

# **Gloucestershire Primary Care Trust 2006/07 Business Plan**

## **1. Introduction**

This business plan covers the last five months of 2006/07. It is a brief plan that describes the essential tasks that face the Trust in the remainder of the year. A more detailed plan will be produced to cover 2007/2008 but for the remainder of this year this plan is restricted to describing the PCT's emerging vision, values and strategic aims and then identifying the key targets facing the PCT and describing how they will be met.

The plan covers the following topics

- Demographic and financial information to set the Gloucestershire context.
- Gloucestershire PCT's emerging vision and values
- Gloucestershire PCT's emerging strategic aims
- Gloucestershire PCT's principal objectives
- The priority tasks facing the Trust in this year
- How the Trust will monitor progress over the remainder of the year.

## **2. Background**

### **2.1 Gloucestershire Primary Care Trust**

Gloucestershire Primary Care Trust was established on 1<sup>st</sup> October 2006. The PCT is responsible for healthcare of a population of 599,242, of whom 16,026 are registered with a Gloucestershire GP, but live outside of the county boundary. There are 430 GPs in 83 Practices; 250 community pharmacists; 293 dentists and 250 optometrists working within the Trust area. The PCT is a relatively large employer with approaching 3,600 employed staff.

The Primary Care Trust's budget for 2006/07 is £671m. Of this, £438m will be spent on commissioning of secondary and tertiary healthcare (acute hospital services, both inside and outside of Gloucestershire), £150m on commissioning primary care services (including prescribing) and £48m on provision of hospital and community services within the PCT area (largely from community based hospitals; community services and general practices). At establishment the PCT was challenged with a projected deficit for the year of £13.3m

### **2.2 Gloucestershire Primary Care Trust functions and priorities**

The South West Strategic Health Authority has described the three main functions of a primary care Trust as:

- engaging with its local population to improve health and well-being;
- commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors; and
- directly providing high quality responsive and efficient services where this gives best-value.

*'The NHS in England: the operating framework for 2006/07'* identified the priorities for the NHS in 2006/07. It states that the NHS remains committed to delivering the plans set out in *'National Standards, Local Action'*, published in 2004 but that there will be a particular focus on:

Achieving robust financial health

and achieving six specific service priorities:

- Reducing health inequalities
- Achieving 31 and 62 day waiting for cancer treatment
- Achieving maximum of 18 week wait form GP referral to hospital treatment
- Year on year reduction of MRSA
- Patient choice and booking
- Access to Sexual Health and Genito -Urinary Medicine (GUM)

### 3. Vision and Values

#### 3.1 Introduction

In October the PCT started to develop a Vision and Values statement that communicates the ambitions, ideals and direction of travel for the new organisation. More work with partners and stakeholders will develop this vision in 2006/07 but at this time the PCT had developed the following Vision and Values statement.

#### **Vision**

Achieving excellence in health for the people of Gloucestershire

Gloucestershire Primary Care Trust will:

listen to local communities and promote quality and innovation in patient care

pay proper attention to partnerships and obtain best value for public money

trust and support our staff and encourage health improvement.

#### **These are our values:**

We should:

- **Involve** service users, carers, staff, partners, and the public in developing services
- Treat our service users and staff **fairly** with respect and politeness
- **Communicate** clearly, honestly and learn from feedback
- Respect the **diversity** of our staff and our population
- Work with our patients to promote and support '**healthy living**' and self care
- Provide services as **close** to the patient's home as possible
- Aim for the highest standards, but be **honest** about what can be achieved and the challenges ahead
- **Celebrate** success and innovation.

## **4. Strategic aims**

### **4.1 Financial Balance**

Gloucestershire PCT will achieve a break-even position at the end of this financial year. This will provide a firm footing for recurring income and expenditure balance in 2007/08. The PCT will meet this aim through the Financial Recovery Plan and Community Change Programme. This will be within the framework set out in the PCT Resource Strategy.

### **4.2 Achieve key NHS targets**

The key NHS targets were set out by the Department of Health in the Operating Framework for 2006/07. They are

- Reducing Health inequalities
- Achieving 31 and 62 day waiting for cancer treatment
- Achieving maximum of 18 week wait from GP referral to hospital treatment
- Year on year Reduction of MRSA
- Patient choice and booking
- Access to Sexual Health and Genito -Urinary Medicine (GUM)

### **4.2 Confirm a safe baseline for Gloucestershire services**

Ensure that the new PCT is fit for purpose in terms of:

- Commissioning services. The PCT will benefit from the "Fitness for Purpose" assessment due in January 2007 which will result in an action plan that will ensure our commissioning is of the highest standard.
- Providing services. The PCT will ensure that a self sufficient provider arm or the organisation is established, supporting the establishment of such an arrangement whilst at the same time holding the provider arm to account for the delivery of efficient and effective clinical services within the budgets allocated.

