

2005/08 PSA Targets	Actions to achieve targets
Health of the Population	
By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women:	
<p>NOTE: <i>Life expectancy varies across the PCT area. For women, life expectancy exceeds the national average of 80.6 but is below the target of 82.5 in all 3 areas (Gloucester City, Forest of Dean and South Tewkesbury). Male life expectancy is below the target in all three areas and below the national average in two areas (2003 Director of Public Health Annual Report).</i></p> <p><i>Based on recent Life Expectancy projections we appear to be just below target for life expectancy for men in Gloucester City and the Forest of Dean, and on course to meet the headline target for women. However, we would expect to improve on this through the many preventive and health promotion interventions targeted at areas of deprivation and through specific interventions to reduce mortality from CHD, cancer, diabetes etc.</i></p>	
<p>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.</p>	<p>Plans are in place for a Crisis Team in the Forest of Dean and Gloucester city areas. The team leader for Gloucester has been appointed along with some team members with further recruitment underway. There are however, some problems with recruitment and we are working with Gloucestershire Partnership Trust to determine how we deliver a service to our residents, which can be developed in a phased way with limited resources. A countywide group is working on the development of a comprehensive CAMHS service. In 2005/06 this will progress through to the development of a primary care level for the service, which will link into existing statutory and non-statutory provision. This will involve the development of graduate workers, linked into the existing PCT Patch Teams with clinical support from specialist CAMHS. This will reflect the model for Adults of Working Age primary care services. Cotswold & Vale lead in this service area and can provide copies of the full strategy.</p>
<p>Substantially reducing mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and</p>	<p>Health inequality mapping has been undertaken (DPH Annual Report 2003 and 2004) and programmes put in place to improve health across the PCT area e.g. smoking cessation services (see PSA smoking-related target below) - physical activity and weight</p>

2005/08 PSA Targets	Actions to achieve targets
deprivation indicators and the population as a whole	management etc.
Substantially reducing mortality rates by 2010 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	<p>These, and other activities, are targeted at areas of multiple deprivation, where inequalities have been identified, through working in partnership with agencies such as Local Authorities, Community and Neighbourhood Projects, Sure Start, Community Counts and other local organisations.</p> <p>An 'Active Life in Older Age' strategy has been developed and is being implemented, with projects underway across the PCT and an 'After Retirement Health & Exercise Group' being run in North Gloucester.</p> <p>The PCT has also been successful in its bid for funding from Neighbourhood Management/Community Counts to employ a Health Promotion Nurse to work with the ethnic minority community and others in a deprived area of the city.</p> <p>There is sustained and increasingly serious commitment to implementing the NSFs for CHD, Diabetes, Older People, Children and the NHS Cancer Plan backed by specific interventions. e.g. for CHD and stroke there is improved management on primary care of hypertension, high cholesterol and diabetes and for cancer, we are working towards improved screening to aid early detection of disease (an evaluation and equity audit of the cervical screening programme is underway).</p> <p>To reduce mortality from CHD in a deprived area, Matson Neighbourhood Project currently utilises a Healthy Living worker to screen for cardiovascular risk factors in a non-medical setting i.e. pubs, libraries and shops etc.</p>
Substantially reducing mortality rates by 2010 from suicide and undetermined injury by at least 20%	The Suicide Prevention Strategy is now at a developmental stage. A workshop has been undertaken in January 2005 and a strategy and associated action plans are now being developed. The Gloucestershire Health Promotion for Mental Well Being includes a strategy for preventing suicides. The PCT funding for Gloucestershire Action for Mental Health and Samaritans has been

