

**Technical Note for the Spending Review 2004
Public Service Agreement 2005-2008**



Updated March 2006

The following tables set out details of how the SR2004 PSA for the Department of Health will be measured. All data collections, unless otherwise indicated, are for England. These technical notes reflect work in progress and will be updated when more detailed work on definitions and monitoring is complete in the autumn.

PSA Priority I: Health of the Population

PSA Target	Technical Note
<p>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.</p> <p>Substantially reduce mortality rates by 2010:</p> <p>- 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</p>	<ul style="list-style-type: none"> • By 2010, increase average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women: <p>The figures above represent a 10% increase on the currently projected increase in average life expectancy, using Government Actuary's Department (GAD) principal projections. Original estimates were based on 2002 based projections. Now updated to 2003 based projections on GAD website http://www.gad.gov.uk/Population/2003/england/weng03cc.xls</p> <p>The update did not make any difference to the overall life expectancy estimates, rounded to one decimal place.</p> <ul style="list-style-type: none"> • Reduction in mortality rates from Circulatory diseases (by at least 40%) and cancer (by at least 20%) in people aged under 75, and from Suicide & undetermined injury (by at least 20%) in people of all ages: <p>Scope:</p> <p>Coronary heart disease and stroke and related conditions: includes all circulatory diseases – International Classification of Diseases ICD-10 codes I00-I99 inclusive. [Data for years prior to 2001 have been adjusted for consistency with the 10th revision of the International Classification of Diseases]</p> <p>Cancer: all malignant neoplasms – ICD-10 codes C00-C97 inclusive. [Data for years prior to 2001 have been adjusted for consistency with the 10th revision of the International Classification of Diseases]</p> <p>Suicide and undetermined injury: ICD-10 codes X60-X84, Y10-Y34 excluding Y33.9. [No adjustment was necessary as data for this cause of death are consistent with those under ICD-9].</p>

PSA Target	Technical Note
<p>indicators and the population as a whole;</p> <p>- from cancer by at least 20% in people under 75 with at least 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;</p> <p>- from suicide and undetermined injury by at least 20%.</p>	<p>Sources of data: For life expectancy - Life expectancies for England as a whole are calculated by the Government Actuary's Department (GAD). For mortality – Numbers of deaths by cause of death are provided by the Office for National Statistics (ONS), from death registrations. Population estimates are calculated by ONS. Mortality rates are directly age standardised to allow for changes in the age structure of the population (using the European standard population as defined by the World Health Organisation).</p> <p>Definitions for all three mortality targets above:</p> <p>Baseline year: The average of the European age standardised rates for the three years 1995, 1996 and 1997.</p> <p>Target year: The average of the three years 2009, 2010 and 2011 plotted against the middle year 2010. Three-year rolling average rates are generally used for monitoring purposes, in preference to single year rates, in order to produce a smoothed trend from the data and to ensure the underlying trend is captured rather than year-on-year fluctuations.</p> <p>By 2010 means by the average of the three calendar years 2009, 2010 and 2011. Thus, the final day of the target period is 31 December 2011. Monitoring data are expected to be available in late summer 2012. [Mid-year population estimates are not usually available until September, and given that 2011 will be a Census year, the estimates for that year may be later than in non-Census years, and subject to further revisions].</p> <p>The target definitions are as set out in the Our Healthier Nation White Paper – www.official-documents.co.uk/document/cm43/4386/4386-10.htm</p> <p>Reporting: Frequency - annual. Timetable - Late summer / early autumn. [Mortality rate data usually available by September, except in Census years when population estimates are subject to later revisions.]</p> <p>Inequalities aspects of circulatory disease and cancer targets:</p> <p>The target is to narrow the absolute gap between the national average rate and the average rate for the Local Authority areas identified as having the “worst health and deprivation indicators” in the baseline years (1995-97). This is a fixed group of Local Authority (LA) areas, referred to as the “Spearhead group”.</p>

