



UK HEALTH

A REPORT INTO DIVERGING STRUCTURE
AND POLICY UNDER DEVOLUTION FOR THE
NATIONAL HEALTH SERVICE IN ENGLAND,
SCOTLAND, WALES AND NORTHERN IRELAND

DECEMBER 2008



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INTRODUCTION

The National Health Service celebrated its achievements and 60th birthday in July 2008.

Since its inception in 1948 to date;

- The United Kingdom population has increased to 60.6m (mid-2006 estimates) from 50m
- Life expectancy has risen to 77.2 years for men from 65.9 years (+11.3 years + 17.1%)
- Life expectancy has risen to 81.5 years for women from 70.3 years (+11.2 years + 15.9%)
- Heart disease and cancer were the major causes of premature death in 1948 and this remains the case in 2005.

This report is a specialist publication consistent with CIPFA's overall aim to develop an expertise in health policy in the separate UK areas and, where possible, to evaluate and showcase effective policy and practice to facilitate discussion on the future delivery of better UK health services.

This report is compiled in the following way.

An Executive Summary is followed by

How the NHS is structured differently in the four UK countries [table 1]

A summary of UK Health Policies is then shown under the following headings

- Patients and Carers rights, choice & redress [table 2]
- Services being re-provided within the Community [table 3]
- Quality of Care [table 4]
- Partnership working between Statutory Agencies [table 5]
- Free Personal Care [table 6]

Use of the Private Sector for

- Commercial Provision of GP services [table 6]
- Use of Independent Sector Treatment Centres [table 6]
- Use of the Private Finance Initiative [table 6]
- Advice on Commissioning [table 6]
- Hospital Car Parking Charging [table 6]
- Prescription Charges [table 6]

Excluded are policies relating to staff, IT and process.

There is further information on Free Nursing and Personal Care in Scotland, the Barnett Formula, Independent Sector Treatment Centres in England and Health Policy enablers in England (Foundation Trusts, Payment by Results, Practice-Based Commissioning and Patient Choice) included within a series of annexes A to D.

The report also contains a data bank on a number of key health indicators and outcomes such as life expectancy, causes of premature death and waiting lists for each country for information and to highlight differing challenges for each country.

This report will show that in England the Health Service is influenced by the economics of the market. Competition, contestability and strong performance management exercised by Strategic Health Authorities are mechanisms linked to the improvement of performance. Budgets have been provided to GPs as practice-based commissioners and there is extensive use of the Private Sector. The latest Darzi review *Our NHS, Our Future* provides a vision for the NHS over the coming 10 years and with it a requirement for robust information systems and data to accurately assess the implications of changes before these are formally approved and implemented. In Scotland and Wales the pursuit of better Health services has been via partnerships, while in Northern Ireland Health and Social Care are truly integrated.

Health indicators included within this report reflect that Scotland has the greatest health need within the UK.

Care has been taken in this report to ensure comparisons between the four UK countries are consistently based and therefore, in a number of instances, the very latest data has not been included.

CIPFA has welcomed and valued comments from the CIPFA Health Panel, CIPFA in the Regions and the UK Health Departments that have all been incorporated into this report, CIPFA hope that you find this publication informative and helpful and would welcome and value your comments sent to the email address below.

Health Policy CIPFA
stephen.strutt@cipfa.org

EXECUTIVE SUMMARY

There has been significant structural change within the National Health Service in the UK.

In England 10 Strategic Health Authorities performance manage Primary Care Trusts that commission care on behalf of their resident population from NHS Trusts (also accountable to SHAs), Foundation Trusts (who are accountable to regulator Monitor) and the Private Sector. In Scotland NHS Trusts were abolished in 2004 with responsibility for planning, commissioning and delivery of health care falling to 14 local Health Boards. Wales and Northern Ireland are in the process of restructuring and proposals are outlined on pages 9 and 10. The key differences are that structures in England accommodate an “internal market” where patients have a choice of provider, and hospitals (and to an extent the private sector) are in competition for elective work. These principles have been set aside for a system based on collaboration and partnership in Scotland and Wales. Within Northern Ireland the period of suspension of the NI Government has meant proposals are not as developed in this area, however Health and Social Care are truly integrated via Health and Social Care Trusts that provide for delivery across the services, and with this the ability to set guarantees on a maximum time any patient will have wait to be discharged after being declared fit. (Reference Table 1)

The argument for the internal market is an improvement in patient choice, quality and cost brought about by competition, and contestability from a number of NHS and private providers. The argument for the partnership approach is that it is intended to reduce bureaucracy, introduce single area plans and work better across the secondary care, community care, primary care and social care divides.

Patients’ rights are very clearly outlined for England within a proposed new NHS Constitution, a right to dignity, confidentiality and choice of approved treatment and provider, a personalised NHS care plan for those with long-term conditions and a piloting of personal health budgets and direct payments. In Scotland the concept of a “Mutual NHS” and a “Bill of Rights” has been developed where patients and carers are seen as partners. Systems in England and Scotland highlight responsibilities for patients. Wales has a commitment to improve the patient experience and to develop a charter for patient rights. Northern Ireland looks to patients with long-term conditions having more control over their treatment and to extend direct payments for health and social care. (Reference Table 2)

For a number of services the transition from acute hospital care to services provided within local communities is common policy in the UK. Proposals are particularly clear within the report by Lord Darzi *High Quality Care for all* for England. For Northern Ireland the ‘polyclinic’ model proposed for England and seen very much in Germany has been implemented for some time (excluding specialists) within integrated health and social care centres such as the Arches and Bradbury Centres in Belfast. Wales is piloting wellbeing centres. Scotland has ruled out Polyclinics. (Reference Table 3)

Policies regarding quality of care are common to all UK countries. England is proposing to link quality directly to payments for providers of health care. Patient views, clinical dashboards, quality accounts, success of treatment and quality of experience will be key indicators in developing this approach. (Reference Table 4)

Partnership working is key across all UK countries. New proposals for England include the piloting of integrated care organisations to commission health and social care, Scotland has integrated health and social care partnerships as sub-committees of the 14 local boards. Wales is developing its partnership approach. (Reference Table 5)

Free personal care was introduced in Scotland in July 2002 and this policy is a significant deviation from the rest of the UK. It means that people aged 65 and over can no longer be charged for this service. A summary of these proposals is included within this report at Annex A. The estimated extra cost of this policy was assessed at £169m for 2007, and these funds were made available. A review led by Lord Sutherland published in April 2008 highlighted that extra resources of approximately £40m per annum and a standardisation of assessment, formal processes, waiting times and service delivery across patches was required to successfully provide this service. (Reference Table 6 – significant policy variations section)

There are significant variations in policy regarding the use of the private sector. Only England has introduced commercially run GP services (61 run commercially and 60 contracts had been out to tender as at July 2008). There is extensive use of Independent Sector Treatment Centres (review shown at Annex C) that are being phased out in the rest of the UK and use of the commercial sector to advise Primary Care Trusts on their commissioning intentions. This latter development requiring a rigorous assessment of standing financial instructions to ensure there are no conflicts of interest.

PFI has been used extensively in England, Scotland and Northern Ireland. Wales have reviewed PFI in relation to overall investment and have concluded that the policy is not value for money in health. PFI does require a rigorous assessment of private and public sector funding options to determine value for money. The Department of Health for England from November 2008 has now agreed an equal share of the benefit between PFI consortiums and the NHS where an initial loan supporting PFI is subsequently refinanced at a lower percentage rate.

Significant policy variations exist for car parking charges. In England there is extensive charging, with £112m collected in 2007/08 and a number of Trusts collecting in excess of £2m a year. In Scotland and Wales they are to be phased out by 2011 and for Northern Ireland they are free for critically ill patients and their relatives.

Prescription charging remains at a rate of £7.10 per item in England, £5.00 per item in Scotland, but free from 2011/12. In Northern Ireland it will be £3.00 per item from January 2009 and free from 2010/11. Wales has had no charge since 2007.

"Prescription charges in Northern Ireland – a cost and benefit review" concluded that demand for prescription drugs is reduced when patients make a financial contribution. Individuals with chronic illness, poor health status, poor educational status, low incomes or high social need have been found to be particularly affected by the cost of medication. Children, students and the elderly are more likely not to have their medication. A number of these groups are covered by exemptions in the UK. Cost was not found to be a factor generally for those with higher incomes. The cost of abolishing charges in Northern Ireland has been assessed at between £13m and £24m, depending on increased demand.

There are significant variations in spending on UK Healthcare. Funds transferred from Westminster to the devolved administrations for public services are based on a Barnett formula that is explained in outline at Annex B.

In 2007/08 the spending per head for health in Scotland was £1,919 compared to £1,676 for England. There is significant interest around the Barnett funding formula. This is often linked to the policies in Scotland of free personal care, free eye tests and free dental check-ups. (Refer Expenditure on Health and Social Care in the four UK countries section)

The discussion around financing has to be seen in the context of health indicators for the four UK countries. If you live in England you are likely to live longer than if you live elsewhere in the UK. If;

- you are male living in Kensington and Chelsea, you are likely to live on average 12.6 years longer than if you live in Glasgow. (Fig 5)
- If you are male living in the Calton District of Glasgow, average life expectancy is only 54 years.
[These statistics reflect the multi-agency challenges of unemployment, low incomes, poor housing, lack of exercise / leisure, poor diet, smoking and a higher than moderate alcohol consumption that can diminish health prospects]
- Scotland has the highest incidence rate of cancer, stroke, deaths from drug poisoning and alcohol abuse, the lowest GP list sizes, the highest number of available NHS beds and the lowest throughput per bed.
(Scotland does provide healthcare over disperse and very remote areas Refer Figs 6,7,9,10,11,12,14)
- England has the lowest waiting time target of 18 weeks from the end of 2008, and the lowest number of people waiting for hospital treatment for its population as at 31 March 2008. (Fig 15)

This publication shows that there are a significant number of healthcare policies across the UK that are similar, but also that a number are changing at a rapid pace in all four countries. Policy changes from after 1 November 2008 are not included in this report.

The Audit Commission has concluded that there have been successes, particularly in strengthening financial and business management as a result of policies such as introducing Foundation Trusts in England. There is significant evidence that a combination of policies has noticeably reduced waiting times, particularly in England. The effectiveness of changes in Wales and Northern Ireland may be more difficult to assess for some time given their present restructuring.

CIPFA supports the Audit Commission view that changes to commissioning structures in England should not be reviewed in the short term and looks forward to following up this study in future years to specifically appraise the improvement in health services that can be attributed to individual and complementary policies.

REFERENCES TO MAJOR HEALTH POLICY DOCUMENTS

England

Policy	Date	Reference
"High Quality Care for all" NHS Next stage review final report	July 2008	ENSRFR
Strategic Health Authorities – "Visions for better healthcare"	June 2008	ENSRV
NHS next stage review: "Our vision for Primary and Community Care"	July 2008	ENSRPC
"The National Health Service Constitution – a draft for consultation"	July 2008	ENSRCon
Engagement analysis: NHS next stage review. "What we heard from the Our NHS, our future process"	July 2008	ENSREa
The Operating Framework for the NHS in England 2008/09	December 2007	EOF
Framework for managing Choice, Co-operation and Competition	May 2008	EFCCC
Changing for the Better – Guidance when undertaking major changes to services	May 2008	ENSRCH

Scotland

Policy	Date	Reference
Our National Health: A plan for action, a plan for change	2000	SONH
Partnerships for Care – White Paper	2003	SPFC
Delivering for Health report by the Scottish Executive - Issued in response to Building a Health Service fit for the Future Report by David Kerr	2005	SDFH
NHS reform (Scotland) service reform act that initiated fundamental change within the NHS in Scotland	2004	SNHSR
Better Health, Better Care	Dec 2007	SBHBC
NHS Reform Bill	2003	SNHRB
Building a Health Service Fit for the Future	2005	SNHFF

Wales

Policy	Date	Reference
“One Wales”	June 2007	WOW
Designed for Life	May 2005	WDFL
NHS plan Improving Health for Wales	2001	WIH
Health Challenge Wales	2003	WHC
Health and Social Care Review 2003	2003	WHSCR

Northern Ireland

Policy	Date	Reference
The Departments (NI) order	1999	NNIO
Press Releases from the Department of Health, Social Services and Public Safety – Northern Ireland	Various	NPR
Ministerial Keynote Policy Speech – “Check against Delivery”	June 2006	NKA

Table 1

The structure of the NHS in the four UK nations

England
<ul style="list-style-type: none">• The Secretary of State for Health is accountable to Parliament for the National Health Service in England.• In 2006 28 Strategic Health Authorities became 10 and 303 Primary Care Trusts became 152 with GPs involved in Commissioning via Practice based Commissioning (PbC) Groups.• The 10 Strategic Health Authorities (SHAs) are the Regional leaders of the Local NHS responsible for strategic development of the local NHS, service and performance management.• Primary Care Trusts are accountable to their SHAs and are responsible for the needs assessment and the commissioning of services for their local populations. Increasingly commissioning decisions are being devolved to PbC groupings with PCTs providing infrastructure and support arrangements to manage this policy effectively. The PbC policy is to be re-invigorated (November 2008).• “Our NHS, Our future” sets out a challenging 10 year vision for the English NHS. This is the final report of lord Darzi’s next stage review. It responds to 10 visions published by each Strategic Health Authority. There is an over-riding objective of high quality care for patients, making the NHS more personalised and a focus on the promotion of good health as well as to tackle illness. Strategic Health Authorities will performance manage the “Darzi” transition. The importance of partnerships to improve health is emphasised.• A new focus on the development of not for profit Social enterprises being established by NHS staff e.g. Central Surrey Health.• A new focus on the establishment of integrated care organisations that will facilitate the Commissioning of Health and Social Care such as that being Commissioned in Surrey.• Establishment of Foundation Trusts not accountable to Strategic Health Authorities but to Independent regulator “Monitor” with greater freedoms than NHS Trusts.• The National Institute for Clinical Excellence (NICE) is to be expanded to set and approve more independent quality standards.• The new Care Quality Commission to have new enforcement powers.

