

United Kingdom National Report for the Open Method of Co-ordination on Health Care and Long-Term Care

June 2005

Introduction

In October 2004, the EU Health Council endorsed the Social Protection Committee's proposal that Member States should prepare preliminary reports covering "the challenges facing their healthcare systems, current reforms and medium term policy". The UK's report is provided here, and contains the following information:

- A. The UK view of how the OMC in healthcare and long-term care can develop effectively
- B. Summary of the UK National Health Service
- C. UK Health Indicators
- D. Access, Financial Sustainability, and Quality

Due to the devolved nature of responsibility for health and long-term care systems within the component countries of the UK, information is provided separately on health service provision within England, Scotland, Wales and Northern Ireland.

The information in this report has been gathered from government White Papers and other relevant legislative texts, which themselves have been subject to widespread public consultation. For example, the English "NHS Improvement Plan" of June 2004 was consulted on widely by relevant organisations and the public in a nationwide exercise. Further engagement with health stakeholders on the Open Method of Co-ordination in healthcare and long-term care will take place as this process unfolds.

A. The UK view of how the OMC in healthcare and long-term care can develop effectively

As the current Treaty recognises, the UK is responsible for the organisation and delivery of healthcare services. However within this clear competence framework we recognise that there is room for significant co-operation within European healthcare systems through a non-regulatory method such as the OMC. The economic significance of health systems in the EU economies, and also the fact that patients move around between systems makes this important.

All Member States do want to share experiences in the modernisation of their systems, apply best practice, and avoid reinventing the wheel. The UK is keen to explore alternative avenues, as long as these are not intrusive.

For the OMC to be effective it must recognise the need to be light touch, as ministers endorsed in the recent SPC opinion on extending the OMC to healthcare and long-term care. The UK has made clear that this process should not lead to new health indicators and that instead the process must use information that Member States already provide in areas such as access, financial sustainability and quality.

Equally, to foster the climate of co-operation and learning, this process must focus on data that enables Member States to learn lessons for their own systems as opposed to comparing performance between Member States. There should be no league tables, or guidelines dictating when MS plan their priorities.

In addition, this process should focus its effort on how best to extract value from EU learning on healthcare issues. It may, for example, be appropriate for the Member States along with the Commission to identify key macro health questions that Member States are keen to learn more about, within the three identified objectives. Other Member States would then be invited to outline how they have tackled these issues and Member States can then get added value from practical examples and solutions that are suggested. Of course, one solution may work well in one Member State but not be suited to another. However, Member States will be able to apply the practical lessons from these examples as they see appropriate in order to tackle the issue identified.

It is also important to recap other work going on within other areas to ensure there is no overlap. The Commission-led Group on patient mobility issues (High Level Group on Health Services and Medical Care) will be helpful at tackling some very **practical** problems to make life easier and safer for the small number of patients who move across borders. What kind of information do you need if you visit a hospital in another country? Can it be made easier for people from smaller countries to find out about centres of excellence on rare conditions in other countries, and so on.

The Council-led Group (Council High Level Health Group) will be a useful forum for tracking major initiatives from across the Commission which could significantly impact on health, and providing a forum for Member States to consider these from a health perspective.

In summary the OMC is an appropriate forum for Member States to have a look at macro issues in health systems – how are we modernising them, how do we know what is working, how can we learn from each other, in a structured way which, however, is not linked to any harmonising legislative activity or new indicators. The UK is keen to engage in a process that encourages collaboration between Member States whilst being clear about respective competencies.

B. Summary of the UK National Health Service

Overview

The government is the dominant supplier of health care to the population of the UK, through the National Health Service (NHS), which provides comprehensive and universal coverage. Visits to the doctor and treatment in hospital are provided free of charge at the point of delivery. Since the NHS is funded by taxation and National Insurance, enrolment is effectively compulsory and based on residency in the UK. People can choose private health care, with or without private insurance, without affecting their access to NHS treatment.

Within government, responsibility for healthcare is devolved to the component countries of the UK, with England, Scotland, Northern Ireland and Wales each responsible in their respective areas.

The Department of Health (DH) in London is responsible for setting health and social care policy in England. This Department, along with its counterparts in Scotland, Wales and Northern Ireland, agrees with the Treasury how much money is to be allocated to the NHS on a three-or four-year cycle. The division of money throughout the United Kingdom is partly constrained by a formula designed to improve the geographic distribution of medical resources. Funding and decision-making are increasingly devolved to a local level.