### **4.3 Establish a new identity and culture for Gloucestershire PCT**

Gloucestershire PCT will establish its own identity and confirm its values and visions during 2006/07. This will include appointments to the Director team and work with stakeholders to confirm strategic aims and objectives.

## 5. Principal Objectives

### 5.1 Financial recovery and achieving income and expenditure balance through the Community Change Programme

The Local Delivery Plan for 2006/07 set out a savings plan to achieve £23M savings. A mixture of schemes and plans were initiated across the entirety of the PCT resource base, some of these constituting the PCT public consultation – *The Future of Healthcare in Gloucestershire* - which ran between July and September 2006. The approach to the savings programme was to constitute a Community Change Programme, accountable to a Community Change Steering Group comprised of the Chairs and Chief Executives of all the Gloucestershire NHS organisations plus the relevant portfolio holders for the County Council. Saving proposals were divided into seven areas under the auspices of the Integrated Service Improvement Programme.

### 5.2 Delivering the key Department of Health targets

Commissioning leads have been allocated to each of the PCT's targets. (Annexe 1) During 06/07 the leads will compile a baseline position in relation to the targets and produce a plan specifying how the target will be achieved or maintained during 2007/08 plus any risks that are perceived at this point. This work will be included in the 2007/08 Trust Business Plan.

In addition to this the PCT is focussing on the 6 key targets specified by the Department of Health in the Operating Framework. These are:

**Health Inequalities** To deliver the LDP trajectories that makes the most progress in reducing health inequalities by 10% by 2010. The initial focus will be on smoking cessation. The PCT is not on target at this point and the action plan to improve this is at annexe 2.

**Cancer** The NHS Cancer Plan sets the ultimate goal that by December 2005 no patient shall wait longer than one month (31 days) from diagnosis of cancer to the beginning of treatment, or more than two months (62 days) from Urgent GP referral for

suspected cancer to the beginning of treatment except for good clinical reasons. The PCT is on target at this point and a report is at annexe 2.

**Waiting** The NHS Plan set out the ultimate goal that by December 2005, the maximum wait time for inpatient treatment will be 6 months and outpatient treatment 3 months. By December 2008 no patient should wait longer than 18 weeks from referral to treatment. The PCT is on target at this point and a report is at annexe 2.

**MRSA** The national target for all Acute Trusts is to reduce the number of MRSA infections from the Trust baseline figure of 2003/04 by 60% by March 2008. The PCT is not on target at this point and the action plan to improve this is at annexe 2.

**Choice** By March 2007 80% of patients to be offered a choice of four or five hospitals for elective referrals for consultant led outpatient appointments at the time that they are referred by their GP or Primary Care Professional. The patient should also be offered a choice of time and date for their booked appointment. 90% of GP referrals to be made via the choose and book software by 31<sup>st</sup> March 2007. The PCT is not on target at this point and the action plan to improve this is at annexe 2.

**Sexual Health** To deliver the 2006/07 LDP trajectories so that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours. The PCT is on target at this point and a report is at annexe 2

### **5.3 Standards for Better Health**

The Standards for Better Health are split into core and developmental standards. The core standards represent a level of service, which is acceptable and should be universal throughout the NHS. The Department of Health had the expectation that all Trusts would be compliant with the core standards from the date of their publication in July 2004. Developmental standards represent targets for improvement and it is expected that all Trusts will be actively working towards the achievement of these standards. (A description of the standards is included within Annexe 3)

The Communications Planning and Performance Directorate is reviewing compliance against core standards and a system is being put in place to ensure that assurance is given to the Integrated Governance Committee and to the PCT Board regarding the degree of compliance by the PCT. The Trust Board will be expected to make a statement of compliance in April 2007.

In 2006/07 the Healthcare Commission are focusing their assessment in three of the seven areas/domains for developmental standards. Assessment of progress in these areas will be in shadow form in 2006/07 and will not feed into the overall annual rating. For PCTs the focus will be on Public Health and improving health and reducing inequalities.

In the period to 31<sup>st</sup> March 2007 each standard - both core and developmental - and subset thereof will be assigned to an interim or substantive director where the majority of the responsibility for the standard would lie. It is proposed that a sub committee of the Integrated Governance Committee, acting as a "Select Committee" is called over a two day period at the end of March. The director assigned to each standard will be required to assure the Select Committee, by a review of evidence, and the evaluation of that evidence, as to whether the standard has been met, or not met. The evidence may be in different forms; from in-house policies and the implementation and understanding of them to external audit and survey.

### **5.3 Fitness for Purpose review**

Fitness for Purpose is an intensive assessment of PCT's commissioning capacity and capability. The process is scheduled to start in Gloucestershire in January 2007. The assessment process takes place over an eight week period and consists of data collection analysis, interviews and feedback. The outcome is a Primary Care Trust Development Plan which identifies capability gaps and sets out actions to improve commissioning competence. This is fed back to the Trust Board in a Board to Board session and this development plan will feature in the Trust business plan for 2007/08.