Scotland

- Responsibility for the NHS in Scotland rests with the Scottish Government, the First Minister and the Cabinet Secretary for Health and Wellbeing. A Scottish Government Health and Community Care Directorate has ministerial responsibility for NHSScotland.
- The Scottish Government sets and monitors national objectives and priorities for the NHS agreed with NHSScotland that comprises of 14 NHS Boards, (11 Mainland and 3 Island) as well as 8 special NHS Boards providing all Scotland services such as Ambulance services, telephone access to unplanned care and a common services agency. NHS Boards are organisations responsible for planning, commissioning and delivering hospital services and those provided by independent practitioners (GPs, Dentists, Community Pharmacists and Opticians).
- At a local level there are Community Health Partnerships or Community Health and Social Care Partnerships covering all areas of Scotland. These are important sub-committees of the NHS Boards responsible for the planning and delivery of community services.

The key changes introduced by the 2004 NHS reform (Scotland) Act legislation were to:

- Dissolve NHS Trusts as single legal entities with staff, assets and functions transferring to Local Health Boards.
- The Establishment of Community Health Partnerships as sub-committees of Boards.
- Extended Ministerial powers to intervene as a last resort to secure the quality of healthcare services.
- A new duty on NHS Boards to co-operate with each other to improve the quality and consistency of care.
- Improvements in the development of regional planning by Health Boards, the promotion of health improvement and public engagement.

Wales

A Minister for Health and Social Services, within a department for Health and Social services holds the Cabinet portfolio for Health reporting to the Welsh National Assembly Government. NHS Wales has three Regional Offices located in North, Mid and West and South East Wales.

Consultation on Revised Health Structures

The NHS in Wales is consulting on significant changes to structures.

A National Advisory Board chaired by the Health Minister will be established.

A separate Delivery Board to be established, chaired by the NHS Wales Chief Executive with responsibility for the day-to-day operational performance of seven new NHS local Boards.

Further work to be undertaken on whether the 7 (reducing from 22) new Local Boards bodies will be allocated some of the responsibilities of Health Commission Wales (the Wales Specialist Commissioning agency).

A unified Public Health organisation will be formed in line with the Assembly Governments "One Wales" commitment.

The restructuring of Health includes the significant consolidation of NHS Trusts. The reforms replicate to an extent the Scottish reforms and the timescale for implementation of these reforms is October 2009, with a period of shadow running from July.

Northern Ireland

The Departments (NI) order 1999 established the Department of Health, Social Services and Public Safety.

- A Minister for Health, Social Services and Public Safety is responsible for the portfolio.
- A review of organisational structures had been delayed by the suspension of the Northern Ireland Assembly between October 2002 and May 2007. Following resumption proposals that had previously been developed have been re-examined and the following proposals are on course to be delivered for April 2009.

The main changes:

- A single Regional Health and Social Care Board replacing four existing Health and Social Care Boards focussing on Commissioning, Resource Allocation, Performance Management and Improvement.
- Five Local Commissioning groups co-terminus with five Health and Social Care Trusts. [Belfast, Northern, Western, Southern and South Eastern].
- Community and Hospital delivery (as now) from single organisations allowing the exploitation of the full potential of integrated Health and Social Care.
- A Regional Agency for Public Health and Social Well being having responsibility for health protection, health improvement and development to address health inequalities and public health issues for all the people of Northern Ireland.
- The present Central Services agency to be dissolved and a Regional Support Services Organisation to provide a range of support functions for the whole of Health and Social Care.
- A single Patient and Client Council to replace the current Health and Social Services Councils with five Local Offices.
- A key policy prior to the suspension of the Northern Ireland Government was to draw a line under the Internal market in favour of co-operation and Partnership working, **this would leave only England with this policy.**
- The regulation and quality improvement authority to review Boards and Trusts against quality standards for Leadership and accountability and safe and effective care.

Actual timeline for change in Northern Ireland

First and second readings	Complete
Committee stage	Sept – Nov 2008
Further consideration stages	December 2008
Final stage and Royal Assent	Jan – Feb 2009
Subordination legislation	Feb – Mar 2009
Implementation	April 2009

Sources: UK Health Departments

Supporting patients and carers' rights, choice and redress

Summary

All four UK countries have important policies supporting patient rights.

In England the Darzi Review "Our NHS, Our Future" has proposed a new NHS Constitution that reaffirms the underlying principles and values of the NHS and patients' rights to a choice of GP, provider of health care (NHS or Private) and approved treatment. Plans for personal health budgets and personalised care plans for those with long term conditions are to be piloted.

Scotland has introduced a concept of the "Mutual NHS" and a "Bill of Rights" where patients have rights, involvement and representation.

Wales has policies to improve the patient experience as outlined in "One Wales".

Northern Ireland has a desire to see personalised care plans for those with long-term conditions and direct payments to give patients more control over their care.

[Policies for England and Scotland explicitly reflect the responsibilities of patients in their own health care.]

Table 2

Supporting patients' and carers' rights, choice and redress	Policy Doc.
<p>England</p> <ul style="list-style-type: none"> • A proposed new constitution, a Patient right to dignity, privacy, confidentiality and choice. Care plans for patients with long term conditions, 5,000 personalised budgets being piloted. • An NHS Constitution proposes a set of principles and values that should guide everything the NHS does, including a commitment to providing a comprehensive service, available to all without discrimination and based on clinical need and not on ability to pay. • The Constitution; <ul style="list-style-type: none"> • Reaffirms NHS principles and values. • Brings together patient rights and resource. • Explains the responsibilities of the public, patients and staff. • Recognises that staff are the most important asset and key to providing quality services. <p>The Constitution proposes a set of key patient rights including:</p> <ul style="list-style-type: none"> • An explanation of all decisions made about funding treatment. • A right to have a say in the planning of local services – the local NHS should reflect what Patients consider to be important. • Patients to have a greater choice of GP practice and better information to help them choose. (NHS choices website to be upgraded). • The introduction of a new right to choice regarding both treatment and provider and to information to enable decisions to be made. • Everyone with a long term condition to have a personalised care plan. • Personal health budgets to be piloted giving individuals greater control over their own care with clear safeguards, direct payments to be piloted. • All patients to receive approved NICE treatments and drugs where these are recommended by their clinician. • Guaranteed maximum waiting times. <p>The Constitution also includes a vision for staff and what is expected from them and the public:</p>	<p>ENSRcon ENSRFR</p>
<p>Scotland</p> <ul style="list-style-type: none"> • A new duty on Health Boards and Special Health Boards to ensure public involvement monitored by the Scottish Health Council. • Patients and service users seen as partners in the NHS with rights and responsibilities. 	<p>SNHRB SBHBC SNHFF</p>

<ul style="list-style-type: none"> • Public ownership strengthened by introducing the concept of a Mutual NHS where patients (partners) have real involvement & representation via a commitment to patients rights. • A Scottish Bill of Rights provides for participation in decisions about health, privacy and confidentiality of personal information, independent support and redress by commenting on care and having concerns addressed, accessible NHS Care and a waiting time guarantee. • Support and encouragement for patients and their carers to manage their own health care needs. • The development of services to improve the patients experience at local level. • Guaranteed maximum waiting times. 	
<p>Wales</p> <ul style="list-style-type: none"> • A programme to support, improve and promote the patient experience. • To draw up a charter for patient rights and legislation on NHS redress. • Improvements in hospital food and nutrition. • The reform of charges for hospital parking and access to telephones and televisions whilst in hospitals (no specific mention of quality of treatment). • Full patient engagement regarding developments and changes. • Access to healthcare assured. • Guaranteed maximum waiting times. 	WOW
<p>Northern Ireland</p> <ul style="list-style-type: none"> • A desire to see personalised care plans for people with chronic conditions such as asthma or diabetes. • Looking further ahead people with long term needs to have more control over their own treatment and care. • Single assessment. An extension of direct payments giving people and families the power to take control over their own social services, such as home helps and personal care. • Guaranteed maximum waiting times. • Guaranteed maximum wait before discharge. • Services designed around individual patients. • Next steps advised within five days of a visit to the GP. 	NKA

Supporting the transition of services from the acute hospital sector to provision within the community

Summary

In England the Darzi review looks to the provision of more appropriate Healthcare provided closer to home with the establishment of new polyclinics with specialists, GPs and nurses.

In Scotland Nicola Sturgeon confirmed in May 2008 that “we have no plans to introduce polyclinics in Scotland. The *Better Health, Better Care Action Plan*, published in December 2007, sets out our objectives to improve access in primary care settings in Scotland. We are working with the existing model of general practice and the wider primary care team, including community pharmacy led services, to deliver these objectives in a way that is appropriate to Scotland’s needs.”

There is also an emphasis on targeted action in deprived areas to prevent future ill health & reduce health inequality. Primary Care teams in less well off areas to have dedicated resources to reach out and help people with higher risks of ill-health and the defining of core services for remote communities and confirming of a need to travel where appropriate for specialist services.

“One Wales” covers the piloting of multi-purpose well being centres and establishing a Rural Health Plan.

Northern Ireland has plans similar to England to extend integrated community centres building on their key strength of Integrated Health and Social Care.

Table 3

Supporting services re-provided within the community	Policy Docs.
<p>England</p> <ul style="list-style-type: none"> • The movement of a number of services currently provided in a hospital setting to a polyclinic/ community model that includes a comprehensive range of staff from hospital specialists, GPs and other health care professionals. • Reconfigured services above to be developed before those provided in the hospital setting are withdrawn. 	<p>ENSRFR</p>
<p>Scotland</p> <ul style="list-style-type: none"> • A systematic review by NHS Boards to develop proposals to care for vulnerable people with long-term conditions to be treated at home or in the community reducing the chance of hospitalisation. • Support for patients and their carers to manage their own health care needs. • Development of a network of rural general hospitals to support remote communities with a core set of services to be provided. • More health care provided locally in GP practices, in community pharmacies and community health centres. • Viewing the NHS as a service delivered predominantly in local communities rather than in hospitals. • Putting the experience of patients and users at the heart of service change “Partners in Change”. • No plans for “Darzi” style polyclinics. 	
<p>Wales</p> <ul style="list-style-type: none"> • Piloting of community well – being centres. • A rural health plan to be published that meets the needs of rural communities. • Comprehensive draft plans for January 2009. 	<p>WOW</p>

Northern Ireland

- A focus on providing more services in the community.
- Forty new health and social care centres. Providing GP practices, nurse led consultation space, diagnostic and treatment rooms for specialist services, dental services, services for the elderly, those with learning and mental health difficulties, accommodation for visiting hospital consultants, GPs, nurses, social care professionals and a community pharmacy. A one-stop shop. Examples being the Arches and Bradbury Centres in Belfast and the Kilkeel Primary Care Centre.
- Plans in place to develop a whole range of integrated clinical assessment and treatment services (ICATS) in the community with the aim of reducing inappropriate referrals to Hospital Consultants backed up with a new information system to advise patients of their next step in the care planning process.
- The development of a range of intermediate care services designed to bridge the gap between hospital care and continuing health and social care in the community.
- A commissioning focus on fully integrated community & primary care.