England

Structures:

Strategic Health Authorities: In England, 28 Strategic Health Authorities (SHAs) look after the healthcare of their region, being responsible for the development of strategies for health services in their local area, ensuring the quality and increasing the capacity of these services. SHAs are accountable to the Secretary of State for Health, who is the government minister responsible for the NHS in England and answerable to Parliament for its work.

Primary care trusts: Health services are divided into 'primary' and 'secondary' care, and are provided by smaller local NHS organisations called 'trusts'. Trusts are purchasing bodies, receiving the majority of the health budget directly, and employing most of the NHS workforce, including nurses, doctors, dentists, as well as allied health workers.

The 303 Primary Care Trusts (PCTs) vary in size and population covered, and are responsible for the provision and commissioning of services. PCTs work with local authorities and local health and social care agencies to ensure the community's health needs are met. They are also responsible for secondary planning, commissioning hospital care, and deciding on the quantity and quality of services provided by hospitals, dentists, patient transport and population screening.

PCTs handle 80% of the total NHS budget, managing budgets for local services. A contracting prospective payments system is being introduced, allowing money to follow patients, with PCTs paying hospitals and other providers on the basis of the number of treatments they carry out.

NHS Trusts: NHS services are run and managed by NHS Trusts. There are three main types of trusts:

- 176 acute trusts, providing medical and surgical care and are usually centred on a teaching or district general hospital; an acute trust may manage more than one hospital;
- 88 mental health trusts, either providing services in hospitals or in the community;
- 31 ambulance trusts

Acute Trusts also decide on a strategy for how the hospital will develop to achieve service improvement. SHA's manage their performance but Trusts are self-governing organisations. Trusts report directly to the Secretary of State and are responsible for the service they provide to the public. They receive most of their income from service level agreements from Primary Care Trusts to provide services. Trusts are also obliged to deliver national priorities.

Foundation Trusts: Since April 2004, certain NHS trusts (the best performing hospitals with 3 star ratings) have been allowed to receive foundation status. The Secretary of State no longer has any powers of direction over Foundation Trusts as they will operate as not-for-profit Public Benefit Corporations. They have a stakeholder board of Governors with a majority of members elected and receive most of their income from legally binding contracts with Primary Care Trusts. Foundation hospitals have the power to manage their own budgets. They are able to borrow money privately and set their own financial and operational priorities.

Foundation Trusts represent the Government's commitment to decentralising the control of public services and are viewed as the way to improve service responsiveness and the standards of care in the NHS. With much more financial and operational freedom than other NHS Trusts, they are tailored to the needs of local populations and run by local managers, staff and members of the public.

Scotland

The first elections for the Scottish Parliament were held in May 1999. The Parliament and its Executive has responsibility for health and social services in Scotland, among other public services, and can pass primary legislation in these areas. The UK Parliament in Westminster retains control over a range of reserved issues, including matters relating to the protection of a single UK market (e.g. the licensing of medicines).

Structures:

NHS Boards: Powers to provide comprehensive healthcare services are conferred by the Scottish Parliament on Scottish Ministers who in turn delegate these functions to 15 area health boards, including three covering small populations in the Islands areas. Ministers fund the health boards and appoint the members of health boards. Boards employ all NHS staff. NHS Trusts ceased to exist in Scotland in 2004 and health boards now carry out the full range of functions including planning and providing healthcare services, public health services, and health improvement.

Community Health Partnerships: In order to provide a clearer focus for integration between primary care, specialist services and social care, NHS Boards are establishing Community Health Partnerships. These multi agency and multi professional partnerships will be expected to reduce health inequalities for their local communities and improve service outcomes, working in new ways with local service users, patients and their carers.

Special Health Boards: Some national functions such as ambulance services, blood donation and product manufacture, telephone health advice and the provision of secure accommodation for the mentally ill are provided by eight special health boards which cover the whole of Scotland.

Wales

The first elections to the National Assembly for Wales were held in May 1999. The Assembly has a smaller range of responsibilities than the Scottish Parliament; for example, the UK Parliament remains responsible for the police and the legal system. The Assembly does not have the power to make primary legislation but legislation specifically for Wales has been taken through the UK Parliament. The Assembly has responsibility for health and the NHS in Wales, and has put in place its own structures, regulations and performance management arrangements to suit the particular circumstances of Wales.

