal management before it is submitted. After submission, the data is cleaned to remove the duplicates and improve data quality. The HES data quality team confirm trusts are happy with the data they have submitted, in a consultation exercise, on an annual basis. Where issues are identified during processing, these are communicated with the trust to drive future improvements. Any data quality issues are highlighted in data quality notes and publications that are made available by HES.
Under-18 conception rate	The data used to monitor this target is derived from two elements, births and legal abortions, which are legally required to be reported (through the Office for National Statistics for births and through the Department of Health for abortions). The Office for National Statistics collates the births and population data, and it receives abortions data under a service level agreement, so that it may calculate conceptions. The National Audit Office has found that the data used is well-established, well-defined and has been collected consistently for some years.
Prevalence of chlamydia in under 25 year olds	Prevalence is currently being monitored through screening volumes in that National Chlamydia Screening Programme (NCSP).The core data set for the NCSP is well established and is collected by the Health Protection Agency and published quarterly. The data set has been approved by the Review of Central Returns (ROCR). Data are published within 8 weeks of the end of the quarter and are available by PCT and LA of residence.
Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in settled accommodation	The data collections to support this indicator will be brand new from 2008/09 and started part-way through the year. Therefore the data in the first year will not be as robust as in future years, these issues will be taken into consideration when analysing the year-on-year data. Furthermore, there are potential issues with definitions as they may be interpreted differently across trusts. The IC has clarified issues as they have arisen and will continue to do so where issues are raised.

To ensure better health and well-being for all DSO	Data Source(s)
Proportion of adults in contact with secondary mental health services in employment	The data collections to support this indicator will be brand new from 2008/09 and started part-way through the year. Therefore the data in the first year will not be as robust as in future years, these issues will be taken into consideration when analysing the year-on-year data. Furthermore, there are potential issues with definitions as they may be interpreted differently across trusts. The IC has clarified issues as they have arisen and will continue to do so where issues are raised.
Proportion of adults in contact with secondary mental health services in settled accommodation	The data collections to support this indicator will be brand new from 2008/09 and started part-way through the year. Therefore, the data in the first year will not be as robust as in future years, these issues will be taken into consideration when analysing the year-on-year data. Furthermore, there are potential issues with definitions as they may be interpreted differently across trusts. The IC has clarified issues as they have arisen and will continue to do so where issues are raised.
Proportion of adults with moderate to severe learning disabilities known to councils with adult social services responsibilities in employment	The data collections to support this indicator will be brand new from 2008/09 and started part-way through the year. Therefore the data in the first year will not be as robust as in future years, these issues will be taken into consideration when analysing the year-on-year data. Furthermore, there are potential issues with definitions as they may be interpreted differently across trusts. The IC has clarified issues as they have arisen and will continue to do so where issues are raised.

To ensure better care for all DSO	Data Source(s)
Healthcare associated infection figures – MRSA	The data collection system is managed by the Health Protection Agency (HPA). All cases are included in the collection and the mandatory reporting must be signed off by trust chief executives each month which ensures the accuracy of the reporting. Furthermore, the HPA cross checks results against other sources of similar information (laboratory systems).
Healthcare associated infection figures – *Clostridium difficile*	The data collection system is managed by the Health Protection Agency (HPA). All cases are included in the collection and the mandatory reporting must be signed off by trust chief executives each month which ensures the accuracy of the reporting. The HPA continually update all of their data retrospectively, and so the baseline figure may be liable to small changes (for instance due to late case addition or recognition of duplications). Unlike MRSA, the HPA do not cross check *c.difficile* data.

To ensure better care for all DSO	Data Source(s)
Number of delayed transfers of care per 100,000 population (aged 18 and over)	All data are recorded by PCTs in conjunction with NHS trusts and local authorities. All cases are included in the collection and the data are validated by the Department.
The proportion of people with long-term conditions supported to be independent and in control of their condition	The Picker Institute, a well respected survey organisation who have worldwide credibility in delivery of patient experience surveys, will manage the survey. National performance is accurate to within 1 percentage point Expectation is for an achieved sample of around 540 people in each primary care trust. The maximum 95% confidence interval for a primary care trust with a sample of this size is +/– 4%.
NHS-reported referral-to-treatment times for admitted patients	The NHS is aware of the high profile of these data and therefore work to ensure accuracy. All submitted referral-to-treatment (RTT) data is subject to validation checks, and is returned to the submitting organisation for revision if it fails these checks. Data completeness indicators are applied to all referral-to-treatment data. These indicators are published alongside performance data each month.
NHS-reported referral-to-treatment times for non-admitted patients	The NHS is aware of the high profile of these data and therefore work to ensure accuracy. All submitted RTT data is subject to validation checks, and is returned to the submitting organisation for revision if it fails these checks. Data completeness indicators are applied to all referral-to-treatment data. These indicators are published alongside performance data each month.
Patient-reported experience of access to GP services	This indicator is derived from the largest survey ever (the GP patient survey). Its size has been agreed between the Department of Health and the British Medical Association as being sufficiently accurate for PCTs, SHAs and England so as to pay individual GP practices. Around 2 million people answered the survey last year. IpsosMORI manage the data collection of the survey and have strong procedures in place to ensure quality of individual survey data.
Timeliness of social care assessment	The data used (RAP – Referrals, Assessments and Packages of Care) is collected and validated by the Information Centre and it is classified as National Statistics. The Information Centre have robust checks in place to ensure data quality.
Timeliness of social care packages	The data used (RAP – Referrals, Assessments and Packages of Care) is collected and validated by the Information Centre and it is classified as National Statistics. The Information Centre have robust checks in place to ensure data quality.