## 5.4 Organisational Development

The Trust's development will continue into 2007/08. In the remainder of this year preparation will take place to allow us to undertake a cultural survey to assess the cultural climate, management and leadership styles to inform organisational development plans for GPCT. For the purpose of this activity culture is defined as the sum of the organisational values, norms – unwritten rules of behaviour, beliefs, attitudes and assumptions that shape the way people behave and get things done. It is anticipated that this work-stream will incorporate the following components:

- Staff survey – questionnaire
- 1:1 interviews of a cross section of managers/leaders within the organisation perceived by staff to be exponents of good practice and poor practice to understand their preferred leadership styles and management practice adopted.
- Facilitated workshops and focus groups with cross section of staff
- Training Needs Analysis

The outcomes in 2007/08 will be

- To develop knowledge and understanding of the cultures of the precursor organisations.
- To compare and contrast against the culture aspired to by GPCT with that of the precursor organisations to scope and scale the cultural gap.
- To develop knowledge and understanding of the of the current management and leadership styles within GPCT.
- To highlight management and leadership strengths, weaknesses and areas for development.

## **5.4 Reporting schedule**

Finance report – monthly reports made to board.

Community Change/ Financial Recovery – The community change programme and progress against the financial recovery plan is monitored closely on an ongoing basis. A monthly report detailing progress against individual schemes is presented to the Board on a monthly basis and to the Strategic Health Authority.

6 key targets – performance against trajectories for the 6 key targets are reported monthly in the performance report to the Board. Where performance is below expected levels actions to improve performance are detailed.

All national targets – are monitored on an ongoing basis depending upon availability of data (monthly or quarterly). Any areas where performance is below expected levels are reported to the Board as an exception within the performance report.

Assurance Framework. The Assurance framework is still being developed. A report covering significant issues will be made to Board after quarter 3 and at year end.

## **6. Risk Management and Assurance**

Gloucestershire PCT will manage the risks that are presented to its principal objectives through its risk management process and will report to the Board on risk and assurance through its Assurance Framework.

### **6.1 Risk Management**

Gloucestershire Primary Care Trust has agreed a risk management strategy. This states that:

“Risk management should be recognised as an integral part of good practice and should be part of an organisation’s culture. It should be integrated into its philosophy, practices and business plans, rather than be viewed as a separate programme. When this is achieved, risk management becomes the business of everyone in the organisation.”

All identified risks are recorded on the PCT Risk Register which is intended as a ‘living’ document that will outline the Trust’s risk profile at any given time.

The Risk Register will include the following:

- Details of the risks identified.
- An assessment of likelihood and consequence (known as the risk rating).
- Any proposed remedial action.
- Appropriate risk management plans, including implementation dates.
- Details of officers responsible for actions.
- Updated progress of action plans and target risk rating.

The Risk Register will be used to generate regular reports to line managers and directors to enable them to monitor the risks within their own areas of responsibility, as well as the periodical reports to the Integrated Governance Committee and the Board. In addition, an annual Risk Management Report will be presented to the PCT Board.

All risks classified as “High” or “Significant” will be used to inform the PCT Assurance Framework.

## **6.2 Assurance**

The Assurance Framework provides the PCT with a comprehensive method for the effective and focused management of the principle risks to achieving its business objectives. It also provides a structure for the evidence to support the annual Statement of Internal Control. The Assurance Framework is driven by the objectives of the PCT. It contains a comprehensive register of the Trust’s principal objectives, risks to achieving objectives, controls and assurance on controls. The full Assurance Framework will be the subject of reports to the Integrated Governance Committee and subsequently significant issues from the Assurance Framework will be reported to the Trust Board after Quarter 3 and at the end of the financial year.

## **Annexe 1- National targets within the Annual Health Check**

### **Existing national targets**

Commitments due to be achieved before March 2005:

- Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge.
- Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.
- All ambulance Trusts to respond to 75% of category A calls within 8 minutes.
- All ambulance Trusts to respond to 95% of category A calls within 14 (urban)/19(rural) minutes.
- All ambulance Trusts to respond to 95% of category B calls within 14 (urban)/19(rural) minutes.
- Maintain a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.
- Maintain a maximum two-week wait standard for rapid access chest pain clinics.
- 3 month maximum wait for revascularisation by March 2005.
- From April 2002 all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days or fund the patient's treatment at the time and hospital of the patient's choice.

Commitments due to be achieved after March 2005:

- Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005, and a comprehensive child and adolescent mental health services by 2006.

- Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four to five different health care providers for planned hospital care, paid for by the NHS.
- Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005.
- Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005.
- 800,000 smokers from all groups successfully quitting at the 4-week stage by 2006.
- In primary care, update practice-based registers so that patients with coronary heart disease and diabetes continue to receive appropriate advice and treatment in line with NSF standards and, by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of coronary heart disease, particularly those with hypertension, diabetes and a BMI greater than 30.
- A minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy by 2006, and 100% by 2007.
- Achieve a maximum wait of 3 months for an outpatient appointment by December 2005.
- Achieve a maximum wait of 6 months for inpatients by December 2005.
- Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.