NKA

Supporting the overall quality of care

Summary

All four UK countries have policies supporting improvement in the quality of care.

The “Darzi review” for England has made quality a central theme. Patient views, success of treatment, quality of experience, clinical dashboards, the publication of quality accounts and payments to providers of services to be based on assessed quality of service.

Table 4

Supporting the overall quality of care	Policy Docs
<p>England</p> <ul style="list-style-type: none"> • A new focus on patient quality, patient views, clinical dashboards. Payments to hospital providers (from 2010) and GPs to be based on top quality clinical performance & access respectively. • Patients own views on both the success of their treatment and the quality of their experience to be published. All registered healthcare providers to publish quality accounts as they publish financial accounts. • A new “quality observatory” to be established in every NHS region to inform local quality improvements. 	ENSRFR
<p>Scotland</p> <ul style="list-style-type: none"> • “<i>Better Health, Better Care: Action Plan</i>” published 2007. This document focuses on three key themes of health improvement, tackling health inequalities and improving the quality of health care. 	SBHBC
<p>Wales</p> <ul style="list-style-type: none"> • Improving patient experience. • Improvements in hospital food and nutrition. • Improvements to hospital cleanliness. • The reform of charges for hospital parking and access to telephones and televisions whilst in hospitals. 	WOW
<p>Northern Ireland</p> <ul style="list-style-type: none"> • An emphasis on patient quality and safety. • The Regulation and Quality Improvement Authority to review boards and trusts against quality standards for leadership and accountability and safe and effective care. 	NKA

Supporting partnership working between statutory agencies

Summary

Partnerships are critically important to all four UK countries.

England has comprehensive policies over partnership working with and between statutory agencies and the third sector.

Scotland and Wales have partnerships as a central policy within health internally and in their relationships with other statutory agencies and the Third Sector.

Northern Ireland has integrated health and social care.

Table 5

Supporting partnership working between statutory agencies	Policy Doc
<p>England</p> <ul style="list-style-type: none"> • Each PCT to commission comprehensive well being and prevention services in partnership with local authorities, with the services offered personalised to meet the needs of the local population. Efforts to be focused on tackling obesity, reducing alcohol harm, treating drug addiction, reducing the incidence of smoking, improving sexual health and improving mental health. • A set of new voluntary agreements between the government, the private and third sectors on actions to improve health outcomes (initial focus on obesity). • Creating new partnerships between the NHS, universities and industry to enable pioneering new treatments and models of care to be developed and delivered to patients. • A piloting of new integrated care organisations, bringing together health and social care professionals from a range of organisations. • Encouragement where PCTs and staff choose to set up social enterprise organisations. 	<p>ENSRFR</p>
<p>Scotland</p> <ul style="list-style-type: none"> • Emphasis on a modern health service in Scotland built on partnership, integration and redesign. New relationships between NHSScotland and Local Authorities. “ instead of the fragmentation of the market which characterised the Health service for much of the 1990s we are seeking to bridge the gap between primary and secondary care and between health and social care essential for developing the new models of care that meet patients needs”. • A new duty on NHS Boards to co-operate with each other to improve the quality and consistency of care and regional planning. • Establishment of community health partnerships and setting a clear agenda for these organisations to work across barriers between primary and secondary care and engage with partners in social care. 	<p>SPFC</p>

<p>Wales</p> <ul style="list-style-type: none"> • Designed for life looks at delivering a healthy Wales through partnerships and not competition and the reform of hospital, community and social services. • An emphasis on strong relationships with local government. • A new national health and social care strategy identifying clearly the needs of different patient groups, what should be done at different levels, ensuring care is streamlined and integrated within a network of services. • Four levels of care identified to meet the needs of user groups, tertiary and highly specialised services, specialised and critical care centre, local acute services and those provided in the local community or sheltered housing. • Supporting social care by: <ul style="list-style-type: none"> • Creating a “level playing field” for domiciliary care service charges. • Further legislation in the areas of vulnerable children, looked-after children and child poverty. • A review of the carers’ strategy and legislation on the rights of carers. • Building on existing workforce plans to include all care staff. • Development of not-for-profit nursing homes. 	<p>WDFL WOW</p>
<p>Northern Ireland</p> <ul style="list-style-type: none"> • Integrated care for health and social services • New safeguarding legislation to be introduced to improve arrangements for child protection. • A movement away from the internal market. 	<p>NKA</p>

Significant policy variations

Summary

Personal Care

A major variation in UK policy is free nursing and personal care introduced in Scotland.

Use of the Private Sector

- **Commercial GP Services**
Extensive arrangements in England
No similar arrangements in Scotland, Wales or Northern Ireland
- **Independent sector treatment centres**
Extensive arrangements within England
Policy being withdrawn in Scotland and Wales
No further plans for extension in Northern Ireland
- **Private finance schemes**
Extensively used in health for England, Scotland and Northern Ireland
Ruled out in Wales
- **Use of the commercial sector to advise on commissioning**
Used in England only

Car parking charges

Extensive application within England

Policies adopted in Scotland, Wales and Northern Ireland to limit or cease charging

Prescription charges

Extensive application within England

Policies adopted in Scotland, Wales and Northern Ireland to limit or cease charging

Table 6

Personal Care	
England	Not free
<p>Scotland</p> <p>Annex A contains the results of an “Independent Review of Free Personal and Nursing Care in Scotland”</p> <p>A report by Lord Sutherland April 2008</p>	<p>The policy to provide personal and nursing care in Scotland free at the point of delivery and assessed according to need was based on the Royal Commission report “with respect to old age” published on 1 March 1999.</p> <p>The subsequent Act that passed through the Scottish Parliament was implemented in July 2002.</p> <p>The act effected three main changes that are shown below:</p> <ul style="list-style-type: none"> • People aged 65+ can no longer be charged for personal care provided in their own home (charges for domestic services are means tested) • People aged 65+ who live in care homes as self funders receive £149pw and £67pw (from April 2008) if required towards personal and nursing care respectively, hotel costs are not funded • People under 65 can also receive £65 towards nursing care
Wales	Not free
Northern Ireland	Not free

The use of the private sector in Health

GP services run by the commercial sector

Reference: NHS at 60, Panorama BBC1 8.30pm
7 July 2008 "NHS for Sale"

England	<ul style="list-style-type: none">• Legislation in 2004 allowed Primary Care Trusts to invite the commercial sector to bid for tenders to run GP services.• At least 61 GP surgeries are run commercially and a further 60 new contracts were out to tender as at July 2008.• Commercial companies are also running GP services from a number of Supermarkets (eg Doctors in Store).
Scotland	<ul style="list-style-type: none">• Looking to repeal the 2004 legislation. Consultation process is in place.
Wales	<ul style="list-style-type: none">• Approach is not favoured as the emphasis within health policy is now to reduce competition.
Northern Ireland	<ul style="list-style-type: none">• Commercial sector is not permitted to run GP services.

Independent sector treatment centres	
England	<ul style="list-style-type: none"> Independent sector treatment centres are extensively used.
Scotland (BBC Health website reporting)	<ul style="list-style-type: none"> Unlikely that another independent treatment centre, such as the one that opened in Stracathro Hospital in 2007, will be sanctioned.
Wales (BBC Health website reporting)	<ul style="list-style-type: none"> Independent Sector Treatment Centres to be phased out by 2011.
Northern Ireland	<ul style="list-style-type: none"> In a Parliamentary response of 5 March 2007, Paul Goggins, The Secretary of State for Northern Ireland confirmed that: “There are currently no plans to develop independent sector treatment centres in Northern Ireland. However, in the context of securing shorter waiting times for patients, I am committed to making appropriate use of the independent sector while at the same time developing additional hospital capacity and reforming hospital systems and processes. Considerable capacity analysis work is ongoing to identify any long-term capacity shortfalls requiring investment, and also any short-term backlogs where the independent sector can assist by providing necessary additional capacity”.

A Healthcare Commission report of the 19 July 2007 reviewed care provision in 23 ISTCs in England. The main findings are shown at Annex C.

Use of the private finance initiative

(BBC Health Website)

England	<ul style="list-style-type: none"> • PFI has been used extensively.
Scotland	<ul style="list-style-type: none"> • PFI has been used extensively.
Wales	<ul style="list-style-type: none"> • A Welsh Assembly spokesman In January 2006 confirmed that: “We have ruled out PFI in the health service because it has not proved value for money, but this does not mean it will be discounted in areas such as transport or affordable Housing.” Many schools and hospitals were built with loans secured under PFI agreements where the repayments are six times greater than the capital building costs. Neath Port Talbot Hospital is a case in point where the loan repayment over 30 years – including maintenance – will exceed £445m, compared with building costs totalling only £66m.
Northern Ireland	<ul style="list-style-type: none"> • PFI has been used extensively.

Commentators have questioned the use of PFI on a number of occasions due to the following factors:

- It has tended to be the only source of major capital investment available for new district general hospitals in the NHS.
- With fixed costs, it can run against the principles of a competitive market in England.
- Health services are tied in for very long contract terms.
- The cost of excellent facilities can be difficult to afford under an average national tariff system, higher facilities costs need to be financed through increased throughput and income.
- The movement of services and income from acute hospital to community settings with a fixed hospital single unitary payment to cover.
- With the introduction of International Financial Reporting Standards, PFI schemes are expected to come onto NHS balance sheets from April 2009 with the associated cost of paying twice for capital that this entails. The Health Service Journal (HSJ) reported that with the introduction of International Financial Reporting Standards, from 1 April 2009 an extra £16bn of PFI debt will be brought onto the NHS balance sheet costing organisations an expected £146m a year (Source: HSJ 7 August 2008).
- The overall cost of PFI over the contract term - although it is argued that PFI has to go through a rigorous comparison with a public sector risk adjusted comparator before being approved.
- Refinancing gains have been significant for private sector partners, although from November 2008 refinancing gains will be shared equally between the sectors in England.

However the private sector has an enviable record of delivering on schemes on time and on budget that the public sector have found hard to match as evidenced by NAO reports.

Use of the private sector to advise on commissioning

England (BBC Panorama)	<ul style="list-style-type: none">• In England the Commercial sector are now advising Primary Care Trusts on their purchasing intentions. Private companies include Aetna; Humana and Health Dialogue solutions are engaged.• There appears at this point that there is no over-arching policy that prevents these companies recommending themselves to become providers, although standing financial instructions should ensure that any conflict of interest is negated.
Scotland	<ul style="list-style-type: none">• No similar proposals being considered.
Wales	<ul style="list-style-type: none">• No similar proposals being considered.
Northern Ireland	<ul style="list-style-type: none">• No similar proposals being considered.

Car parking charges on NHS property

Reference: BBC Health Website "The NHS in Numbers: Then and now" 4 July 2008
<http://news.bbc.co.uk/1/hi/health/7486044.stm>

Car parking charges	
England	Extensive charging - (£112m collected 2007/08) Examples of Income Heart of England Foundation Trust - £2.5m University Hosp. Coventry and Warwickshire £2.2m Nottingham University Hospitals £2.1m Cambridge University Hospitals £2m
Scotland	Charges to cease with effect from 31/12/ 2008 except at PFI Hospitals
Wales	Charges only applicable at Hospitals where Car Parks are being run by the Private Sector
Northern Ireland	Free for cancer, dialysis patients and relatives of critically ill patients

Prior to the Policy outlined above, NHSScotland had commissioned a review of hospital car parking charges that reported in November 2007.

This recommended reduced parking charges for patients considered to be on low income, e.g.:

- Patients in receipt of benefits or credits that are income related or are in receipt of a valid NHS tax credit exemption certificate or named on a valid HC2 certificate.
- Are between 16 and 19 and are counted as dependent on someone classified as having a low income.
- Are the next of kin or parent or guardian of an in-patient in a long stay, high dependency or intensive care unit.
- Exceptionally at clinical discretion.

Free parking to be considered where:

- A patient or visitor is visiting a hospital very frequently eg patients undergoing renal dialysis, radiotherapy, chemotherapy.
- A patient requires to park for long periods or all day.
- Individuals are attending in a volunteer capacity for example as a blood donor or as a volunteer driver.

Prescription Charges

Reference: BBC Health Website "A four way split on the NHS" 4 July 2008
<http://news.bbc.co.uk/1/hi/health/7457357.stm>

There are now significant variations in the charging policy for prescriptions for those that are not exempt from charges.