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	finalised and agreed. There is additional work being undertaken to establish a better understanding of the pattern of suicide in the hard to reach groups, with a view to adjusting our interventions accordingly.
Reduce health inequalities by 10% by 2010 as measured by:	
<ul style="list-style-type: none"> ▪ Infant mortality ▪ Life expectancy at birth 	<p>The Countywide breast feeding strategy is progressing and by June 2005, five breast feeding support groups will be active. Three of the five groups cover areas or pockets (super output areas) of multiple deprivation and special need.</p> <p>The PCT works closely with seven Neighbourhood/Community Development Projects in areas of multiple deprivation, that are linked up with GPs to promote healthy living services covering areas such as weight management, healthy eating, smoking cessation, 'walking to health', sports activities and exercise classes. Interventions focussed on reducing smoking in pregnancy are currently being consolidated. The PCT has also developed links with the countywide Healthy Schools Initiative with 100/123 primary schools, 12/19 secondary schools and 2 out of 3 special schools, so far signed up (including for example healthy eating, 5 A Day, personal and sexual education and advice). There is also active promotion of healthy eating in women of child-bearing age, particularly pregnant and breast feeding women in areas of deprivation and the Living and Learning Partnership at GL1 Leisure Centre (in the City Centre) also provides health promotion advice.</p> <p>The PCT continues to actively build its partnership working to address primary causes of poor health in deprived areas with the Local Strategic Partnerships, Local Authorities, Voluntary Community Organisations, Crime and Disorder Reduction Partnerships and neighbourhood renewal organisations such as Neighbourhood Management - Community Counts and Sure Start.</p>

2005/08 PSA Targets	Actions to achieve targets
Tackle the underlying determinants of ill health and health inequalities by:	
<p>Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less</p>	<p>A comprehensive smoking cessation service is now operating across the county with tobacco control work operating alongside stop smoking initiatives in many settings. The service has now reached its full complement of staff and the commencement of a locally enhanced service has embedded smoking cessation strategies into the majority of primary care practices. The service employs a specialist midwife to work with pregnant smokers and has trained Smoking Advisers to reach those smokers from disadvantaged groups and those who find it hard to stop. The PCT also operates a voucher scheme and has achieved its nine-month target of quitters for 2004/05.</p> <p>An evaluation and equity audit of the service is currently underway (report due in April 2005), after which some changes <i>may</i> be made (if needed) to better target manual groups and areas of deprivation. From April 2005, the PCT will be responsible for healthcare in Gloucester Prison. A health needs assessment is planned (awaiting Ethical approval) and will include addressing smoking policy in the prison and the need for smoking cessation services.</p>
<p>Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.</p>	<p>A new countywide childhood obesity strategy and related interventions and services will need to be developed along with exploring new/alternative ways of working in partnership with non-statutory providers. It is envisaged that the Countywide Weight Management programme, originally set up to address the relevant milestones of the NSF for Coronary Heart Disease, will be able to be funded within existing allocations. The service which is primarily focussed on adults will be reviewed, particularly in the context of its application among children and the need to develop appropriate care pathways. There is good engagement of primary, secondary and special schools in the Healthy Schools</p>

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	<p>project. Alongside this there is active promotion of the 5-a-day programme. A pilot project in White Cross school is working with 9 & 10 year-old overweight girls who would not normally access physical activities. A partnership between the PCT, Sport England and the Forest of Dean County Council is actively promoting healthy exercise.</p> <p>Discussions are underway with the Child Health Department about routine data capture in support of this target. Plans are under development to capture data at three intervals: children at 9 months, > 5years and > 11 years (this would appear to be possible using existing database and by modifying existing reporting procedures/requirements).</p>
<p>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).</p>	<p>The county has achieved a 16.26% reduction in teenage pregnancies, based on the most recent data (2001), and so is in a good position to achieve the 2010 target. The PCT currently funds a scheme that provides free emergency hormonal contraception (EHC) through 18 community pharmacies. In addition, Gloucester has benefited from increased funding as a result of a Public Service Agreement between the County Council and the Office of the Deputy Prime Minister. This has resulted in increased services for young people, for example, additional extended school nurse drop-ins, provided advice, pregnancy testing, condoms and EHC. Furthermore an action plan will be developed in accordance with the Public Health White Paper.</p>
Long Term Conditions	
<p>In primary care, update practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.</p>	<p>Plans and priorities continue to be developed collaboratively within the County CHD Local Implementation Team and Diabetes Managed Network Group (DMN). The group has paid particular consideration to optimum clinical outcomes and treatment regimes as set out within the National Service Framework Agreement, together with the implementation of appropriate NICE guidance. The group is informed by representatives from</p>