- Delayed transfers of care to reduce to a minimal level by 2006.

## **New national targets**

### **Priority 1: Improve the health of the population**

- 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 (from the Our Healthier Nation baseline, 1995-1997):
  - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
  - From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
  - From suicide and undetermined injury by at least 20%.
- Reduce health inequalities by 10% by 2010 (from a 1997-99 baseline) as measured by infant mortality and life expectancy at birth.
- Tackle the underlying determinants of ill health and health inequalities by:
  - Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups 1 (from 31% in 2002) to 26% or less.
  - Halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baselines) in the context of a broader strategy to tackle obesity in the population as a whole. (Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport).
  - Reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy

to improve sexual health (Joint target with the Department of Education and Skills).

### Priority 2: Supporting people with long-term conditions

- To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk and to reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline), through improved care in primary care and community settings for people with long-term conditions.

### Priority 3: Access to services

- To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.
- Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline) and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

#### Priority 4: Patient/user experience

- Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider as measured by independently validated surveys. The experience of black and minority ethnic groups will be specifically monitored as part of these surveys.
- Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:
  - Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008.
  - Increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.
- Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.
- Halve the MRSA bacteraemia infection rate by March 2008.

**Annexe 2 – Action Plans and progress against targets**

**GLOUCESTERSHIRE PRIMARY CARE TRUST  
2006/07 BUSINESS PLAN : Progress to date**

<b>Section 1 Key National Targets 06/07</b>	<b>Key Indicators</b>	<b>Key Milestones (PSA= public service agreement target)</b>	<b>Likelihood of achieving target :1 low, 5 high</b>	<b>Current position</b>	<b>Lead Director</b>
<p><b>Priority Target: MRSA Infection Control</b> Achieve year on year reductions in methicillin resistant Staphylococcus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available</p>	<p>Indicators are under review and not available at this time.</p>	<p>20% reduction per year</p>	<p>1</p>	<p>The PCT is measured as part of the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) level of recorded MRSA infections.</p> <p>GHNHSFT has put in place an action plan to minimise the rates of infection within the two District General Hospitals. An internal process is in place to closely monitor the implementation of the action plan and it will form part of performance monitoring through the PCT/GHNHSFT contract monitoring quality group.</p> <p>GHNHSFT do not expect to be able to meet the nationally set target in this year, due to the low baseline against which a 20% reduction is required. In addition this programme will have a lead in implementation time before improvements in performance will be seen.</p>	<p>JM</p>

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
				Performance will be reviewed in January to agree ongoing actions and expected activity.	
<p><b>Priority Target Health Inequalities Smoking Cessation</b> Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.</p>	<p>Smoking status among the population aged 15 to 75 years</p> <p>Progress of four week smoking quitters</p>	<p>Patients with CHD, diabetes, stroke, COPD or asthma who smoke, offered smoking cessation advice</p> <p>PSA06A PSA08A PSA08B</p>	<p>3</p> <p>1</p>	<p>The Gloucestershire Smoking Advisory Service (GSAS) has recently been reconfigured. Referrals have been low during the reconfiguration period with some agencies believing that the service had ceased. GSAS has put in place the following actions to advertise the service and improve performance in the latter half of the year.</p> <ul style="list-style-type: none"> <li>• An internal training programme for 'Support to Stop' Advisers.</li> <li>• A countywide launch for the newly reconfigured service including details of the new base and low cost telephone number.</li> </ul> <p>A campaign to support 'Smoke Free England 2007' (evidence from Scotland and Ireland is that there was an increase in smokers referring themselves to services following the announcement of smoke free legislation).</p>	SA
<p><b>Priority Target 18-week maximum wait</b> To ensure that by</p>	<p>Percentage of patients treated within 18 weeks where the patient</p>	<p>PSA13A</p>	<p>4</p>	<p>The 2008 target refocuses attention towards the overall patient wait, including the time during which a patient waits for an outpatient appointment, any diagnostic tests and any</p>	JH

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
<p>December 2008 patients wait not longer than 18 weeks from GP referral to consultant-led hospital treatment.</p>	<p>pathway involves an admission against national milestones and locally agreed referral to treatment (RTT) trajectories, by month.</p> <p>Percentage of patients treated within 18 weeks where the patient pathway does not involve an admission against national milestones and locally agreed referral to treatment (RTT) trajectories, by month.</p> <p>The number of patients waiting longer than 13 weeks and 6 weeks for MRI and CT tests</p>	<p>PSA13B PSA 13C PSA 13G</p>		<p>further wait whilst a definitive treatment is provided (e.g. surgery, or drugs being prescribed for a newly diagnosed medical condition). This is therefore a challenging target for the PCT, and one that is likely to require the commissioning of additional outpatient, diagnostic and elective capacity. The PCT will also need to pair this with an increasing focus on pathway redesign and service review to ensure that unnecessary waits are significantly reduced. Modeling work is currently being undertaken in preparation for the Local Delivery Plan, and this will give the PCT a clearer idea of the capacity and financial requirements to achieve both the 18 week target by December 2008, and the associated interim milestones. Due to financial restraints, it has not been possible to make significant reductions in waiting times during the 2006/7 financial year. A greater 'step' change is therefore required during 2007/8. As part of the LDP process, a decision will need to be taken around the degree to which capacity from non NHS acute providers (including the independent sector, primary care, and the voluntary sector) can also</p>	