To ensure better care for all DSO	Data Source(s)
Proportion of all deaths that occur at home	The data, death registrations, are National Statistics produced by the Office of National Statistics so the quality is rigorously assured.
Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)	The indicator uses Referrals, Assessments and Packages of Care (RAP) data and Personal Social Services Expenditure (PSSEX1) data which are National Statistics. A revised version of the indicator has been developed from 2009/10.
Percentage of women who have seen a midwife or a maternity health professional for an assessment of health and social care needs, risk, and choices by 12 weeks of their pregnancy	This is a new indicator for which data collection for Qs 1 & 2 only is available. However, not all PCTs have the systems to collect the data in place yet so it is not complete, although where available data completeness is improving. Q3 data will be collected using amended definitions, and this will provide baseline data for plan refresh. A reasonable assessment of improvement in data quality will be available in Q4. With regards to performance, a full assessment of performance in each quarter will not be available until two quarters later, when data on number of births can be matched to data on number of women in that cohort who were assessed by 12 weeks and 6 days of their pregnancy. Thus, Q3 08/09 assessment data will be compared with Q1 09/10 birth data to provide the first full assessment of Q3 performance. To provide a timely indication of progress against the indicator and allow an initial check of data completeness, data will also be collected on total number of assessments, so that it will be possible to calculate the proportion of assessments in each quarter that are undertaken in 12 weeks.
Self-reported experience of patients and users	The national patient survey programme collects structured and systematic feedback on the quality of service delivery from the patient/service users' point of view. In this way, it provides highly robust measures of NHS performance – at organisation level, but also both regionally and nationally.
Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community based services	The data used (RAP – Referrals, Assessments and Packages of Care) is collected and validated by the Information Centre and it is classified as National Statistics. The Information Centre have robust checks in place to ensure data quality.

To ensure better care for all DSO	Data Source(s)
Patient and user-reported measure of respect and dignity in their treatment	Data is drawn from the national patient survey programme which collects structured and systematic feedback on the quality of service delivery from the patient/service users' point of view. In this way, it provides highly robust measures of NHS performance – at organisation level, but also both regionally and nationally.
Parents' experience of services for disabled children and the 'core offer'	This is a new collection for which a baseline is yet to be established. Baseline (national) data will not be available until May 2009. Local level data will not be available until 2010. At this juncture we cannot be sure of the quality of data that will be available. It will, however, be rigorously sampled and tested in the interim.

To provide better value for all DSO	Data Source(s)
Number of emergency bed days per head of weighted population	Data is collected through Hospital Episode Statistics, the quality of which is internally assessed by trusts before being submitted to the Information Centre. Any issues identified with the data during processing and cleaning to remove any duplication are communicated with trusts for future data collections.
Financial balance (PCT)	The reported 2007/08 final outturn is available from the PCT's published annual accounts. These accounts are subject to audit and in 2007/08 there were no qualifications of accounts as regards the reported financial position. The in-year forecast out-turn is collected on a quarterly basis through the Financial Management and Analysis framework. The quality of the data is monitored via the strategic health authority and the financial forecast position is signed off by the Director of Finance and the Chief Executive. Any issues identified with the data during processing are communicated with PCTs for future data collections.
Prescribing indicator	Data source not yet confirmed
Public confidence in local NHS	Data source not yet confirmed
NHS estates energy/ carbon efficiency	All NHS organisations e.g. trusts, PCTs, foundation trusts provide data through the ERIC system. These organisations are responsible for their own data quality. Potential errors are reported to them and they make changes if required.

Annex C: Progress on PAC reports

Prescribing costs in Primary Care

PAC recommendation	Department of Health response
The NHS could save more than £200 million a year, without affecting patient care, by GPs prescribing lower cost but equally effective medicines. Many drugs are available in both branded and generic versions, and the latter is usually much cheaper than the brand name drug, for which the manufacturers have to recover research and development costs.	The Department has a long standing policy of encouraging generic prescribing to ensure that lower cost generics are used as soon as higher cost branded medicines lose their patent rights. A quarterly Better Care, Better Value (BCBV) indicator on statins encourages more systematic use of therapeutically equivalent low cost generic statins in place of higher branded statins. The NHS has already realised around £80 million of these identified savings through more efficient use of statins.
The proportion of prescriptions written by chemical name rather than by brand name, known as generic prescribing, rose from 51 per cent in April 1994 to 83 per cent in September 2006. But only 59 per cent of prescription items were actually dispensed as generics in 2005, mainly because not all drugs prescribed were available in generic form. For some common conditions doctors have a choice of clinically equally effective drugs, some of which are available in generic form whilst others are only available as branded medicines. Where it is clinically appropriate, GPs should prescribe those available in generic form. Comparing GP practices and PCTs on indicators of efficient prescribing is an effective way of influencing prescribing behaviour. The Department, in conjunction with the NHS Institute for Innovation and Improvement, should develop more 'Better Care, Better Value' prescribing indicators to measure the proportion of generics dispensed and the level of potential savings where more cost-effective prescribing would generate significant savings, such as for renin-angiotensins used to treat high blood pressure. Strategic health authorities should use these indicators to hold PCTs to account for prescribing costs.	The NHS Institute for Innovation and Improvement is close to finalising three new BCBV indicators on generic savings, proton pump inhibitors, and anti-hypertensive drugs. We anticipate the new indicators will be introduced by early in 2009.

