

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

2005/06 BUSINESS PLAN : QUARTER 4 – 1 JANUARY 2006 TO 31 MARCH 2006

SECTION 1 NATIONAL TARGETS

| National Targets | Key Milestones | Likelihood of achieving target (1 low, 5 high) | Current position at quarterly update | Lead Director and responsible committee/external assessment process |
|--|---|--|--|---|
| <p>By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women</p> | <p>Measures of progress in 2005 – based on recent Life Expectancy projects we appear to be just below target for life expectancy for men in Gloucester City and the Forest of Dean, but 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.</p> | <p>3</p> | <p>Life expectancy varies across the PCT area. For women, life expectancy exceeds the national average of 80.6 years and should meet the 2010 target overall, however Gloucester City is projected to miss the target of 82.5. Male life expectancy is below the national average overall but specifically in two areas. Gloucester and Forest of Dean).</p> <p>Plans are in place for targeting areas of deprivation for health improvement interventions (e.g. smoking cessation) and also for specific groups (e.g. BME and Diabetes Specialist Nurse & Health Promotion Facilities).</p> | <p>HA</p> |
| | <p>Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to Child and Adolescent Mental Health Service by 2006.</p> | <p>3</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 NHS 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.</p> <p>There is the implementation of a psychiatric liaison service in the county underway.</p> | <p>JF</p> |

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| | Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75. | 3 | <p>Health inequality mapping has been undertaken (DPH Annual Reports 2003 and 2004) and programmes put in place to improve health across the PCT area e.g. smoking cessation services – physical activity and weight management.</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. Also three projects in Community Counts area.</p> | <p>HA CHD NSF Group</p> <p>Health Improvement & Partnership Group</p> |
| | <p>Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75.</p> <p>Substantially reducing mortality rates by 2010 from suicide and undetermined injury by at least 20%.</p> | <p>3</p> <p>3</p> | <p>With a reduction in the inequalities gap of at least 6% between the areas with the worst health and deprivation indicators and the population as a whole.</p> <p>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.</p> <p>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. Public Health Lead (Diana Billingham) has developed a suicide prevention strategy. Need to link this into wider mental health strategy led by C&T PCT.</p> | JF |

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| Reduce health inequalities by 10% by 2010 as measured by: - Infant mortality - Life expectancy at birth | Breast Feeding Strategy | 5 | The countywide breast feeding strategy is progressing and by June 2005, five breast feeding support groups were active. Three of the five groups cover areas of multiple deprivation and special need and the remaining two cover areas with pockets of deprivation. | HA |
| | Promoting Healthy Living | 4 | <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 such as weight management, healthy eating, smoking cessation, and physical activity opportunities. 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).</p> <p>The PCT was awarded one off funding from the Queen's Nursing Institute to deliver an active ageing training programme for care staff working in care homes for older people. Although funding eased the work has continued as part of a mainstream work.</p> | HA |
| | Addressing causes of ill health | 4 | 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 / Children's Centres. | HA |

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| Tackling the underlying determinants of ill health and health inequalities by: | Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less. | 3 | <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 PCT has achieved its three year rolling target ahead of schedule.</p> <p>From April 2005, the PCT is responsible for healthcare in Gloucester Prison. A health needs assessment is now complete & report being written. Action has already been taken to address smoking policy in the prison and the need for smoking cessation services.</p> <p>Gloucestershire NHS Community went Smoke-free on 8th March 2006, ahead of December deadline. Some minor issues currently being monitored.</p> | HA |
| | 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. | 3 | <p>A new countywide childhood obesity strategy and related interventions and services is being developed along with exploring new/alternative ways of working in partnership with non-statutory providers. The funding ceased on 31st March 2006 for the countywide Weight Management programme. A service review will be carried out.</p> | HA |
| | 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). | 4 | <p>The county has achieved a 17.7% reduction in teenage pregnancies, based on the most recent data (2002), 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.</p> <p>An action plan will be developed in accordance with the Public Health White Paper.</p> | HA |

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| Develop and Implement Plans for Long Term Conditions | 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. | 4 | <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 the patients/carers, GHT, GAST, PCTs SHA CHD collaborative and public health. Progress is monitored through quarterly audit of practice registers and is supported by the work of PCCAG. A recent review of CHD services across Gloucestershire and as an audit of CHD registers by the audit commission has been helpful in informing developments in this area. The implementation of QOF and its early assessment also indicates a positive impact on the management of patients with long term conditions. CHD (LIT will also monitor systematic treatment regimes and identify/share good practice.</p> <p>A Primary Prevention sub-group has recently been tasked with consideration of the identification and treatment of those at risk of cardiovascular disease.</p> | HA CHD and Diabetes Group |
| | 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. | 4 | 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. Funding has been identified within the LDP and additional screeners and graders have been appointed to support the move towards the annual screening targets, as set out in the national target and NSF. | JF |