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
	<p>The number of patients waiting longer than 13 weeks and 6 weeks for 13 key diagnostic tests</p> <p>The number of patients waiting longer than 13 weeks and 6 weeks for all other diagnostic tests</p>			<p>contribute to the required reductions in waiting times. It is acknowledged however that the most significant demand is likely to continue to be placed on local NHS hospital providers. Monthly monitoring of progress, against the new RTT definitions, will be in place by January 2007.</p>	
<p><b>Priority Target Patient Choice and Booking</b> To ensure that every hospital appointment will be booked for the convenience of the patient (by implementing Choose and Book system) and every patient is offered a choice of at least</p>	<p>The PCTs planned trajectory for outpatient booking through Choose and Book from April 2006 to March 2007</p> <p>Outpatient booking through Choose and book from April 2006 to March 2007</p>		3	<p>The actions listed below have been agreed in order to improve performance.</p> <p>The PCT will be:</p> <ul style="list-style-type: none"> <li>• Submitting revised trajectories to the SHA, based on the evidence that total referrals to outpatients are significantly lower than those predicted in the trajectory, and therefore actual percentage utilisation is currently higher than that reported.</li> <li>• Reminding practices what they need to do in order to obtain the Enhanced Service incentive payments. Communication will be</li> </ul>	JH

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
four providers	<p>Percentage of patients eligible for choice an booking surveyed in the financial year 2006/07 who answered positively to a question regarding being offered a choice of hospital</p> <p>Percentage of patients eligible for choice and booking who answered positively to a question regarding receiving written information to help make their choice</p>			<p>issued to practices from the Interim Director of Commissioning/ Primary Care, to reinforce the terms of the Enhanced Service. This requires practices to achieve 50-90% utilisation during Sept 06 - Feb 07 to retain the initial incentive payment and trigger the final payment.</p> <ul style="list-style-type: none"> <li>• Agreeing trajectories for individual practices, not currently achieving required utilisation.</li> </ul> <p>There are 9 practices in the county who are not currently signed up to the Enhanced Service. This means that there is a significant risk to the PCT achieving the 90% target. The PCT will be identifying those practices that have failed to sign up to the Enhanced Service and will conduct a more detailed analysis into the barriers that are preventing engagement. Once the analysis is complete, the PCT will agree actions to overcome these barriers and achieve sign up.</p>	
<b>Priority Target Cancer 31 and 62 day waits</b>	Substantially reduce mortality rates by 2010 from cancer by	A maximum waiting time of 31 days from	5	Two week wait, this target is currently being met and sustained, this has been achieved by clinical and administrative being increased.	

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
<p>To ensure the sustained delivery throughout 2006/07 of a maximum waiting time of two months from urgent referral to treatment, and of one month from diagnosis to treatment, for all cancers.</p>	<p>at least 20% in people under 25 with a reduction of the inequalities gap of at least 6%</p> <p>Maximum waiting time of 1 month from diagnosis to treatment</p> <p>Maximum wait of two months from urgent referral to treatment</p> <p>Maximum wait of two weeks from urgent GP referral to first out patient appointment</p> <p>Breast cancer screening for women aged 50 to 70 years</p> <p>Implementation of NICE improving</p>	<p>diagnosis to treatment and 62 days from referral to start of treatment for all cancers by December 2005.</p> <p>PSA03A</p>		<p>The position is monitored on an ongoing basis. 31 day target, the 98% target is now being achieved partly by the development of delivering pathways which provide timely treatments. 62 day waits are largely being met, this has been possible with further specialist pathways such as head and neck. Also the development of set criteria, and single process for approval of PET scans for certain conditions will help to streamline the process and further assist with delivery of targets. One of the areas that is closely monitored is the referrals from hospital of diagnosis to hospital of treatment, resulting in shared breaches. Weekly monitoring of these targets is continuing at both Trust and PCT level, and is supported by comprehensive individual patient tracking and breach analysis systems. Pathway redesign is continuing as part of plans to achieve improving outcomes guidance in all sub-specialities.</p>	<p>JH</p>