PAC recommendation	Department of Health response
The proportion of lower cost prescriptions for some common conditions varies greatly between primary care trusts (PCTs), for example between 28 per cent and 86 per cent for statins. Strategic health authorities should work with the National Prescribing Centre to spread best practice in prescribing and help those PCTs that have difficulty implementing switching programmes to learn from PCTs that have successfully done so.	Electronic systems maintained by the Prescription Pricing Division of the NHS Business Services Authority contain a range of indicators and comparators, which are useful to PCT prescribing advisers. The service is subject to continuous development and enhancement. There are indications of considerable progress by PCTs and they are taking action in many areas to reflect their local circumstances. The BCBV indicators have generated a lot of publicity. PCTs are now taking action on their own account, backed up by the National Prescribing Centre.
Despite large variations between PCTs in prescribing efficiency, nearly all GP practices achieve maximum points on the 'medicines management' indicators in the Quality and Outcomes Framework. Practices are rewarded for meeting a prescribing adviser 'at least annually', and agreeing 'up to three' actions relating to prescribing. The Department should strengthen the medicines management indicators when the Quality and Outcomes Framework is next renegotiated, and set more ambitious prescribing improvement targets for practices in order to be awarded the medicine management points. The Framework should also reward GPs for prescribing drugs that are available in generic form when clinically appropriate.	The Department considers that enhanced BCBV indicators supported as appropriate by other incentives is the best means of securing further efficiencies, allowing QOF to concentrate on quality of treatment. A review of the QOF concluded that PCTs needed to take action to ensure that QOF assessment is robust and SHAs should performance manage them in doing this. Revised guidance, on the Primary Care Contracting website, includes ways to help PCTs deliver QOF checks in a way that is supportive to practices, whilst ensuring that the NHS and patients are getting the best out of the framework.

PAC recommendation	Department of Health response
One in five GPs responding to the NAO's survey said pharmaceutical companies had more influence on prescribing decisions than official advisers. Whenever a gift is given by a company, there is a risk that it will have an inappropriate influence on the recipient's behaviour. The Department should specify the minimal level above which gifts, hospitality, etc provided to prescribers by pharmaceutical companies should be disclosed to the PCT. PCTs should publish an annual register of this information.	The Department does not feel there is need for further regulation. Advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994 by Medicines and Healthcare Products Regulatory Agency (MHRA). There is also a requirement under both the Performers List and General Medical Services Contracts Regulations 2004 for doctors to maintain a register of gifts and to show PCTs on request. The dealings of pharmaceutical representatives are regulated by the Association of the British Pharmaceutical Industry's Prescription Medicines Code of Practice Authority (PMCPA). If anyone believes that the pharmaceutical representative is behaving inappropriately, they can report the individual or company to the PMCPA. Self-regulation works and sanctions have been taken against companies, with two being suspended from the ABPI.The industry issued a revised Code in 2006, which took account of many of the issues raised by the Health Select Committee inquiry into these areas. The MHRA has statutory powers through the Medicines (Advertising) Regulations 1994 to take action if self-regulation does not work.
Hospital consultants' prescribing choices are bound by agreed 'formularies' of cost-effective drugs, but GPs are generally not subject to formularies. Although prescribing decisions must be sensitive to the needs of the individual patient, evidence on the cost and clinical effectiveness of treatments for a particular disease should apply consistently across the country. The Department should encourage PCTs to pilot joint primary/ secondary care formularies. Strategic health authorities should work with the National Prescribing Centre to promote agreement and consistency of formularies across primary and secondary care, and across PCTs.	The National Prescribing Centre is undertaking some work, as part of the NHS Constitution activity, to provide advice to PCTs about local decisions on funding for drugs for which NICE guidance is not available. DH believes this will lead to more collaboration by PCTs on prescribing decisions, facilitated by strategic health authorities.

PAC recommendation	Department of Health response
88 per cent of prescription items are dispensed free, and the remainder for a standard charge not directly linked to actual cost. The Department should do more to make patients aware of the costs of drugs, and hence the importance of not wasting them, for example by displaying on dispensed drugs information such as the cost of the specific items dispensed or an indication of the typical cost of items to the NHS. Unused and wasted drugs cost the NHS at least £100 million a year. The Department of Health does not have robust or up to date information on the cost of drugs wastage or a good understanding of the varied and complex reasons why patients do not always use their drugs. It should commission research to establish the extent to which medicines are not used, and establish the reasons why patients do not take their drugs.	The Department of Health has commissioned a joint research team from the York Health Economics Consortium (YHEC) of the University of York, and the School of Pharmacy, University of London, to undertake research into the scale, causes and costs of waste medicines. The research teams have begun the preliminary work in undertaking the research and are due to report in mid 2009.
Generic versions of drugs can vary considerably in appearance, colour and packaging. This variation can be confusing for patients, particularly elderly patients on several medications, and can increase the risk of patients taking their drugs wrongly, or not at all. The Department should explore with the industry the scope to achieve greater consistency of appearance, labelling and/or packaging of the more common drugs supplied to the NHS.	If the Department's research indicates that the appearance of generics is a significant contributory factor in medicines wastage, it will explore with MHRA whether it is feasible to conduct relevant discussions with generic manufacturers.