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	<p>patient/carers, GHT, GAST, PCTs, SHA, CHD Collaborative and Public Health. Progress is monitored through local PCT CHD and Diabetes groups and is supported by the work of the CHD Collaborative and the Gloucestershire Primary and Community Care Audit Group (PCCAG). It is envisaged that a current audit of CHD registers by the Audit Commission will help to inform further improvements in this area. The implementation of the Quality and Outcomes Framework and its early assessment also indicates a positive impact on the management of patients with long term conditions. CHD LIT and will also monitor systematic treatment regimes and identify/share good practice.</p>
<p>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.</p>	<p>Capital funding has been secured from the Department of Health to develop the Gloucestershire Retinal Screening Service and additional digital cameras have now been purchased. Indicative funding has been identified within the LDP to expand the service and support the move towards annual screening in the timescale as set out in the national target and NSF.</p>
<p>To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline), through improved care in primary care and community settings for people with long-term conditions.</p>	<p>Improvement of health outcomes for vulnerable people at risk will be facilitated by using the Single Assessment Process and patient held records. The District Nurse roles will be central to developments as will Treat and Leave services and coordination of 'message in a bottle' service for vulnerable adults. The appointment of Community Matrons will be a key development in improving care in the primary and community care settings. The PCT in partnership with Social Services has also instigated a 'Patch Works' Project which seeks to address improved integration between statutory and non-statutory organisations and the effective management of long-term conditions (drawing on experience of the Evercare, Castlefield's and Unique Care models). The PCT-wide Care Homes Project, also in partnership with Social Services links in with the chronic disease management programme in using a multidisciplinary team approach to empower care homes where appropriate to care for people in the</p>

2005/08 PSA Targets	Actions to achieve targets
	<p>homes rather than admission to hospital. The monitoring of admissions to hospital via the Information Team provides the raw data that helps to inform all our developments in this area. Other initiatives running parallel with these developments include the participation in Phase III of the Primary Care Collaborative (Chronic Disease Management) and referral of appropriate patients into the Expert Patient Programme (EPP).</p> <p>There is an intention to develop the capacity of the EPP (incrementally over time) to facilitate the expansion of the programme so that by 2008, 10 courses (160 patients) are delivered per annum. Where possible, EPP coordinators will work together and tutors will be pooled across the three county PCTs to ensure that EPP programmes can be developed and delivered effectively. In 2005/06 a local countywide initiative will provide clear signposting in primary and secondary care to ensure that appropriate patients with long-term conditions access the course and therefore take more control of their health.</p> <p>A Planning Meeting had been organised for mid-March to determine strategy and coordinate the implementation of the various threads of work currently being undertaken by the Trust for the improvement of care and services for people with long-term conditions.</p>
<p>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.</p>	<p>The 30 minute Door to Needle Time has been consistently achieved across both acute hospital sites at GHNHSFT, however problems with the transmission of the MINAP data and the slower than anticipated roll-out of the thrombolysis roll-out have had an adverse effect on the 60 minute Call to Needle Time target.</p> <p>Paramedics at five sites have now been trained in the delivery of thrombolysis and a number of patients have now successfully received pre-hospital thrombolysis. Thrombolysis training is now being delivered to both to both paramedics and technicians and it is envisaged that all paramedics will have undertaken training by April 2005. A Countywide Early Thrombolysis Implementation</p>