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| | 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. | 4 | <p>The original plan was for the appointment of Community Matrons as key development in improving care in the primary and community care settings. The PCT in partnership with Social Services also instigated a 'Patch Works' Project 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). In partnership with Social Services the PCT case management approach is now being rolled out as a key strategic objective for 2005/06 and to deliver the PCT Financial Recovery Plan.</p> <p>The PCT is also including residents living in long term care homes actively as part of the programme in positive recognition that this group of older people are some of the most vulnerable and have complex needs and a high rate of admission to secondary care.</p> | JF |
| | | 4 | Other initiatives running parallel with these developments include the participation in Phase 3 of the Primary Care Collaborative (Chronic Disease Management) and referral of appropriate patients into the Expert Patient Programme (EPP). 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. | JF |

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| | <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>1</p> | <p>The Gloucestershire Early Thrombolysis Implementation Team (GETIT) is meeting regularly to identify and implement the necessary changes to improve performance in the 60 minute Call to Needle Time target, however the Gloucestershire Ambulance Service continues to struggle to achieve this target. Problems with the transmission of data and the slower than anticipated roll-out of the paramedic thrombolysis training programme have had an adverse effect on the 60 minute Call to Needle Time target. (The PCT failed this target in 2004/05).</p> <p>All paramedics and technicians have now completed their 12 lead ECG and thrombolysis training and all vehicles are now equipped with the appropriate equipment and transmission. GAS experiences a skill-mix imbalance resulting in higher than expected double technician crews. The age threshold for admission of thrombolysis has been increased from 75 to 80 years old which will increase the predicted number of patients eligible for thrombolysis therapy. The 'call time' has been redefined as call to emergency services and MINAP data is regularly being validated between GAS and GHT. An audit of those patients who are admitted to GHT and then subsequently go on to have thrombolysis is now underway.</p> <p>Work around ensuring that suitable pre-hospital thrombolysis protocols are in place across county MIUs is now underway.</p> | <p>HA</p> |

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| <p>Access – Choose and Book – by the end of 2005 every hospital appointment to 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.</p> | <p>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 the NHS.</p> | <p>4</p> | <p>At the end of Q4 all patients were able to pre-book a first outpatient or elective admission. 15 GP Practices were using the choose and book software and 108 patients had been booked using this system.</p> | <p>JF (County choose and Book Forum)</p> |
| <p>Waiting Times – reductions in wait times across a number of areas leading to new maximum waiting times by December 2005.</p> | <p>A maximum waiting time of 31 days from diagnosis to treatment and 62 days from referral to start of treatment for all cancers by December 2005.</p> | <p>2</p> | <p>Latest data (March 2006) shows that the 31 day target is largely being achieved, but further work needs to be done to achieve the 62 day target (in line with national position). Weekly monitoring of these targets is continuing at both Trust and PCT level, and is supported by comprehensive individual patient tracking (with data completeness now only just below national average) and breach analysis systems. Pathway redesign is continuing as part of plans to achieve improving outcomes guidance in all sub-specialities.</p> | <p>JF</p> |
| | <p>A maximum wait of 6 months for inpatients by December 2005.</p> <p>Maximum wait of 3 months for an outpatient appointment by December 2005.</p> | <p>5</p> | <p>Waiting times for West Gloucestershire patients have traditionally been ahead of national targets. 13 week (outpatient) and six month (inpatient) targets have been met and maintained since the end of December 2005.</p> <p>There is ongoing work to ensure ongoing monitoring and development of elective capacity, alternatives (including primary care and independent sector) to secondary care provision, and appropriate thresholds for treatment. Service and care pathway redesign initiatives are being co-ordinated through the County Capacity Planning Group. Monthly monitoring is in place to track both in and out of county targets.</p> | <p>JF</p> |

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| <p>By 2008 no-one to wait more than 18 weeks from GP referral to hospital treatment.</p> | <p>Assisted by choice of MRI and CT scans after 18 weeks</p> | <p>4</p> | <p>This is a challenging target for the PCT. Current planning assumptions are to work towards an 8 week outpatient/2 week diagnostic and an 8 week in-patient wait. This work is being co-ordinated through the county Capacity Planning Strategic Group. This group is also overseeing the inter-related area of capacity from the Independent Sector (IS). A number of nationally and locally driven workstreams will contribute to planning and progress in this area including:</p> <ul style="list-style-type: none"> • Service and pathway redesign • Demand Management • Interventions Not Normally Funded • Community Hospital Strategy • Practice Based Commissioning • National IS procurement • GMS Enhanced Services <p>Implementation of DoH 10 High Impact Changes.</p> | <p>JF</p> |