PSA Target	Technical Note
<p>Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth</p>	<p>LA areas are ranked on each of 5 strongly correlated variables:</p> <ul style="list-style-type: none"> • Male average life expectancy at birth • Female average life expectancy at birth • Circulatory disease mortality rate among under 75s • Cancer mortality rate among under 75s • Deprivation (as measured by the ODPM Index of Multiple Deprivation 2004, LA Summary, average scores) [ODPM = Office of the Deputy Prime Minister] <p>Each LA is given a score depending on whether it is in the “worst” quintile for 0, 1, 2, 3, 4 or 5 of these indicators. Life expectancy and mortality rates are assessed against their positions in 1995-97 (the baseline period), while the current (2004) version of the ODPM Index of Deprivation is used. (“Worst” = lowest for average life expectancy, and highest for mortality rates and deprivation scores).</p> <p>Included in the target group are those LAs, which are in the “worst” quintile for at least 3 of the 5 indicators. The list of included LAs and their associated PCTs can be found on the DH website at http://www.dh.gov.uk/assetRoot/04/09/54/13/04095413.pdf</p> <p>Reducing Health Inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth:</p> <p><u>Infant mortality – reducing the gap by social classification:</u> Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole. Age group: under one. Definition of infant mortality rate is the mortality rate among children aged under one year per 1,000 live births.</p> <p>The target is to narrow the relative gap between the rate in routine and manual groups and the population as a whole (i.e. the percentage difference between the two rates)</p> <p>Target reduction by year 2010: at least 10%. This formulation takes account of the changes to the National Statistics socio-economic classification (NS-SEC) by ONS from 2001 onwards. Routine and manual groups are defined by the father’s</p>

PSA Target	Technical Note
	<p>occupation as recorded on the child's birth certificate. The routine and manual category is formed by combining classes 5, 6 and 7 (i.e. lower supervisory and technical, semi-routine and routine).</p> <p>Baseline year: the three year average 1997-99. (This remains the same as for the original infant mortality inequalities target).</p> <p><u>Life expectancy – reducing the gap by area:</u></p> <p>Starting with Local Authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the “worst health and deprivation indicators” and the population as a whole.</p> <p>(NB “worst health and deprivation indicators” as defined above. The group of areas is referred to as the “Spearhead group”).</p> <p>This has been revised from the previous (PSA 2002) target in order to be consistent with the new inequalities aspects of the cancer and circulatory disease targets. This affects both the baseline year and the targeted geographical areas, which are now on a different basis and fixed.</p> <p>The target is to narrow the relative gap between the “Spearhead” areas and the national average</p> <p>Areas. This is a change from the previous (PSA 2002) target, which was to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. It has now been changed for consistency with the inequalities elements of the circulatory disease and cancer mortality targets. The same LA areas as described above are used for comparison with the national average.</p> <p>Target reduction by year 2010: at least 10%. This target is currently monitored using Local Authority areas because of the relative stability of their boundaries and availability of historic trend data for LAs.</p> <p>Target year: The average of the three years 2009, 2010 and 2011 plotted against the middle year 2010. Thus the final day of the period is 31 December 2011. Final monitoring data are expected to be available in winter 2012 / spring 2013, subject to the availability of data on population estimates.</p>

PSA Target	Technical Note
	<p>Baseline year: The average of the three years 1995, 1996 and 1997.(Previous baseline was 1997, 1998 and 1999 – now changed for consistency with the inequalities elements of the circulatory disease and cancer mortality targets). Three-year rolling averages are generally used for monitoring purposes in preference to single year rates. This is in order to produce a smoothed trend from the data and to ensure the underlying trend is captured rather than year-on-year fluctuations.</p> <p>Sources of data: For infant mortality, the data are derived from the Office for National Statistics (ONS) linked file, linking information on birth and death registrations. A 10% sample of records are linked in this way. For life expectancy, figures for LAs are calculated by ONS. ONS data for both are published in 'Health Statistics Quarterly', and are also available on the National Statistics website at http://www.statistics.gov.uk/.</p> <p>Reporting: Frequency – annual. Timetable - Winter. [Calculation of life expectancy at birth requires population estimates to be finalised. In a Census year, these are subject to later revisions]</p>
<p>Tackle the underlying determinants of health and health inequalities by:</p> <p>Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.</p>	<ul style="list-style-type: none"> ● Smoking <p>Scope: Adults aged 16 and over in England</p> <p>Definitions: Prevalence from General Household Survey (GHS); routine and manual socio-economic groups defined by NS-SEC</p> <p>Data source: ONS General Household Survey</p> <p>Baseline year: 2002 for both adults and routine / manual groups (2002 is shorthand for 2002/03 GHS). The 2002 baseline figure for smoking among adults is 26% and for routine and manual groups 31%.</p> <p>Target year: 2010. In practice this will mean the 2010/11 financial year GHS survey data</p>

