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SECTION 2 – STANDARDS FOR BETTER HEALTH

CORE STANDARDS FOR EACH OBJECTIVE (S4BH reference)	National target or performance management standard	Key milestones	Current likelihood of achieving standard (low =1, 5=high)*	Current position at quarterly update	Lead Director, responsible committee/ external assessment process
1. SAFETY					
C1. (a) Identify and learn from patient safety incidents	Serious incident review process in place internally, including SUI reporting to the SHA. Regular reports from Datix incident recording system presented to Board sub-committee.	Establish PCT incident reporting systems. Integrated Governance Committee to oversee root/cause analysis of incidents and action taken. Training for staff in incident/near miss identification and reporting. Improvements in practice.	4	Datix training held for new staff Nov.2005 New personnel in Performance Directorate now overseeing incident and risk management. Integrated Governance Committee established as Board sub-committee *Operational risk group organized to communicate learning from incidents*	AF IG Committee NHSLA CNST RIDDOR
C1. (b) Ensure patient safety notices/alerts acted on	A defined cascade/ dissemination system is in place from MDAs etc.	Establish cascade mechanisms.	5	Cascade system in place.	AF IG Committee DoH NPSA
C2. Protect children by following child protection guidelines	Defined processes for identifying, reporting and taking action on child protection issues in accordance with the	Working effectively with partners and communities to protect and support children.	4	PCT lead GP for child protection resigned – advert out to find replacement.	JM

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	Children Act and the outcomes of the Victoria Climbie report.			Concern identified over gap in school age child protection arrangements – school nursing engaged in discussions to resolve. *PEC CG Lead and Named Nurse for child protection have agreed that between them they will manage any CP issues that should arise until replacement for Lead GP is appointed.* *LMC Chair and Nurse Consultant for CP are also available for advice.* *School Nurses have set up review group to look at services and CP issues will form part of this review.*	

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C3. Following NICE interventional procedures guidance	Best practice and professional guidance on implementation of NICE guidance/procedures.	Effective county arrangements for new NICE procedures and intentions.	3	County system in operation. Review by CGSC of implementation procedures. INNF appeals mechanism.	JF GHNHSFT SLA County INNF Panels
C4. (a) Healthcare organisations keep patients, staff and visitors safe by having system to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standard of hygiene and cleanliness, achieving year on year reductions on Methicillin-Resistant Staphylococcus Aureus (MRSA)	MRSA 20% reduction year on year.	MRSA reductions year on year	3	Measured on behalf of the county 2004/05 figures not an improvement over 2003/04. *Quarterly reports are to be produced in 2006 for Community Hospital rates, (but will not indicate the origins of the MRSA).* *Interim local Clinical Waste policy in situ.* *Education and audit rolling programmes are being implemented* *Implementation of new countywide IC policies*	JM
	Clean patient care environments.	PEAT assessments in Jan – March 2006	5	2005 assessments completed	JF PEAT

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C 4. (b) and (c) Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices and minimised and by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.	Minimising risks of acquisition and use of medical devices including decontamination processes. Regular audits of high risk areas e.g. surgical theatres.	Compliance with Decontamination regulations by March 2007. Local audit undertaken of areas of non compliance.	3 4	**Insufficient assurance in draft declaration for Annual Health Check**. *SLA for CSSD provision.* *QOF Indicator PM4* *Decontamination audit of all reusable items and action plan in place.* *Partnership with Estates – audit of reusable equipment.* *Prison using CSSD at GHNHSFT.* *Audit of Endoscopy* *Audit of Community Hospitals.*	JM

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C4. (d) Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.	Medicines handled safely and securely.	PCT Medicines Management team oversee patient/medicine controls in PCT provider services. Incidents are reviewed.	4	Regular meetings with GHNHSFT Medicines Management Team	AF PCT Medicines Management Committee GMMC
C4. (e) Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that 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.	Disposal of waste managed to minimize risks to patients, staff and the public.	Understanding of new environmental waste regulations. Agreement of county-wide protocols for management of waste.	2	**Insufficient assurance is draft declaration for Annual Health Check**. County-wide discussions underway. Isolated incidents where patient or staff safety is compromised are followed up. Action plan agreed for Annual health Check	AM Health and Safety Committee JF - Service delivery

