



*National Standards,
Local Action*

**Health and Social Care Standards
and Planning Framework**

2005/06–2007/08

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Local Action*

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READER INFORMATION

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Description	This document sets out a standard-based planning framework for health and social care and standards for NHS health care to be used in planning, commissioning and delivering services. It covers the core and development standards covering NHS health care and the health and social care planning framework and targets for 2005–2008.
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Action required	In planning, commissioning and delivering local services, take into account the standards, planning framework and targets
Timing	Standards for Better Health have immediate effect. The Planning Framework 2005–2008 comes into effect in April 2005. However, organisations will want to follow the timetable set out in the document for developing local plans and targets.
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CHLORINE FREE PAPER

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Foreword from the Secretary of State

Patients have a right to take it as a given that every effort is made to ensure that their care and treatment is both safe and effective. We have already achieved a great deal with the spread of clinical governance throughout the NHS, the establishment of the National Institute of Clinical Excellence, and with the publication of National Service Frameworks. On the frontline, clinicians and managers have worked highly effectively and with dedication to create a modern, caring NHS which puts the needs of the public first.

National Standards, Local Action sets out how we can build on the achievements to date. At its heart is a new framework of standards – *Standards for Better Health*. We have made enormous progress with increasing capacity and ensuring that waiting times have fallen. The focus of NHS reform is now shifting to improving the quality of care patients receive. The NHS will develop into a health service rather than one that focuses primarily on sickness. There will be a sustained drive to reduce inequalities in health. There will be few national targets and greater scope for local organisations to tackle local priorities. We can now concentrate on delivering an NHS that is more qualitative and focused on what the public and patients want from a 21st century health system.

The standards will achieve two important things. First, they will set the foundations for a common high quality of health care throughout England. Second, they will clarify what the NHS can and should be reaching for in its ambitions, both for the public and for the people who work within it.

Improvements in the quality of care against these standards will be supported and rewarded by the Healthcare Commission's new assessment framework and by the assessments of the Commission for Social Care Inspection. The independent inspections will make sure that the incentive is there for continuing quality improvements.

I am confident that the new approach, building on the improvements we have achieved in the National Health Service and social care, will result in the development of a truly world class service with patients at the forefront.

A handwritten signature in black ink, appearing to read 'John Reid', with a long horizontal flourish underneath.

John Reid
Secretary of State for Health

Preface from the Chief Executive

This document sets out both the framework that we want National Health Service (NHS) organisations and social services authorities to use in planning for the next three financial years and the standards which all organisations should achieve in delivering NHS Care.

This is part of an integrated approach which brings together for the first time the planning framework, national standards and the new Payment by Results system to provide a clear direction of travel and incentives for local organisations.

It represents a real change from what has gone before. It emphasises local actions, local ambition and local innovation.

The *NHS Improvement Plan* takes us into the next phase of reform of the health service. It sets a vision of 21st century health care and improved health. This vision should take precedence over old ways of doing things and institutional barriers, where these stand in the way of improving services to people. Organisations are expected to challenge the past, use innovation and creativity to determine new local solutions, and set new horizons for local services.

I would draw your attention to five points:

- **a focus on health and well-being across the whole system**

This requires health organisations and Local Authorities to work even more closely together and to pay attention to the whole range of health and social care services. The framework emphasises the need to set local targets in partnership alongside the smaller number of national targets set out here.

In the autumn we will be publishing a white paper on public health and a new vision for adult social care, which will also cover the needs of people with physical and learning disabilities and their carers, to enlarge and deepen this renewed focus on health and well-being.

- **giving the individual – the patient, service user or client – more power to improve their care and drive the whole system**

The framework emphasises the importance of improving the whole experience of individuals, with particular attention to tailoring services for patients with long-term conditions, promoting independence for older people and supporting self care and the “expert patient”.

- **improving both quality and equality**

The standards-based approach in both health and social care means that organisations need to take account of the quality and safety of all their services, not just where there is a national target for improvement. They also need to make sure that they are reaching **all** parts of their population and working to reduce inequalities in health and in access to all services. Particular attention will be paid to black and minority ethnic communities where they are disadvantaged in this way.

- **addressing the needs of children as well as the adult population**

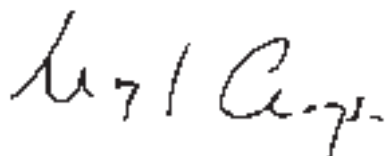
Recent changes, which have made the Department for Education & Skills the lead Government department for children, should not mean that NHS organisations, in particular, take less account of children in their planning. The Children's National Service Framework (NSF) and the follow up to *Change for Children*, both of which will be published in the autumn, will reinforce the importance of planning for children across the whole of health, Local Authorities and the voluntary sector.

- **review and change the way we work to improve delivery**

The improvements of the last few years, new investment, energy, commitment and hard work, will all help drive these changes. However, in making even faster and more fundamental improvements, organisations will need to:

- understand and use the new Information Technology (IT) systems and staff contracts alongside the insights from service redesign and improvement techniques; and
- take advantage of all the new freedoms and incentives in the system, whether as NHS Foundation Trusts or through Payment by Results.

This framework sets out how the NHS alone will spend over £250 billion over the next three financial years, with around 80% of this going directly to Primary Care Trusts (PCTs). Over this period, reform will be increasingly apparent with new incentives, new organisations, new freedoms and new approaches to service delivery and health promotion. This reform and the new investment mean that we should be planning confidently and ambitiously for the future.



Sir Nigel Crisp
Chief Executive Department of Health and the NHS

21 July 2004

Introduction

1. This document sets out the framework for all National Health Service (NHS) organisations and social service authorities to use in planning over the next financial three years. It looks to Primary Care Trusts (PCTs) and Local Authorities (LAs) to lead community partnership by even closer joint working to take forward the *NHS Improvement Plan*. Building on joint work on Local Strategic Partnerships (LSPs), they will need to work in partnership with other NHS organisations in preparing Local Delivery Plans (LDPs) for the period 2005/06 to 2007/08.
2. The *NHS Improvement Plan*, published in June 2004, set out the next stage of the Government's plans for the modernisation of the health service. It signalled three big shifts:
 - putting patients and service users first through more personalised care;
 - a focus on the whole of health and well-being, not only illness; and
 - further devolution of decision-making to local organisations.
3. All this requires much greater joint working and partnership between PCTs, LAs, NHS Foundation Trusts, NHS Trusts, independent sector and voluntary organisations. This is happening in many parts of the country, but needs to be made more consistent.
4. A parallel shift is now required in the way improvements in people's health and care are planned and delivered. This means moving away from a system that is mainly driven by national targets to one in which:
 - *standards* are the main driver for continuous improvements in quality;
 - there are *fewer national targets*;
 - there is greater scope for addressing *local priorities*;
 - *incentives* are in place to support the system; and
 - all organisations locally play their part in *service modernisation*.
5. This document describes this new system.

A Standards-Driven System

6. A new framework of Health Care Standards – *Standards for Better Health* – is being published as part of this document and is at Annex A. It represents the Government’s response to the consultation on the Health Care Standards, which was launched in February 2004, and puts quality at the forefront of the agenda for the NHS and for private and voluntary providers of NHS care. It describes the level of quality that health care organisations, including NHS Foundation Trusts, and private and voluntary providers of NHS care, will be expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health. In each of these domains the individual standards fall into two categories:
 - *core standards*: which bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect; and
 - *developmental standards*: which signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services that continue to improve in line with increasing patient expectations.
7. *Standards for Better Health* will form a key part of the performance assessment by the Healthcare Commission (HC) of all health care organisations. The Commission for Social Care Inspection (CSCI) inspects regulated care services, such as care homes, against minimum national standards drawn up by the Department of Health (DH) in consultation with the social care community and people using health and social care services¹. They are designed to drive up standards by identifying areas for improvement.

National Service Frameworks and NICE Guidance

8. National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance are integral to a standards-based system. They have a key role in supporting local improvements in service quality. Organisations’ performance will be assessed not just on how they do on national targets but increasingly on whether they are delivering high quality standards across a range of areas, including NSFs and NICE guidance.
9. We will continue to develop NSFs and other national strategies where these are needed.² There are forthcoming NSFs for children, renal services and long-term conditions. NSFs should be considered as part of the developmental standards. Over the course of the three-year planning period for this Planning Framework, the NHS together with LAs will need to be able to demonstrate that they are making progress towards achieving the levels of service quality described in the NSFs and national strategies. Both the Healthcare Commission and CSCI will undertake thematic reviews of progress, jointly when appropriate.