PSA Target	Technical Note
<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 (Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport)</p>	<p>Reporting: Annual data. The lag between the end of the collection period and data being published is around 12 to 15 months.</p> <ul style="list-style-type: none"> • Obesity <p>Scope: Children aged between 2 and 10 years (inclusive) in England.</p> <p>Obesity: Prevalence of obesity as defined by the National BMI percentile classification (from the 1990 reference population from T J Cole et al) and measured through the Health Survey for England. Children above the 95th percentile of the 1990 reference curve are defined as obese.</p> <p>Halt the year on year increase: Obesity in 2–10 year olds rose, on average, by 0.8% per year between 1995 and 2002. Halting the increase would mean no significant change in prevalence between the two three year periods 2005/06/07 and 2008/09/10.</p> <p>Data source: Health Survey for England. We are also exploring with colleagues in DH and DfES the cost and feasibility of options for other sources of data in order to obtain more local level information.</p> <p>Baseline year: Due to the small sample size, the baseline will be the weighted average for the three-year period 2002/03/04.</p> <p>Target year: by 31 December 2010, in practice this will mean 2010-11 calendar year</p> <p>Reporting: Annually (aggregate trend data will be available every three years). The lag between the end of the collecting period and data being published is around 12-15 months. More information can be found at; http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4126385&chk=Qb6Blx</p> <p>OGD contributions to PSA: The delivery of this joint PSA target will be supported by a range of programmes including: a) the joint DfES and DCMS PE, School Sport and Club Links project which seeks to increase the percentage of school</p>

PSA Target	Technical Note
<p>Reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. (Joint target with the Department for Education and Skills)</p>	<p>children who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum; b) the joint DfES and DH National Healthy Schools Programme which seeks to promote a whole school approach to healthy living; c) the joint DfES and DH "Food in Schools" Programme which seeks to promote a whole school approach to a range of food issues.</p> <ul style="list-style-type: none"> ● Teenage Pregnancy <p>Definition: The under-18 conception rate is the number of conceptions to under-18 year olds per thousand females aged 15-17. It is calculated on a calendar year basis.</p> <p>Base Year: Calendar year 1998. The baseline rate is 46.6 conceptions under 18 per 1000 females aged 15-17</p> <p>Target Year: Calendar year 2010 (data will be published in February 2012). The target year rate is 23.3 conceptions under 18 per 1000 females aged 15-17</p> <p>Source of Data: ONS conception statistics are compiled from birth registrations and abortion notifications (miscarriages are not included). Conception rates are calculated using ONS mid-year population estimates. This is a well-established, published statistical series. (Further details are available on the ONS website: http://www.statistics.gov.uk)</p> <p>The target is measured using the percentage difference in England's 1998 under-18 conception rate and the rate for the latest year data are available. (All percentage changes are calculated using unrounded rates). Formula: <i>Percentage change = (Latest rate-1998 rate)/1998 rate*100</i></p> <p>Reporting: Annually. Annual conception data are released by ONS each February (14 months after the calendar year to which they relate. For example, conception data for 2004 were released in February 2006). The 14 month lag is mainly because conception data are compiled partly from birth registrations (which legally can be undertaken up to 6 weeks after birth). Therefore ONS may not have information to identify a conception until up to 11 months after the date of that conception.</p>

