MEETING OF UTTLESFORD FUTURES HELD AT 1.00 PM AT COUNCIL OFFICES HIGH STREET GREAT DUNMOW ON 26 JANUARY 2005

Present:- Councillor Catherine Dean – Chairman.
Councillor Barbara Hughes and Gaynor Bradley, Sarah McLagan, Mick Purkiss, Alex Stewart and Tracy Turner (Uttlesford District Council); Councillor John Whitehead and Christopher White (Essex County Council); Dale Atkins (Uttlesford PCT); Sue Sumner (Uttlesford PCT & CUSV); David Westcott (Council for Voluntary Service Uttlesford); Paul Garland (LA21); Ann Jones (Essex Youth Service); Maggie Evans (North & West Essex Community College); and Peter Fuller-Lewis (Uttlesford Association of Local Councils & PPIF).

1 **SAFFRON WALDEN INITIATIVE PRESENTATION**

Councillor Stephen Jones, John Ready and Peter Riding attended the meeting and gave a presentation on the study for improving Saffron Walden Town Centre which had been supported by Uttlesford Futures. John Ready gave a comprehensive presentation and outlined the options for improvement and gave details of the consultation and public participation arrangements. He expressed the gratitude of Saffron Walden Initiative for the support which had been given by Uttlesford Futures. Peter Riding added that the next step would be to get the project professionally costed and phased and understood that this would cost approximately £2,100. He asked whether any further financial assistance could be given to enable this work to be completed.

Members of Uttlesford Futures thanked the Saffron Walden Initiative for the work which had gone into this project and for the excellent presentation and said that the application for funding would be considered later in the meeting.

2 **FAMILY SUPPORT CENTRE PRESENTATION**

A presentation was made by PC Karl Llewellyn concerning domestic violence. He said that during the year to 1 January 2004, there had been 377 reported domestic violence incidents and this had reduced to 330 in the year to 1 January 2005. He said that he was particularly grateful for the work of the Uttlesford Community Support Group and the facilities provided by the Family Support Centre at Mole Hill Green Village Hall, Takeley. Andrew Thompson then gave a presentation on a case study in Uttlesford.

Members of Uttlesford Futures thanked them both for this fascinating presentation.

3 **APOLOGIES AND WELCOME**

Apologies for absence were received from Councillors Menell and Murphy, Sue Harrison, Glyn Pritchard, Peter Pearson, Paul Taylor, Melanie Walker and John Williams.

The Chairman welcomed Tracy Turner who had recently been appointed as the Executive Manager (Strategy and Performance) with Uttlesford District Council.

4 **MINUTES**

The Minutes of the meeting held on 2 November 2004 were approved as a correct record.

5 **MATTERS ARISING**

In relation to the Youth Survey undertaken by Priority Research, it was noted that it was not possible to undertake detailed post survey interviews due to the anonymity provided in the original survey. Officers would clarify how gaps in the survey and the development of an action plan would be pursued.

Christopher White gave a brief update on the revised constitution and said that Peter Pearson would be producing a report during February which could be considered at the next meeting of Uttlesford Futures.

6 **EDUCATION UPDATE**

Maggie Evans reported that funding had been provided for the following three projects: Working With the Care Sector; Producing a Role Model Directory of Successful Young People and Supporting Family Learning and Literacy. She also reported on funding which had been provided to secondary schools; work to identify business skills gaps and the appointment of an educational advisor.

7 **PUBLIC HEALTH WHITE PAPER**

Alex Stewart gave a presentation on progress with the Public Health White Paper entitled Choosing Health. He said that Uttlesford Futures had a lead role to deliver the community well being agenda and agree a shared vision and agenda for action in order to improve health. He set out a suggested approach which would include utilising information and data, investment arrangements, joint appointments where relevant and joint planning processes.

8 **HEALTH UPDATE**

Dale Atkins provided details of the health and social care standards and planning framework and a summary is attached to these Minutes. He said that the key messages were:-

- Need to ensure that planning takes place in close partnership with local authorities and particularly in conjunction with the LSP (Uttlesford Futures);

- An opportunity to set local targets, but in conjunction with local partners;

- Health care commission indication is that “pilots” for local target setting will take place during 2005/06 with the aim of rolling out for 2006/07;

- Health and social care standards will form the basis for new performance assessment for NHS organisations. Star ratings will be discontinued from 1 April 2005 and there will then be classification of performance into one of five categories: very good, good, satisfactory, unsatisfactory or serious concerns;

- Part of the monitoring process will involve seeking views of local partners which may be a role for the LSP.