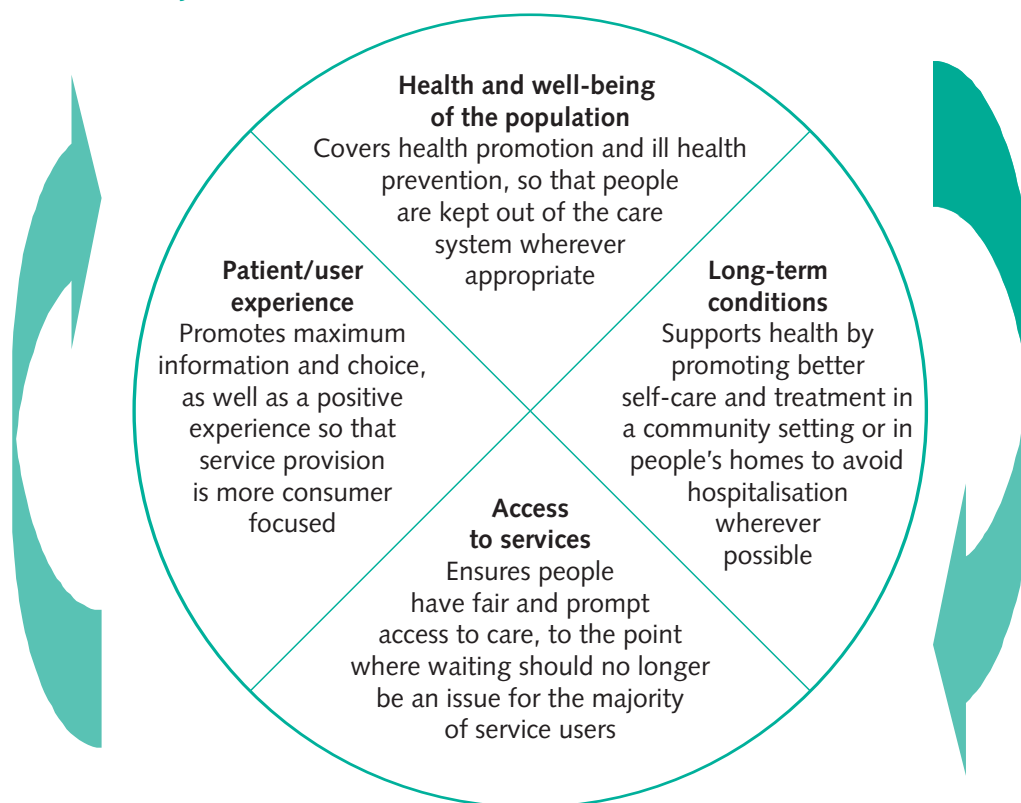
1 These standards can be found at <http://www.dh.gov.uk/policyandguidance/healthandsocialcaretopics/socialcare/csciproject>

2 There are already NSFs on coronary heart disease, diabetes, mental health, older people’s services and paediatric intensive care, as well as the NHS Cancer Plan, the national strategy for sexual health and HIV, and a major programme of work to implement recommendations from the Shipman inquiry.

Fewer National Targets

10. PCTs, working with LAs, NHS partners and other organisations, will be expected to contribute to the achievement of national priorities and targets. Where this requires a contribution from NHS Foundation Trusts or private and voluntary health care providers, PCTs should ensure this is specified in their commissioning contracts. The targets will be fewer than in the last planning round and different in type:
- the Priorities and Planning Framework (PPF) for 2003/04 to 2005/06 set out effectively 62 national targets. This document sets out 20 national targets;
 - over half the new targets are about health outcomes and patient experience, compared to the last planning round when over two thirds of the targets and national requirements were wholly or partially based on inputs; and
 - there will be greater flexibility for local organisations to determine how they should contribute to the delivery of national priorities.
11. The national priorities for the three financial years 2005/06 to 2007/08 for the NHS and social services are based on the Department of Health's Public Service Agreement (PSA). There is one target – on Methicillin Resistant Staphylococcus Aureus (MRSA) – which is not part of the PSA. The national targets cover four broad priority areas, as set out below:

The National Priority Areas



12. The specific national targets within the four priority areas are set out in Annex B. They apply to all people equally and to all age groups unless specified.

Maintaining Existing Commitments

13. Whilst there is a need to focus on new priorities, it is essential that the levels of service set through the previous 2003-06 planning round, which will have been achieved by April 2005, are maintained. This is particularly important for existing commitments on access to ambulances, primary care professionals and GPs, A&E and other hospital-based services. Performance against existing commitments from the previous 2003-06 planning round which extend beyond April 2005 will also need to be met and maintained in the new planning round. These are listed at the end of Annex B. Performance against existing commitments will feed into the Healthcare Commission's performance rating of NHS bodies, including NHS Foundation Trusts, alongside its assessment of their performance on the other Health Care Standards.

Local Targets

14. The reduced number of national targets will create more headroom for PCTs to set local targets in response to local needs and priorities. This Planning Framework does not set prescriptive guidance on these local targets, but instead sets out a framework of principles within which organisations should consider their local needs and priorities. PCTs will need to agree the local targets with LAs and other partner organisations. The Department of Health will not monitor performance against local targets centrally, but they will be subject to assessment by the Healthcare Commission.
15. PCTs will need to take into account specialist services which can only be commissioned effectively on a pan-PCT or still broader basis. PCTs, with SHA support, are expected to act collaboratively to secure these services and their improvement. A good example would be effective commissioning of specialist mental health services for deaf people.

Principles for Local Target Setting

In developing local plans PCTs should ensure they:

- are in line with population needs;
- address local service gaps;
- deliver equity;
- are evidence-based;
- are developed in partnership with other NHS bodies and LAs; and
- offer value for money.

16. Contextual information on each of the local planning principles is set out below:

i) Population needs

PCTs and their partners will need to consider the particular needs of their population, taking into account different needs and priorities within each community. PCTs should demonstrate that, as well as using epidemiological data and general survey data to identify the differing needs of their populations, they have listened to the views of patients and the public and in particular have taken account of the results of patient and user surveys. PCTs will want to work in partnership with LAs and Local Authority Overview and Scrutiny Committees, or with Patients' Forums, to assess population needs across the local health and social care economy, and will need to show that they have considered needs across the care pathway.

ii) Local service gaps

In order to set local priorities, PCTs and their partners will need to consider gaps in existing service provision, guided by benchmarking information, Healthcare Commission and CSCI reports where available, and taking account of NSFs and national strategies. As the choice programme progresses, organisations should analyse the impact of improving choice, tracking the experience of their patients to identify where local services are not meeting patient aspirations.

iii) Equity

PCTs and their partner organisations should demonstrate that they have taken account of different needs and inequalities within the local population, in respect of area, socio-economic group, ethnicity, gender, disability, age, faith, and sexual orientation, on the basis of a systematic programme of health equity audit and equality impact assessment. This should address issues of race equality.

Health equity audits identify how fairly services or other resources are distributed in relation to the health needs of different groups. By using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery, health equity audits should help organisations address inequalities in access to services and in health outcomes, such as the inequalities experienced by black and minority ethnic groups.

iv) Evidence-based

Local targets and plans must be informed by a robust evidence base of both clinical and cost effectiveness. In assessing the evidence base, organisations will need to be guided by the evidence set out in NICE guidance, NSFs and national strategies.

v) Partnership with Local Authorities

PCTs will need to work in partnership with LAs (particularly social services), other NHS organisations, service providers, patients and service users in setting their local plans so that they are based around the whole care pathway and not limited by individual organisational boundaries. PCTs may want to identify an NHS and LA lead for each target. They should demonstrate that they have agreed the contribution each organisation will make, and made arrangements for monitoring progress and reviewing delivery across the local health and social care economy.

vi) Value for money

PCTs and their partners will need to agree plans which achieve value for money locally. They will also need to participate in the national value for money initiatives outlined in the section below.