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2. CLINICAL AND COST EFFECTIVENESS					
C5. a) Patients achieve healthcare benefits that meet their needs. PCT conforms to procedures for adoption of NICE technology appraisals in accordance with Implementation of NICE guidance	Review of NICE technology appraisals to ensure taken into account when planning and delivering treatment and care	Effective county arrangements to agree implementation arrangements and monitor patient and financial outcomes. LDP responds to NICE work programme.	5	County arrangements in place. INNF appeals process for patients.	JF GHNHSFT Contract Board INNF Panels
C5 b) Clinical care provided under supervision and leadership	Effective professional supervision and leadership arrangements in place.	Annual appraisals of all GPs and employed clinical staff.	4	Annual appraisal process in place. *Nurse Leadership Scheme* *Setting-up Clinical Supervision*	*JM*
C5 c) Clinicians continuously update skills and techniques	Continuous professional development in place for all practicing clinics.	CDP plan in place for all practising clinicians	4	Annual CPD process in place. *Portfolios and CPD, PDPs.* *Protected learning time/training events.* *PCT checks professional registrations*	A Mc JF
C5 d) Regular clinical audit participation by clinicians	Evidence of engagement in clinical audit and learning from outcomes	PCT employed clinicians undertake regular clinical audit	4	PCT employed clinicians engage in PCCAG audits	PCCAG PEC *PCCAG Training*

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				PCCAG Annual Report CGSC Annual Report. Draft Clinical Audit Strategy.	*Programme.* *PCCAG Monthly Reports to CGSC*
C6. Co-operation between health and social care organizations to meet patients' individual needs	Integrated health and social care	Patients receiving effective treatment and care, needs and preferences taken into account, with seamless co-ordination.	3	Occupational Therapy Service	*HA* Joint Supervision with Social Services
3. GOVERNANCE					
C7. Arrangements in place for effective clinical and corporate governance in accord with statutory legislation and guidance a) Apply principles of sound clinical and corporate governance.	All statutory requirements for monitoring clinical and corporate governance are met.	Integrated Governance Committee established. Statement on Internal Control approved by Auditors.	4	Integrated Governance Committee set up as sub committee of the Board Review of terms of reference by CGSC	AF Integrated Governance NHSLA Healthcare Commission

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C 7 b) Support all employees in openness, probity, accountability and economic and effective use of resources.	Employees abiding by NHS Code of Conduct and SOs/SFIs	Code of Conduct distributed to all employees. SOs/SFIs updated and distributed.	4	Code of Conduct sent out in new employee packs. SOs/SFIs to be updated.	AF IG Committee Audit Committee
C7 c) Undertake systematic risk assessment and risk management.	Board sub committee level of assurance on adequate risk management.	Incident reporting procedure and system in operation. Risk register *format agreed by IGC and risk register reviewed on regular basis*	4	Risk Strategy to be revised. Incident reporting mechanism in place. Integrated Governance Committee is set up. Operational risk group to communicate risk learning across PCT	AF IG Committee Audit Committee
C7 d) Ensure financial management achieves accountability, economy and effectiveness.		Budget monitoring in place. Audit Committee work programme. Business Continuity plans in place for transition to new PCT FRP agreed to achieve financial balance.	4	Audit Committee meetings Regular reports to Board	MT Audit Committee

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		Practice based commissioning framework in place.			
C7 e) Challenge discrimination, promote equality and respect human rights.	Equal opportunities provided in recruitment and HR processes. Promotion of equity, dignity and race equality. Whistle Blowing Policy.	Race Equality Action Plan. *Designated leads for Diversity and Equality and Dignity at Work Officers.*	4	Race Equality Scheme adopted by Board in May 2005. Diversity Officer started work 2005.	AM HR HA Race Equality
C7 f) Meet existing performance requirements.	21 Existing PCT targets	Access targets Cancer targets A&E waits Choice Mental Health targets Reduce DToCs	4	Reported to PEC and Board and reviewed by AGW at monthly meetings.	AF Performance Management JF Delivery
C8. a) Support staff to raise concerns about service delivery/impact on patient care	Whistle blowing policy in place. Staff survey undertaken annually. Use of assessments review e.g. QOF.	Over 60% response on Staff Survey.	4	Staff Survey out with teams. QOF 2005/06 preparations underway.	All Directors Staff Survey Whistle blowing policy GP QOF data
C8 b) Personal development programmes which value	Annual PDP process for staff	Implementation of KSF job profiles and training programme	4	KSF roll out planned and implementation arrangements in place	AM IWL A4C KSF