He said that the five key themes were:-

- A focus on health and well being across the whole system;

- Getting the individual the patient, service user or client more power to improve their care and drive the whole system;

- Improving both quality and e-quality;

- Addressing the needs of children as well as the adult population;

- Review and change the way we work to improve delivery.

9 **YOUTH FORUM**

Gaynor Bradley said that the Youth Forum was a joint project between the Youth Service and Uttlesford District Council. A local democracy evening had recently been held and three issues (transport/access to leisure at reduced rates/provision of soap in schools) had been raised. She updated Members with progress on these issues and other activities. She said that the membership of the Youth Forum was increasing.

10 **BUDGET UPDATE**

Alex Stewart reported that there was currently £5,150 unspent in the budget. Contributions were still awaited from the PCT and the police.

Consideration was then given to the request from Saffron Walden Initiative for a contribution to enable the professional costing and phasing of the Town Centre Project to be undertaken.

It was agreed that a grant of £2.100 be made to the Saffron Walden Initiative to enable this work to be undertaken.

Christopher White suggested that if there were any under spend in the budget, it should be made available to ADAS to assist with the provision of a workshop in June. Other Members agreed that this should be supported and he would obtain further details of costings to be considered at the next meeting.

It was also noted that BAA, the largest employer in the area, had not made a contribution to Uttlesford Futures and it was agreed that a letter be sent to them asking for financial assistance in the work of Uttlesford Futures.

11 **STAFFING UPDATE**

Alex Stewart reported that the post of Strategic Funding Officer was being re-advertised this week and it was hoped that interviews would be held at the end of February.

12 **COMMUNITY STRATEGY UPDATE**

Alex Stewart said that the draft strategy would be circulated to Members of CSAT in the near future.

13 **TRANSPORT FORUM UPDATE**

Councillor Catherine Dean gave an update on progress with the work of the Transport Forum. She referred to a study on transport and in particular, proposals to provide a cycle/pedestrian path between Audley End Station and Saffron Walden town. She said that the safer cycling paper prepared by Councillor Mike Hibbs would be considered by the Saffron Walden Initiative. She also referred to bus services and the implications of the Disability Discrimination Act and added that these issues would be kept under review.

14 **JOBS AND ENTERPRISE IN NON- DEPRIVED AREAS**

Alex Steward said that the LGIU had arranged a national action-learning day in deprived areas. However, whilst Uttlesford did not fall into this category there were many problems with young people accessing jobs and learning and it was felt that a similar event should be held for areas like Uttlesford. Alex Stewart and Maggie Evans would pursue this matter further with the LGIU.

15 **ITEMS FOR NEXT MEETING**

It was noted that the draft mapping exercise was nearing completion and a report would be made to the next meeting. Sue Sumner also asked that the Compact be included on the next agenda.

16 **FUTURE MEETINGS**

It was noted that future meetings would be held on 8 March and 28 April 2005 at the Dunmow Council Offices and would commence at 2.00 pm unless otherwise notified.

National Standards,
Local Action
Health and Social Care Standards
and Planning Framework
2005/06–2007/08

Uttlesford NHS
Primary Care Trust

UPCT SUMMARY

For information to :
PCT Board, PCT PEC and
Local Strategic Partnership (Uttlesford 'Futures')

Introduction This document provides a summary of the Standards and Targets contained within the full document : *' National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06–2007/08'.* A copy of the full document is available upon request.

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.

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.

Key Messages :

- need to ensure that planning takes place in CLOSE PARTNERSHIP with Local Authorities and particularly in conjunction with the Local Strategic Partnership (LSP) – locally Uttlesford 'Futures'.

- an opportunity to set LOCAL TARGETS, but in conjunction with local partners.

  Note 1 - 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.*

  Note 2 – It is yet to be determined to what level 'local' will refer eg SHA, Sub – Economy or PCT.

- overall intention is to reduce the number of 'top down' targets for PCTs, including the discontinuation of Controls Assurance (but not the assurance framework); thus allowing the above increased opportunity for developing more local targets

- PCTs to DEVELOP their COMMISSIONING systems. 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.