Country	Prescription charges	Prescription items per person dispensed 2006
England	£7.10 per item	15.1 (SE 13.8) (NE & NW 17.8)
Scotland	£5 from April 2008 No charge from 2011/12	15.4
Wales	No charge since 2007	19.9
Northern Ireland	£3 from January 2009 and free of charge by April 2010	16.8

"Prescription Charges in Northern Ireland: A cost and benefit review December 2007" reviewed literature on the relationship between prescription cost and access to medicine. The findings suggested that:

- Whenever patients make some financial contribution towards the cost of their medicines, the demand for prescription drugs is reduced. There is some evidence that as the charge increases that there is decreased utilisation of medicines.
- Compliance with medication is a complex factor and cost is only one factor which may influence a patient's decision to have their prescription dispensed.
- Although there is no evidence of a direct link between prescription charges and ill-health there is evidence that poor compliance with prescribed medication can lead to increased resource utilisation in health services e.g. hospital admissions.
- The search found that individuals with chronic illness, poor health status, poor educational status, low incomes, high social need have been found to be particularly affected by the cost of medication.
- Children, students and the elderly are more likely to decide not to have their medication dispensed as a result of cost.
- Patients for whom cost was not identified as a barrier were generally healthy, of higher income or the charge studied was lower than the UK charge.
- Patients have been shown to modify their behaviour by choosing not to have their prescription dispensed, substitute their medication for an over the counter alternative that is cheaper or to alter the dose.
- In the UK there are significant exemptions from prescription charging. The exemption categories can be grouped as age related, Income or benefit related, for specified medical conditions, maternity certificates and contraceptives. There are also pre-payment certificates that cap a patient's expenditure on prescription items.

The cost assessed in Northern Ireland of abolishing prescription charges is between £13.1m to £24m depending on the subsequent level of increased prescribing as a consequence of abolition.

Expenditure on health and social care in the four UK countries

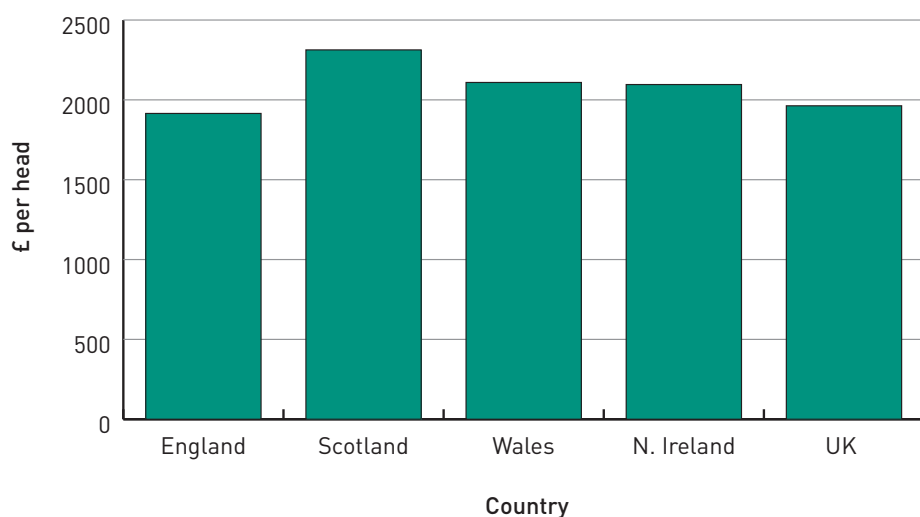
Summary

Expenditure on Health per capita within England for 2007/08 was lower than for Wales and Northern Ireland, and significantly lower than for Scotland.

[When reviewing costs in health it is important also to consider these in relation to the health needs of each population and those factors that will have an influence on cost such as providing services to populations in remote and sparsely populated areas].

Expenditure on health and personal social services 2006-07

(Source: United Kingdom Health Statistics No 3 2008)

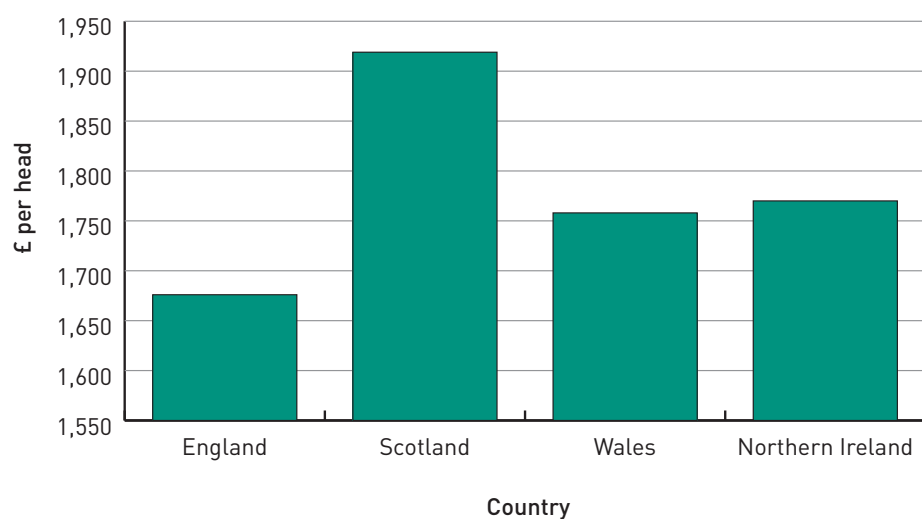


Country	£m	£ per head	% expenditure	% of population	Population Mid-2006 estimates
England	97,196	1915	81.7	83.8	50,762.9
Scotland	11,834	2313	9.9	8.4	5,116.9
Wales	6,254	2109	5.3	4.9	2,965.9
Northern Ireland	3,651	2096	3.1	2.9	1,741.6
UK total	118,935	1963	100.0	100.0	60,587.3

Expenditure on health 2007-8

Source: BBC Health Website "A four way split on the NHS" 4 July 2008

<http://news.bbc.co.uk/1/hi/health/7457357.stm>



Country	£ per head	Population
England	1,676	50,762.9
Scotland	1,919	5,116.9
Wales	1,758	2,965.9
Northern Ireland	1,770	1,741.6

Scotland, Wales and Northern Ireland receive public expenditure allocations via "The Barnett Formula". Although a detailed review of this is outside of the scope of this paper, details of the Barnett Formula are included at Annex B.

Health indicators and outcomes

A data bank of health indicators has been included in this report to give an appreciation of the health profile of individual countries across the UK and the subsequent challenges being faced by each.

Summary

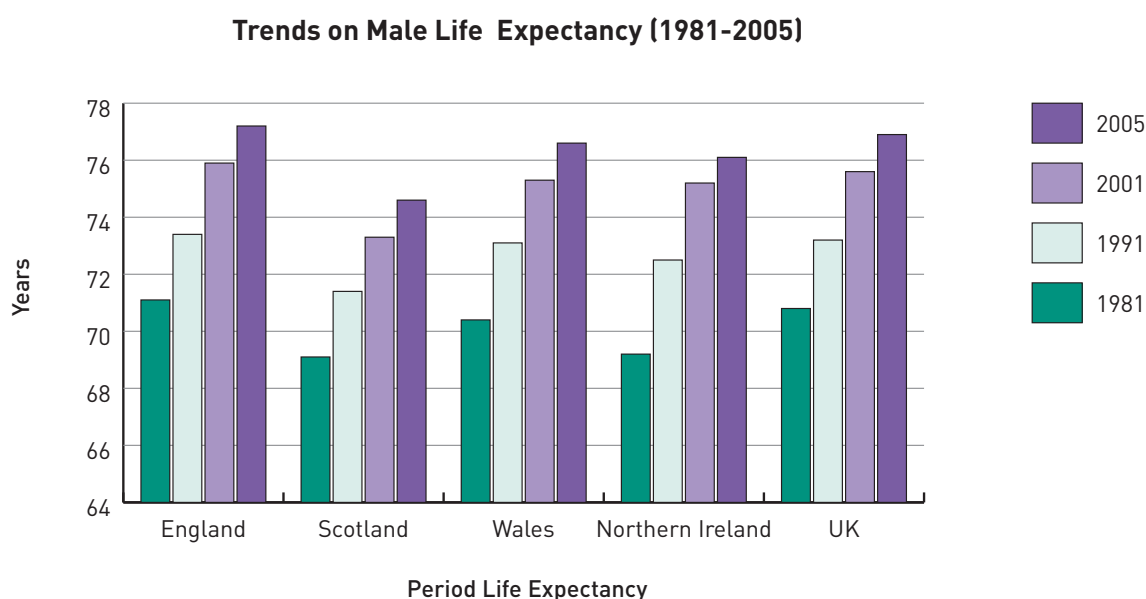
- Fig 1 England has the longest period life expectancy for males
- Fig 2 England has the longest period life expectancy for females
- Fig 3 England has the better period life expectancy at specified ages for males
- Fig 4 England has the better period life expectancy at specified ages for females
- Fig 5 Compares life expectancy for Kensington and Chelsea with Glasgow
- Fig 6 Shows Scotland has the highest incidence per capita for premature death from cancer (all types)
- Fig 7 Shows Scotland has the highest incidence per capita of death from lung cancer
- Fig 8 Shows that Wales has the highest incidence per capita of death from coronary heart disease
- Fig 9 Shows that Scotland has the highest incidence per capita of death from stroke
- Fig 10 Shows that Scotland has the highest incidence per capita of death from drug poisoning
- Fig 11 Shows that Scotland has the highest incidence per capita of death from alcohol-related conditions
- Fig 12 Shows that Scotland has the lowest average GP list size
- Fig 13 Shows a distribution of hospital and community staffing in the UK
- Fig 14 Shows that Scotland has a higher number of available beds per population, a lower number of admissions per bed and a higher average length of stay
- Fig 15 Shows that England has a current target for the lowest waiting times
- Fig 16 Shows as at the 31 March 2008 a lower overall waiting list for England
- Fig 17 Shows a rapid decline in waiting lists from 1996/67 for all countries but particularly for England

Variations in UK Health Indicators including Life Expectancy, Health Service Inputs & performance outputs across the UK

Figure 1

Trends in life expectancy for males at birth for selected years

(Source: United Kingdom Health Statistics No 3 2008)



Country	Period Life Expectancy 1981	Period Life Expectancy 1991	Period Life Expectancy 2001	Period Life Expectancy 2005	+/-UK 2005
England	71.1	73.4	75.9	77.2	+0.3
Scotland	69.1	71.4	73.3	74.6	- 2.3
Wales	70.4	73.1	75.3	76.6	- 0.3
Northern Ireland	69.2	72.5	75.2	76.1	- 0.8
UK	70.8	73.2	75.6	76.9	-

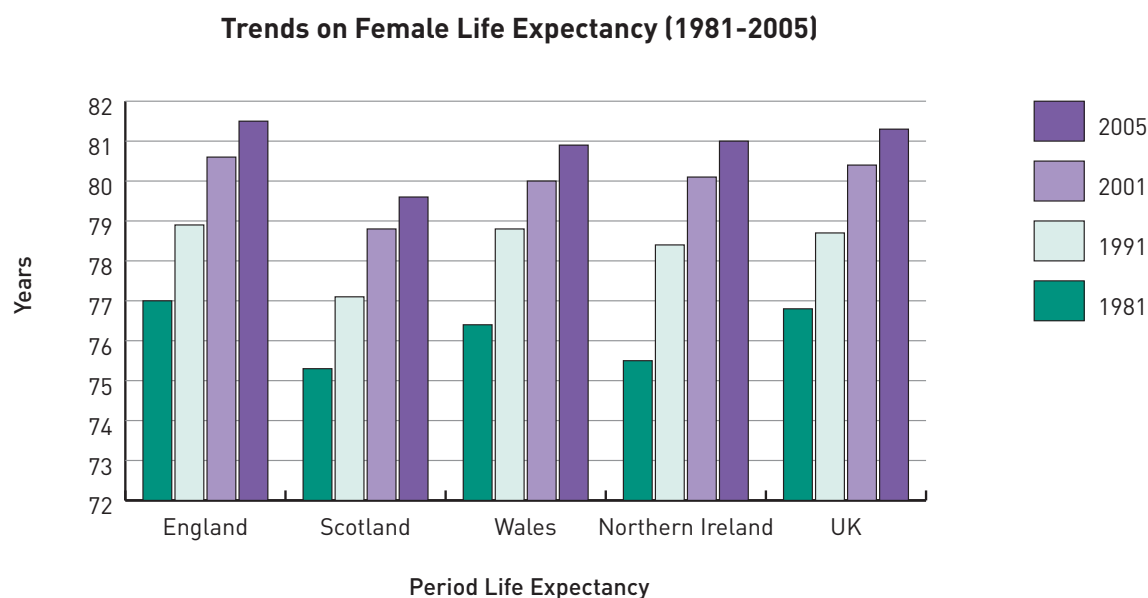
The trends reflect an estimate of the average life expectancy at birth and reflect mortality among those living in the area at the time of death rather than those born in the area.