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staff and address under representation of minority groups					
C9. Management of healthcare records from creation to disposal and abiding by data protection requirements	Management within information governance arrangements	Information Governance Toolkit updated *for end March 2006* Progress to be monitored by Integrated Governance Committee.	3	**Insufficient assurance in draft declaration for Annual Health Check**. Information Governance seminar to be held on 20th Jan 2006.	AF IG Steering Group
C10. Undertake employment checks	Qualified staff registered with appropriate bodies. Professionals abide by published codes of practice	Pre-employment checks. Use of Code of Practice incurring performance issues.	5	Ongoing	AM CRB data
C11. Staff are recruited trained and qualified for roles including mandatory training and professional development	Staff are trained and qualified for roles undertaken with regular reviews.	Obtain data or competency levels and training needs.	4	Ongoing	All Directors
C12. Only participate in research governance	Use nationally accredited research governance	Ensure all research abides by County	5	Agreement of operation of framework through	JM

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using a framework	frameworks	Governance Framework		RDSU SLA *Monthly research governance reports to CGSC*	RDSU Ethics Committee
4. PATIENT FOCUS					
C13. Systems in place to:	a) Treat Patients with dignity and respect.	Underpinning all PCT business	4	In SLAs with other providers inspected by PEAT team and PPI Forum	JF PPI Forum PEAT
	b) Obtain appropriate consent for contact with patients use of information.	PCT policy in place.	5	Need to monitor use of policy. *Chaperone policy.* *Consent forms documentation which patients sign.* *Consent policy currently under review.*	
	c) Confidential use of patient information by staff.	Abide by Data Protection Act and Caldicott principles.	5	Procedures in place to ensure confidentiality and obtain consent to share.	JF Caldicott Guardian Information Governance Steering Group Induction

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C14. Systems in place to:	a) Provide accessible information and procedures to register complaints and feedback on quality of services.	Widely available leaflets and information and in different languages.	5	*PCT Complaints Policy including support available to patients, i.e. ICAS.* *Links with PALS* *Telephone translation service through Language Line.*	*JF*
	b) Ensure non-discriminatory complaints management.	All people offered equal access and rights.	5	*Equality and Diversity Policy.*	A Mc Race Equality
	c) Act on any concerns and make improvements in services.	Feedback concerns raised through complaints or PPI members to key PCT forums which can action change.	4	Use Integrated Governance Committee to make links to identified service improvement needs	JF
C15. Where food is provided:	Patients are offered choice, it is prepared safely, provides a balanced diet and personal dietary needs are met.	Feedback from patients sought through complaints, PPI Forum, PEAT visits	5	Regular meetings of food and service providers with PCT staff receiving feedback. Outcomes of PEAT review excellent.	JF

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C16. Accessible information is made available on services, treatment and care including what to expect during treatment.	Patients expressing preferences and making choices about care. Patients with long term conditions are encouraged to develop self care	Patients are supported in being offered explanations and choice about care options, including self managing their care.	4	Roll out of Expert Patient Programme PCT Case Management programme.	JF
5. ACCESSIBLE AND RESPONSIVE CARE					
C17. User and carers views are sought when planning and improving health services	Effective involvement of users and carers in planning service improvement and change.	Involvement of users and carers in the PCT key planning groups.	4	PPI Forum chair attends PCT Board meetings Stakeholder engagement in Community Hospitals development.	JM JF
C18. All members of the population to be offered equal access and choice in access to services and treatment.	Existing targets for PCTs Waiting times: ▪ Max. 6 month wait for all inpatients by Dec. 2005	Achievement of weekly/monthly activity and waiting list profiles.	5	Achieved Dec 2005.	AF (Performance Management) JF (Delivery