Resource Allocation and Value for Money

17. PCT allocations for 2005/06 have already been set and this will allow PCTs to begin planning earlier than in the past. Allocations for 2006/07 and 2007/08 will be confirmed later in the year. The precise timing will be confirmed when ONS population projections are available. As part of this process, the Department of Health will review the pace of change towards allocation targets.
18. Following Sir Peter Gershon's review of efficiency savings in the public sector, the Department of Health has been set a target to achieve efficiency savings of 2.7% per year over the period 2005/06 to 2007/08. These savings will be achieved through a mixture of cost efficiency and quality improvements and include savings made in the NHS, adult social care, the Department of Health and Arm's Length Bodies. Several areas were identified for which NHS and social care organisations should plan to make savings. These include:
 - making better use of staff time, including through service redesign, workforce reform and implementation of the National Programme for IT. This should contribute around half of the total savings;
 - making better use of NHS buying power to get better value for money in procurement of goods and services;
 - rationalising back office functions (such as finance, HR and IT) and improved use of shared service centres; and
 - improve the commissioning of adult social care, this should generate around 10% of the total savings.

Aligning Incentives with Patients and Professionals

19. The new NHS and social care system will be incentivised to deliver better services for patients and users. Developments are now being made in three broad areas:
- independent performance assessment by the Healthcare Commission and CSCI;
 - a new system of financial incentives to support patient choice; and
 - the development of commissioning.

Independent Performance Assessment

20. The responsibility for assessing and reporting on the performance of PCTs, Trusts and NHS Foundation Trusts³ rests with the independent Healthcare Commission, and with the independent Commission for Social Care Inspection for social services and regulated care services. The Healthcare Commission has responsibility for developing assessment criteria that it will use to determine whether core standards have been met, and to judge progress against developmental standards. The Healthcare Commission will be consulting on its assessment criteria in autumn 2004. The performance of PCTs, Trusts and NHS Foundation Trusts for the year 2005/06 will be assessed on this new basis.
21. The Healthcare Commission's performance ratings will be based on its annual review of PCTs, Trusts and NHS Foundation Trusts. One of the elements this overall assessment of performance will draw on is thematic reviews of particular services in NHS bodies, such as services for children or older people. The Healthcare Commission's annual assessment will inform decisions on whether to allow organisations to apply for NHS Foundation Trust status.
22. CSCI will undertake each year an assessment of local councils' performance in discharging their social services responsibilities. It will take into account a wide range of information and data, derived from performance indicators, councils' own Delivery and Improvement Statements (covering progress against national and local priorities), and service and regulatory inspections. Each autumn CSCI will then publish judgements about each council's performance and prospects in delivering services to children and adults. Those judgements are made against published standards and criteria. They form the basis of councils' social services star ratings, published in November, and inform the Comprehensive Performance Assessment of councils, published by the Audit Commission.

Financial Incentives

23. A central feature of the new system is the change in financial incentives introduced through Payment by Results. The new financial incentives support a devolved, standards-driven and patient-led system by ensuring that negotiations are focused on quality not price and that finance flows with patients' choices.

³ Some functions of NHS Foundation Trusts, particularly relating to their financial activities, will be assessed by the Independent Regulator of NHS Foundation Trusts.

24. From 1 April 2005, Payment by Results will, with a limited number of exceptions, apply to all admitted patient care, all outpatient care and accident and emergency services. The national tariff to be applied from April 2005 will be published at the end of September 2004 and guidance on the transitional phase to full implementation in 2008 will follow in October.
25. Alongside this Planning Framework, we are also publishing our response to the issues raised following our consultation document *Payment by Results: Preparing for 2005*.⁴ The response takes the development of the policy forward, reflecting both the views of stakeholders on technical issues and also the next stages of the Government's plans for modernising the NHS set out in the *NHS Improvement Plan*.
26. Key decisions set out in the response include:
- retention of a separate tariff for elective and non-elective care based on spells;
 - exploration of the need for a separate tariff for same day/overnight stay emergencies;
 - introduction of a system that allows for additional payments for patients who, for clinical reasons, remain in care beyond the expected length of stay recognised in the tariff; and
 - the transition to full tariff in 25% increments from 1 April 2008 with modification of the maximum annual cost savings to reach tariff, from 3% to 2%.
27. Next steps in preparing for 2005/06 are:
- to ensure that Payment by Results supports our objectives for public health and chronic and long-term care management. Development of the Healthcare Resource Groupings (HRGs) under version 4 will facilitate this. This will include the systematic unbundling of HRGs; allowing PCTs and providers to split elements of the payment where alternative modes of service delivery are developed, offering appropriate incentives for the substitution of alternative care services in different settings. We will continue to work closely with the NHS on these matters; and
 - to work closely with PCTs to ensure that the detailed design of Payment by Results supports effective commissioning and to ensure that PCTs themselves are fully prepared to take advantage of the opportunities that Payment by Results provide for reshaping services.
28. The Payment by Results system will need regular review to ensure that the effects are in line with the policy aims. Work is in hand to develop incentives for the whole patient journey, not only the hospital element, and to improve incentives to integrate social care provision into the patient experience.

Developing Commissioning Systems

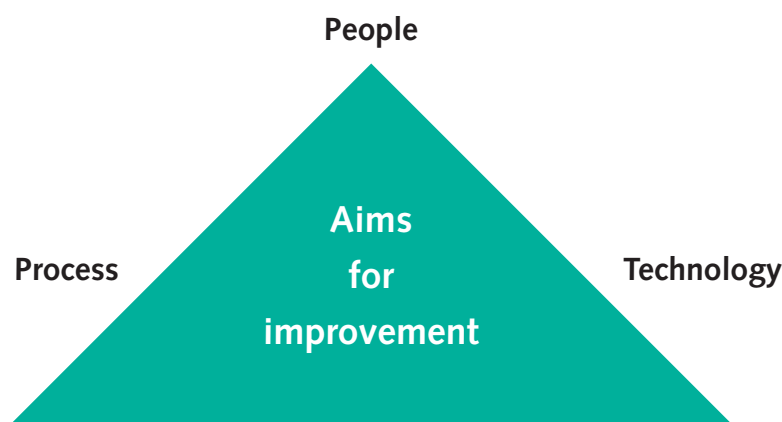
29. To deliver national and local priorities PCTs will need to make full use of the commissioning levers available to them. PCTs will need to ensure that their Service Level Agreements with Trusts and their contracts with NHS Foundation Trusts and private and voluntary health care providers are specific about the levels of service being commissioned. Commissioning levers include:
- appropriate contracting, monitoring and performance management arrangements to ensure that sustainable out-of-hours services are commissioned which meet the quality standards;
 - using the new General Medical Services (GMS) and Personal Medical Services (PMS) contracts to deliver preventative services and high standards of care to people with chronic diseases;

⁴ This can be found at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en.

- for people requiring planned hospital care, using core and flexible contracts to support the flow of funds to alternative providers where patient choice and/or capacity demands dictate;
- agreeing explicit criteria for referral and treatment thresholds and trigger points within service level agreements and contracts. This includes involving patients more directly in decisions about treatment;
- devolution of commissioning to GP practices. From April 2005, PCTs should give indicative commissioning budgets to those GP practices that wish to have them. This will provide practices with further incentives to manage referrals effectively and to re-invest any savings to improve NHS services; and
- using local commissioning arrangements to improve NHS primary dental services.

Modernisation

30. Achievement of the priorities set out above will not be possible without a continued drive to modernise services and working practices. National initiatives, through the work of the NHS Modernisation Agency, National Programme for IT (NPFIT) and new workforce contracts, provide a major platform for modernisation. The Care Service Improvement Partnership has been established to harness and co-ordinate service improvement support in social care. PCTs and LAs now need to ensure that these national programmes are used as levers for change locally.



Service Redesign

31. PCTs should use the work of the NHS Modernisation Agency, its partners and its successor organisations, to support local efforts to redesign services. Through its work with thousands of clinical teams across the NHS, the NHS Modernisation Agency has identified ten best practice changes through service redesign. These changes focus on significant gaps between current NHS performance and best practice. They affect large numbers of patients and have system-wide benefits. If implemented widely by every NHS organisation, they will deliver significant improvements in the patient experience, as well as gains in clinical quality, staff experience and productivity.