Structures:

NHS trusts: The main providers of hospital care in Wales are the 13 trusts. Between them, they manage 17 large acute hospitals plus a large number of community hospitals and other facilities. There is also an all-Wales ambulance trust.

Primary care: Primary care in Wales is provided by family doctors (GPs), dentists, optometrists etc who, like in England, are predominantly contractors rather than employees of the health service.

Local Health Boards: Local Health Boards (LHBs) were created in April 2003. The 22 LHBs share their boundaries with Wales's 22 unitary local authorities (i.e. the local government). LHBs and the local authorities have a statutory

duty to work in partnership to develop local Health, Well-being and Social care strategies. Each LHB has a widely-representative board of 22 people including GPs and other health professionals, members of the local authority, a patient, a carer and others. LHBs are responsible for determining the health needs of their local population and commissioning services from trusts, primary care and others to meet these; around three quarters of the budget is allocated directly to LHBs for this.

Regional Offices of the Assembly: The Assembly Government has set up three regional offices to improve its ability to support and manage the performance of the NHS across Wales.

Other organisations: There are a number of other NHS and related organisations, including Health Commission Wales, which commissions specialist services for the whole of Wales, and the National Public Health Service. The National Leadership and Innovation Agency for Healthcare is a national, strategic resource for NHS Wales, aimed at building leadership capacity and capability to deliver continuous service improvement, optimising technology, innovation and the implementation of leading-edge practice. Community Health Councils inspect hospital premises and provide advocacy and support for patients with grievances.

Northern Ireland

The Northern Ireland Assembly was set up in April 1998. It has similar executive and legislative powers to the Scottish Parliament. The Assembly has been suspended on a number of occasions as a consequence of the unstable political situation in Northern Ireland. During these periods direct rule from Westminster is introduced.

Structures:

Health and social care in Northern Ireland (NI) is delivered on an integrated basis by the Health and Personal Social Services (HPSS), which is accountable to the Department of Health, Social Services and Public Safety.

Health and Social Services (HSS) Boards: The 4 HSS boards commission health and personal social services for their resident populations from a range of providers, including HSS Trusts, and voluntary and private sector bodies. Each Board has a number of Local Health and Social Care Groups which operate as committees of the Boards. They are made up of primary care professionals and community representatives and provide local input to the planning and design of services in their areas.

Health and Social Services Trusts: These are the main providers of health and personal social services and work within the commissioning arrangements agreed with HSS Boards. Although managerially independent, Trusts are accountable to the Minister. There are 19 HSS Trusts in Northern

Ireland, some providing hospital services only, some (uniquely in the UK) community and personal social services and some, both hospital and community services.

Health and Social Services Councils: These are independent statutory bodies funded by the Department which represent the interests of the public and users of health and social services.

NI Ambulance Service Trust: This provides ambulance services for the whole of Northern Ireland.

There are also nine agencies that provide specific regional services e.g. the Health Promotion Agency and the NI Blood Transfusion Service Agency.

C. UK Health Indicators

All of the component countries in the UK have set targets on a number of indicators relating to health, long term care and tackling poverty and social exclusion. These are collated in the UK National Action Plan on Social Inclusion 2003-05ⁱ, and further detailed below.

England

The Dept of Health's Public Service Agreementsⁱⁱ and the Dept for Work and Pensions 'Opportunity for All' strategyⁱⁱⁱ provide indicators covering key aspects of health, health inequalities and wider determinants, for example:

- by 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women;
- substantially reduce mortality rates by 2010, including:
 - from heart disease and stroke and related diseases by at least 40% in people under 75;
 - from cancer by at least 20% in people under 75;
 - from suicide and undetermined injury by at least 20%.
- reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth;
- reducing adult smoking rates to 21% or less by 2010;
- halting the year-on-year rise in obesity among children under 11 by 2010;
- reducing the under-18 conception rate by 50% by 2010.

The indicators are broadly based across demographic and socio-economic groups. For instance, the DH PSA inequalities target on life expectancy is geographically based, while targets on infant mortality and smoking in manual groups have a socio-economic focus. Other indicators such as teenage pregnancy, accidental injury (among children) and care for the elderly have an age focus. The UK NAP addresses aspects of financial exclusion.