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
	outcomes guidance (IOGs)				
<p><b>Priority Target Sexual health and access to Genito-Urinary Medicine (GUM)</b> To deliver a 2006/07 LDP trajectory so that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours.</p> <p>Reducing the under 18 conception rate by 50% by 2010</p>	<p>Access to genito-urinary medicine (GUM) clinics</p> <p>Access to contraception</p> <p>Access to termination of pregnancy services</p> <p>Under 18 conception rate</p>	<p>By 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours.</p>	<p>5</p>	<p>The waiting time for GUM appointments is decreasing. The county-wide target for 2006/07 is 50% to have an appointment within 48 hours. Performance is significantly above this locally agreed trajectory for this financial year. This is because high levels of people presenting for a GUM clinic attend a 'walk in' clinic. By definition they are referred and seen at the same time. As a result performance is exceeding planned expectations this year, however achieving the 48 hr target for 100% of GUM appointments is far more challenging. Some work is being undertaken to model the numbers of 'walk in' patients against the number of booked appointments to enable managers to plan actions to improve the performance in 2007 08 to meet the target of all patients having an appointment within 48 hours by March 2008</p> <p>The county has achieved a 17.7% reduction in teenage pregnancies, based on the most recent data (2004), and so is in a good position</p>	<p>JF</p>

Section 1 Key National Targets 06/07	Key Indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target :1 low, 5 high	Current position	Lead Director
(from the 1998 baseline), as part of a broader strategy to improve sexual health				to achieve the 2010 target. The PCT currently funds a scheme that provides free emergency hormonal contraception (EHC) through 18 community pharmacies. In addition, Gloucester has benefited from increased funding as a result of a Public Service Agreement between the County Council and the Office of the Deputy Prime Minister. This has resulted in increased services for young people, for example, additional extended school nurse drop-ins. An action plan will be developed in accordance with the Public Health White Paper.	

Section 2 Existing National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
Primary Care Access Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours			5	Achieved in 2005/06 and on target for this year	JH
<p>Ambulance response</p> <p>All ambulance Trusts to respond to 95% of category A calls within 19 minutes</p> <p>All ambulance trusts to respond to 75% of category A calls within 8 minutes</p> <p>All ambulance trusts to respond to 95% of category B calls with 19 minutes</p>			1	<p>The Great Western Ambulance Service NHS Trust (GWAS) is committed to improving ambulance response standards in all areas of the Trust (encompassing Gloucestershire, Bristol and Wiltshire). A remedial action plan is being formulated</p> <p>The following are some of the actions that are planned for the Gloucestershire Sector: Emergency Medical Dispatch - Centre Reconfiguration The Trust will temporarily move the receipt of '999' emergency calls to the Emergency Medical Dispatch Centre located in Almondsbury (considered nationally to be a centre of excellence in terms</p>	JH

Section 2 Existing National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
				<p>of the processing of '999' calls).  Emergency Care Practitioners (ECPs)  ECPs are trained to treat patients with minor injuries at the scene and, where appropriate, avoid the long and often unnecessary journey to an acute hospital. This will help improve performance by releasing ambulances only where they are clinically necessary. The Trust has 4 fully trained Emergency Care Practitioners (ECPs) currently working in the Gloucester Emergency Medical Dispatch Centre and in the Gloucester and Cheltenham areas. By January 2007, there will be 6 more trained ECPs in the Gloucestershire sector.</p>	
<b>CAMHS</b> Commissioning a comprehensive Child and adolescent mental health service	24/7 availability to assess urgent mental health needs. specialist mental health assessments take place within 24 hours of assessment		5	Achieved in 2005/06 and on target for this year  Services are in place for older children and for children with a learning disability. However, this can result in a patchy service and on review it is our view that although some services are available, a full range is not	JH

<b>Section 2 Existing National Targets</b>	<b>Key indicators</b>	<b>Key Milestones (PSA= public service agreement target)</b>	<b>Likelihood of achieving target (1 low, 5 high)</b>	<b>Current position</b>	
	<p>when needed.</p> <p>Full range of CAMHS services in place for children with a learning disability</p> <p>Appropriate Services for 16 and 17 year olds</p>			explicitly commissioned in this area. Work is underway to achieve this by December 2006	
<b>Crisis Resolution</b> Commissioning of crisis resolution/home treatment services	Number of people receiving crisis resolution services		2	Target for CRHT unlikely to be achieved – new Crisis Team in Gloucester City not fully operational yet. 2006 target of 1021. Methodology for counting home treatment needs clarifying with SHA lead. The methodology has changed from previous years target..	JH
<b>Delayed Transfer of Care</b>	Reduced to a minimal level		5	Achieved in 2005/06 and on target for this year	JF
<b>Diabetic Retinopathy</b>	A minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic		4	The 80% target of people with diabetes to be offered screening for the early detection of diabetic retinopathy was attained in April 2006. However, the number of people with diabetes has continued to rise beyond local projections. The retinopathy screening service have requested additional funding (via the 2007/08)	JH