Ten high impact changes through service redesign

- Treat day care surgery (rather than inpatient surgery) as the default system for elective surgery
- Improve patient flow across the NHS system by improving access to key diagnostic tests
- Manage variation in the patient admission process
- Smooth variation in patient length of stay and patient discharge
- Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting
- Increase the reliability of therapeutic interventions through a “care bundle” approach

- Apply a systematic approach to care for people with chronic conditions and prevention of disease
- Minimise the number of queues by redesigning schedules
- Optimise patient flow through service bottlenecks using process templates
- Redesign and extend roles to develop effective patient pathways

Note: Further information on this work will be available in autumn 2004 at <http://www.modern.nhs.uk>

More Staff Working Differently

32. Whilst we are not setting detailed workforce targets for local organisations, we will expect Local Delivery Plans to demonstrate that robust workforce plans are in place to support delivery of national targets through increases in the size of the workforce, roll out of new ways of working and improvements in workforce productivity. This will be facilitated by new GP and consultant contracts and *Agenda for Change* and by the extra capacity available from new independent sector providers. Workforce development and service redesign will also be underpinned by strengthening commitment to lifelong learning and skills enhancement for staff at all levels.

Getting Information to Work for Patients and Users

33. The National Programme for IT will make a major contribution to the delivery of the highest standards of health care across the NHS by providing the right information, in the right place, at the right time. NHS care records will go live in summer 2004, with a second phase in June 2005; by 2005 e-prescribing will be a national service for 50% of transactions, with full implementation by 2007. Nationally available patient records and modern, innovative IT systems will support patient choice, improve accuracy in treatment and prescribing, and enable greater efficiency. They will capture the information patients are interested in and support the information needs of the Healthcare Commission. For patients with both health and social care needs, the use of a single assessment process and electronic social care records will allow effective and efficient information sharing between health and social care. A national framework for benefits realisation will support the implementation of the National Programme to ensure that IT solutions have a direct and positive impact on performance. PCTs should work with SHAs and other partner organisations to:
- ensure that the NPfIT technical solutions are successfully implemented, as co-ordinated by the five regional clusters and in line with the contracts;
 - ensure local funding is made available to complement national investment in the programme. Without local investment the aims of the National Programme will not be achieved and the contracts will not deliver value for money; and
 - ensure local plans are agreed with partner organisations to realise the benefits of NPfIT, through the effective involvement of patients and frontline staff.

Timetable for Decision-Making and Local Delivery Plans

34. The timetable below sets out the main stages and decision-making points in the forthcoming planning round. PCTs will need to develop their Local Delivery Plans in partnership with other NHS bodies and LAs. In doing so they will need to set out annual trajectories to ensure delivery of national targets, as well as outline their plans for local targets, which will both inform the Healthcare Commission's performance ratings assessment. Further information on technical data requirements and LDP format will be available in the autumn. Final LDPs, including milestones for national targets, will then need to be agreed with SHAs.

July 2004

- This Planning Framework sets out national targets and requirements, alongside a framework for local priority setting. It reconfirms PCT allocations for 2005/06 so that early planning can begin.
- *Standards for Better Health* places this in the overall context of minimum expectations and further quality improvements.
- The Healthcare Commission publishes NHS performance ratings for 2003/04.

Autumn 2004

- The Healthcare Commission consults on its standards-based assessment criteria, which will inform NHS Trust, NHS Foundation Trust and PCT annual reviews and performance ratings from 2005/06 onwards.
- PCT allocations for 2006/07 and 2007/08 are announced later in the year, so that detailed planning over the three-year period can commence (timing subject to availability of ONS projections).
- LDP monitoring guidance is issued, which will set out the format and process for data to be returned to the Department of Health for monitoring national targets.
- CSCI performance ratings for Local Authority social services departments are published in November, with a separate judgement for children's and adults' services feeding into the overall star rating.
- The provisional announcement of the Local Government settlement is made in November.
- The Comprehensive Performance Assessment of Local Authorities (incorporating judgements about social services) is published by the Audit Commission in December.

Spring (end March) 2005

- The Healthcare Commission completes its consultation, announces its standards-based assessment criteria and sets out how its new assessment system will work.
- PCT LDPs are agreed and signed off by SHAs; SHA level plans are agreed and signed off by the Department of Health.
- The final announcement of the Local Government settlement is made in February.
- The deadline for local councils to have set legal budgets for 2005/06.

Annex A – Standards for Better Health

Introduction

1. From April 2005 there will be a new performance framework for the NHS and social care, driven by *Standards for Better Health*, which set out the level of quality all organisations providing NHS care will be expected to meet or aspire to across the NHS in England.

Why Standards?

2. The standards set out in this document have been developed with two principal objectives. First, they provide a common set of requirements applying across all health care organisations to ensure that health services are provided that are both safe and of an acceptable quality.
3. Second, they provide a framework for continuous improvement in the overall quality of care people receive. The framework ensures that the extra resources being directed to the NHS are used to help raise the level of performance measurably year-on-year.
4. The scope of the new quality programme which is emerging in the NHS is bold and broad-based. Underpinning this has been the concept of clinical governance – a unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect a change of culture in NHS organisations to one where:

“openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received.”

(Sir Liam Donaldson, Chief Medical Officer)

Overall aims

5. *Standards for Better Health* sits at the heart of the new relationship between central Government and the NHS, under which it is the role of the Department of Health to set broad, overarching standards defining the Government’s high level expectations of the health service. These should be comprehensive but at a level of detail that allows scope for local determination of what works best and for the new independent inspectorate to make judgments about what levels of performance are acceptable at any one time.
6. A strong underlying theme is the need to reduce the burden of unhelpful standards and guidance on the NHS over time. We are conscious of the large number of requirements that have (in the past) been set centrally, either directly from the Department itself or by its Arm’s Length Bodies. Some of the Department’s own standards are currently under review and the review of Arm’s Length Bodies will provide an opportunity to rationalise either standards themselves or some of the reporting requirements that they currently impose. The development of the new high level standards set out here represents the first step toward simplifying and rationalising the expectations on the service. It also provides an excellent opportunity to reduce the burden of current requirements, although the process of doing so

will necessarily take some time to evolve. While *Standards for Better Health* will synthesise a large number of existing rules and guidance, NHS bodies will continue to be subject to the wider regulatory framework, such as health and safety legislation.

7. The final but key aim of these standards is to underpin the delivery of high quality services which are fair, personal and responsive to patients' needs and wishes, which are provided equitably and which deliver improvements in the health and well-being of the population. This aim can only be achieved if these benefits are delivered to **all** groups within our society. The standards must therefore be interpreted and implemented in ways which:
- Challenge discrimination
 - Promote equality of access and quality of services
 - Support the provision of services appropriate to individual needs, preferences and choices
 - Respect and protect human rights
 - Further the NHS's reputation as a model employer
 - Enable NHS organisations to contribute to economic success and community cohesion.

NHS Improvement Plan

8. The new standards reflect the direction set by the *NHS Improvement Plan*. In particular, the core standards will underpin patient choice by determining which health care organisations may provide care under the NHS.
9. Furthermore, the developmental standards describe the framework for quality improvement that have been taken forward in the *NHS Improvement Plan*. There is, in particular, a new focus on public health. These standards, in line with the *NHS Improvement Plan*, stress the importance of reducing inequalities and of organisations working together to provide a whole systems approach to care, tailor made for the individual patient. Raising standards in this way will deliver more personalised care and ensure that all patients, including those from disadvantaged groups, are able to benefit.

Taxonomy

10. A key element in simplifying and rationalising the approach to standards setting will be the adoption of a common framework for all matters related to performance and a common language so that terms such as "standards" have a clearly understood, shared meaning. It is our clear intention that the domain structure set out in this document should become the common framework, not only for standards set by the Department and for the inspection process itself, but also for the whole performance agenda whether national or local.
11. From now on, the Department of Health will define the most frequently used terms in the following way:

Standards

Standards are a means of describing the level of quality that health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.

Quality Requirements

Quality requirements will be established through the National Service Frameworks. They describe the care which clinicians and others will use to guide their practice.

Criteria

Criteria are ways of demonstrating compliance with, and performance relevant to, a standard. They establish specific, objective expectations, drawing on such evidence and indicators as the Healthcare Commission may establish.