The Office for National statistics published updated statistics in October 2008 that showed period life expectancy for males born between 2005 and 2007 had risen to 77.5 years, 74.8 years, 76.7 years, 76.2 years and 77.2 years for England, Scotland, Wales, Northern Ireland and the UK respectively.

Figure 2

Trends in life expectancy for females at birth for selected years

(Source: United Kingdom Health Statistics No 3 2008)



Country	Period Life Expectancy 1981	Period Life Expectancy 1991	Period Life Expectancy 2001	Period Life Expectancy 2005	+/- UK 2005
England	77.0	78.9	80.6	81.5	+ 0.2
Scotland	75.3	77.1	78.8	79.6	- 1.7
Wales	76.4	78.8	80.0	80.9	- 0.4
Northern Ireland	75.5	78.4	80.1	81.0	- 0.3
UK	76.8	78.7	80.4	81.3	-

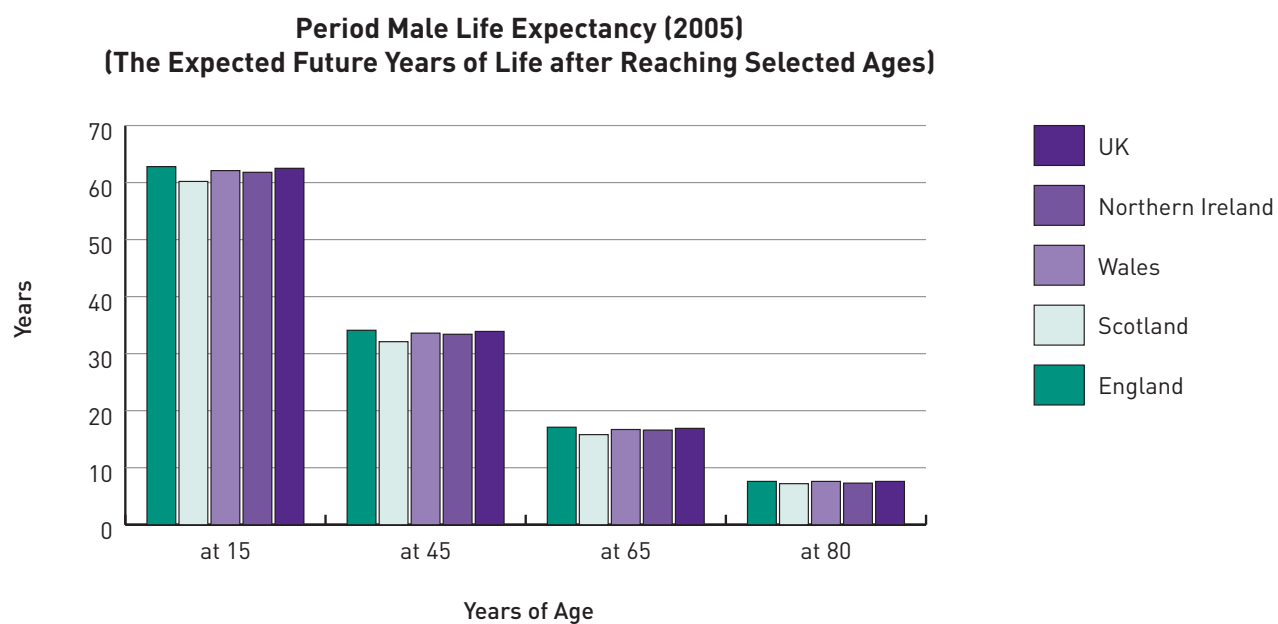
The trends reflect an estimate of the average life expectancy at birth and reflect mortality among those living in the area at the time of death rather than those born in the area.

The Office for National statistics published updated statistics in October 2008 that showed period life expectancy for females born between 2005 and 2007 had risen to 81.7 years, 79.7 years, 81.1 years, 81.2 years and 81.5 years for England, Scotland, Wales, Northern Ireland and the UK respectively.

Figure 3

Period life expectancy for males at specific ages 2005

(Source: United Kingdom Health Statistics No 3 2008)

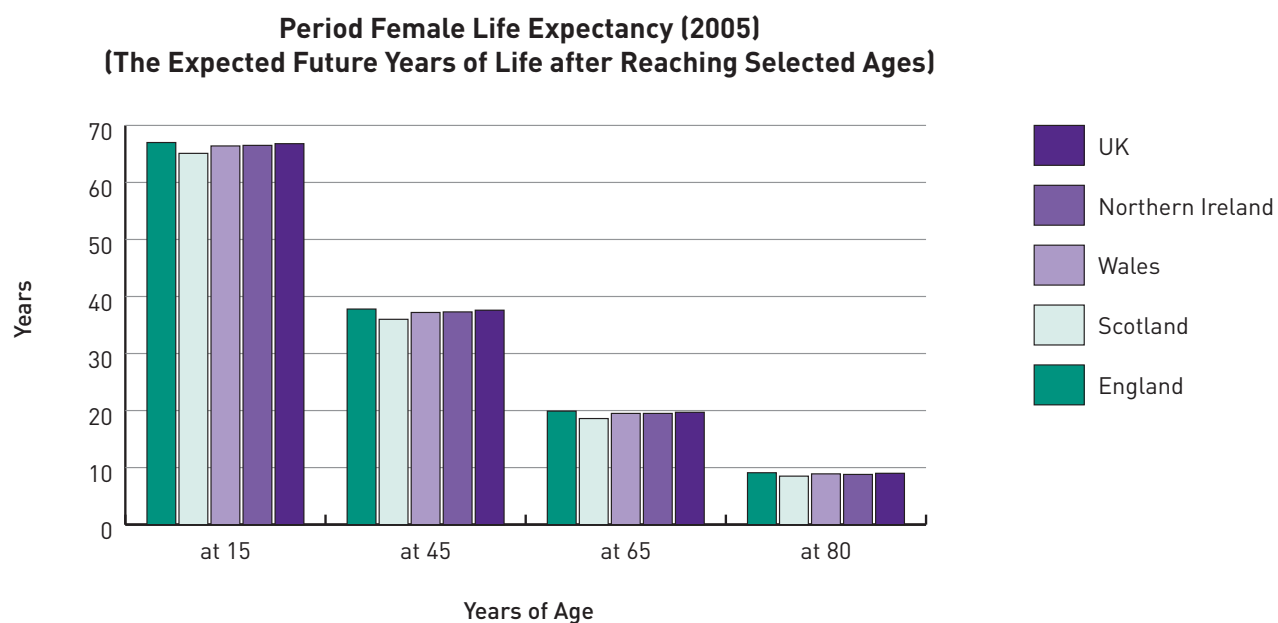


Country	Period Life Expectancy at 15	Period Life Expectancy at 45	Period Life Expectancy at 65	Period Life Expectancy at 80	+/- UK 2005 (At 15)
England	62.8 (77.8)	34.1 (79.1)	17.1 (82.1)	7.6 (87.6)	+ 0.3
Scotland	60.2 (75.2)	32.1 (77.1)	15.8 (80.8)	7.2 (87.2)	- 2.3
Wales	62.1 (77.1)	33.6 (78.6)	16.7 (81.7)	7.6 (87.6)	- 0.4
Northern Ireland	61.8 (76.8)	33.4 (78.4)	16.6 (81.6)	7.3 (87.3)	- 0.7
UK	62.5 (77.5)	33.9 (78.9)	16.9 (81.9)	7.6 (87.6)	-

Figure 4

Period life expectancy for females at specific ages 2005

(Source: United Kingdom Health Statistics No 3 2008)



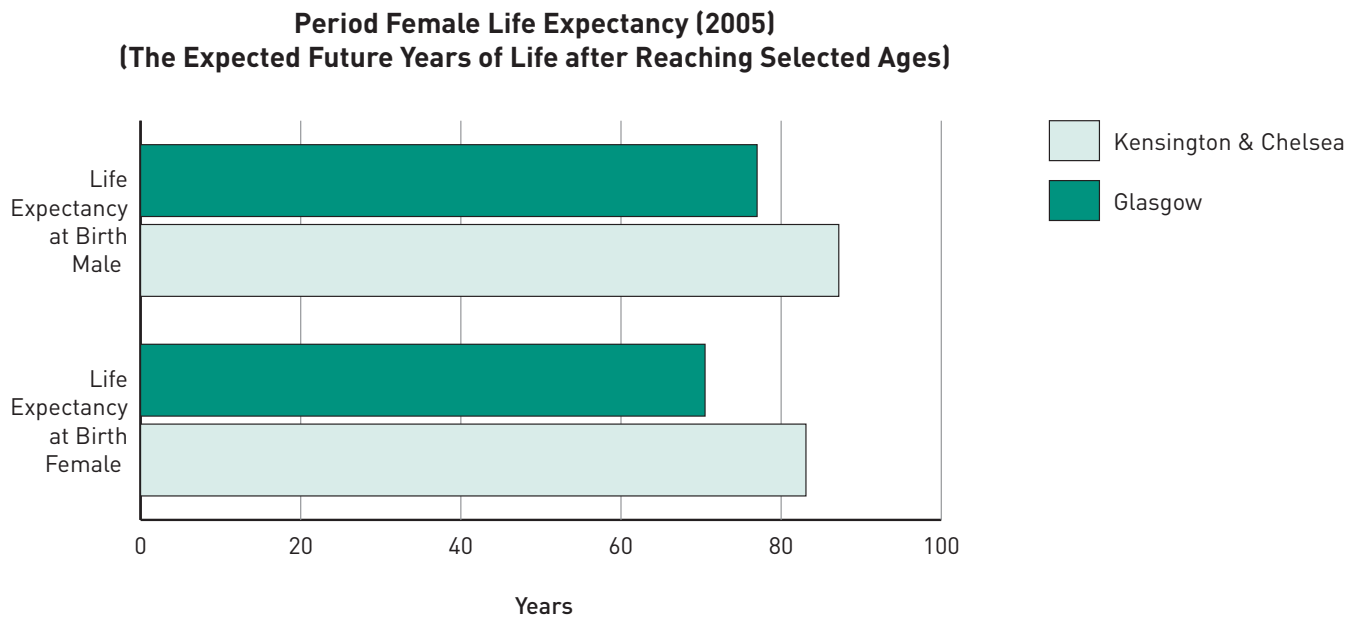
Country	Period Life Expectancy at 15	Period Life Expectancy at 45	Period Life Expectancy at 65	Period Life Expectancy at 80	+/- UK 2005 (At 15)
England	67.0 (82.0)	37.8 (82.8)	19.9 (84.9)	9.1 (89.1)	+ 0.2
Scotland	65.1 (80.1)	36.0 (81.0)	18.6 (83.6)	8.5 (85.5)	- 1.7
Wales	66.4 (81.4)	37.2 (82.2)	19.5 (84.5)	8.9 (88.9)	- 0.4
Northern Ireland	66.5 (81.5)	37.3 (82.3)	19.5 (84.5)	8.8 (88.8)	- 0.3
UK	66.8 (81.8)	37.6 (82.6)	19.7 (84.7)	9.0 (89.0)	-

Figure 5

Highest and lowest life expectancy at birth in the UK (ONS 2004-6)

(Source: BBC Health Website "How UK nations provide their NHS" 4 July 2008)

<http://news.bbc.co.uk/1/hi/health/7486044.stm>



The figures for Glasgow reflect an aggregate covering wards of high socio-economic families and wards classed with multiple deprivation. The difference in life expectancy between these wards can be as high as 30 years.