<b>Section 2 Existing National Targets</b>	<b>Key indicators</b>	<b>Key Milestones (PSA= public service agreement target)</b>	<b>Likelihood of achieving target (1 low, 5 high)</b>	<b>Current position</b>	
	retinopathy by 2006, and 100% by 2007.			LDP, without which they assert, the 80% target will not be sustained and the 100% December 2007 target will not be achieved.	
<b>Revascularisation</b>	Maintain three month wait		5	Achieved in 2005/06 and on target for this year	JH
<b>Practice Based Registers</b>	Coronary Heart disease patients called for review  Diabetes patients called for review	In primary care, update practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater	5	Achieved in 2005/06 and on target for this year  The implementation of the Quality & Outcomes Framework has had a very positive impact on the management of chronic diseases, particularly CHD and Diabetes. All practices have well established and maintained disease registers, with established criteria and a regular programme of reviews to manage their patients according to best practice.  A good proxy for the review of patients on disease registers is Blood Pressure monitoring, a key element of review in both CHD and Diabetes. Data from the QOF system on BP monitoring shows that for Gloucestershire 94% of CHD patients had been monitored in the past 12 months, and for the Diabetes register the figure was 95%.	JH

Section 2 Existing National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
		than 30.			
<b>Thrombolysis</b>	10% increase in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help		2	<p>There continues to be improvement in performance against this indicator. In 2005/06, the % of eligible patients with a call to needle time within 60mins was 31% against a 58% target. Performance to date for 2006/07 has risen to 48% against a 68% target.</p> <p>The recent amalgamation of Glos. Ambulance Service within Great Western Ambulance Service has provided opportunities for shared learning and good practice to be rolled out in a consistent fashion across the AGW area. GAS has now been brought under the umbrella of the AGW Cardiac Network Pre-hospital Thrombolysis Group and leaders have a track record of improvement.</p> <p>Recent developments include the improvement of robust links between GAS and GHT in the collection, recording and submission of data, the widening of the eligibility criteria for those qualifying for thrombolysis (e.g. increased age from 75 &gt; 80), re-launch of the pre-hospital thrombolysis service and introduction of regular newsletter with performance updates,</p>	JH

Section 2 Existing National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
				increased level of support from clinicians and the setting up of re-routed failed telemetry to other hospitals when transmission fails. It is anticipated that these and other service improvements will result in continued improvement in performance against target.	
<b>A&amp;E Waits</b>	Maintain four hour maximum wait		5	Achieved in 2005/06 and on target for this year	JH

Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
<p>Stroke and Heart Disease</p> <p>Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.</p>	<p>Blood pressure readings for CHD patients</p> <p>Cardiovascular disease mortality</p> <p>Cholesterol levels</p> <p>Diabetes: management of blood sugar</p> <p>Practice Based registers for risk of CHD events</p>	<p>By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women</p> <p>PSA 01A PSA 01B PSA01C PSA01D</p>	<p>5</p>	<p>Performance, incentivised by QOF continues to produce impressive results:</p> <p>CHD: The % of patients with CHD who have a record of BP measurement – 96.8%</p> <p>CHD: The % of patients with CHD with last blood pressure reading is 150/90mmHG or less is 84.8%</p> <p>CHD: The % of patients with CHD who have a record of cholesterol measurement - 92.2%</p> <p>CHD: The % of patients with CHD who have a cholesterol measurement of 5mmol or less – 78%</p> <p>CHD: The % of patients with CHD who have a cholesterol measurement of 4mmol or less – 35%</p> <p>Diabetes: The % of patients with diabetes who have a record of HbA1c measurement – 94%</p> <p>Diabetes: The % of patients with diabetes whose last HbA1c measurement was 7.5 or less – 57%</p> <p>Diabetes: The % of patients with diabetes whose last HbA1c measurement was 6.5 or less – 27%</p>	



Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
<p><b>Obesity</b> Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.</p>	<p>GP recording of body mass index (BMI) status</p> <p>Childhood obesity data Reception year height and weight recording.</p>	<p>Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. PSA10B</p>	3	<p>The School Nursing Service has recruited additional staff within its financial envelope to undertake the childhood obesity monitoring. An operational plan in place to achieve the target by May 07 in time to upload the screening results to the Department of Health. The service will offer screening to all eligible children whose parents consent. It is anticipated that some parents may decline and some children may be absent on the census day but we anticipate that we will achieve the target. Further work is in progress with the Local Education Authority to pilot the use of teaching assistants to assist the School nursing service in delivering this service.</p>	
<p>Long Term Conditions To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days</p>	<p>Community matrons</p> <p>Emergency bed days</p> <p>Number of very high intensity users</p>		3	<p>Several work-streams have been identified to pull together work within the county on Long Term Conditions. These form an outline strategy for implementation in health and social care.</p> <p>The main direction for this strategy is to support much better identification of this patient group, at an earlier stage of illness, whilst self management and primary care</p>	JF

Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.				<p>support are appropriate and possible. The 80% of patients with a LTC that have early symptoms will be identified using an algorithm developed by the Department of Health, which will also then show us the remaining 20% who are currently intensive users of health services both in primary and secondary care. Once we have identified these patients we can then see where they could be best treated in the model. Within primary care with disease monitoring and proactive self management, with support from the GP and Practice Nurse, or by a combination of this and some input from a wider multidisciplinary team, to include social care, or by highly skilled nurse practitioners, working with the MDT to manage complex, very poorly patients. Because of the peaks and troughs generated by these particular disease pathways, we would expect the management of the patient to move from different parts of the healthcare team, escalated and deescalated, according to the needs of the patient.</p> <p>There are several projects currently underway across different parts of service provision and</p>	

Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
				<p>commissioning, involving a redesign of the District Nursing service, the redesign of local healthcare services and the change in commissioning responsibilities with the emergence of GP commissioning clusters. These will all affect the implementation and uptake of the broad care co-ordination model that has been drafted to date. The challenge now is to ensure the agreement and understanding around this model of care is translated into and across all other project developments, involving all stakeholders.</p> <p>Discussions are underway with the strategic Health Authority to test the indicators for this target. The service meets the overall aims but does not hit the target for Community Matrons.</p>	
<p><b>Drug misusers</b> Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year</p>	<p>Drug misusers sustained in treatment</p>	<p>Increase year on year the proportion of users successfully sustaining or completing treatment programmes</p>	<p>3</p>	<p>Achieved in 2005/06 and on target for this year</p> <p>The current financial restrictions mean that progress towards interim milestones may be limited in 2006/07 and this in turn will create additional financial and operational pressures in respect of meeting the 2008 target.</p> <p>On a countywide basis the target for numbers</p>	<p>JH</p>

Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
the proportion of users successfully sustaining or completing treatment programmes.		PSA14A		into treatment is being achieved in Q2 and indications are green for year end.  The retention target is 78% in Q2 and therefore amber against stretch target of 85%. Investigation is taking place on whether this is data collection or operational.	
<b>Patient Experience</b> Secure sustained national improvements in NHS patient experience by 2008 ensuring that individuals are fully involved in decision about their health care including choice of provider.	Indicator not available. to be measured by independently validated surveys		4	This is a new target and the exact measure is not yet available. However, The PCT is working with the newly formed Patient Forum to review progress towards establishing Local involvement Networks (LINKS) and to ensure community involvement.	AF
<b>Older People</b> Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where	Community equipment  New Older Peoples Mental Health: Up to date assessment of older peoples needs		4	There is planned development of services to improve the quality of life of vulnerable older people. The partnership with Social Services reflects a shared approach to investment. This includes supporting the consolidation of a well-being strategy for older people and the appointment of a community stroke co-	JF

Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
possible by supporting them to live in their own home by 1% annually in 2007 and 2008, and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	and services.			<p>ordinator to support primary care in the management of strokes within the community.</p> <p>Adoption of the Single Assessment Process throughout the PCT will minimise duplication and ensure effective working both within and across agencies. There is an increased focus on the needs of older people with mental health needs and their carers through expanding the skills of intermediate care services to include Mental Health expertise. This work will enhance the major service reconfiguration currently underway in GPT and acute OPMH inpatient services. Reconfiguration of services to enhance the availability of skilled nursing and care services is being piloted to provide palliative care services at home wherever possible to replace a reliance on nursing home care unless this is the service of choice.</p> <p>The PCT and GCC have been successful in gaining funding support for the Partnership Older Peoples Project (POPP) in the county to ensure all care homes have access to an expanded care homes support team working</p>	

Section 3 New National Targets	Key indicators	Key Milestones (PSA= public service agreement target)	Likelihood of achieving target (1 low, 5 high)	Current position	
				<p>with staff providing care for older people living in long term care homes to ensure that appropriate levels of care and support minimises the need for inappropriate hospital admissions and timely discharge for both rehabilitation and care support.</p> <p>The Health Care of Older People block of the LAA has Falls prevention as a key priority for investment and co-ordination to support healthy active older age, and reduce the number of fractures in older people over 75.</p>	



### **Annexe 3 Core and Developmental standards – Standards for Better Health**

There are seven domains, which are listed here, along with their expected outcome. Within each domain there are a number of core and developmental standards that Trusts are measured against.

#### First Domain – Safety

##### Domain outcome

Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

#### Second Domain – Clinical and Cost Effectiveness

##### Domain outcome

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes

#### Third Domain – Governance

##### Domain outcome

Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.

#### Fourth Domain – Patient Focus

##### Domain outcome

Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other (especially social care) which services impact on patient well-being.

### Fifth Domain – Accessible and Responsive Care

#### Domain outcome

Patients receive services as promptly as possible, have choice in access to services and treatments and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

### Sixth Domain – Care Environment and Amenities

#### Domain Outcome

Care is provided in environments that promote patients and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

### Seventh Domain – Public Health

#### Domain outcome

Programmes and services are designed and delivered in collaboration with all relevant and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.