Targets

Targets refer to a defined level of performance that is being aimed for, often with a numerical and time dimension. The purpose of a target is to incentivise improvement in the specific area covered by the target over a particular timeframe.

Benchmarks

Benchmarks are used as comparators to compare performance between similar organisations or systems.

Who the standards are for

12. The standards themselves will be taken into account by those providing NHS care directly, no matter what the setting, those managing the health service, those commissioning health care and, most importantly, for the general public.
13. The standards apply to the provision of all NHS services in the full variety of settings, including NHS Foundation Trusts, and the voluntary and private sectors insofar as they provide care to NHS patients.
14. They are also for the Healthcare Commission who have responsibility for assessing the quality of health and health care provided in England. The Commission's role is set out more fully below.

Response to consultation

15. The standards published here were subject to a full twelve-week public consultation. A summary of the main points made in response to the consultation will be available on the DH website – www.dh.gov.uk

How the standards framework is structured

16. The standards set out in this document are organised within seven “domains”, which are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The domains encompass all facets of health care, including prevention, and are described in terms of outcomes. The seven domains are:
 - Safety
 - Clinical and Cost Effectiveness
 - Governance
 - Patient Focus
 - Accessible and Responsive Care
 - Care Environment and Amenities
 - Public HealthOutcomes for each domain are specified.
17. Within these domains there are two types of standards, core and developmental.

Core standards

18. The core standards do not of themselves set out new expectations of the NHS, but are based on a number of standards or requirements that already exist. They describe a level of service which is acceptable and which must be universal. **Meeting the core standards is not optional. Health care organisations must comply with them from the date of publication of this document.**

Developmental standards

19. Service provision which only meets the core standards will be no more than acceptable at the date of publication of this document. The focus of attention, both on the part of the Healthcare Commission in its annual reviews and on Trusts themselves, will be on progress against the developmental standards. These are broad-based and comprehensive in their scope and are framed so as to provide a dynamic force for continuous improvement over time. Through the annual review process they will enable health care organisations themselves, health care professionals and, most importantly, the public to see progress made year-on-year.
20. The developmental standards are designed for a world in which patients' expectations are increasing. The levels of investment now being made in the NHS make achievements against these standards realistic. Progress is expected to be made against the developmental standards across much of the NHS as a result of the *NHS Improvement Plan* and the extra investment in the period to 2008. **The Healthcare Commission will, through its criteria for review, assess progress by health care organisations towards achieving the developmental standards.**
21. The core standards will therefore serve a platform or "bottom rung" for progress against the developmental ladder. They serve as a marker for where the service is now. They also serve to assure the public that all services, wherever provided, will be safe and of an acceptable quality.

National Service Frameworks and NICE Guidance

22. National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance are integral to a standards-based system. They have a key role in supporting local improvements in service quality. Organisations' performance will be assessed not just on how they do on national targets but increasingly on whether they are delivering high quality standards across a range of areas, including NSFs and NICE guidance.
23. We will continue to develop NSFs and other national strategies where these are needed¹. There are forthcoming NSFs for children, renal services and long-term conditions, and a national strategy on sexual health. NSFs should be considered as part of the developmental standards. Over the course of the three-year planning period for the Planning Framework, the NHS together with Local Authorities will need to be able to demonstrate that they are making progress towards achieving the levels of service quality described in the NSFs and national strategies. Both the Healthcare Commission and CSCI will undertake thematic reviews of progress, jointly where appropriate.

¹ There are already NSFs on coronary heart disease, diabetes, mental health, older people's services and paediatric intensive care, as well as the NHS Cancer Plan, the national strategy for sexual health and HIV, and a major programme of work to implement recommendations from the Shipman inquiry.

The inspection function

24. As well as establishing the power for the Secretary of State for Health to set standards, the Health and Social Care (Community Health and Standards) Act 2003 also established the Healthcare Commission and set out its functions. These include undertaking an annual review of the provision of health care by (and for) each NHS body in England, including Foundation Trusts. Its judgements will be based on criteria, which it is charged with developing and which have to be agreed with the Secretary of State. These criteria have to take account of the standards set out in this document.
25. In undertaking its reviews, the Commission will focus on achievement against the developmental standards. However, it will also need to be satisfied that all trusts are meeting the core standards. The Commission will be responsible for determining *how* it assesses core performance, although the process will need to take account of targets that the Department has set and which are now assumed to be achieved. For this reason, we are including one core standard (C7 f) that cross refers to a number of existing requirements (as listed in Appendix 1 to these standards) which are currently being met and must continue to be met.
26. The outcome of the Healthcare Commission's review will therefore enable the public to identify progress against the standards by individual organisations. The reviews will also help to determine which Trusts are to be considered for Foundation Trust status. If, exceptionally, a Trust fails to satisfy the Commission that it meets the core standards, then consideration will need to be given to how performance should be improved. In such cases, it will normally be for the Trust to develop proposals for improvement in negotiation with its Strategic Health Authority. Exceptionally, the legislation gives powers to the Commission to recommend to the Secretary of State, or in the case of Foundation Trusts the Independent Regulator, that they take special measures in relation to any significant failings. It should be noted that the Independent Regulator has additional powers to intervene in the case of Foundation Trusts which are failing to discharge their responsibilities in other ways

The independent sector

27. The standards apply with immediate effect to services provided under the NHS, whether within NHS bodies or within the independent or voluntary sector. As foreshadowed in the consultation document, there will be an appropriate phasing in of the applications of these standards to cover other services provided entirely by the independent sector.
28. At present the requirements of the Care Standards Act mean that the Healthcare Commission is required to undertake inspections of all registered independent establishments once every year against the National Minimum Standards for Independent Health Care. The Healthcare Commission intends to harmonise and align its inspection and review methodologies for the independent and NHS sectors. The Government will also make legislative changes as necessary to enable an equal approach to inspection of the independent and NHS sectors against the same standards, when Parliamentary time allows.
29. Until then, independent providers will continue to be regulated against the Care Standards Act, its Regulations and National Minimum Standards. Those commissioning NHS services from the private sector must also take compliance with the *Standards for Better Health* into account before commissioning contracts are made. However, in practice, the Government has already taken the National Minimum Standards fully into account when setting the *Standards for Better Health*, and the Healthcare Commission will seek to avoid creating additional or inconsistent requirements during this transitional period through its adaptation of assessment methods, commissioning and harmonisation work.

30. The application of these standards to the independent sector and the timing of integration will be undertaken in consultation with representative organisations of the independent sector. This will include consultation on final proposals for these directions and initiatives.

Partnership working

31. While these standards are confined to the provision of NHS health care, they recognise the need to develop services in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care. In particular, they must be read and interpreted to allow for the statutory duties of partnership on all NHS bodies and Local Authorities established under the Health Act 1999 and the Health and Social Care (Community Health and Standards) Act 2003. This introduced requirements on both the NHS and Local Authorities to work together to achieve the co-operation needed to bring about improvements in health care.
32. In particular, there is a considerable emphasis within the developmental standards to adopting a whole system approach to health service provision.

Core and Developmental Standards

The outcome for these standards is specified for each domain. The core standards set out below are not optional. They should be met from the date of publication of this document. Progress is expected to be made against the developmental standards across much of the NHS as a result of the *NHS Improvement Plan* and the extra investment in the period to 2008. Demonstrating improvements against the developmental standards will be essential to achieve an overall high performance rating.

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.

Core standard

- C1 Health care organisations protect patients through systems that
- a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and
 - b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.
- C2 Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.
- C3 Health care organisations protect patients by following NICE Interventional Procedures guidance.
- C4 Health care organisations keep patients, staff and visitors safe by having systems to ensure that
- a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;
 - b) all risks associated with the acquisition and use of medical devices are minimised;
 - c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;
 - d) medicines are handled safely and securely; and
 - e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Related
Developmental
Standard:
D1

Developmental standard

- D1 Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.

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.

Core standards

- C5 Health care organisations ensure that
- a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;
 - b) clinical care and treatment are carried out under supervision and leadership;
 - c) clinicians continuously update skills and techniques relevant to their clinical work; and
 - d) clinicians participate in regular clinical audit and reviews of clinical services.
- C6 Health care organisations co-operate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Related
Developmental
Standard:
D2

Developmental standard

- D2 Patients receive effective treatment and care that:
- a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;
 - b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences;
 - c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and
 - d) is delivered by health care professionals who make clinical decisions based on evidence-based practice.