PSA Priority II: Long Term Conditions

PSA Target	Technical Note
<p>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, through improved care in primary care and community settings for people with long-term conditions.</p>	<p>Scope: Patients - All people (including children) with long-term conditions; that is diseases or conditions, which current medical interventions can control, but not cure. Examples include diabetes, asthma, arthritis, heart failure, chronic obstructive pulmonary disease, depression, and a range of disabling neurological conditions. This list is deliberately not exhaustive to provide for local flexibility and scope for prioritisation to meet local needs.</p> <p>Many people with long-term conditions can manage them well most of the time, with access to support in primary care and systematic and tailored disease management programmes when appropriate. The most at risk and vulnerable people (drawn from those with more than one condition) have more complex needs and require more proactive support. This population is estimated at some 250,000, and each will be supported by a key worker who is co-responsible with the individual for the care plan, and responsible for co-ordinating services to meet the health and care needs identified in the plan.</p> <p>Definitions:</p> <p>Emergency bed days would be defined as relevant emergency medical and surgical bed days.</p> <p>Exclusions: The following admissions not included in Emergency Bed Days data are:</p> <ul style="list-style-type: none"> - infectious and viral diseases - Gynaecological: abortion and childbirth complications - Road Traffic accidents <p>The most at risk vulnerable people are regarded as <i>very high intensity users</i> of care. These are defined as individuals that have multiple chronic conditions (on average three) and who make very high use of secondary care – some 0.5% of the population (or around 250,000 people). These people should be offered a personalised care plan to be implemented through a proactive local care co-ordinator in partnership with the patient him/herself. The intention will be to ensure that proactive and co-ordinated care, as set out in the individual care plans, is delivered in primary and community settings for these <i>very high intensive users</i> to help maintain their health and avoid unnecessary use of acute inpatient hospital services.</p>

PSA Target	Technical Note
	<p>Sources of Data:</p> <p>Bed-days: Hospital Episode Statistics (HES) data. Data on emergency bed days are available on a provisional basis 9 months after quarter end. These will provide a leading indicator, with definitive outturn data available 9 months after year-end.</p> <p>Care Plan: Options are being explored for measuring and assessing the progress of the implementation and effectiveness of Care Plans. These include; a sample evidence-based information gathering exercise, using a geographical spread of patients to obtain qualitative information on Care Plans. There is also the potential to include information about Care Plans via a national case management tool. Both of these options are intended to feed into a nationally rolled-out balanced scorecard to be managed locally by PCTs.</p> <p>Baseline: 2003/04 emergency bed-days as defined above under 'Definitions'</p> <p>Target Year: End March 2008</p> <p>Reporting: Bed days: Annual</p>

PSA Priority III: Access to Services

PSA Target	Technical Note
<p>To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.</p>	<p>Scope: All NHS GP referrals to a consultant, including outpatients, subsequent diagnostic tests and elective treatment.</p> <p>Definitions: “GP referral to hospital treatment”: Start point: Patient booking of first outpatient appointment. End point: start of treatment</p> <p>The final principles and definitions guidance, due to be published in Spring 2006, will provide further information on the definitions for 18 weeks.</p> <p>Hospital Treatment: The treatment pathway will end where:</p> <ul style="list-style-type: none"> • The patient and consultant agree that no diagnostic (or further diagnostic) or inpatient treatment are necessary, i.e. there is no Decision to Treat. • The patient is admitted as an inpatient or day case or undergoes first definitive treatment in outpatients • The decision is made that a period of watchful waiting or active monitoring is appropriate. <p>Planned principles and definitions guidance will provide further information on definitions.</p> <p>Patient Choice: Planned guidance will set out the interaction between Access and Patient Choice, and the technical note will be updated in light of this.</p> <p>Source of data: Full “GP referral to hospital treatment” waiting times will be monitored through the new IT systems procured by CfH in 2008/09. Tactical measurement systems will be used in the interim. Eight pioneer health communities have been selected to develop simple and effective ways of measuring referral to treatment times ahead of the development of the CfH strategic solution.</p> <p>Definitions: Monitoring of individual stage of treatment waiting times</p> <p>Progress towards the 18-week target will be measured by waiting times for individual stages of treatment until the launch of the full “GP referral to hospital treatment” measure.</p>

PSA Target	Technical Note
	<p>Diagnostics waiting time: Coverage: Imaging, Pathology, Endoscopy, Physiological Measurement (excluding therapy and screening services). For imaging, physiological measurement and endoscopy, the diagnostic waiting time is the interval between the date the request for a test/procedure is made and the date that the test/procedure is carried out. For pathology, the diagnostic waiting time is the interval between the date the request for a test is made and the date that the results are available in the laboratory.</p> <p>Source of data: Two new data collection have been introduced in early 2006 to monitor diagnostic waiting times: i. monthly data collection looking at waiting times and activity for 15 key tests/procedures ii. biannual census looking at waiting times of over 6 weeks for all diagnostic tests/procedures</p> <p>Further information on the data collections can be found at: www.18week.nhs.uk</p> <p>Outpatient appointment waiting time: The waiting time of patients seen for their first outpatient appointment following referral by a GP to a consultant will be the interval between the booking of the appointment and the date when the patient is seen at the outpatient clinic. For patients who fail to attend, the waiting time is the interval between the last missed appointment and the date the patient sees the doctor for the first time for outpatient treatment.</p> <p>Source of data: Aggregate DH returns. As set out in www.doh.gov.uk/waitingtimes/ . Changes will be required to collections to enable capturing of appropriate time bands.</p> <p>Inpatient treatment waiting time: Waiting times begin from the date the clinician decided to admit the patient. For patients who fail to attend, the waiting time is the interval between the last missed appointment and the date the patient sees the doctor for inpatient treatment. The waiting time needs to be adjusted to remove any periods of suspension.</p> <p>Source of data: Aggregate DH returns. As set out in www.doh.gov.uk/waitingtimes/. Changes will be required to collections to enable capturing of appropriate time bands.</p>