Scotland

Scottish Ministers have set similar targets on a wide range of indicators relating to health and healthcare, in the context of tackling health inequalities^{iv}. The Health Improvement targets include:

- Achieve a 60% reduction in deaths from CHD in people under 75 between 1995 and 2010
- Achieve a 50% reduction in deaths from cerebrovascular disease (stroke) in people under 75 between 1995
- Achieve a 20% reduction in death from cancer in people under 75 between 1995 and 2010
- Improve Life Expectancy (LE) and Healthy Life Expectancy (HLE) for men and women
- Reduce inequalities in LE, HLE for men and women

- Address health inequalities by increasing by 15% the rate of improvement for most deprived populations in the areas of coronary heart disease, cancer, rate of adult smoking, smoking during pregnancy, teenage (13-15 years) pregnancies, and suicides for 10-24 year olds.

Wales

Wales has developed specific national health targets (health gain targets) and indicators for coronary heart disease, cancer, mental health, the health of children and older people, which were published in 2004^v. They provide a long-term measure of health outcome and health inequalities 2002 to 2012. These health outcome targets will be underpinned by indicators covering the determinants of health to provide a short to medium term measure of progress at the local and national levels for improving health and reducing health inequalities in Wales.

Northern Ireland

An Inequalities Monitoring System was set up in 2003 in response to an action point in the Department of Health, Social Services and Public Safety new Targeting Social Need Action Plan^{vi}. It comprises a basket of indicators which monitor area differences in morbidity, utilisation and access to health and social care services over time in the most deprived and rural areas across Northern Ireland. Indicators such as life expectancy, teenage birth rates and hospital admissions due to major diseases are all included and reported on.

The baseline results covering 2001/02 were first presented in the report Equality and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview^{vii}. The morbidity and utilisation data was later updated to cover results from 2002/03 in an update Bulletin in 2004^{viii} and further update reports will be produced periodically.

D. Access, Financial Sustainability, and Quality

Details are provided below on the three broad principles of access, quality, and financial sustainability of healthcare services. Due to the devolved responsibility for healthcare systems within the component countries of the UK, information is provided separately for England, Scotland, Wales and Northern Ireland.

England

Ensuring access to care: One of the fundamental principles of the NHS is that there should be equal access to treatment for all, based on clinical need and regardless of the patient's ability to pay. The recent combination of investment and reform is now beginning to make a real difference, with patients having faster access to the care they need. Since 1997:

- The maximum waiting time for an operation has fallen from 18 months to less than nine months;
- The maximum waiting time for an outpatient appointment has fallen from 26 weeks to 17 weeks;
- 98% of patients are seen, diagnosed and treated within four hours of arrival at accident and emergency.

When the current programme has been delivered by 2008, the 1997 maximum wait of 18 months for only part of patients' treatment will have been reduced to 18 weeks for the whole journey.

This investment is also resulting in recruitment and retention of the workforce required to tackle these issues. There are 1,331,087 staff in NHS England, either directly employed or under contract. Of these, 34,855 are general medical practitioners; 82,951 are hospital doctors, 397,515 are qualified nurses. There are 128,833 qualified scientific, therapeutic and technical staff and 17,272 qualified ambulance staff, and 90,110 practice staff other than nurses. There are 368,285 clinical support staff and 211,489 NHS Infrastructure support staff, which includes managers, administrative, estates.

From the end of 2005, patients will have the right to choose from at least four to five different healthcare providers, including Independent Treatment Centre providers, with the NHS paying for this treatment. In 2008, patients may choose from any provider (NHS or independent sector), provided they meet NHS standards and treat within the national maximum NHS price. Patients will have access to their personal HealthSpace on the internet, where they can see their care records and note their individual preferences. By the end of 2005 electronic booking and electronic prescribing services will be available.

The UK has had considerable experience in relation to patient mobility both in terms of sending patients overseas for treatment and in providing treatment to overseas patients mainly from the European Economic Area. We have provided information to the Cross Border working group on the UK experience to date. Patients are referred for treatment under EU secondary legislation

regulation 1408/71 (the E112 arrangements) but also through direct referrals set up by Dept of Health and managed by the NHS. Legal obstacles to PCTs referring patients on their own initiative have been removed (following ECJ judgements in this area). There are likely to be further legal developments following the UK Watts case currently before the ECJ. Nevertheless, there are major programmes in progress within England to increase significantly the level of capacity available to meet the needs of NHS patients in the main General and Acute elective specialties towards the 18-week waiting target from 2008.