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| Increase the participation of problem drug users in drug treatment programmes by 100% by 2008. | Increase year on year the proportion of users successfully sustaining or completing treatment programmes. | 3 | <p>In 2004/05 the PCT 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 has increased the number of treatment slots within its new service during 2005/06 to enable this target to be met.</p> <p>On a countywide basis the target for numbers into treatment and to sustain has been achieved.</p> | AF (NM) |
| Improving the Patient/User Experience | Secure sustained national improvements in the NHS patient experience by 2008, ensuring that individuals are fully involved in decision about their health care, including choice of provider as measured by independently validated surveys. | 4 | <p>The PCT has developed a strategy for Patient and Public Involvement in place.</p> <p>Patient Surveys are being undertaken; however the PCT is seeking to establish more proactive mechanisms to further improve the patient and user experience.</p> <p>A PPI Forum is overseeing implementation of the PPI strategy across the whole PCT with representatives from each PCT directorate, the voluntary sector, community interests and the local authority.</p> <p>A Race Equality Action Group has been established, chaired by a PCT Non-Executive Director.</p> <p>The group is charged with establishing a climate for diversity and race equality in all aspects of health care including the patient/carer experience.</p> <p>Each Directorate has a lead for Race Equality who has been progressing the work outlined in the PCT's Action Plan. A Countywide Action Group has agreed to develop a Single Equalities Scheme with a new action plan incorporating all legal requirements.</p> | JM (PPI) HA (Race Equality) JF(Choice) |

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| | | | <p>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), Patient Advisors and the current spread of Case Management Programme (Chronic Disease Management) are all geared to involving individuals in decisions about their healthcare delivery and associated choices.</p> <p>Evaluation by individual expert patient programme participants is carried out.</p> | |
| | <p>Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by: Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008, increasing in 2008 the proportion of those supported intensively at home to 34% of the total of those being supported at home or in residential care.</p> | 4 | <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.</p> <p>The PCT care homes support team is working with staff providing care for older people living in long term care homes to ensure that appropriate levels of care and support minimises the need for inappropriate hospital admissions.</p> | JF |

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| | Delayed transfers of care to reduce to a minimal level by 2006. | 2 | <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. A strategic group monitors the number of delays in the system and operational groups are in place to oversee changes in services as required. The PCT is currently implementing its Community Hospital Strategy which will increase the focus on intermediate care and rehabilitation within its community 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.</p> <p>There is an action plan in place for the re-shaping of some aspects of intermediate care services which is reviewed on a monthly basis.</p> | JF |
| Infection Control | 20% reduction in infections year on year (for the whole of Gloucestershire) from 45 in 2003/04 through to 18 in 2007/08. | 3 | <p>Although not meeting the target for the year Gloucestershire Health Community has a bedday bacteraemia rate of 0.12 which is lower than the England average of 0.17.</p> <p>Quarterly reports are being produced in 2006 for the Gloucestershire Health Community but these will not indicate the origins of the MRSA.</p> | JM |
| | MRSA action plan to be prepared by each NHS Trust, setting out specific actions, and timescales for completion and showing how each organisation is managing reductions in MRSA rates. | 4 | <p>MRSA action plan (on behalf of Gloucestershire health community) submitted to AGW in October 2004. In combination with the Gloucestershire Hospitals Foundation NHS Trust MRSA action plan, the Gloucestershire Health community was commended on its approach to tackling MRSA.</p> <ul style="list-style-type: none"> • Key services provided for PCT patients – Foundation Trust contract to be used to monitor quality, including infection rates and responses. | JM |

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| | | | <ul style="list-style-type: none"> • Use of hospital acquired infection surveillance system (currently ICNet) to monitor performance ie. Bed days lost and number of rates of particular by site. • Primary care – to create a greater focus on infection control arrangements which reflect the patient journey through primary, community and hospital services. • To monitor performance of infection control, and particularly the control of MRSA, at PCT board level. <p>The Modern Matron for Dilke Community Hospital is now working with county Infection Control Team.</p> | |
| | <p>Cleanyourhands Campaign – National Patient Safety Agency alerted heralded the Cleanyourhands, targeted at acute Trusts in 2004/05 and requiring the installation of alcohol hand based hand rub and gel near to every bed.</p> <p>Saving Lives campaign – new DoH initiative.</p> | 5 | The Gloucestershire Hospitals Foundation NHS Trust went live as an implementation site for the Cleanyourhands Campaign, with monitoring and feedback to the rest of the Gloucestershire health community. Campaign in the community setting has progressed now. | JM |
| | Inclusion of infection control team member in Patient Environment Team (PEAT) assessments for 2004/05. | 5 | The outcomes of the 2005 final PEAT assessments undertaken in January and February were that the environment for the two community hospitals was graded as excellent, with food graded as excellent at Dilke and good at Lydney. | JF |