PSA Target	Technical Note
	<p>Period of suspension for inpatients/outpatients: period of time the patient was unavailable for admission for medical reasons or because of personal commitments (eg. Holidays).</p> <p>By 2008 is 31 December 2008</p> <p>Note: These technical notes are indicative of the target definitions and monitoring requirements, which are being developed. More detailed information on the principles and definitions for 18 weeks is therefore proposed for Spring 2006.</p>
<p>Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.</p>	<p>Scope: This target (excluding that part relating to those who only receive treatment whilst in prison and who do not receive any treatment in the community).is owned by the Department of Health and applies to all those in drug treatment in England.</p> <p>Definitions</p> <p>Drug treatment programmes: structured treatment occurring within Tiers 3 and 4, that aims to stabilise, reduce or eliminate drug misuse and/or dependence, while also minimising the adverse criminal and health effects of drug misuse. Drug treatment programmes also aim to rehabilitate the misusers into society. Full definitions of the Tiers of Service Provision are contained within <i>Models of Care for Adult Users 2002</i>. (National Treatment Agency)</p> <p>The key measures are defined as:</p> <ul style="list-style-type: none"> • the number of problem drug misusers in treatment programmes in a financial year • the percentage of drug misusers admitted into treatment in a financial year who were retained in continuous treatment for 12 weeks or more measured over their latest treatment journey. <p>Baseline:</p> <p>The baseline year for the in treatment target is 1998/99. The numbers of users in treatment in 1998/99 (excluding treatment in prisons) was estimated using 2000/01 census data along with national data on numbers in treatment collected via the National Drug Treatment Monitoring System (NDTMS) in 2001/02. The baseline estimate of numbers in treatment in 1998/99</p>

PSA Target	Technical Note
	<p>is 85,000. This figure is a revision of the previously estimated 102,000 and is based on an independent analysis conducted in 2005 by the National Drug Evidence Centre, University of Manchester¹. This analysis estimated the degree to which multiple counting of individuals resulted in an over estimate of the numbers in treatment in 2000/2001.</p> <p>NDTMS data for 2003/04 is available at national and local level and will be used as a baseline for all future monitoring of those “in treatment” at local level. Strategic Health Authorities (SHAs) will use 2003/04 data to set baselines against which Primary Care Trusts (PCTs) will set planned increases in line with the national target.</p> <p>The percentage of drug misusers admitted into treatment in the financial year, who were retained in treatment for 12 weeks or more was introduced as a proxy measure of treatment effectiveness in 2005. This measure examines early treatment experience across the whole treatment system and is considered more able to accurately impact upon and assess performance towards the second part of the PSA. This measure replaces the previous annual audit and follows on from a series of cross government workshops on ways in which treatment effectiveness and performance can be improved. NDTMS data for 2004/5 at national and local level will be used as the baseline.</p> <p>Data Source: The NDTMS is operated by the National Treatment Agency. These figures are published annually to measure progress against targets each year.</p> <p>The NDTMS has a more tightly defined focus on structured treatment than the Regional Drug Misuse Databases used previously to monitor drug treatment and focuses on those in treatment who are receiving on-going structured care within tiers 3 & 4 e.g. community based specialist drug services, specialist in-patient treatment, GP’s prescribing services and residential rehabilitation. The central requirements will not include non-structured treatment services e.g. tier 2 interventions, as this data is often not linked to unique individuals and is not recorded centrally.</p> <p>The Department of Health does not own that part of the target that relates to individuals who only receive drug treatment whilst in prison and who do not receive any treatment in the community. The NDTMS does not currently gather information about individuals treated in prisons and it has not been possible to identify a baseline for the numbers receiving treatment in 1998. The prisoners receiving treatment will be monitored separately, with a view to achieving a level of provision that is to</p>

¹ Re-examining the baseline for the numbers of persons in drug misuse treatment during 1998-1999. National Drug Evidence Centre, University of Manchester 2005.