Improving services and support for people with dementia

PAC recommendation	Department of Health response
There are over 560,000 people in the UK with dementia, costing the economy some £14 billion a year, yet dementia has not been a NHS priority. In response to C&AGs report, the Department is now developing a National Dementia Strategy. The strategy should have a clear timetable for implementation and should include criteria for evaluation and reporting progress and addressing areas of under performance such as poor diagnosis or availability of interventions recommended by NICE. It will also require an effective communications strategy to engage patient groups, health and social care professionals, the Royal Colleges, health and social care inspectorates, and the voluntary sector, all of whom are essential to improving care for people with dementia.	In its response to the PAC report, the Department agreed that the strategy should have a clear timetable for implementation and that it should include criteria for evaluation and monitoring of progress. Public consultation on the strategy began in June 2008 as planned. Although originally planned for publication in October 2008, the development of the strategy has taken a little longer than anticipated and the launch will now take place in the new year. Given the priority being attached to the strategy, the needs of those with dementia have already been addressed in the NHS Operating Framework for 2008-2009 and in the Department's business plan. The governance arrangements for developing the strategy have included an external reference group (ERG). This included a range of key stakeholders involved in providing services for people with dementia, as well as people with dementia and carers. The Chief Executive of the Alzheimer's Society, Neil Hunt, chaired this group. The ERG established three separate sub-groups to examine the issues of public and professional awareness, diagnosis, and quality of care. They were asked to produce recommendations on what is needed in the short, medium and long-term to best address the needs of people with dementia. The views of the ERG were forwarded to the Department in April, and were closely followed in the recommendations contained in the draft strategy, published on 19 June. The Department agreed with the Committee that good communication would essential both in developing the strategy and in the implementation and monitoring phases. Contact was made at an early stage with a range of stakeholders not represented on the ERG or its sub-groups. A series of 23 listening events also took place throughout England before the draft strategy was published, involving people with dementia, carers, key NHS and social care staff, relevant voluntary bodies and others with an interest.

PAC recommendation	Department of Health response
	The formal consultation involved over 50 public consultation events throughout the country, with key stakeholders represented. Over 500 written responses to the draft strategy have also been received, and these will be taken into account in producing the final strategy and implementation plan. The Department will ensure that the strategy and implementation plan will be widely publicised with an effective communication strategy in place.
Unlike cancer and coronary heart disease there is no single individual with responsibility for improving dementia services. Without clear leadership there is a risk that dementia care will continue to lack priority. The Department should appoint a Senior Responsible Officer to drive through the dementia strategy, learning from the model used for cancer services.	David Behan, Director General for Social Care, Local Government and Care Partnerships, is the Senior Responsible Officer in the Department of Health for the development of the National Dementia Strategy. The development of the strategy has been led jointly by Professor Sube Banerjee, the Department's senior professional advisor on older people's mental health, alongside Jenny Owen, Executive Director of Adults, Health and Community Wellbeing for Essex County Council. This was designed to ensure that professionals with both health and social care backgrounds were leading the strategy. In addition, the Dementia Strategy Programme Board, (which has been chaired by David Behan and has overall responsibility for the delivery of the strategy) includes key individuals from across the Department to ensure that a coherent and coordinated programme of work is developed. The Department is still considering whether there is a compelling case for a National Clinical Director as part of the strategy.
Between half and two thirds of people with dementia never receive a formal diagnosis. Diagnosis should always be made, regardless of whether interventions are available. The rate of diagnosis could be significantly improved by GP practices receiving greater support from mental health services; by the Royal College of Psychiatrists and the Royal College of GPs developing a dementia care pathway including guidance on the importance of early diagnosis; and by the Institute of Innovation and Improvement promulgating good diagnostic practice.	The Department agreed with the conclusions reached by the Committee on the need for the diagnosis of dementia to be made in all cases and the importance of that diagnosis being made as early as possible. This, and the need for a clear and simple dementia care pathway have been identified as central issues to be covered in the final strategy.

PAC recommendation	Department of Health response
There is poor awareness amongst the public and some professionals of dementia and what can be done to help people with the disease. The Department should commission a dementia awareness campaign to increase understanding of the symptoms of dementia, emphasising that there are interventions and treatments which can slow the progress of the disease and help people with dementia and their carers lead independent lives for longer.	The Department agreed with the Committee's conclusions on the need to improve public and professional awareness. There is currently a general low level of public and indeed professional understanding of dementia. There is also a widespread mis-attribution of symptoms to "old age" and a resultant unwillingness by some of those suffering from dementia, and their families, to seek help. This can be echoed in non-specialist professional groups, with a false view that there is little or nothing that can be done to assist people with dementia and their carers. There also remains within society a real problem of stigma and fear associated with dementia which can delay early diagnosis and the accessing of good quality care. The National Dementia Strategy will therefore focus on: developing a better understanding of dementia by public and professionals alike; ensuring that better information is provided on how to seek help and what help and treatment is available; tackling the stigma and misunderstandings that currently exist; and improving the education and training of all those working in the health service and social care to ensure that the needs of people with dementia are fully met (this will be a major cross-cutting theme to be addressed in the strategy).