Promoting High-Quality Care: There have been improvements in the quality of care, achieved through the development and delivery of National Service Frameworks. More treatment and care are also available closer to home. There has been clear progress in tackling the country's biggest killer diseases, with premature deaths from cancers and heart disease falling at the fastest rate of any European country. Patient choice has begun to have an impact on the way in which the NHS works: in future, with waiting times no longer the main issue, the NHS will be able to concentrate more on helping patients to decide on the time and place of their care. The NHS will provide better support to people with illnesses or medical conditions that they will have for the rest of their lives, such as diabetes, asthma, and some mental illnesses. Prevention of disease and tackling inequalities in health will also assume a greater priority in the NHS.

In national surveys, patients are increasingly positive about the quality of their care. By 2008, the Healthcare Commission will inspect all providers, whether in the NHS or in the independent sector. This independent health inspectorate is responsible for inspecting the quality of hospitals and other NHS organisations. Star ratings are awarded depending on how a Trust has performed against a set of performance indicators set by the Healthcare Commission. Hospitals are rated as having zero to three stars - the more stars the better.

To deliver this vision, investment in the NHS will rise to £90 billion by the year 2007/8. In return for this investment the NHS will offer the following:

- Patients will be treated within a maximum of 18 weeks from referral by their GP, and those with urgent conditions will be treated much faster;
- Patients will be able to choose between a range of providers, including NHS Foundation Trusts and Independent sector providers;
- Patients will be able to be treated at any facility that meets NHS standards, within the national maximum price that the NHS pays for the treatment they need;
- Patients will have access to a wider range of services in primary care, including access to services nearer their workplace;
- Electronic prescribing will improve the efficiency and quality of prescribing;
- Users of social care will be empowered through the expansion of direct payments;
- In every care setting the quality of care will continue to improve, with the Healthcare Commission providing an independent assurance of standards, and patient safety being a top priority;

- People with complex long-term conditions will be supported locally by a new type of clinical specialist, to be known as community matrons;
- Major investment in services closer to home will ensure much better support for patients who have long-term conditions, enabling them to minimise the impact of these on their lives;
- There will have been further progress in tackling the biggest killer diseases, with the country on track to secure by 2010 a 40% fall from 1997 in death rates from heart disease and stroke, and a 20% fall in death rates from cancer;
- The NHS is developing into a health service rather than one that focuses primarily on sickness and will, in partnership, make further in-roads into levels of smoking, obesity and the other major causes of disease. There will be a sustained drive to reduce inequalities in health;
- Local communities will have greater influence and say over how their local services are run, with local services meeting local priorities;
- Primary Care Trusts will control over 80% of the NHS budget;
- The independent sector will provide up to 15% of all elective procedures within the NHS so that patients have real choice;
- All NHS Trusts will be in a position to apply for NHS Foundation Trust status;
- More staff will work in the NHS and will be encouraged to work more flexibly in a way that best responds to patients' needs;
- There will be incentives for healthcare providers to offer care that is efficient, responsive, of a high standard and respects people's dignity.

Guaranteeing the Financial Sustainability of accessible, high-quality care: One of the fundamental principles of the NHS, that it should be financed by collective funding through national taxation, is the most effective way to ensure that quality care is available to all. Sustained investment is transforming the NHS: investment has increased from £33 billion in 1996/97 to £67.4 billion in 2004/05. Spending on buildings and equipment has increased from £1.1 billion to £3.4 billion. From 1997 to 2004, the average spending per head of population has increased from £680 to £1,345. Total (public plus private) health spend as a percentage of gross domestic product (GDP) in the UK for the year 2004-05, is forecast at 8.3 per cent. The spending plans announced by the Chancellor mean that by 2007-08 we expect the UK share of GDP spent on health to be 9.2 per cent - well above the current European average.

Scotland

Ensuring access to care: The National Health Service in Scotland operates on the same principles as elsewhere in the United Kingdom: comprehensive services are provided to every citizen, regardless of economic circumstances or of where they live, and are free at the point of delivery. These services are funded from general taxation. For a few services, such as dentistry and prescriptions, fees are charged, with exemptions for children, the elderly and people on low incomes.