PSA Target	Technical Note
	<p>be agreed in the light of plans currently under development by the Department of Health and the Home Office for the expansion of drug treatment in prisons.</p> <p>Target Year: The date that will be used for measuring whether the PSA Target for the increase in numbers in treatment by 2008 has been met is 31 March 2008. However, the data itself will not be available until later that year, probably September 2008.</p> <p>Reporting Frequency : annual; Timing: – Final data for each financial year is expected to be published late autumn</p>

PSA Priority IV: Patient/User Experience

PSA Target	Technical Note
<p>Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.</p>	<p>Scope: The national survey programme will gather feedback from patients on different aspects of their experience of care in NHS trusts. This will be done through a rolling programme of structured surveys covering inpatients (adults and children), outpatients, emergency care, maternity care, mental health services, ambulances and primary care. We acknowledge the mixed economy and the fact that NHS patients will choose to have their healthcare needs met in a wider range of provider facilities. The Department of Health will work with the Healthcare Commission to review the survey programme to take account of this. Details of surveys including new developments are published at http://www.healthcarecommission.org.uk The experiences of users of social care services are not captured through this PSA.</p> <p>Source of data and support materials: Patient surveys are run by each NHS trust under the administration of the Healthcare Commission. For each survey the Healthcare Commission publishes a wide range of materials including:</p> <p>National Reports: A series of reports summarising key findings for each survey http://healthcarecommission.org.uk/NationalFindings/Surveys/fs/en</p> <p>Overall: <i>“Unpacking the patient experience: variations in NHS patient experience in England.</i> Analyses of variations in patients’ reported experience and perceptions (by selected respondent socio-demographics) are available on the Healthcare Commission website. The survey scheme allows the Healthcare Commission to analyse survey results by different groups of patients e.g. by ethnicity, sex and age. http://www.healthcarecommission.org.uk/assetRoot/04/00/34/96/04003496.pdf http://www.healthcarecommission.org.uk/assetRoot/04/02/12/07/04021207.pdf</p> <p>Improving the patient experience: based on 5 key dimensions rated by patients as important: access and waiting; safe, high quality co-ordinated care; building closer relationships; a clean, comfortable, friendly place to be; better information, more choice. The NHS Plan requires each NHS Trust and PCT to obtain feedback from patients about their experience of care. Success will be defined through increasingly positive national survey results under each patient dimension. Trusts and PCTs are required to analyse their survey data to identify the low scoring components in particular, and plan and implement appropriate local improvement activities.</p>

PSA Target	Technical Note
	<p>Involvement in decisions about healthcare, including choice of provider: The surveys include questions measuring the extent to which patients wanted to be involved and whether those needs were met. The policy on choice of provider commenced in Dec 2005 and will be tested in a Department of Health sponsored national level Primary Care survey during 2006.</p> <p>Methodology: The methodology carries forward from the SR 2002 PSA. It has been developed jointly by the Department of Health and the Healthcare Commission, and is based on the scoring system used by the Healthcare Commission for deriving performance indicators (PIs) for use in the annual health check. For each of the five patient experience dimensions within each separate survey, a <i>nationally aggregated patient experience index score</i> is calculated from a set of core questions. Details of how survey questions are scored are at http://ratings2005.healthcarecommission.org.uk/more_information.asp. The Healthcare Commission will be responsible for independently validating index scores. We will explore further development of the methodology with the Healthcare Commission, including the appropriateness of aggregation and weighting.</p> <p>Baseline: We have temporarily removed the baselines from the technical notes, as the Healthcare Commission has revised their method for calculating index scores. The Department of Health has approved the changes and will publish the revised baselines and time series scores by the end of April 2006.</p> <p>Administration of survey programme: The Healthcare Commission is responsible for administering the survey programme. Through a series of contracts, they arrange for experienced research companies to identify and develop questionnaires, and provide documentation and advice for trusts on how to conduct surveys. The role of the contractors also extends to deciding on survey sample sizes and acting as a data centre to collate, check quality, and analyse the survey data. Details can be accessed through the Healthcare Commission website or through http://www.nhssurveys.org/</p> <p>Operations: Trusts will fund and administer local surveys in line with published guidance (including the survey timetable and sampling approaches) and posting of data to a central point. This will not apply to the 2006 Primary Care Trust survey of Local Health Services. Instead the Department of Health has arranged an independent national level survey for 2005/06. This is in response to a review of the PCT survey initiated by the Healthcare Commission in summer 2004. During 2006 there will be a wider review of the survey programme carried out in partnership with the Healthcare Commission.</p>