PAC recommendation	Department of Health response
	As a first step, the Department has commissioned a public awareness campaign to be undertaken by the Alzheimer's Society. This was launched in May 2008. The Society sent a supply of leaflets to all GPs in England, to be made available for patients in surgeries. Copies were also made available in pharmacies, libraries, community centres and other appropriate venues. The leaflet encourages people who are worried about their memory or someone else's memory to talk to their GP, call the Alzheimer's Society helpline, go to the Alzheimer's Society website, or request more detailed information in an information booklet. The leaflet and booklet is available in a range of languages and accessible versions. The materials are intended to raise public awareness about dementia; to encourage people to seek help when appropriate; to enable the diagnosis of dementia earlier; and to signpost people to appropriate local help and support. Follow up evaluations will survey GPs, people who requested information, helpline call volumes, and booklet request volumes.
People with dementia require support from multiple health and social care professionals but this is often difficult to manage. On diagnosis, people with dementia and their carers should be given a single health or social care professional contact point to improve the co-ordination of care between the various services and professionals. The contact point could be a social worker or a community psychiatric nurse, for example.	The Committee rightly acknowledged the difficulty of managing the course of this complex illness over the passage of time, given the number of different health and social care professionals that may need to be involved as needs develop and change. The Department agreed that an identified single point of contact would be desirable for people with dementia and their carers, to coordinate care over time. This was covered in the consultation document issued in June, and will be addressed explicitly in the final strategy.

PAC recommendation	Department of Health response
Between half and two thirds of carers do not receive the carers assessment to which they are entitled. Carers often struggle to cope with caring for a relative with dementia at home, particularly if the person with dementia has challenging behaviour, leading to costly admission to a care home or hospital. The Department should emphasise to local health organisations and their social care partners that they need to develop an action plan which gives priority to assessing and meeting the needs of carers. The Department should develop a commissioning toolkit to help demonstrate the cost & benefits of the different options for providing support, including respite and domiciliary care.	The Department recognises that not enough carers request the carer's assessment to which they are entitled. This is one of the reasons why the Department is investing significantly in the development of a new national information helpline and website for carers. The helpline will be on stream from Spring 2009. The Government's Carers' Strategy *Carers at the heart of 21st century families and communities* (published on 10 June 2008) also recognises the importance of health organisations working in partnership with local authorities to assess the needs of carers in their local populations as part of the Joint Strategic Needs Assessment (JSNA). The JSNA together with the Local Area Agreement (LAA) form a major part of the new local performance framework which will help to deliver more joined up services and improve outcomes for carers as well as the people they care for. The indicator on carers from the National Indicator Set (Carers receiving needs assessment or review and a specific carers' service or advice and information – NI 135) is one of the most popular targets selected by local authorities and their partners and has been identified as a priority in over half the LAAs in England. The Government is investing £255 million over the next 2 years starting in April 2009 to support the Carers' Strategy and in particular a number of pilot initiatives and evaluations. These include looking at the cost-effectiveness and outcomes of different types of breaks for carers, and looking at how the NHS can better support carers through closer working with local authorities and the third sector and involving carers as expert partners in care in the planning and delivery of services. The £255 million includes £150 million additional funding in PCT allocations over the next 2 years for breaks for carers. The NHS Operating Framework for 2009/10 also refers to the Carers' Strategy, and in particular states that PCTs should work with their local authority partners and publish joint plans on how their combined funding will support breaks for carers, in a personalised way.

PAC recommendation	Department of Health response
62 per cent of care home residents are currently estimated to have dementia but less than 28 per cent of care home places are registered to provide specialist dementia care. Few care home staff have specialist nursing qualifications or have been trained in dementia care. There is high turnover of staff and high vacancy levels and some staff do not have English as a first language. Poor standards of care have resulted in instances of inappropriate medicines management and complaints that people are not afforded sufficient dignity and respect. The Commission for Social Care Inspection should assess staff qualifications and training as part of its review of the quality of care for people with dementia, and local mental health services should use the findings when allocating resources to community psychiatric teams so they can provide adequate outreach services to support care homes.	The issue of registration of care homes providing for people with dementia is not straightforward. Guidance issued by the Commission for Social Care Inspection makes clear that not all services that provide support for people who have a diagnosis of dementia must be registered as providing dementia care. Nor does it mean that a care home that is not so registered is unable to support a person with a diagnosis. Most people with dementia are supported by general services in their own home, or in a non-specialist care home, and this is entirely appropriate. Specialist mental health services should be targeted to those people who have more complex needs and require a higher level of expertise in their management and treatment. However, the Department needs to be confident that the services offered by all care homes fully meet the needs of all those residents with dementia. This was addressed in the draft strategy issued in June and will also be covered in the final strategy, as will the issue of registration. The draft strategy focused very closely on the issue of the education and training of staff, as have the responses of those commenting on the draft. The Department recognises that a majority of people in care homes have different types and degrees of dementia, and the proportion is likely to increase over time. All the more reason therefore why staff in care homes should be appropriately trained to care for residents with dementia. This will be a key issue to be addressed in the final strategy.