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.

Core standards

C7	Health care organisations a) apply the principles of sound clinical and corporate governance; b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources; c) undertake systematic risk assessment and risk management (including compliance with the controls assurance standards); d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources; e) challenge discrimination, promote equality and respect human rights; and f) meet the existing performance requirements set out in Appendix 1.	Related Developmental Standard: D3
C8	Health care organisations support their staff through a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.	Related Developmental Standard: D7
C9	Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	Related Developmental Standard: D6
C10	Health care organisations a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and b) require that all employed professionals abide by relevant published codes of professional practice.	Related Developmental Standard: D7
C11	Health care organisations ensure that staff concerned with all aspects of the provision of health care a) are appropriately recruited, trained and qualified for the work they undertake; b) participate in mandatory training programmes; and c) participate in further professional and occupational development commensurate with their work throughout their working lives.	

- C12 Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

Related
Developmental
Standard:
D3

Developmental standards

- D3 Integrated governance arrangements representing best practice are in place in all health care organisations and across all health communities and clinical networks.
- D4 Health care organisations work together to
- a) ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service;
 - b) implement a cycle of continuous quality improvement; and
 - c) ensure effective clinical and managerial leadership and accountability.
- D5 Health care organisations work together and with social care organisations to meet the changing health needs of their population by
- a) having an appropriately constituted workforce with appropriate skill mix across the community; and
 - b) ensuring the continuous improvement of services through better ways of working.
- D6 Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.
- D7 Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

Fourth Domain – Patient Focus

Domain Outcome

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

Core standards

- C13 Health care organisations have systems in place to ensure that
- a) staff treat patients, their relatives and carers with dignity and respect;
 - b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and
 - c) staff treat patient information confidentially, except where authorised by legislation to the contrary.

- C14 Health care organisations have systems in place to ensure that patients, their relatives and carers
- a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;
 - b) are not discriminated against when complaints are made; and
 - c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.
- C15 Where food is provided, health care organisations have systems in place to ensure that
- a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and
 - b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

Related
Developmental
Standard:
D8

- C16 Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

Related
Developmental
Standard:
D9

Developmental standards

- D8 Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.
- D9 Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are
- a) encouraged to express their preferences; and
 - b) supported to make choices and shared decisions about their own health care.
- D10 Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.

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.

Core standards

- C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.
- C18 Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.
- C19 Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Related
Developmental
Standard:
D11

Developmental standard

- D11 Health care organisations plan and deliver health care which
- reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice;
 - maximises patient choice;
 - ensures access (including equality of access) to services through a range of providers and routes of access; and
 - uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

Sixth Domain – Care Environment and Amenities

Domain Outcome

Care is provided in environments that promote patient 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.

Core standards

- C20 Health care services are provided in environments which promote effective care and optimise health outcomes by being
- a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
 - supportive of patient privacy and confidentiality.
- C21 Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Related
Developmental
Standard:
D12

Developmental standard

- D12 Health care is provided in well designed environments that
- promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and
 - are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections.

Seventh Domain – Public Health

Domain Outcome

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

Core standards

- C22 Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by
- co-operating with each other and with Local Authorities and other organisations;
 - ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and
 - making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.
- C23 Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.
- C24 Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

Related
Developmental
Standard:
D13

Related
Developmental
Standard:
D13

Developmental standard

- D13 Health care organisations
- identify and act upon significant public health problems and health inequality issues, with Primary Care Trusts taking the leading role;
 - implement effective programmes to improve health and reduce health inequalities;
 - protect their populations from identified current and new hazards to health; and
 - take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

Appendix 1: Existing commitments to be maintained

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.

Note: The underlying definitions for these standards – and the split between rural and urban services – will be clarified later in 2004, as part of the current ambulance review.

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 service 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 CHD 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 CHD, 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.

Appendix 2: Glossary

Access:	the extent to which people are able to receive the information, services or care they need.
CHAI:	The Commission for Healthcare Audit and Inspection was established by the Health and Social Care (Community Health and Standards) Act 2003 and is now known as the Healthcare Commission.
CHI:	The Commission for Health Improvement was, until April 2004, the independent, inspection body for the NHS. Its functions were transferred to the Healthcare Commission.
Clinical audit:	a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in health care delivery.
Clinical governance:	a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.
Clinical network:	connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience.
Clinician:	professionally qualified staff providing clinical care to patients.
Controls assurance standards:	standards covering buildings, land, plant and non-medical equipment; catering and food hygiene; decontamination of re-usable medical devices; emergency planning; environmental management; financial management; fire safety; fleet and transport management; governance; health and safety management; human resources; infection control; information management and technology; management of purchasing and supply; medical devices management; medicines management; professional conduct and liability; records management; risk management; security management and waste management. Full details can be found on http://www.hcsu.org.uk
Crime and disorder reduction partnerships:	partnerships between the police, Local Authorities, probation service, health authorities, the voluntary sector, and local residents and businesses which work to reduce crime and disorder in their area.
Criteria:	criteria devised and published by the Healthcare Commission, and approved by the Secretary of State, with reference to which the Healthcare Commission must, each financial year, conduct a review of the provision of health care by and for each English NHS body, and each cross-border SHA.
Cross-border SHA:	a special health authority performing functions in respect of both England and Wales.

English NHS body:	a Primary Care Trust, Strategic Health Authority or NHS Trust, all or most of whose hospitals, establishments and facilities are situated in England, or an NHS Foundation Trust or special health authority performing functions only or mainly in respect of England.
Foundation Trust:	a public benefit corporation established by the Health and Social Care (Community Health and Standards) Act 2003 which is authorised to provide goods and services for the purpose of the health service.
Governance:	a mechanism to provide accountability for the way an organisation manages itself.
Healthcare Commission:	established in April 2004 as the independent body encompassing the work of the Commission for Health Improvement (CHI). It will inspect health care provision in accordance with national standards and other service priorities and will report directly to Parliament on the state of health care in England and Wales.
Health care organisation:	English NHS bodies, cross-border SHAs and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients and the public.
Health care professional:	a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Health care:	services provided for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.
Health care associated infection:	all infections acquired as a direct or indirect result of health care.
Health inequalities:	differences in people's health between geographical areas and between different groups of people.
Health promotion:	includes the provision of information on healthier lifestyles for patients, and how to make the best use of health services, with the intention of enabling people to make rational health choices and of ensuring awareness of the factors determining the health of the community.
Local Strategic Partnerships:	non-statutory bodies intended to bring together the public, private, voluntary and community sectors at a local level. Their purpose is to improve the delivery of services and quality of life locally.
Medical devices:	all products, except medicines, used in health care for diagnosis, prevention, monitoring or treatment. The range of products is very wide: it includes contact lenses and condoms; heart valves and hospital beds; resuscitators and radiotherapy machines; surgical instruments and syringes; wheelchairs and walking frames.