Area	Life expectancy at birth male	Life expectancy at birth female	Variance female v male (Years)	Variance female v male years (%)
Glasgow	70.5	77.0	6.5	9.2
Kensington & Chelsea	83.1	87.2	4.1	4.9
Variance (yrs)	12.6	10.2	-	-
Variance(%)	17.9	13.2	-	-

Principal killers - all age deaths

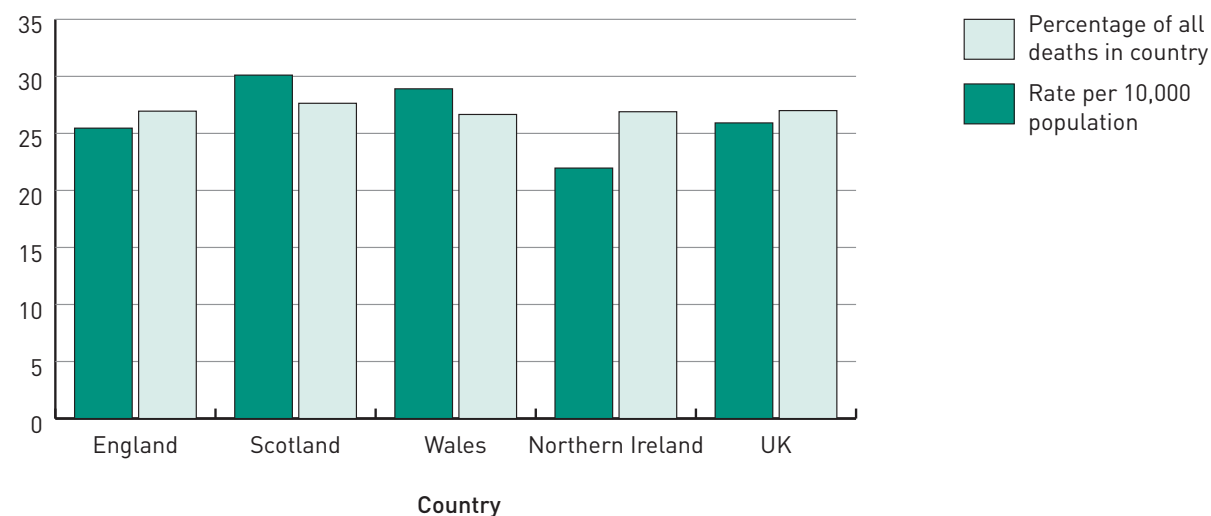
[Source: *Regional and Social differences in Coronary Heart Disease 2008*, British Heart Foundation, Scarborough P, et al]

Country	All age deaths 2005
England	479,678
Scotland	55,747
Wales	32,162
Northern Ireland	14,224
UK	581,811

Figure 6

Cancer all age deaths 2005 (ICD codes C00-D48)

[Source: *Regional and Social Differences in Coronary Heart Disease 2008*, British Heart Foundation, Scarborough P, et al]

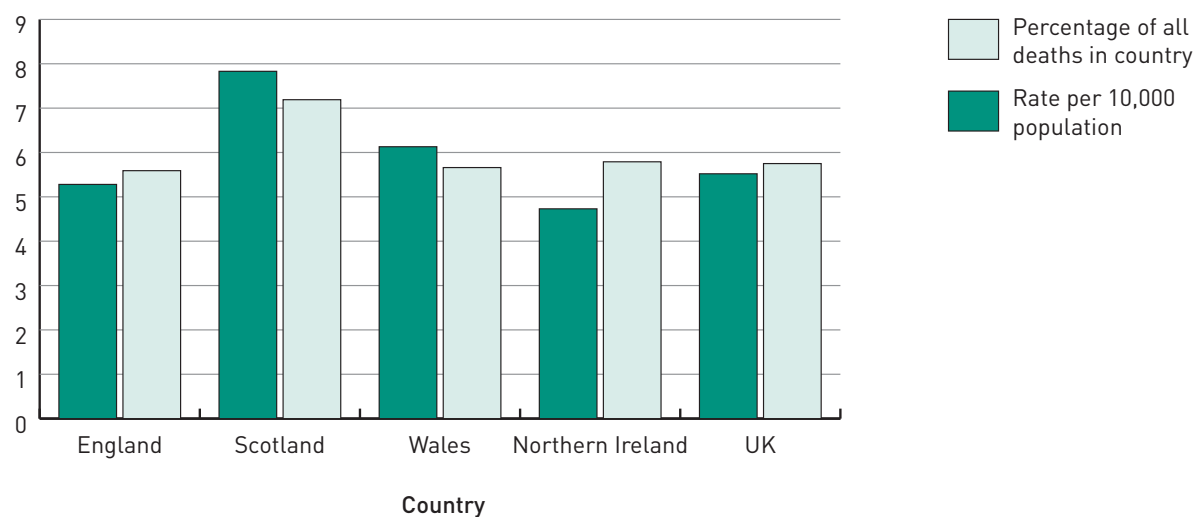


Country	Male	Female	Total	ONS mid-2006 pop. estimates	Rate per 10,000 population	Percentage of all deaths in country
England	67,196	62,057	129,253	50,762.9	25.46	26.95
Scotland	7,782	7,626	15,408	5,116.9	30.11	27.64
Wales	4,389	4,186	8,575	2,965.9	28.91	26.66
Northern Ireland	1,946	1,880	3,826	1,741.6	21.96	26.90
UK	81,313	75,749	157,062	60,587.3	25.92	27.00

Figure 7

Lung cancer all age deaths 2005 (ICD codes C33, C34)

(Source: *Regional and Social differences in Coronary Heart Disease 2008*, British Heart Foundation, Scarborough P, et al)

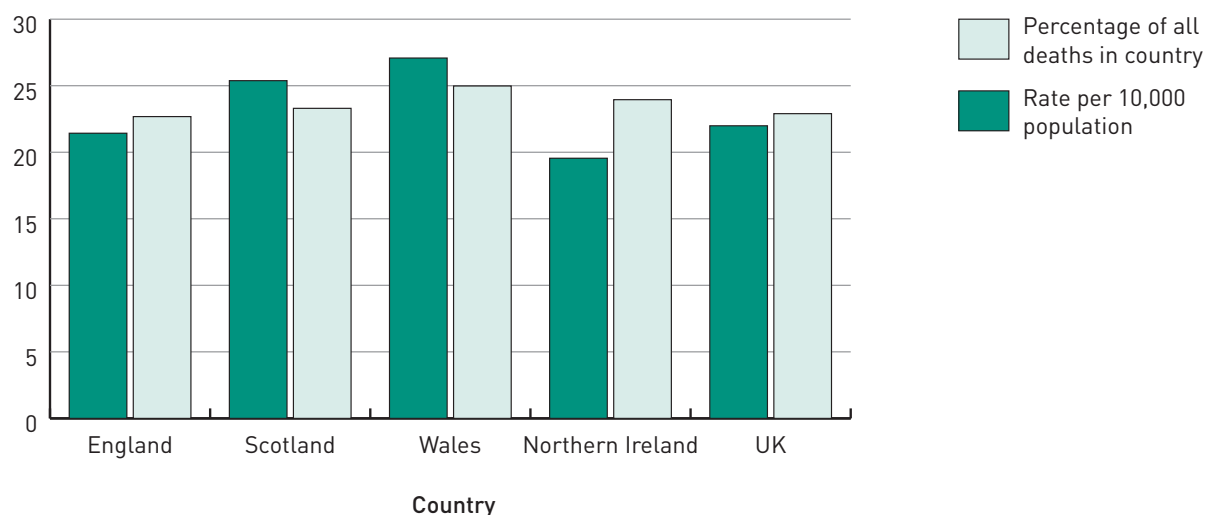


Country	Male	Female	Total	ONS mid-2006 population estimates	Rate per 10,000 population	Percentage of all deaths
England	15,692	11,119	26,811	50,762.9	5.28	5.59
Scotland	2,195	1,814	4,009	5,116.9	7.83	7.19
Wales	1,065	756	1,821	2,965.9	6.13	5.66
Northern Ireland	505	319	824	1,741.6	4.73	5.79
UK	19,457	14,008	33,465	60,587.3	5.52	5.75

Figure 8

Coronary heart disease all age deaths 2005 (ICD codes I00 –I52)

(Source: *Regional and Social differences in Coronary Heart Disease 2008*, British Heart Foundation, Scarborough P, et al)

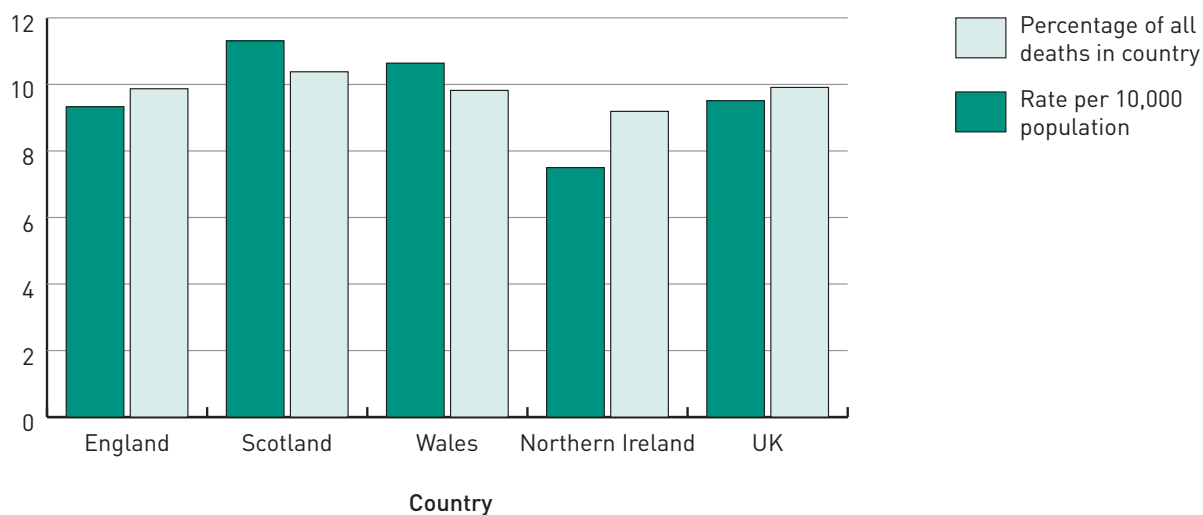


Country	Male	Female	Total	ONS mid-2006 pop. estimates	Rate per 10,000 population	Percentage of all deaths
England	56,554	52,259	108,813	50762.9	21.43	22.68
Scotland	6,655	6,335	12,990	5116.9	25.38	23.30
Wales	4,090	3,943	8,033	2965.9	27.08	24.98
Northern Ireland	1,781	1625	3,406	1741.6	19.55	23.95
UK	69,080	64,162	133,242	60587.3	21.99	22.90

Figure 9

Stroke all age deaths 2005 (ICD I60 –I69)

(Source: *Regional and Social differences in Coronary Heart Disease 2008*, British Heart Foundation, Scarborough P, et al)

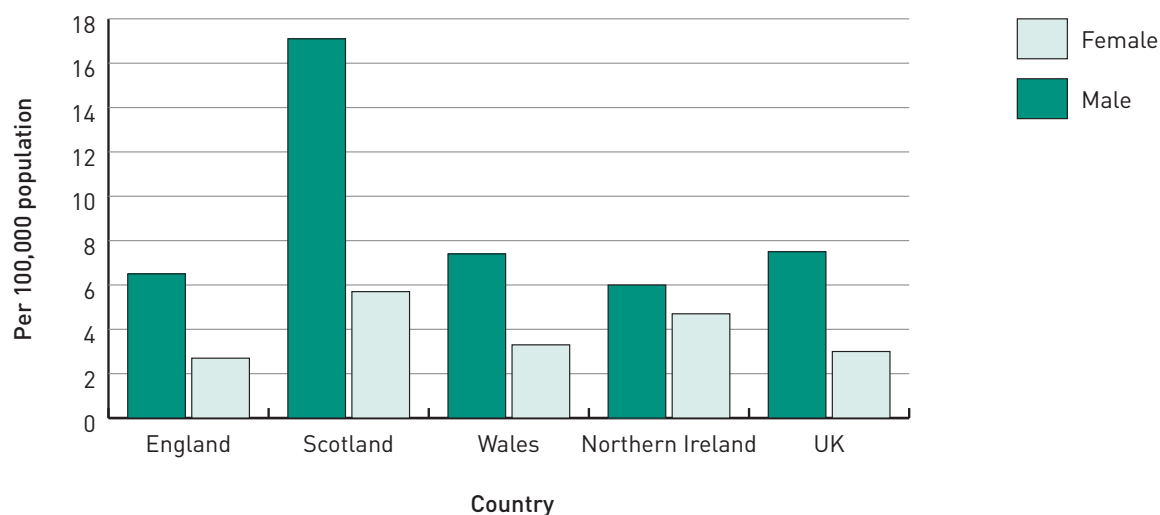


Country	Male	Female	Total	ONS mid-2006 population estimates	Rate per 10,000 population	Percentage of all deaths
England	18013	29379	47392	50762.9	9.33	9.87
Scotland	2134	3655	5789	5116.9	11.31	10.38
Wales	1215	1943	3158	2965.9	10.64	9.82
Northern Ireland	499	808	1307	1741.6	7.50	9.19
UK	21,861	35,785	57,646	60587.3	9.51	9.91