PAC recommendation	Department of Health response
Hospital care for people with dementia is often not well managed, increasing the risk of longer stays, admission to a care home and deterioration in the patient's health. Hospital staff generally focus on the physical reason for admission and can fail to identify or deal with dementia as a disease, resulting in longer stays and poorer outcomes than for people who are psychiatrically well. To improve the cost effectiveness of acute care, families of people with dementia should hold a copy of the care record so that paramedics will be able to make an informed decision whether the person needs to be taken into hospital or can be treated at home. For older patients admitted and known or suspected to have cognitive impairment, hospitals should routinely undertake a mental health assessment.	The Department agreed with the Committee that general hospital care for people with dementia is not always optimal. This is likely to be due in part to the levels of training for the different staff involved, but also to internal management of care procedures. The quality of care in acute settings was addressed in the draft strategy and will also be covered in the final strategy when it is published. There will be a need to improve the general skills of hospital staff and also a need to enable the availability of specialist input into general hospitals. The Committee's recommendations on families holding a copy of the care record, and on hospitals undertaking a mental health assessment for people with cognitive impairment has been considered by the strategy working group and will be addressed in the final strategy.

Improving corporate functions using shared services

PAC recommendation	Department of Health response
The number of NHS organisations using NHS Shared Business Services will need to increase significantly if the forecast annual savings of £250 million are to be secured by 2014-15. To encourage greater participation, the Department of Health should lead by example by setting a firm date to become a customer now that the system has been redesigned to meet the Department's needs. Where corporate services are retained in-house, the Management Boards of NHS organisations should be clear that the decision represents better value for money than alternative options such as NHS Shared Business Services or outsourcing.	The Department set a date of 1 October 2008 on which to move its financial systems across to NHS Shared Business Services (NHS-SBS). This has been partially achieved: support for a number of IT services was successfully transferred to NHS-SBS on the 29th of September 2008. Transfer of the financial and accountancy elements of the service have been delayed pending resolution of a number of complex technical and legal issues relating to the safeguarding of data accessed from outside the European Union.
Within the NHS, less than 30% of invoices received reconcile with purchase orders, increasing the risk of incorrect or unjustified payments. The Department of Health should work with NHS organisations, regardless of whether they are customers of NHS Shared Business Services, to achieve a dramatic improvement in the proportion of invoices that match to purchase orders, improving productivity and timeliness.	The Department will be writing to NHS bodies to focus improvement in this area and also speaking to the Audit Commission to explore the usefulness of Commission work in this area.

Report on NHS Summarised Accounts 2006-7 – achieving financial balance

PAC recommendation	Department of Health response
Following two years of deficits the NHS as a whole delivered a £515 million net surplus in 2006-07. This was achieved by top slicing some budgets and holding them in reserve, targeted support for organisations with the most significant financial problems and tighter performance management of NHS finances by the Department.	The Department made financial recovery and the restoration of financial balance a key priority for the NHS in 2006-07. In order to place the NHS on a firm and stable financial footing, decisive action was needed in 2006-07. The framework for this action was established in early 2006 and had the following key components: increased transparency of financial reporting at all levels; putting those organisations with the most significant financial problems through a formal turnaround process; and tighter performance management of NHS finances from the Department.
A small core of NHS organisations have a combined deficit of £917 million, 80 per cent of which exists in 10 per cent of organisations. Building on lessons learned from the turnaround programme, strategic health authorities need to support these organisations to achieve financial balance through, for example, helping to devise recovery plans, establishing networks to exchange good practice, training to improve financial management and facilitating the sharing of financial expertise.	Throughout 2007-08, the proportion of organisations reporting a deficit position reduced from 22 per cent at the end of 2006-07 and to three per cent by the end of 2007-08. In addition, the level of gross deficit has been brought under control, and has significantly reduced from £917 million at the end of 2006-07 to £125 million in the 2007/08 final accounts. A small number of organisations continue to face significant financial challenges and we are working with SHAs to improve their financial performance.
There are significant regional variations in the financial performance of the NHS. While every strategic health authority area improved its financial standing compared to 2005-06, performance ranged from a deficit of £153 million in the East of England to a surplus of £189 million in the North West. The Department should establish the reasons behind the variations in financial performance through benchmarking and establish whether they reflect geographical differences in health care needs, provision and quality.	Local benchmarking is being carried out by PCTs and trusts across the NHS, but it should be noted that the longer standing deficits are clustered in certain parts of the country, of which the East of England is one. The deficits in these organisations are long standing and deep-rooted and their recovery has taken about a year longer than organisations in other parts of the NHS. Whilst there have been variations in financial performance across the NHS throughout 2007-08, the NHS in all areas of the country has shown significant improvement in its financial performance, ending the year with all regions reporting surplus positions. East of England is the most improved region in 2007-08, moving to a surplus of some £85 million, an improvement of £238 million over 2006-07.