National Service Frameworks:	<p>NSFs</p> <ul style="list-style-type: none">• set national standards and identify key interventions for a defined service or care group;• put in place strategies to support implementation; and• establish ways to ensure progress within an agreed timescale. <p>The NSFs published to date cover:</p> <ul style="list-style-type: none">• mental health• coronary heart disease• older people• diabetes• paediatric intensive care <p>NSFs on children, renal services and long-term conditions (focusing on neurological conditions) are in preparation.</p>
NICE:	<p>the National Institute for Clinical Excellence is a special health authority for England and Wales. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current “best practice”. The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.</p>
NICE guidance:	<p>guidance covering three areas of health:</p> <ul style="list-style-type: none">• Clinical guidelines cover the appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales.• Technology appraisals cover the use of new and existing medicines and treatments within the NHS in England and Wales.• Interventional procedures cover the safety and efficacy of interventional procedures used for diagnosis or treatment.
Patient:	<p>those in receipt of health care provided by or for an English NHS body or cross-border SHA.</p>
Primary care:	<p>first-contact health services directly accessible to the public.</p>
Primary Care Trust:	<p>a local health organisation responsible for managing local health services. PCTs work with Local Authorities and other agencies that provide health and social care locally to make sure the community’s needs are being met.</p>
Public health:	<p>Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. Public health functions include:</p> <ul style="list-style-type: none">• Health surveillance, monitoring and analysis• Investigation of disease outbreaks, epidemics and risk to health• Establishing, designing and managing health promotion and disease prevention programmes• Enabling and empowering communities to promote health and reduce inequalities• Creating and sustaining cross-Government and inter-sectoral partnerships to improve health and reduce inequalities• Ensuring compliance with regulations and laws to protect and promote health• Developing and maintaining a well educated and trained, multi-disciplinary public health workforce• Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities

- Research, development, evaluation and innovation
- Quality assuring the public health function

Public Service Agreement:	The PSA for the Department of Health sets out the priorities for the Department's spending programme and, for each priority, the target(s) it is expected to achieve.
Quality assurance:	a systematic process of verifying that a product or service being developed is meeting specified requirements.
Research governance framework:	defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards and applies to all research undertaken within the remit of the Secretary of State for Health.
Risk management:	covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.
Service user:	an individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.
Star rating:	<p>the Healthcare Commission's performance ratings system places NHS Trusts in England into one of four categories:</p> <ul style="list-style-type: none">• Trusts with the highest levels of performance are awarded a performance rating of three stars• Trusts that are performing well overall, but have not quite reached the same consistently high standards, are awarded a performance rating of two stars• Trusts where there is some cause for concern regarding particular areas of performance are awarded a performance rating of one star• Trusts that have shown the poorest levels of performance against the indicators or little progress in implementing clinical governance are awarded a performance rating of zero stars.
Strategic Health Authority:	<p>responsible for:</p> <ul style="list-style-type: none">• developing plans for improving health services in its local area;• making sure local health services are of a high quality and are performing well;• increasing the capacity of local health services so they can provide more services; and• making sure national priorities are integrated into local health service plans.
Systematic risk assessment:	a systematic approach to the identification and assessment of risks using explicit risk management techniques.

Appendix 3: Extracts from the Health and Social Care (Community Health and Standards) Act 2003

The “Duty of Quality”:

45 Quality in health care

- (1) It is the duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.
- (2) In this Part “health care” means-
 - (a) services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and
 - (b) the promotion and protection of public health.
- (3) In subsection (2)(a), “illness” has the meaning given by section 128(1) of the 1977 Act.

The Power for the Secretary of State to prepare and publish standards, and the duty of upon every English NHS body and cross-border SHA to take account of the standards:

46 Standards set by Secretary of State

- (1) The Secretary of State may prepare and publish statements of standards in relation to the provision of health care by and for English NHS bodies and cross-border SHAs.
- (2) The Secretary of State must keep the standards under review and may publish amended statements whenever he considers it appropriate.
- (3) The Secretary of State must consult such persons as he considers appropriate-
 - (a) before publishing a statement under this section;
 - (b) before publishing an amended statement under this section which in the opinion of the Secretary of State effects a substantial change in the standards.
- (4) The standards set out in statements under this section are to be taken into account by every English NHS body and cross-border SHA in discharging its duty under section 45.

CHAI’s annual reviews, reviews and investigations, their use of set criteria and the requirement upon CHAI to take into account the standards:

50 Annual reviews

- (1) In each financial year the CHAI must conduct a review of the provision of health care by and for-
 - (a) each English NHS body, and
 - (b) each cross-border SHA,and must award a performance rating to each such body.
- (2) The CHAI is to exercise its function under subsection (1) by reference to criteria from time to time devised by it and approved by the Secretary of State.
- (3) The CHAI must publish the criteria devised and approved from time to time under subsection (2).
- (4) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

51 Reviews: England and Wales

- (1) The CHAI has the function of conducting reviews of-
 - (a) the overall provision of health care by and for NHS bodies;
 - (b) the overall provision of particular kinds of health care by and for NHS bodies;
 - (c) the provision of health care, or a particular kind of health care, by and for NHS bodies of a particular description.
- (2) If the Secretary of State so requests, the CHAI must conduct-
 - (a) a review under subsection (1)(a);
 - (b) a review under subsection (1)(b) of the overall provision of a kind of health care specified in the request; or
 - (c) a review under subsection (1)(c) of the provision of health care, or health care of a kind specified in the request, by or for NHS bodies of a description so specified.
- (3) The Secretary of State must consult the Assembly before making a request under subsection (2).
- (4) In conducting a review under this section in relation to any health care the CHAI must take into account-
 - (a) the standards set out in statements published under section 46, where the health care is provided by or for an English NHS body or cross-border SHA;
 - (b) the standards set out in statements published under section 47, where the health care is provided by or for a Welsh NHS body.

52 Reviews and investigations: England

- (1) The CHAI has the function of conducting other reviews of, and investigations into, the provision of health care by and for English NHS bodies and cross-border SHAs.
- (2) The CHAI may in particular under this section conduct-
 - (a) a review of the overall provision of health care by and for English NHS bodies and cross-border SHAs;
 - (b) a review of the overall provision of a particular kind of health care by and for English NHS bodies and cross-border SHAs;
 - (c) a review of, or investigation into, the provision of any health care by or for a particular English NHS body or cross-border SHA.
- (3) The CHAI has the function of conducting reviews of the arrangements made by English NHS bodies and cross-border SHAs for the purpose of discharging their duty under section 45.
- (4) If the Secretary of State so requests, the CHAI must conduct-
 - (a) a review under subsection (2)(a);
 - (b) a review under subsection (2)(b) of the overall provision of a kind of health care specified in the request;
 - (c) a review or investigation under subsection (2)(c), or a review under subsection (3), in relation to the provision of such health care by or for such body as may be specified in the request.
- (5) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

Annex B – National Targets

Priority I: Improve the Health of the Population

National Targets

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, 1995-97):
 - 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; and
 - 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 groups¹ (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 baseline) 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); and
 - 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 for Education and Skills.)

Note: There may be some change to the detail of these targets in the light of the outcome of the Public Health White Paper *Choosing Health?* later this year.

¹ As defined by the National Statistics socio-economic classification. Routine and manual groups cover local supervisors and technical occupations, semi-routine occupations, routine occupations and those who have never worked or are in long-term unemployment.

Improve the Health of the Population

1. This priority area is made up of a number of distinct elements, which will be prominent in the Public Health White Paper *Choosing Health?* to be published later this year. The White Paper will provide a detailed strategy for the implementation of policies which will improve the health of the population. PCTs, in partnership with LAs, NHS and other local organisations, will need to take the White Paper Strategy into account when developing their policies that will contribute to the delivery of the new national targets. In doing so they will wish to focus on the key current challenges:
 - i) **Reducing mortality from heart disease:** the NHS interventions which will result in the largest reductions in deaths from heart disease and stroke by 2010 are management of hypertension, high cholesterol, and diabetes in primary care, both for people with established disease and those at high risk. Positive effects will also be achieved by reductions in smoking, and in “call to needle time” for thrombolysis. The National Service Frameworks for coronary heart disease, diabetes, older people and children provide models of care to support achievement of reduced mortality.
 - ii) **Reducing mortality from cancer:** the NHS interventions which will result in the largest reductions in deaths from cancer by 2010 are earlier detection; shorter waiting times for diagnosis and treatment along the care pathway (as set out in the *NHS Cancer Plan*); and optimal treatment and support of people diagnosed as having cancers (in line with NICE guidance). The *NHS Cancer Plan* and the NICE guidance provide models of care to support achievement of reduced mortality. Reductions in smoking rates will also have a longer-term impact on reducing cancer mortality rates.
 - iii) **Reducing inequalities in health outcomes:** all PCTs should work in partnership with LAs, using health equity audit, to demonstrate that effective interventions are provided for all groups in the population, targeting those with highest needs.
 - *inequalities in life expectancy* – key interventions are likely to be that, in the poorest areas and groups, there is a significant reduction in smoking prevalence, and targeted action on prevention and treatment of cardiovascular disease (CVD) and cancers. There may also be local inequalities factors affecting access to primary care services, such as those experienced by minority ethnic groups;
 - *infant mortality* – key interventions include a focus on reductions in smoking in pregnancy; improving nutrition of women of childbearing age, particularly those who are pregnant or breastfeeding; increased breastfeeding initiation and duration rates; effective antenatal care; and providing high quality midwifery, obstetric and neonatal services in a culturally sensitive way, together with effective family support;
 - *national health inequalities* – this will require PCTs with the largest burdens of heart disease and cancer to set and achieve particularly stretching local targets, with a strong focus on the over 50s, especially those with established disease or high risk factors.
 - iv) **Reducing mortality from suicide:** interventions which will help deliver this target are described in the *National Suicide Prevention Strategy*, and the *National Service Framework for Mental Health*. Unemployment and social isolation are important risk factors for deteriorating mental health and suicide. Information on how to help people with mental health problems gain and retain work, and improve community engagement, is set out in the report on mental health by the Government’s Social Exclusion Unit. PCTs should support access to assessment, treatment and care for all those at risk, paying particular attention to the needs of those from black and minority ethnic communities and other groups that may be hard to reach.