Figure 10

Deaths relating to drug poisoning 2006

(Source: United Kingdom Health Statistics No 3 2008)



Deaths from drug poisoning

(per 100,000 population)

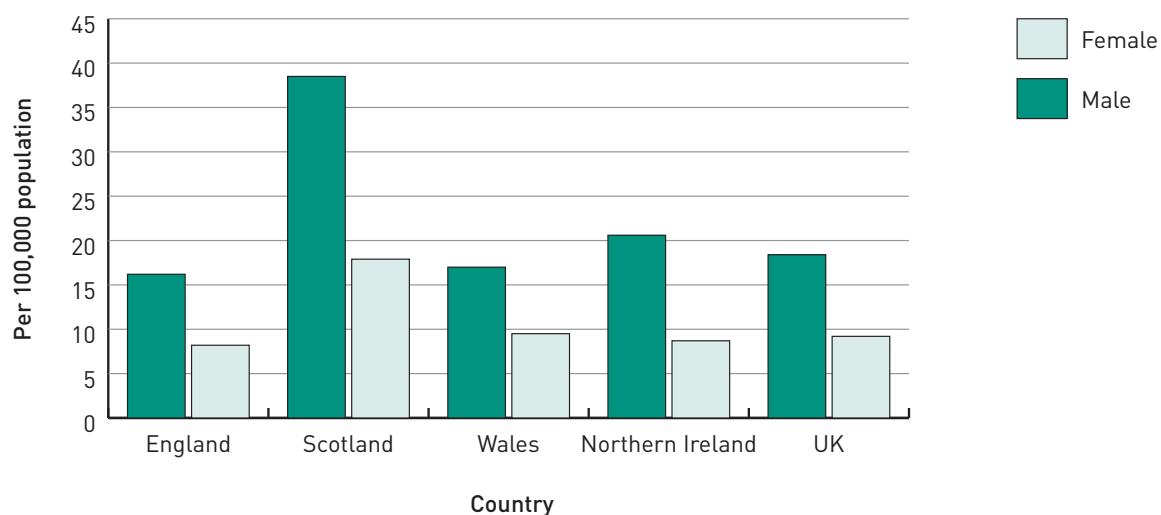
Country	Male	Female
England	6.5 6.6*	2.7
Scotland	17.1	5.7
Wales	7.4	3.3
Northern Ireland	6.0	4.7
UK	7.5	3.0

* residents and non-residents for direct comparison with Scotland & Wales

Figure 11

Alcohol related deaths 2006 – death rates per 100,000 population

(Source: United Kingdom Health Statistics No 3 2008)



Deaths from alcohol

(per 100,000 population)

Country	Male	Female
England	16.2 16.3*	8.2 8.3*
Scotland	38.5	17.9
Wales	17.0	9.5
Northern Ireland	20.6	8.7
UK	18.4	9.2

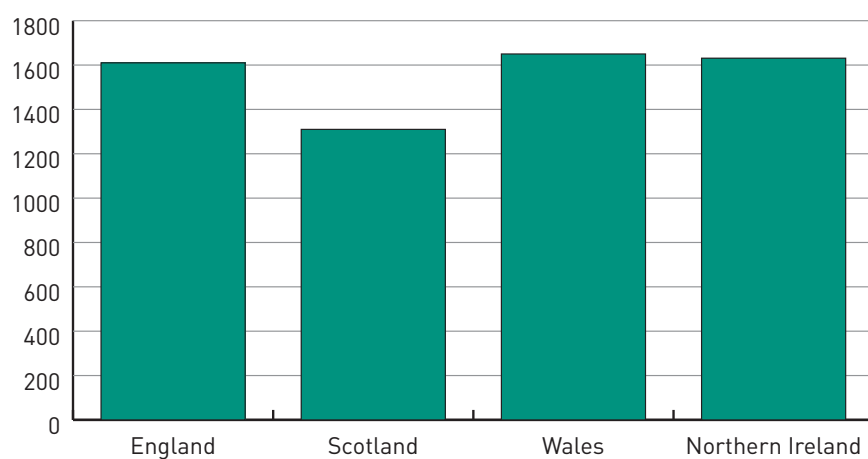
* residents and non-residents for direct comparison with Scotland & Wales

Figure 12

General practitioner comparisons as at 30 September 2006

(Source: United Kingdom Health Statistics No 3 2008)

Average List Size Per GP (September 2006)



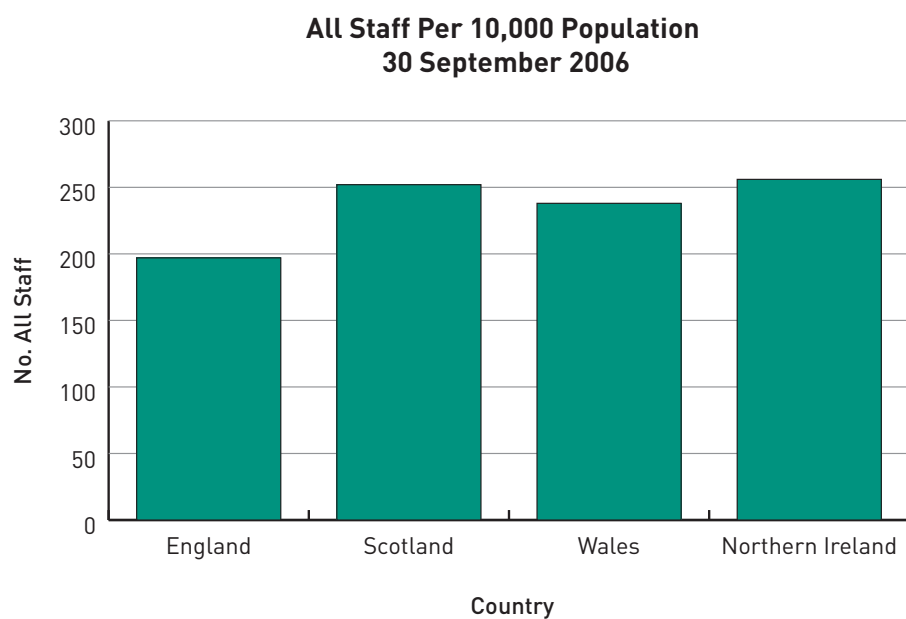
Country	Numbers of practices	Numbers of GPs	Average list size per GP
England	8,325	33,091	1,610
Scotland	1,032	4,132	1,310
Wales	496	1,882	1,650
Northern Ireland	363	1,110	1,631
UK	10,216	40,215	-

Note: GP list sizes higher than ONS resident population estimates

Figure 13

NHS Hospital and Community Health Service staff as at 30 September 2006

(Source: United Kingdom Health Statistics No 3 2008)

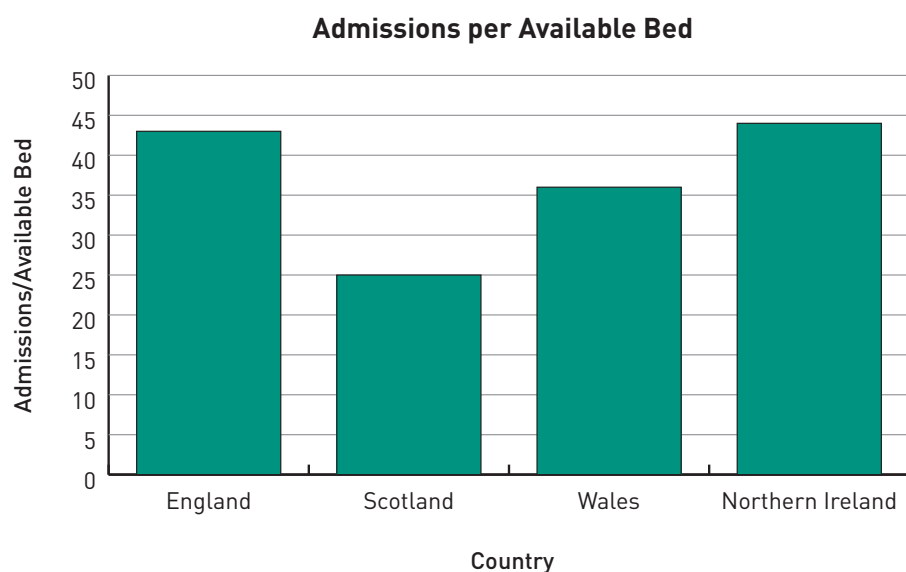


Country	Medical & Dental % (000s)		Nursing Midwifery & HV % (000s)		All Staff (000s)	All Staff per 10K population
England	9	89.9	32	319.9	999.6	197
Scotland	10	12.9	44	56.7	128.8	252
Wales	8	5.6	40	28.2	70.6	238
Northern Ireland	8	3.6	30	13.4	44.6	256

Figure 14

Hospital inpatient and day case activity 2005/6

(Source: United Kingdom Health Statistics No 3 2008)



Country	Average daily available beds	Admissions per available bed	Admissions per 1,000 population	Average length of stay (Days)	Day cases (000s)
England	3.8	43	160	6.8	4,113
Scotland	5.4	25	135	7.4	379
Wales	4.7	36	170	6.9	111
Northern Ireland	4.7	44	205	5.6	159

Figure 15

Inpatient/day case waiting time targets

(Source: UK Health Departments)

Country	Policy
England	18 Weeks by the end of 2008
Scotland	18 Weeks by the end of 2011, with a new Patients' Rights Bill consultation September 2008 recommending a maximum wait of 12 weeks (within the 18-week overall journey) for inpatient and day case treatment, once this has been agreed between the patient & clinician.
Wales	26 Weeks by the end of 2009
Northern Ireland	13 Weeks by March 2009

Figure 16

Waiting list performance 2007/08 by country and region

(Source: www.performance.doh.gov.uk)

Region	Population (000's)	Numbers Waiting at 31 March 2008	% Waiting
North East	2,555.7	25,977	1.02
North West	6,853.2	78,582	1.15
Yorkshire & Humber	5,142.4	52,226	1.02
East Midlands	4,364.2	42,396	0.97
West Midlands	5,366.7	52,860	0.98
East of England	5,606.6	64,817	1.16
London	7,512.4	73,629	0.98
South East Coast	4,248.3	42,997	1.01
South Central	3,989.5	36,559	0.92
South West	5,124.1	56,180	1.10
England Total	50,763.1	526,223	1.04
Scotland	5,116.9	62,489	1.22
Wales	2,965.9	50,631	1.71
Northern Ireland	1,741.6	36,664	2.11
UK Total	60,587.3	676,007	1.12

Figure 17

Waiting list trend

[Source: *Information in Practice: Effect of diverging policy across the NHS*, Arturo Alvarez-Rosete et al. BMJ October 2005]

Country	% Population Waiting 1996/97	% Population Waiting 2002/03	% Population Waiting 2007/08
England	2.3	1.9	1.0
Scotland	n/a	n/a	1.2
Wales	2.2	2.5	1.7
Northern Ireland	2.7	3.3	2.1

Free nursing and personal care in Scotland

The policy to provide personal and nursing care in Scotland free at the point of delivery and assessed according to need was based on the Royal Commission report “with respect to old age” published on the 1 March 1999.

The subsequent act that passed through the Scottish Parliament in 2002 was implemented in July 2002.

The act effected three main changes that are shown below:

- People aged 65+ can no longer be charged for personal care provided in their own home (charges for domestic services are means tested)
- People aged 65+ who live in care homes as self funders receive £149pw and £67pw (from April 2008) if required towards personal and nursing care respectively, hotel costs are not funded
- People under 65 can also receive £65 towards nursing care

One of the results of this change in policy has been the withdrawal of UK funded attendance allowance from Scottish people in receipt of free personal care in residential settings by the Department of Work and Pensions (DWP). A saving assessed at £30m pa retained by the DWP.

A report by Lord Sutherland “Independent Review of Free Personal and Nursing Care in Scotland” was published in April 2008 covering the first five years of the operation of the new policy.

The report looked to address a number of points including financing, consistency of provision between local authorities, the use of waiting lists and differing eligibility criteria, food preparation, legal matters and the uplifting of residential care allowances.