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	<p>Team (GETIT) has been established to monitor and assess progress and activity around the delivery of early thrombolysis targets and to further develop the service accordingly. An audit of those patients deemed suitable for thrombolysis by the Gloucestershire Hospitals Trust, will help to identify inform developments in this area.</p> <p>Consideration is also being given to the introduction of bolus thrombolytic therapies in A&E which would have a further positive impact on Door to Needle and Call to Needle times.</p>
Access	
<p>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.</p>	<p>Choice commissioning principles have been drafted and a baseline assessment of current choices has been completed. A Choose & Book county steering group is established and choices will be finalised as part of the Service Level Agreement negotiations for 2005/06. A Patient's Forum group is to be established to assist in PPI in choice. Booking targets are on course to be met however it is unlikely that they will be achieved through electronic means given the delay in PAS replacement. Plans are in place to implement choice for cataract operations from December 2005 and for cardiology from April 2005.</p>
<p>Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005.</p>	<p>Additional work will be required particularly around the Urology and Colorectal services and associated care pathways. This will inevitably require an approach that provides both additional investment and service redesign and development of appropriate care pathways. Data collection and analysis to establish a more accurate prediction of trajectories and numbers will inform much of this work. A development of primary care based prostate cancer services will be piloted in a number of Gloucestershire practices (including West Glos.) to explore the breadth of management possible within primary care and to avoid unnecessary visits to hospital for tests and outpatient drug</p>
<p>Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005.</p>	

2005/08 PSA Targets	Actions to achieve targets
	therapy.
Achieve a maximum wait of 3 months for an outpatient appointment by December 2005.	Waiting times for West Gloucestershire patients are ahead of national targets. We are continuing to develop and expand a range of initiatives to control demand into secondary care and provide more local access through alternative care pathways e.g. there are reviews currently around the provision of dermatology services and the provision of a Nurse Consultant-led Carpal Tunnel surgical service managed and undertaken within the PCT. We continue to have patients who elect to be seen by Welsh Providers where waiting times are in excess of English targets.
Achieve a maximum wait of 6 months for inpatients by December 2005.	There is ongoing development to ensure adequate investment in elective capacity and alternatives to secondary care provision. There is monthly monitoring in place to track both in and out of county targets. We are currently profiling an expected 99, 6-month waiters by the year end. Our aim is to clear outstanding waiters next year and build activity to sustain the 6-month targets. A Choice and Booking sub-group has been formed to review existing and develop improved care pathways. Specific initiatives include the development of an orthopaedic foot triage service, a locality commissioning scheme being piloted to enable GPs to reinvest funding in alternative services to the benefit of local patients and the development of a Referral Management Centre. The PCT has also embarked on and embraced a number of demand management initiatives examples of which include the expansion of Phase II of the Heart Failure Service (to identify those patients admitted to secondary care with more complex and palliative care needs) and the identification of those patients with more than two admissions within a 12-month period for local follow-up and intensive case management if appropriate. The PCT continues to monitor activity with GHT in line with the Clinically Prioritise and Treat principles.

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<p>To ensure that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment.</p>	<p>This continues to be a challenging target for the PCT, particularly given current discussions on the affordability of waiting time performance. Current planning assumptions are to work towards an 8-week out-patient/2-week diagnostic and an 8-week in-patient target. This work will be coordinated through a County Capacity Planning Strategic Group which is to be established. It is envisaged that this group will also oversee the inter-related area of the Independent Sector (IS). A number of workstreams will contribute to the planning and progress in this area including:</p> <ul style="list-style-type: none"> ▪ Demand Management ▪ Interventions Not Normally Funded ▪ Community Hospital Strategy ▪ Practice Based Commissioning ▪ National IS procurement ▪ GMS Enhanced Services ▪ Implementation of DoH 10 High Impact Changes
<p>Increase the participation of problem drug users in drug treatment programmes by 100% by 2008</p>	<p>In 2004/05 the PCT has developed a new primary care service to increase capacity for the treatment of substance misuse clients inline with LDP requirements. The target is a year on year increase until 2008 and the PCT is planning to increase the capacity within its new service during 2005/06 to enable this target to be met. There are some difficulties related to the collection and validation of numbers in treatment, this is being looked at on a countywide basis in Gloucestershire.</p>
<p>Increase year on year the proportion of users successfully sustaining or completing treatment programmes.</p>	
<p>Patient/User Experience</p>	
<p>Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including</p>	<p>The PCT is in the process of developing a new strategy for Patient and Public Involvement which will involve the setting up of monthly review meetings to assess and monitor the following:</p>