There are 149,896 staff in NHS Scotland, either directly employed or under contract. Of these, 4,269 are General Medical Practitioners; 10,003 are hospital doctors, 45,540 are qualified nurses. There are 16,071 qualified scientific, therapeutic and technical staff. There are 26,368 clinical support staff (non-qualified nurses, AHPS, scientific & professional, technical and all ambulance staff) and 45,447 NHS Infrastructure support staff, which includes managers, administrative, estates. Scotland has 4 University medical schools for the training of doctors. Large numbers of nurses and other clinical staff are also trained through Universities contracted to the Scottish Executive.

Every year in Scotland, there are about:

- 40 million visits to community pharmacies
- 15 million visits to a GP surgery (and about 10 million GP consultations)
- 4 million outpatient appointments
- 1.5 million visits to hospital accident and emergency departments
- 1 million hospital admissions
- 500,000 admissions from the waiting list for elective (planned) treatment

Promoting High-Quality Care: Scotland has a poorer record on healthy life expectancy than most other western European nations, and there are larger gaps between the health experience of rich and poor people in Scotland. A key objective of the NHS in Scotland and of Scottish Ministers is to improve health generally through persuading and supporting people to make healthy lifestyle choices (diet, exercise, smoking, drinking). These services are aimed particularly at people with the poorest health record, to try to narrow the health gap between rich and poor.

NHS Boards are required to agree local health plans with the Scottish Executive Health Department and their overall performance is monitored. Ministers have set a range of targets for Boards, including maximum waiting times for primary care appointments, for first outpatient appointments in hospitals, and for admission to hospital for inpatient or daycase treatment. In December 2004 Ministers set Boards additional, challenging maximum waiting times targets that have to be achieved by the end of 2007. These will include targets for diagnostic procedures.

A wide range of highly specialised services is provided in Scotland. Very small numbers of patients are transferred for highly specialised treatment to hospitals in England. The NHS in Scotland carries out heart transplantation and liver transplantation surgery, and a full range of cancer treatment.

Guaranteeing the Financial Sustainability of accessible, high-quality care:

Ministers provided around £7 billion a year to NHS Boards in Scotland in 2004-05. The balance of the health budget of £8 billion goes on centrally-managed activity. This includes the special health boards, medical education, information services and scientific research.

Wales

Issues specific to Wales: Parts of Wales, particularly the former mining and industrial areas in the Valleys in south Wales, have some of the worst health indicators in Europe, with reduced life expectancy and high levels of heart disease and cancer, coupled with a deprived local economy. Despite greatly increased funding for the NHS in Wales, the demand on acute hospitals is considerable, with very high levels of emergency admissions (as opposed to planned operations), resulting in long waiting times for treatment. The causes are complex, but contributing factors include a large population of elderly people and widespread poor health.

Responding to the Issues: The Welsh Assembly Government commissioned an independent review of health and social care in Wales and is implementing the recommendations which focus on Prevention; Optimising Service Delivery; Involving People; and Performance and Accountability. It is taking a twin-track approach to tackle the causes of poor health and focusing services on results. This includes implementing a resource allocation model which targets resources to Local Health Boards on the basis of the direct health needs of their residents.

There is considerable emphasis placed in Wales on a partnership approach to tackling poor health and the determinants bringing together groups from national and local government, the NHS, voluntary organisations, businesses and community representatives. Local authorities have responsibility for providing social services, as well as a range of other relevant responsibilities covering aspects of the environment, housing and local economy. The close relationship between NHS and local authorities is seen as vital to improving population health, and to relieving pressure on the acute sector of the NHS through better care at home particularly of the elderly.

The aim is to reduce the emphasis on acute hospital treatment by improving illness prevention, developing more comprehensive primary care to reduce the need for people to be admitted to hospital, and encouraging better social care provision to help them to return home quickly with the necessary support. Patients and the public are being given a greater role in local decisions about the NHS in a variety of ways.

Guaranteeing the Financial Sustainability of accessible, high-quality care: The Welsh Assembly Government determines how its total budget is allocated to the portfolios for which it has devolved responsibility. In 2005-06, the budget for health is £4.6 billion, nearly double the funding on health when the Assembly was established in 1999. The funding is due to increase to approximately 5.2 billion by 2007-08.

Ensuring access to care: There have already been significant improvements in access to services in the last few years and by 31 December 2009 the maximum total waiting time from GP referral to treatment, including waiting times for diagnostic tests will be 6 months.