PAC recommendation	Department of Health response
There is some evidence that financial balance was achieved by slowing down or postponing some healthcare. While the overall quality of NHS health care, as rated by the Healthcare Commission, has improved, 14 primary care trusts made financial savings by requiring their provider trusts to freeze or slow down non-essential planned treatments. To minimise the risk of this happening again NHS organisations need to agree annual work plans and supporting budgets before the start of the financial year, profile work as far as practicable, and have reliable information early enough to take remedial action where health service provision is put at risk.	The Department agrees with the Committee's recommendations with regard to planning and supporting budgets before the start of the financial year, profiling work where practicable and having reliable information early enough to take remedial action. Financial recovery has to take place alongside, and not at the expense of, service improvements. The Department acknowledges that failure to keep a tight grip on financial performance undermines service delivery for patients. The certainty of the system of loans introduced in 2006-07, has allowed NHS trusts to recover their financial position in a planned and structured way that has been agreed with strategic health authorities and the Department, and has in turn allowed appropriate and affordable patient services to be maintained. From 2006-07, the Department increased the emphasis of reporting on the year-to-date position in its reporting to both the Departmental Board and the NHS Management Board. Throughout 2007-08, the Department continued to collect both year-to-date, and forecast information, on balance sheet, income and expenditure, and cash flow data. Key indicators of financial performance were collected on a monthly basis and with SHAs required to provide explanations of any significant variations. During 2008-09, the Department will maintain this strong focus on year-to-date financial data and will collect key indicators of financial performance on a monthly basis. The 2008/09 Operating Framework has set out a financial framework that fully supports improvements in services within available resources, whilst also delivering on national priorities. One of the benefits of planning for a surplus is that it gives organisations the flexibility to respond to changes in demand and avoid the need to freeze or slow down non-essential planned treatments.

PAC recommendation	Department of Health response
More robust costing systems are essential if the NHS is to achieve longer-term financial stability. Under Payment by Results, NHS organisations receive income based on the work they perform in accordance with tariffs increasingly agreed nationally. Where costs are fixed there is a risk that income may not be sufficient to cover them resulting in a deficit. Management boards of NHS organisations need to be confident that their financial systems are fit for purpose to enable all costs to be understood, analysed in sufficient detail, and managed effectively.	The Department collects both programme budgeting and national reference costs information and these exercises require organisations to analyse and understand the costs they are incurring. Some organisations have introduced Patient Level Information and Costing Systems (PLICS) and this is an area the Department will continue to develop with the NHS. The Department recently finalised a set of best practice costing standards with the intention of introducing them across the NHS. This will greatly improve the ability of organisations to benchmark their performance as well as enabling the Department to have greater assurance on the quality of information used for costing.
Financial forecasting is not sufficiently reliable and needs to improve. Maintaining financial balance requires accurate and timely forecasting of income and expenditure. Forecast financial position data provided by NHS organisations throughout 2006-07 was often inaccurate. Strategic health authorities should identify those organisations, which consistently provide poor forecasts and help them improve through training and sharing of good practice.	For 2007-08, Payment by Results tariffs and the Operating Framework have been issued earlier than in previous years. This has helped the NHS in developing more robust plans and there has been less movement in the forecasts. Through 2007-08 there is evidence of improved forecasting. Since quarter two of 2007/08 the forecast outturn has shown little variation including very little movement between draft and audited accounts. For 2008-09 the forecast at quarter one shows stability when compared to the 2007-08 year-end. This is further evidence of improved financial management in the NHS.
There is a clear link between financial performance and the quality of service provided. NHS organisations which perform well financially tend to provide better quality services. Sound sustainable financial management is therefore vital in delivering improved health care. In reviewing performance and capability, the senior management of NHS organisations should assess how well their financial and clinical staff engage and the extent to which financial awareness is embedded in their organisations. Where this is deficient, an improvement programme with key milestones should be put in place.	Improvements have been made by staff across the NHS, both clinicians and financial managers, who have worked hard throughout 2006-07 and 2007-08 to reduce inefficiency, make savings and reduce deficits, whilst at the same time meeting all new national targets and improving quality of care for patients. One of the main factors in the NHS achieving financial recovery over last three years has been about the deficit organisations returning to balance rather than simply about organisations' underspends.

PAC recommendation	Department of Health response
The Department and the NHS are forecasting a surplus of £1.8 billion in 2007-08. While maintaining financial stability is important, large surpluses increase the risk that the NHS will be perceived as delivering less health care than it could have done if resources had been fully utilised. NHS organisations will need to be able to demonstrate to their local stakeholders that the level of health care delivered meets local priorities and needs.	The NHS reported a net surplus of £1.67 billion in 2007-08. It also delivered what it said it would on 18 weeks and healthcare associated infections, whilst maintaining a high level of performance against its other key indicators. The NHS surplus at quarter one of 2008-09 shows that nearly all the baseline and the additional resources for 2008-09 are being deployed. This continues our strategy of flexibility to be able to respond to fluctuations in demand, whilst maintaining sufficient funds for investment in new services.

Caring for vulnerable babies: the reorganisation of neonatal services in England

PAC recommendation	Department of Health response
The decision to establish a Neonatal Task Force is an important development, with the potential to improve the care for vulnerable babies. The Department should set the Task Force clear objectives and associated milestones for improving services, and monitor achievements against these milestones to ensure delivery of the objectives by the end of 2008-09.	The Department will set the Task Force clear objectives and milestones. The intention is that the Task Force will complete its work programme by November 2009, having set out its proposals for improving services and proposals for monitoring achievements to ensure delivery of the objectives.
The re-organisation of neonatal services into clinical networks has had limited impact in reducing geographic variations in mortality rates. Prematurity and illness in newborn babies are associated with a complex range of factors, including social deprivation, ethnicity and maternal age. Primary care trusts need to improve their understanding of the changing demographics of their local population and model the impact on demand for neonatal services to target intervention and prevention strategies on key high-risk groups.	The Department's framework document, *Maternity Matters: Choice, access and continuity of care in a safe service*, published in 2007, sets out the strategy for modernised maternity services, placing safety, quality and improving standards of care at the heart of its vision. It promotes the provision of coordinated maternity and neonatal care delivered through networks. This will ensure all women and their babies have equitable access to the whole range of specialist services where necessary. *Maternity Matters* recognises that for the best health outcomes, it is important women access maternity care at an early stage. The Department has developed a maternity indicator to increase the proportion of women who access maternity services by 12 completed weeks of pregnancy for a health and social care assessment of needs, risk and choices. This will enable women from high risk groups to be identified at an early stage and an individualised care plan developed. The Department also published in December 2007 the *Implementation Plan for Reducing Health Inequalities in Infant Mortality*. This plan featured key interventions to help reduce the infant mortality rate between disadvantaged groups and the whole of the population and provided examples of good practice to help narrow the infant mortality gap. *Health Inequalities: Progress and Next Steps* (published June 2008) includes a commitment to establish a health inequalities infant mortality national support team to help deliver the recommendations of the plan.