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<p>choice of provider as measured by independently validated surveys.</p>	<ul style="list-style-type: none"> ▪ Complaints ▪ Risk (Incident Reporting - linking into Clinical Governance reviews). <p>Patient Surveys are being actively undertaken; however the PCT is seeking to establish more proactive mechanisms to further improve the patient and user experience.</p> <p>The PPI Reference Group will continue to develop and support the role of the community representatives of the Patch Teams in identifying need and reengineering services to better meet these needs. We also continue to build on and improve the existing successful Expert Patient Programme and initiatives such as the 'Look After Your Legs' (self-care of those with leg-ulcers) and the recent Stroke Survey, will contribute to improving the way services are provided and delivered. We are also piloting the delivery of person-centred care training in our two community hospitals to ensure that people with complex physical, psychological and social needs are fully engaged with the development of their care plans. We continue to develop our complaints procedures and a comprehensive patient feedback process alongside General Practice will help to ensure that we reflect, learn and improve our response to suggestions made from patient and relatives.</p> <p>A Race Equality Action Group has been established, chaired by a PCT Non-Executive Director. The group is charged with establishing a climate for diversity and race equality in all aspects of health care including the patient/carer experience. It is expected that the move to implement the Choice agenda will positively impact on the patient experience. Continued roll-out of the Expert Patient Programme, Fair Access (race equality) and active participation of Patient Advisors in the current spread of the Primary Care Collaborative (Chronic Disease Management) are all geared to involving individuals in decisions about their healthcare delivery and associated choices</p>

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<p>Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by: Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008, Increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care</p>	<p>There is planned development of services to improve the quality of life of vulnerable older people. The partnership with Social Services reflects a shared approach to investment. These include supporting the consolidation of a well-being strategy for older people and the appointment of a community stroke co-ordinator to support primary care in the management of strokes within the community. Adoption of the Single Assessment Process throughout the PCT will minimise duplication and ensure effective working both within and across agencies. Increased focus on the needs of older people with mental health needs and their carers through expanding the skills of intermediate care services to include Mental Health expertise. Reconfiguration of services and investment to enhance the availability of skilled nursing and care services to provide palliative care services at home wherever possible to replace a reliance on nursing home care unless this is the service of choice. There is ongoing review and restructuring community nursing services to support the role of community matron, and implementation of the case management approach to the care of vulnerable older people. There is investment in SMART technology in partnership with Housing, and Social Services.</p> <p>Indicative funding within the LDP for part-share of a Consultant post for Mental Health in Older People will support service re-design and help sustain older people in the community together with providing increased choice.</p>
<p>Delayed transfers of care to reduce to a minimal level by 2006.</p>	<p>There has been a further expansion of intermediate care services including those at community hospitals, to allow patients to be transferred to a care setting appropriate to their needs. There is a strategic group which monitors the number of delays in the system and operational groups in place to oversee changes in services as and when required. The PCT is currently implementing its Community Hospital Strategy which will increase the focus on intermediate care and rehabilitation within its community</p>

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	hospitals. The PCT has supported service re-design at Great Western Court which has resulted in the greater flexibility of bed use and more appropriate use of GWC an intermediate care facility.
Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	Gloucester Hospitals NHSFT have successfully applied to the National Patient Safety Agency to become an early implementer site for the 'Clean Your Hands' campaign which commenced at the beginning of January 2005. Participation in the campaign will assist the Trust in successfully meeting the requirements of Patient Safety Alert 2004 and help prevent Hospital Acquired Infections. Compliance ensures that alcohol hand rubs are available at the point of care (at every bed) and at the entrance to each ward by April 2005. The programme will also raise awareness of the issue through the use of a poster campaign which will involve both clinical role models and patients.