Promoting High-Quality Care: Quality of care and safety is monitored by *Healthcare Inspectorate Wales* to ensure the continuous improvement. In addition *The Advisory Board for Healthcare Standards in Wales* has been set up to manage the process of adopting the National Assembly's healthcare standards.

The Assembly Government sets standards and targets for the NHS in Wales to meet. This has been broadened to include a system based on a balanced scorecard approach, which looks at each organisation not only on delivery of targets, but on its internal systems, infrastructure, staff leadership and external relationships. The aim is to encourage organisations continuously to improve.

Northern Ireland

The population of Northern Ireland (NI) generally experiences poor health. One quarter of people (25%) in NI (2003), considered that they had a limiting long standing illness. This is greater than for England & Scotland (18%) and Wales (22%). In particular, NI has higher levels of mental health problems and the rate of births with a congenital malformation in NI is over twice the level in England and Wales.

NI has a younger age profile than other UK countries but the elderly population is increasing more rapidly i.e. people aged 75 and over in NI are projected to increase by 37% between 2004 and 2019 whereas the comparative UK figure is for 26% growth. Overall deprivation levels in NI are high with GDP, disposable income and working age employment being much lower than the UK average.

Ensuring access to care: The majority of patients in Northern Ireland do not have to wait long for treatment. 95% of people on the inpatient or day case waiting list receive treatment within 12 months and 74% within 3 months. Reducing the length of time patients wait for treatment is a key priority and waiting times have reduced significantly in recent years. Inpatient and day case waiting lists have fallen by 18.2% from 60,190 patients waiting at September 2002 to 49,250 at December 2004.

However, the number of patients waiting for a first outpatient appointment continues to increase. For the quarter ending December 2004, the number waiting for a first appointment was 164,672, an increase of 11.6% on December 2003. 96% of outpatients are seen within a year of referral and 70.3 % within three months.

Sustained efforts are being made to bring waiting times in Northern Ireland into line with the rest of the United Kingdom. There will be a longer-term shift of emphasis in Northern Ireland towards the measurement of total waiting times from referral to treatment. In the short-term, targets have been put in place, including that by 31 March 2006 there will be:

- a maximum waiting time of 15 months for inpatient or day case surgery and 9 months by 31 March 2007, with:
 - 3 months for cardiac surgery
 - 6 months for cataract surgery, and 3 months by 31 March 2007
 - 9 months for major joint replacement, and 6 months by 31 March 2007.
- 95% of patients requiring hospital inpatient and day case treatment are admitted within 12 months of being placed on a list.

The March 2005 Health and Personal Social Services Information and Communications Technology (ICT) Strategy outlines the three main aims of developing electronic care records, electronic care communications and electronic information. This will establish an electronic integrated community health and social care record for each patient by 2008. Electronic transfer of pathology results and digital imaging, and electronic prescribing will also be introduced, along with electronic referral and booking systems.

Guaranteeing the Financial Sustainability of accessible, high-quality care:

In general, the standard of health within Northern Ireland remains lower than the UK average. Improving health and well being remains a priority for the government in Northern Ireland. This priority is reflected in sustained investment in Health and Social Services over the past five years. The Budget for Health and Social Services has almost doubled in the last five years from £1.9bn in 200-01 to £3.33bn in 2005-06.

While this is a significant increase in investment. it represents a lower real terms growth in spending than in England, some 24.3% compared to 26.25%. Within this context Northern Ireland is taking forward a programme of Reform and Modernisation which will result in improved outcomes for patients and clients and will meet the needs of more people by streamlining processes, treating more people in primary care rather than more expensive hospitalisation, reducing the length of stay in hospital and using staff more flexibly by increasing the roles and responsibilities of lower paid staff.

The level of funding per head on health for Northern Ireland in 2002-03 was some £1,214. While this is ahead of England and Wales (although lower than Scotland) it is important to note that there are differences in demographic profile, morbidity and socio-economic status of the populations of the four countries which would impact on the level of spend per capita in each region.