- v) **Reducing adult smoking rates and tackling obesity:** the Public Health White Paper to be published in autumn 2004 will set out comprehensive proposals for action. PCTs should plan to ensure that all care contacts across the system are used to promote advice on stopping smoking and on healthy eating and exercise. Increasing the number of long-term quitters through NHS Stop Smoking Services will be central. Reducing obesity, particularly in children under 11, requires further development of NHS services and interventions in primary care, specialist obesity services, and work with schools.
- vi) **Reducing teenage pregnancies:** The Public Health White Paper later this year will cover teenage pregnancy and will also set out comprehensive proposals for tackling sexually transmitted infections (STIs). The sexual health areas which will be particularly relevant for PCTs and their Local Authority partners to cover in their plans are: STI (and HIV) rates; holistic access times (covering both STI and reproductive health); and contraceptive and sexual health services provision.

Priority II: Supporting People with Long-Term Conditions

National Target

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.

Supporting People with Long-Term Conditions

2. Research evidence indicates that a targeted approach and more effective management in the community can prevent inappropriate admissions, cut lengths of stay in hospital, and improve patient experiences and outcomes.
3. People with long-term conditions benefit from a comprehensive holistic assessment of their current and anticipated health and social care needs and wishes. The result will be a care plan for each person (and her/his carer(s)) which she or he has agreed with her/his lead care professional on behalf of the agencies involved. The plan will set out agreed health objectives and care needs and the contributions of the individual and of each agency. It will be reviewed regularly to evaluate outcomes and identify changes in the needs and wishes of the patient (and carers).
4. The level of support that people need will vary with time and the progression of their conditions. Many people with long-term conditions can manage their conditions well most of the time, with access to support in primary care and systematic and tailored disease management programmes when appropriate. There are some people (often those with more than one condition) whose needs are more complex, who require more proactive support with a key worker co-ordinating services.
5. PCTs, working with LAs and other NHS partners, need to agree plans that will support delivery of the national target. These should take into account the objectives set out in the *NHS Improvement Plan*:
 - the *Expert Patients Programme* will be rolled out nationally by 2008 to enable thousands more people with long-term conditions to take more control of their health;
 - the *new contract for GPs* introduced in April 2004 will reward family doctors who deliver higher standards of care to patients;

- patients with complex long-term conditions will be supported by *community matrons*, and by 2008 every PCT will be offering these services;
 - people with long-term conditions will benefit from the rapid implementation of NICE guidance on cost effective drugs and NICE guidelines, for example on MS and epilepsy.
6. The forthcoming NSF on long-term conditions will support the broader work on long-term conditions by describing the quality of health and social care services that people with long-term neurological conditions can expect to receive, and will also be relevant to other long-term conditions.

Priority III: Access to Services

National Targets

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.

Access to Services

7. This target applies to acute elective hospital care, but PCTs are encouraged to agree local plans to reduce waiting for other types of treatment. We would expect average waits in 2008 to be around nine weeks from GP referral to treatment, with waits for an outpatient consultation not normally exceeding six weeks. PCTs, in partnership with NHS and other provider organisations, are encouraged to set and achieve even more ambitious goals locally. PCTs will need to ensure they have robust plans to deliver the 2008 maximum waiting time target. PCTs' annual trajectories will be agreed with SHAs as part of the planning process and PCTs will hold providers to account for delivery through commissioning arrangements.
8. **Diagnostic Services:** The maximum wait of 18 weeks by December 2008 includes diagnostic procedures and tests, encompassing all those diagnostic procedures and tests required for the consultation. There will be shorter waits for patients with suspected cancer – a maximum of two months from urgent referral to treatment from December 2005 and one month from diagnosis to treatment – again requiring faster access to key diagnostic services. PCTs and their partners will be encouraged to plan for early reductions in key areas of diagnostic waits, such as MRI, CT scans and endoscopy.
9. **New capacity and diversity of provision:** The *NHS Improvement Plan* signals that independent sector providers will increase their contribution to the care of NHS patients and may provide up to 15% of surgical procedures and an increasing number of diagnostic procedures by 2008. PCTs and their partners are encouraged to plan for significant plurality of provision, including Treatment Centres, to improve value for money and to benefit patients. PCTs should also have made contingency plans and have put in place adequate risk management strategies to address unforeseen capacity shortfalls.
10. **Problem drug users:** PCTs will need to work with their partners to commission drug treatment services that will increase the number of drug users in treatment, improve successful programme completion rates, and support the delivery of treatment to drug using offenders and local Criminal Justice Intervention Programmes. Variations in the quality and availability of drug treatment services can most effectively be addressed by following the optimal models of care pathways in the National Treatment Agency's *Models of Care* and NICE guidelines relating to substitution prescribing.

Priority IV: Patient/User Experience

National Targets

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 experiences 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; 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.

Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.²

Patient/User Experience

11. **Patient experience and choice:** Survey results will be analysed and presented, at the national level, by different patient groups, including ethnic groups. Given that evidence shows relatively poor take up of services by people from black and minority ethnic communities, PCTs should work with local provider organisations to improve (a) the way people from black and minority ethnic communities are consulted about local health and health care issues and (b) the way their experience is monitored.
12. PCTs and their partner organisations need to agree local plans that will support delivery of the national target. Patient choice will enable patients to personalise their care to best meet their preferences. To deliver the choice element of the new national target, PCTs and their partners will be expected to plan so that:
 - from April 2008, patients requiring planned hospital care will have the right to choose to have their treatment in any health care provider that meets the Healthcare Commission's standards and which can provide care within the price the NHS will pay.
13. PCTs should ensure that adequate patient information and support processes are set up and, particularly, to provide targeted support for hard-to-reach individuals and communities, including black and minority ethnic groups. PCTs should be considering how to increase patient choice in primary care and for patients with long-term conditions.
14. **Support for older people to live in their own homes:** LAs should take the lead on delivering the national target for older people, working with NHS partners. The Personal Social Services interventions that will improve older people's quality of life, and help them to live independently in their own homes, include home help/home care, such as help with routine household tasks, personal care, taking a client to an appointment or shopping; encouraging housing schemes with built-in care support; daycare; respite care for carers; direct payments so that clients can purchase their own services; and equipment and adaptations to help individuals to live in their own home. Helping people to live at home by investing in home care shifts the balance away from institutional care and builds on the development of person-centred, needs-based services so that older people have more choice about the care that they receive.

² Data on MRSA is already collected and published. Data on glycopeptide-resistant enterococci, *Clostridium difficile* – associated diarrhoea, and post-surgical infection in orthopaedics will be published from 2005.

15. **Reducing MRSA infections:** The NHS interventions which will result in reductions in MRSA bacteraemias (blood stream infection) rates and other infections include improved hand hygiene and aseptic technique. *Winning Ways – Working together to reduce Health Care Associated infection in England* sets out a wide range of activities to reduce infection, including MRSA blood stream infections. PCTs are expected to plan with their partner organisations to make an agreed contribution to this national target and to agree organisation specific plans, through service level agreements and contracts.

Existing Commitments

16. The existing commitments in the table below arise from the previous 2003-06 planning round and extend into the period of the new planning round. PCTs and their partner organisations are expected to deliver these commitments by their target dates, and to maintain that level of performance beyond the target date. Performance against existing commitments will be covered by Healthcare Commission assessments, which inform performance ratings.

- 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 service 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 CHD 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 CHD, 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.



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