PAC recommendation	Department of Health response
Whilst three-quarters of neonatal units have reviewed the types and intensity of care a unit should be able to provide safely, the resultant re-designation has yet to be implemented in full. All networks should work with their relevant primary care trusts to use the information from local strategic needs assessment to inform the designation of neonatal units, taking into account the standards recommended by the relevant professional groups. Primary care trusts should base their commissioning of neonatal services on units being able to demonstrate that they have the right levels of suitably qualified and experienced staff to provide the designated levels of care.	In line with the recommendations of the Review of Commissioning Arrangements for Specialised Services, published in May 2006, Specialised Commissioning Groups (SCGs) are planning to designate their local providers of specialised Level 2 and Level 3 neonatal care. The nominated lead SCG is supporting the designation process by providing leadership and support as well as model documentation. SCG's will aim to complete the designation process in 2010–11. It is important that PCTs and Specialised Commissioning Groups base their commissioning of neonatal services on units being able to demonstrate that they have the right levels of suitably qualified and experienced staff to provide the designated levels of care. To assist in this process, the Task Force will develop quality standards for a comprehensive workforce. It will also develop a toolkit for use by all those commissioning neonatal services by autumn 2009.
There are currently no formal arrangements for performance managing neonatal networks. In return for continued funding of networks, strategic health authorities should agree a set of performance measures and review networks' performance against these objectives. Strategic health authorities should also require the two areas without a formal managed network to establish them as a priority.	The Taskforce will develop by autumn 2009 a suite of quality standards which can be used locally to create indicators covering quality, efficiency and capability. The Department is working with both areas to ensure they are covered by formal managed networks. The Northern Network is currently working to formalise its board, while in Essex a review has been established to assess the options for the future network arrangements. Its recommendations will go out to public consultation in October 2008 with implementation in the 2009-10 commissioning cycle.
There are wide variations and mismatches in costs and charges between neonatal units for the different levels of care provided, and units' understanding of costs is generally poor. Improving understanding of costs drivers is essential if the Department's plan to introduce a Payment by Results tariff is to be effective. In setting tariffs for neonatal care, the Department should ensure that the full costs, including the costs of meeting professional staffing standards and providing transport services, are taken into account.	The Department will be using reference costs to get the information it needs and will be issuing costing methodology guidance to aid the NHS in producing 2008-09 reference costs, for return to the Department in summer 2009. This collection will be used to inform the national tariff development. The NHS has been informed it needs to collect the minimum dataset from 1 April 2008. Healthcare Resource Groups (HRGs) have been developed and are in place for use from 1 April 2008, in line with the minimum dataset. The quality of information received (activity and costs) will determine whether and when a national tariff could be implemented.

PAC recommendation	Department of Health response
There are serious shortages in the numbers of neonatal nurses with an average of nearly three vacancies per unit for nurses qualified in neonatal care. Strategic health authorities and the new Neonatal Task Force should develop a national action plan to address neonatal nurse shortages, including developing recruitment and retention initiatives based on good practice. In the meantime, strategic health authorities should increase the number of neonatal training courses.	The Taskforce has a working group concentrating on workforce issues. One of the objectives of the group is to develop targeted action plans to assist local decision making, in addressing the neonatal nursing shortages, incorporating skill mix, staffing levels, recruitment, retention and commissioning of education and training to support an appropriately skilled workforce by autumn 2009.
Only half of networks provide specialist neonatal transport services 24 hours a day, seven days a week. Some 73 per cent of units experienced delays in transporting babies and 44 per cent believed that care had been compromised as a result. Strategic health authorities working with networks need to develop local partnering arrangements so that neonatal units have 24-hour access to appropriately staffed transport services.	All networks have access to some form of transport for transfer of neonates but the taskforce's working group on transport will consider all of the options for providing access to 24 hour transport services. These will be outlined in some quality standards for transfer available by autumn 2009.
On average, in 2006-07, each neonatal unit had to close to new admissions once a week due to a lack of baby cots. A third of neonatal units operated above the recommended occupancy rates of 70 per cent and three units operated above 100 per cent. High occupancy rates could have major implications for patient safety due to increased risk of infection or inadequate staffing levels. The functionality of the National Cot Locator needs to be improved so that it identifies occupancy levels in order to meet the needs of networks and units wishing to transfer babies.	The working group on data for commissioning will review the National Cot Locator and make recommendations for its future by Spring 2009. The Department will assist the networks, commissioners and SHAs to work together to ensure there is sufficient neonatal capacity to meet the continually rising number of births and complex births within their local area

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