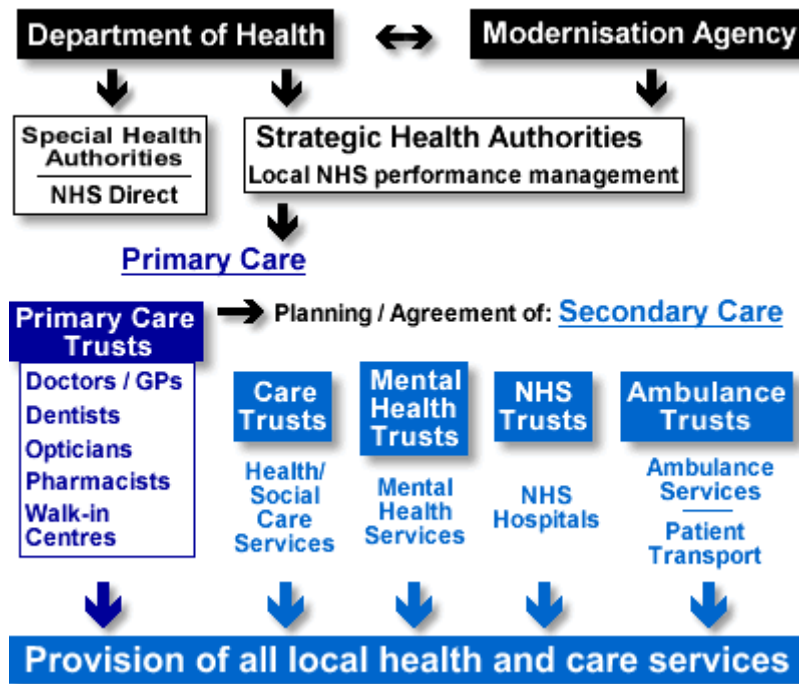
Promoting High-Quality Care: Underpinning the Department's Modernisation and Reform agenda is the promotion of safe and effective care and continuous quality improvement. The aim is to ensure that, regardless of where people come into contact with the HPSS, and whatever their circumstances, they receive consistent, high-quality services. There has been a statutory duty of quality in place in NI since 2003. This sets accountability at a local level for the delivery of services and for continuous improvement in quality. Improvements in quality and safety of local services are centred on five broad themes, to will be further developed over the next three years:

1. Improvements in governance arrangements within the HPSS;
2. The setting of standards against which service providers can be measured;

3. New arrangements for the regulation, inspection and review of services;
4. Improved accountability arrangements; and
5. Links with national standard setting and patient safety bodies.

To support HPSS bodies in this work, a range of controls assurance standards has been introduced on a phased basis since 2003-04. In addition, the DH Modernisation Agency has been contracted to provide support to HPSS organisations in implementing clinical and social care governance. A number of new standards will be introduced over the coming years including further controls assurance standards; care standards and quality standards supporting implementation of clinical and social care governance. All of these standards will assist HPSS organisations in assessing risk and in the reporting on the quality of service provision. They will also provide greater transparency for the public on what care they are entitled to expect from the HPSS, and facilitate organisations in the demonstration of good governance.

Annex 1: The division of responsibility within the English NHS:



Annex 2: References to health resources:

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- ⁱ UK National Action Plan on Social Inclusion 2003-05
<http://www.dwp.gov.uk/publications/dwp/2003/nap/nap.pdf>
- ⁱⁱ Dept of Health England Public Service Agreements:
<http://www.dh.gov.uk/AboutUs/HowDHWorks/ServiceStandardsAndCommitments/DHPublicServiceAgreement/fs/en>
- ⁱⁱⁱ Dept for Work and Pensions 'Opportunity for All' strategy
<http://www.dwp.gov.uk/ofa/index.asp>
- ^{iv} Partnership for Care' Scotland's Health White Paper:
<http://www.scotland.gov.uk/library5/health/pfcs-00.asp>
- ^v National high-level targets and indicators for Wales:
www.cmo.wales.gov.uk/content/work/health-gain-targets/index-e.htm
- ^{vi} Targeting Social Need Action Plan, 2001, Northern Ireland Department of Health, Social Services and Public Safety:
<http://www.dhsspsni.gov.uk/publications/archived/2001/tsneeds.pdf>
- ^{vii} Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview: see Chapter 8 for relevant data:
http://www.dhsspsni.gov.uk/publications/2004/equality_inequalities/equality_in_inequalities.asp
- ^{viii} N Ireland Health and Social Care Inequalities Monitoring System, Update Bulletin 2004:
<http://www.dhsspsni.gov.uk/publications/2004/iqs-1stupdate-bulletin04.pdf>