Five Key Themes :

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

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

- improving both quality and equality

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

- review and change the way we work to improve delivery

3 x AREAS OF STANDARDS / TARGETS to be met :

1. ***DOMAINS*** (7 areas : 1. Safety 2. Clinical and Cost Effectiveness 3. Governance 4. Patient Focus 5. Accessible and Responsive Care 6. Care Environment and Amenities 7. Public Health)

2. Maintaining ***EXISTING COMMITMENTS*** (eg Achieve a maximum wait of 6 months for inpatients by December 2005)

3. Addressing ***NATIONAL PRIORITIES*** (eg 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)

1. DOMAINS

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.

The seven domains are:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus
- Accessible and Responsive Care
- Care Environment and Amenities
- Public Health

Core and Developmental Standards

First Domain – SAFETY
(Lead Director : Jane Kinniburgh with significant support from Marc Davis)

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.

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
(Lead Director : Marc Davis with significant support from Jane Kinniburgh)

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
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.

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
(Lead Director : Jane Kinniburgh with significant support from Adrian Marr)

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.

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.

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.

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.

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.

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
(Lead Director : Adrian Marr – as Acting CEO)

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.

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.

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
(Lead Director : Sallie Mills Lewis)

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.

Developmental standard

D11 Health care organisations plan and deliver health care which :

a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice;
b) maximises patient choice;
c) ensures access (including equality of access) to services through a range of providers and routes of access; and
d) 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
(Lead Director : Adrian Marr)

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) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
b) 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.

Developmental standard

D12 Health care is provided in well designed environments that :

a) promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns

b) 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
(Lead Director : Glyn Pritchard)

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 :

a) co-operating with each other and with Local Authorities and other organisations;
b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices;
c) 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.

Developmental standard

D13 Health care organisations :

a) identify and act upon significant public health problems and health inequality issues, with Primary Care Trusts taking the leading role;
b) implement effective programmes to improve health and reduce health inequalities;
c) protect their populations from identified current and new hazards to health; and
d) 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.

2. COMMITMENTS
(Lead Director initials in brackets)

DUE TO BE ACHIEVED BEFORE MARCH 2005

• Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge. *(SML)*

• Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours. *(MD)*

• All ambulance trusts to respond to 75% of Category A calls within 8 minutes. *(SML)*

• All ambulance trusts to respond to 95% of Category A calls within 14 (urban)/19(rural) minutes. *(SML)*

• All ambulance trusts to respond to 95% of Category B calls within 14 (urban)/19(rural) minutes. *(SML)*

• Maintain a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals. *(SML)*

• Maintain a maximum two-week wait standard for Rapid Access Chest Pain Clinics. *(SML)*

• 3 month maximum wait for revascularisation by March 2005. *(SML)*

• 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. *(SML)*

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. *(SML)*

• 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. *(SML)*

• Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005. *(SML)*

• Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005. *(SML)*

• 800,000 smokers from all groups successfully quitting at the 4-week stage by 2006. *(GP)*

• 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. *(MD)*

• 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. *(MD)*

• Achieve a maximum wait of 3 months for an outpatient appointment by December 2005. *(SML)*

• Achieve a maximum wait of 6 months for inpatients by December 2005. *(SML)*

• 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. *(SML)*

• Delayed transfers of care to reduce to a minimal level by 2006. *(CR)*

3. NATIONAL PRIORITIES

PRIORITY I: IMPROVE THE HEALTH OF THE POPULATION National Targets
(Lead Director : Glyn Pritchard)

• 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)
  – 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.)

PRIORITY II: SUPPORTING PEOPLE WITH LONG-TERM CONDITIONS
(Lead Director : Christine Richardson with significant support from Marc Davis & Jane Kinniburgh)

• 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.
• 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.

PRIORITY III: ACCESS TO SERVICES
(Lead Director : Sallie Mills Lewis)

• Waiting Times.
Expected that average waits in 2008 to be around nine weeks from GP referral to treatment, with waits for an outpatient consultation not normally exceeding 6 weeks. PCTs, in partnership with NHS and other provider organisations, are encouraged to set and achieve even more ambitious goals locally.

• 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. 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.

• 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.

• Problem drug users:
Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

PRIORITY IV: PATIENT/USER EXPERIENCE

Patient/User Experience
(Lead Director : Adrian Marr)

• 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.

• 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.

• 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.

• **Support for older people to live in their own homes:**
(Lead Director : Christine Richardson)

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.

• **Reducing MRSA infections:**
(Lead Director : Glyn Pritchard)

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.

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