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	▪ Max 13 week wait for all outpatients by Dec. 2005.	Achievement of weekly/monthly activity and waiting list profiles.	5	Achieved End Dec 2005	AF (Performance Management) JF (Delivery)
	▪ 2 week max. wait for urgent GP suspected cancer referrals.	Achievement of weekly/monthly activity and waiting list profiles.	5	Continues at 100% achieved	"
	▪ 31 day max. cancer diagnosis to treatment by Dec. 2005	Achievement of weekly/monthly activity and waiting list profiles.	3	On target but remains at risk	"
	▪ 62 day max. cancer urgent referral to treatment by Dec. 2005	Achievement of weekly/monthly activity and waiting list profiles.	3	On target but remains high risk	"
	▪ 3 month max. wait for revascularisation by March 2005.	Achieved	5	Achieved	"
	▪ Deliver a 10% increase per year in the	68% Dec 2005	3	The baseline was set in 2002/03 at circa 38%	"

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	proportion of people receiving thrombolysis within 60 mins of a call for services.			Expectations of reaching up to 50% Call to Needle time target at December 2005. As the target has risen 10% year on year, this compares to a 05/06 target of 68%	AF (Performance Management) JF (Delivery)
	CAMHS: ▪ All patients to have access to crisis services by 2005.	To be measured in quarter 4.	3	To be measured in qtr4	JF
	Mental Health (adults): ▪ Access to crisis services by 2005.	Access for % of population	4	PCT on target	AF (Performance Management) JF (Delivery)
	NHS choice of access - Choose and Book targets:	Measured across the whole year an by monthly milestones.			
	▪ By the end of 2005, every hospital appointment to be booked for the convenience of the	Hospital booking staff trained and technically able to accept bookings through Choose and Book	5	Community hospital booking staff trained. Working towards full technical readiness. Support arrangements	JF

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	patient. ▪ By end of 2005, patients to be able to choose from 4 to 5 health care providers.	Monthly milestones	5	with voluntary organizations established. Countywide helpline in place for patients not referred through Choose and book.	AF (Performance Management) JF (Delivery)
	Diabetic retinopathy screening: ▪ 80% diabetics to be offered screening and treatment by March 2006.	Members of team have been recruited	4	Measured across whole year 73% update in screening	HA
	4 week smoking quitters: ▪ Achieve target number of successful quitters at 4 week stage by 2006.	Quarterly reports of progress to targets	3	Achieved On target but increasing challenge/poor quit rates in areas of deprivation therefore medium risk.	HA
	Delayed Transfers of Care: ▪ Reduce to a minimal level by 2006.	Monthly milestones Reduction month on month	4	System in place Increased patient throughput had made it difficult to reduce numbers	JF

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C19. Patient needs and access standards met for emergency services	Existing targets for PCTs Ambulance Trust targets-				AF (Performance Management) JF (Delivery)
	▪ Category A calls meeting 8 minute target (75%).	75%	4	69.3% at Dec 2005	"
	▪ Category A calls meeting 14/19 minute target (95%).	95%	5	93.6 %achieved at Dec 2005	"
	▪ Category B calls meeting 14/19 minute target (95%).	95%	5	90.4% achieved at Dec 2005	"
	▪ 98% patients waiting a max. of 4 hours in A & E.	98%	4	98% achieved in last quarter of 2005	"
	▪ Access to a GP within 48 hours.	100%	5	100% achievement.	"
	▪ Access to a primary care professional within 24 hours	100%	5	100% achievement	"