It determined that the sustainability of the policy was dependent on accurately forecasting the future costs of long-term care and that:

- The cost of introducing this policy was originally assessed by the Care Development Group based on the best information available
- Estimates put the extra cost at:
 - £125m in 2002
 - £137m in 2007
 - £227m in 2022
- These estimates were updated to reflect the loss of attendance allowance and Central Government support for the additional costs of free personal and nursing care resulting in
 - £107m for 2002/03 (9 months) rising to
 - £169m for 2007/08

The report makes a number of short-term recommendations to stabilise difficulties in funding assessed at £40m, and further medium and longer term recommendations. These are summarised below:

Short term

- A current funding gap should be addressed by the Scottish Government; this has been assessed at approximately £40m per annum
- Allowances for residential & nursing care should be up-rated annually in line with inflation (from 1/4/2008 new rates of £149 & £67 for personal and nursing care apply respectively)
- There should be a standardisation of assessment for personal and nursing care, in addition standardisation of processes, waiting times and delivery of services
- There should be clear national priorities and outcomes for older people
- Costs should be adequately monitored and reported by improving information flows
- A performance framework should be introduced to improve local accountability
- There should be a reinstatement of the £30m a year attendance allowance
- Efforts should be renewed to improve public information and understanding of the policy
- There should be greater consistency in interpretation and application of ordinary residence legislation

Medium term within the next five years

- Demand for free personal & nursing care to be reviewed and re-modelled regularly and the implications built into local government finance settlements and capacity planning
- All sources of finance to be reviewed for the long-term care of the elderly, including health, social care housing and attendance and disability allowance

Longer term

- A new longer term vision to be established for dealing with the challenge of greater numbers of elderly people

ANNEX B

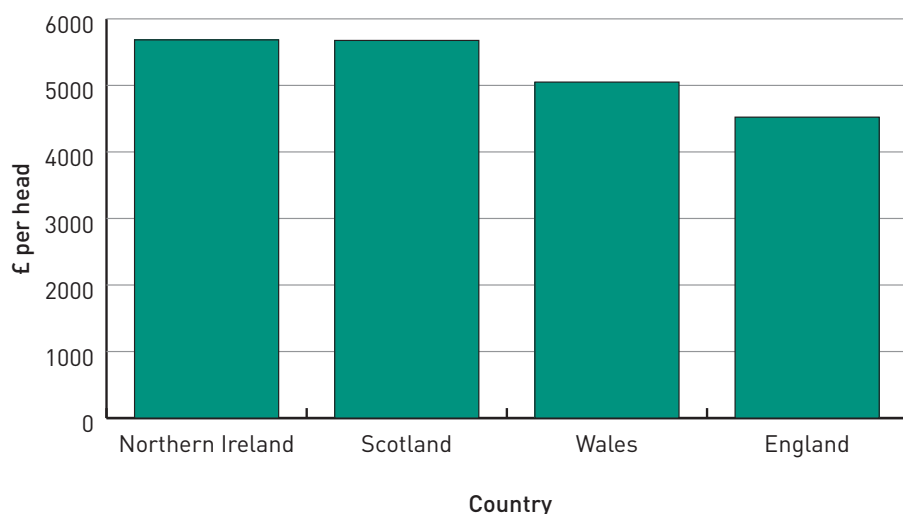
The Barnett Formula

Resource allocations to Scotland – does it receive its fair share?

Source: "Fair Shares? Barnett and the Politics of Public Expenditure"

(Institute of Public Policy Research, London 2008)

Public Expenditure Comparison Across the UK 2007-08



Northern Ireland	£5,684 per head	126% of England
Scotland	£5,676 per head	125% of England
Wales	£5,050 per Head	111% of England
England	£4,523 per Head	100%

There has been considerable interest in how resources are distributed by Westminster to the devolved administrations of Scotland, Wales and Northern Ireland.

Resource allocation in the UK is based on the Barnett Formula. Lord Barnett was the Labour Chief Secretary to the Treasury; he drew up a system for the division of public spending in 1978 to allow for Scotland's larger physical area, lower average incomes and its particular acute needs in health care and housing.

The principles of the Barnett Formula are:

- A block allocation to the devolved administrations based on historic spending patterns and population.
- In relation to Scotland it receives 12% of total public spending.
- For every incremental £1 the Government distributes approximately 82p goes to England, 10p to Scotland and 5p to Wales & 3p to Northern Ireland.

One of the current anomalies within the Barnett Formula is Capital Schemes where for example the London' Crossrail project of £16bn will trigger an automatic payment of £1bn to Edinburgh. Other projects such as regeneration funding for the Olympics create uncertainty as to whether they should be subject to the formula.

The perceived benefits being seen by the Scottish Population are reported regularly.

Policy Area	England	Scotland
Prescription charges	£7.10 per item (£6.85 in original article)	From April 2008 £5 charging to be phased out from 2011
Eye tests	£18.85	Free
Dental check-up	£15.90	Free
Elderly care	With assets over £22,250 (£20,500 in Original Article) all care costs to be paid	Free Personal Care

References: *Daily Mail* 22 October 2007 and 15 November 2007

Detailed consideration of the Barnett Formula is outside the scope of this work. However, The Institute for Public Policy Research has outlined several options for reducing the perceived disparity, including a needs-based equalisation system, moving to full fiscal autonomy (linking public expenditure with a responsibility for raising income) and a further preferred hybrid model.

Healthcare Commission report of the 19 July 2007 reviewing care provision within independent sector treatment centres in England

A Healthcare Commission report of 19 July 2007 reviewed care provision in 23 Independent Sector Treatment Centres (ISTCs) in England. The main findings are shown below.

The report offered reassurance about the quality of services provided in ISTCs and that patients surveyed rated services highly.

However, it said that there are still gaps in the data to consistently compare the quality of care in ISTCs with that of the NHS.

The report specifically highlights the following points:

- As far as the quality of ISTC data allows, we looked at a range of indicators for most of the procedures, including the rates of emergency readmission to hospital within 30 days of discharge, which were lower in ISTCs than the national average in the NHS. This is in keeping with their mix of patients, which excludes those with the most complex needs. All emergency readmissions are referred to the NHS.
- While patients in both ISTCs and the NHS tend to rate experiences positively, the Commission's survey found patients in ISTCs were generally even more positive about their care than those in the NHS. Ninety-six percent of the patients surveyed rated their overall care as "excellent" or "very good".
- Of the 33 issues explored in the patient survey, patients assessed ISTCs consistently better than the NHS on 28 of them. Looking at the areas with the most difference:
 - 98% of those surveyed said the toilets and bathrooms were "very clean" or "fairly clean" in ISTCs, compared to 92% in the NHS
 - 65% of those surveyed said they were given a choice of admission date in ISTCs compared to 27% in the NHS
 - 96% of those surveyed said they were told who to contact if they were worried about their treatment in ISTCs compared to 76% in the NHS
 - 98% of those surveyed said that there were enough nurses on the wards in ISTCs compared to 92% in the NHS
- Overall the views of the experienced NHS consultants who accompanied the review team on visits were positive. Most were impressed with the facilities they visited and reported that procedures in the centres broadly matched those of the NHS. Observations during surgery indicated that clinical practice was of a good quality.
- In the course of its own inspections, the Commission found some evidence that the standard of care in ISTCs had on occasion fallen short of expected standards. For example, as a result of inspections under the Care Standards Act, one centre was required to improve its procedures for checking and counting swabs and needles used during ophthalmic surgery and for minimising the risk of cross-contamination during surgery. Another was required to keep clearer records of equipment and to cut the risks of contamination during endoscopies. In both cases, the provider complied quickly.

ANNEX D

Health policy enablers in England

A number of key policy initiatives have been introduced by the Department of Health, these are:

Foundation Trusts (FT)
Payment by Results (PbR)
Practice Based Commissioning (PbC)
Patient Choice

Foundation Trusts

NHS Foundation Trusts (FTs) were introduced in England by the Health and Social Care (Community Health and Standards) Act 2003.

Foundation Trusts differ from NHS Trusts in the following respects

- FTs are not subject to Department of Health control.
- FTs are accountable to local residents who are invited to become members and governors.
- Initial Authorisation and FT regulation is carried out by Independent Regulator Monitor, who has powers to intervene if an FT does not comply with its Terms of Authorisation.
- Any change in use of scheduled or protected assets must be sanctioned by Monitor.
- FTs have a Private Patient Cap, whereby to benefit NHS patients the amount collectable from Private Patients as a % is capped to the % of the preceding NHS Trust.
- FTs have different financial duties, they are not subject to a statutory break even duty and there is no requirement to remain within an external financing limit.
- FTs are able to borrow commercially to support their Investment strategy within Monitor's guidance, retain surpluses (net surplus £514m for 2007/08) and invest to meet local needs.

Payment by Results (PbR)

Payment by results was introduced in 2003/04 as a single-rules-based approach to paying for acute and specialist NHS hospital services.

Before PbR NHS Trusts relied on locally negotiated block contracts that had lacked transparency. PbR creates a definitive link between the activity undertaken, the complexity of that activity and payment.

The policy aims being to:

- Enable faster access to more appropriate, patient responsive services.
- Drive efficiency.
- Ensure a fairness and transparency of funding.

This policy is a central enabler to facilitate the other central policies of FTs, Practice Based Commissioning and Patient Choice.

The policy has relied on robust costing returns and has been subject recently to a major consultation on how to improve a system that is not easily applicable to community or primary care services or long term conditions.

Practice Based commissioning (PbC)

What is Practice Based Commissioning (PbC) and what are the intended benefits?

- PbC is about engaging practices and other primary care professionals in the commissioning of services. Through PbC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions.
- Under PbC, practices receive information on how their patients use health services. This information can be used for the redesign of services by front line clinicians for the benefit of patients.

The benefits of PbC have been outlined by the Department of Health as:

- Better clinical engagement: PbC gives Practices and Primary Care Professionals the freedom to develop innovative, high-quality services for their patients. Using information on current health service usage, primary care professionals can understand how resources are used, and identify areas that will benefit from redesign.
- Better services for patients: PbC enables primary care professionals, working across boundaries with secondary care clinicians and others, to redesign services that better meet the needs of their patients. Patients can benefit from a greater variety of services from a larger number of providers in settings that are closer to home or more convenient for them. Patients will also benefit from reduced waiting times when they do need to go to hospital.
- Better use of resources: By giving practices the ability to develop new services for patients within a framework of accountability and support, PbC will improve access, extend patient choice and help restore financial balance.

Patient Choice

- Free Choice means that the majority of patients being referred to hospital will be able to choose where they wish to be treated. Choice is an important way of empowering individual patients and enabling them to help to drive improvements in services. By enabling new providers to enter the internal market, it should also encourage innovation. The information required to support Free Choice should also increase the transparency of service quality.
- 'Free Choice' has been fully introduced in England from April 2008 for all patients who require an elective referral. They can choose to be treated by any provider that meets NHS eligibility criteria, and can book their first appointment on-line.
- To avoid competition on price, all elective care activity offered under patient choice (as applicable) will be based on national tariff.
- Pricing Payment by Results (PbR) guidance applies the national tariff to activity commissioned by PCTs from eligible providers under Free Choice. Income for activity commissioned under Free Choice should be at the national tariff, adjusted for Market Forces Factor (MFF) as applicable to the provider's geographical location (i.e. tariff x MFF).

How effective has the reform agenda been in England?

Reference: A joint report by the Healthcare Commission and the Audit Commission “*Is the Treatment Working*” June 2008 looked at progress with the NHS reform Agenda

The research concluded that a number of the reforms, particularly those focused on encouraging better financial management (PbR and Foundations Trusts) are beginning to work. There is some evidence that competition from a diverse range of providers, including the private sector, has led to improved services in some areas.

A number of the reforms need time to deliver, improved commissioning, systems reform, infrastructure – particularly data collection - need strengthening. Foundation Trusts have yet to grasp opportunities to deliver innovative models of patient care, yet this is starting to emerge as interest in retained surpluses for the sector is rising.

The reports conclude that new policies should be introduced with measurable aims and objectives, and have a clear evaluation strategy in place.

The full report can be viewed at www.audit-commission.gov.uk

The Chartered Institute of
Public Finance and Accountancy

Registered with the Charity
Commissioners of England and Wales No. 231060

Registered office:
3 Robert Street
London WC2N 6RL
Tel: 020 7543 5600
Fax: 020 7543 5700

www.cipfa.org.uk