PSA Target	Technical Note
	<p>Reporting Ethnicity As part of achieving wider Government objectives on racial equality, in <i>National Standards, Local Action: Health and Social Care Standards and Planning Framework</i>, DH has committed to specifically monitor the experiences of black and minority ethnic groups as part of the patient surveys. Survey results will be analysed and presented, at the national level, by different patient groups, including ethnic groups. This information will also be reported annually in the Government's Race Equality and Community Cohesion Strategy.</p>
<p>Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:</p> <ul style="list-style-type: none"> - increasing the proportion of older people being supported 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 	<p>Scope:</p> <p>Part 1</p> <p>Definition: the people being helped to live at home are those that receive community based services but are not in residential or nursing care. Only those that are care managed by social services, i.e. are assessed by social services and have a care plan, will be included in the target.</p> <p>The number of care managed clients aged 65 and over receiving services to help them live at home expressed as a rate per 1,000 population measures the support provided to care managed clients. This is a current PAF PI AO/C32. The numerator is taken as a snapshot at 31 March.</p> <p>DH and the Health and Social Care Information Centre (HSCIC) are working with LAs to develop a national collection to count the number of people who are not care managed but benefit from services from voluntary and community organisations that receive grants from social services departments. In the future we expect the benefit to both care managed clients and those receiving service directly from grant funded organisations will be measured.</p> <p>Explanation: Even though the PSA only includes targets for growth in 2006-07 and 2007-08 councils will be expected to act to improve services in the previous year, 2005-06. This is being monitored through the existing indicator C32 in the PSS PAF PI set, its status as a Best Value indicator and CSCI's monitoring and inspection arrangements.</p>

PSA Target	Technical Note
supported at home or in residential care.	<p>Those receiving direct payments (as well as those receiving other community-based services) will be included in this measure.</p> <p>Target Year: March 2008</p> <p>Baseline year: 2005-06</p> <p>Sources of data: HSCIC RAP return, ONS population estimates</p> <p>Reporting: Frequency – annual, Timing – autumn</p> <p>Part 2</p> <p>Definition: the number of people supported intensively to live at home is the number of households receiving more than 10 contact hours of home care and six or more visits per week, older people defined as 65+.</p> <p>The total being supported by social services at home or in residential care is the number of people supported intensively to live at home plus the number of people in residential or nursing homes whose care is funded by the local council.</p> <p>Explanation: The baseline for the % rate of 'intensive home care as a proportion of intensive home and residential care' using PAF PI B11 calculated for older people rather than all adults was 28.6% in 2002-03 [the baseline year]. In 2004-05 the % rate had risen to 32.0%.</p> <p>The numerator is the number of households receiving more than 10 contact hours of home care and six or more visits per week (including those people in very sheltered/extra care housing). This is used as a proxy for the number of older people receiving intensive support. Those using direct payments to purchase an intensive home care package are not included. The measure is taken from a survey of a sample week in September.</p> <p>The denominator is the numerator plus the population of older people supported by councils in residential care and nursing homes. The population of supported residents is measured as a snapshot at 31 March.</p>

PSA Target	Technical Note
	<p>All these figures are net of the 30,000 older people in England (as of April 2002) on 'preserved rights', previously paid via social security benefits, but transferred to Local Authority responsibility since April 2002. The number of people on 'preserved rights' is reduced year on year by a projected 20% mortality rate.</p> <p>Target year: March 2008</p> <p>Baseline year: 2002-2003</p> <p>Sources of data: HSCIC HH1, HSCIC SR1 return, PAF PI published data (latest 2004-2005)</p> <p>Reporting: Frequency - annual; Timing – autumn</p>