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6. CARE ENVIRONMENT AND AMENITIES					
C20. Environments supportive of effective care and optimising health outcomes	(a) Safe and secure environment for patients and staff. (b) Privacy and confidentiality	New Counter Fraud Security Management initiative. *Designated Local Security Management Specialist now in place and attends Information Governance Group.*	5 5	Active involvement of local security management specialist privacy/confidentiality in accordance with patients' wishes and national policy.	AM (Security) JF (Environment)
C21. Environments promoting patient and staff well being and meeting the specification for clean NHS premises.	Comfortable, clean and secure environments. Meeting external inspection assessments. Subject of infection control requirements.	Staff and patient feedback encouraged. PPI Forum feedback. Reports from Infection control Team.	5	High scores in 2005 PEAT assessment	JF PPI Forum PEAT
7.PUBLIC HEALTH					
C22. Promoting health demonstrating improved health of the community and narrowing health inequalities by:	(a) Co-operating with local authorities and other organisations. (b) DPH Annual Report informing policies and practice.	LSPs in place and functioning. DPH Annual Report used for planning purposes.	4	*In progress* *2005 in progress*	HA LSP CDRP HA

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	(c) Making an effective contribution to local partnerships including local strategic partnerships and crime and disorder reduction partnerships.			*In hand*	HA
C23. Systematic and managed disease prevention and health promotion programmes which meet national service framework and national plan targets.	NSF specific *targets in relation to disease prevention and well being.* *Choosing Health & PSA Targets.* *Health Trainers*	• *Smoking Cessation Services* • *Tobacco Control* • *Weight Management* • *Physical Activity* • *Mental Well Being* • *Sexual Health* • *Dugs/Alcohol Interventions & Services*	4 *4* *3* *3* *1* *4* *4*	*Countywide Obesity Strategy under development.* *Health Trainers – LDP Bid needed to secure resources.*	HA
C24. Protect the public with a response to incidents and emergency situations affecting normal provision of services.	Major incident plan Business Continuity Plan	PCT Emergency Planning Group work programme Undertook Exercise Glevum in November 2005. Pandemic Flu preparations	4	County planning for Major Incidents and Pandemic Flu. PCT Planning for major incident response and pandemic flu	AF

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GLOSSARY

A&4C	Agenda for Change
ACPC	Area Child Protection Committee
AGW	Avon, Gloucestershire & Wiltshire
CAMHS	Child and Adolescent Mental Health Services
CHD	Coronary Heart Disease
CICC	Community Infection Control Committee
CGSC	Clinical Governance Steering Committee
CNST	Clinical Negligence Scheme for Trusts
CP	Child protection
CPD	County Professional Development
CRB	Criminal Records Bureau
DoH	Department of Health
DToCs	Delayed Transfers of Care
eSAP	(electronic) Single Assessment Process
ESR	Electronic Staff Record
FOI	Freedom of Information
FRP	Financial Recovery Plan
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
GMMC	Gloucestershire Medicines Management Committee
GSAS	Gloucestershire Smoking Advice Service
HPA	Health Protection Agency
HSE	Health and Safety Executive
IG Committee	Integrated Governance Committee
IG Steering Group	Information Governance Steering Group
IM&T	Information, Management and Technology
INNF	Interventions Not Normally Funded
IWL	Improving Working Lives
KSF	Knowledge & Skills Framework

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LDRP	Crime and Disorder Reduction Partnership
LMC	Local Medical Committee
LSP	Local Strategic Plan
MDA	Medical Devises Alert
NCRS	National Care Records Service
NED	Non-Executive Director
NHSLA	NHS Litigation Authority
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NSF	National Service Framework
OSC	Overview and Scrutiny Committee
PACS	Picture Archiving and Communication System
PALs	Patients Advice and Liaison Service
PCCAG	Primary and Community Clinical Audit Group
PDP	Personal Development Plan
PEAT	Patient Environment Action Team
PEC	Professional Executive Committee
PGDs	Patient Group Directives
PLT	Protected Learning Time
PSA	Public Service Agreement
PPI	Patient and Pubic Involvement
QOF	Quality and Outcomes Framework
RDSU	Research and Development Support Unit
RIDDOR	Reporting for Injuries, Diseases and Dangerous Occurrences Regulations 1995
SFIs	Standing Financial Instructions
SHA	Strategic Health Authority
SLA	Service Level Agreement
SOs	Standing Orders
SSDP	Strategic Service Development Plan
SUI	Serious Untoward Incident