

IMPROVEMENT, EXPANSION AND REFORM: THE NEXT 3 YEARS

PRIORITIES AND PLANNING FRAMEWORK 2003 - 2006

Preface

The extra money coming into Health and Social Services gives us the opportunity to make real improvements. We can expand through recruiting new staff, developing new services and creating new facilities. Even more importantly we can transform the quality of services by raising standards, tackling inequality, becoming more accessible and flexible and designing our services around the needs and choices of the people we serve.

This is about both quality and growth. The real test for success will be whether people can feel the difference and believe the services they receive are truly designed around them.

These are hugely ambitious goals. They will take time to deliver. Making progress over the next three years will be demanding and difficult and require real determination and discipline. It will need us to:

- focus on priorities, we cannot make progress at the same pace in every area
- extract the maximum value from every pound
- be prepared to change old practices, be creative and take uncomfortable and difficult decisions in the drive to improve quality and respond to people using services

Local plans

This document sets out what organisations need to do over the next three years. It identifies national priorities and targets which organisations need to build into their local plans. These targets are challenging but simply achieving them will not be enough to guarantee success. Organisations need to challenge old perceptions of public service and build public confidence in new systems. Cultural change is an essential part of the transformation. Crucially the NHS at all levels needs to embrace diversity in provision and choice for patients

This cultural change can only be achieved through the increased involvement of the public, staff, service users and our partners. Each brings their own perspective. We need each of them to contribute to progress.

Developing these plans should itself involve all these different people and be part of that cultural change. In every area our staff, the people using services and the public need to understand what we are doing, what progress is being made. They need to be able to advise and share in the drive for improvement and quality.

Nigel Crisp
Chief Executive

1. Introduction

- 1.1 The NHS Plan will deliver for the people of the country a health service fit for the 21st century with services designed around the needs of patients and improved health outcomes, particularly for the poorest in our society. Similarly the aims for social care are to improve services, promote independence and well being, and protect and support the most vulnerable.
- 1.2 The vision is to offer prompt, convenient, high quality services with people exercising greater choice. It is a vision where staff are fairly treated, properly rewarded and able to use their skills to the full.
- 1.3 Over the next three years we need to increase the range and quality of services, and improve the service user's experience. The emphasis will be on:
- making measurable progress, particularly in the highest priority areas
 - developing the capacity needed to deliver these plans: increasing staffing numbers and providing more facilities, more equipment and more providers of services and care
 - changing the way the whole system works to help staff and organisations deliver on these ambitious goals particularly by ensuring patients and users have greater choice over services
- 1.4 It is about improvement, expansion and reform.
- 1.5 This paper sets out the priorities for the next three years for the NHS and social services and describes what local organisations and communities need to do to plan for and implement these improvements.
- 1.6 During these three years the whole health and social care system will be changing with most notably:
- more choice for patients
 - payment being made for results in the NHS so increasing the incentive for delivery (a consultation document on Reforming NHS Financial Flows will be published shortly)
 - new incentives for both social services and health to provide appropriate services for older people outside hospital
 - increasing freedom for high performing organisations, including the establishment of the first foundation hospitals in the NHS
- 1.7 At the same time every organisation needs to:
- ensure the safety of its patients and users and the quality of its services, including developing clinical governance arrangements
 - ensure people are fully informed and involved in their own care and in planning and reviewing services and that services are provided equitably to all who need them

- take into account in its planning the progressive implementation of the working time directive and the expected introduction of new contracts.
- take part in emergency planning and ensure that the necessary arrangements are in place
- continue to modernise the way in which services are delivered, with the learning about good practice being spread between organisations
- provide for the continuing training, re-training and development of individuals, offering new skills and competencies
- be involved in the introduction of new information and communications systems

2. Planning framework

2.1 Planning in the past has been done annually and constrained by time pressures and the requirement for multiple plans. For the first time ever health services are now able to plan over a three-year period with, later this autumn, local health services receiving three-year budgets. Following the completion of the Local Government Finance Review, councils will have some confidence about the distribution of resources available over the next three years, including for social services. This will allow organisations to look in-depth at their services, plan change with confidence and implement improvements year on year. Against this background planning consists of the following six steps which need to be followed through in each organisation and community:

- identifying the national and local priorities and the key targets for delivery over the next three years
- agreeing the capacity needed to deliver them
- determining the specific responsibilities of each health and social care organisation
- creating robust plans which show systematically how improvements will be made and which are based on the involvement of staff and the public
- establishing sound local arrangements for monitoring progress and NHS performance management which link into national arrangements
- improving communications and accountability to the public locally so as to demonstrate progress and the value added year on year

Each of these steps is described briefly in this paper.

3. The priorities

3.1 The priorities for this period are based on the Department of Health's Public Service Agreement which is shown at Appendix A.

3.2 The health and social care priorities are:

- improving access to all services through:
 - better emergency care
 - reduced waiting, increased booking for appointments and admission and more choice for patients
- focusing on improving services and outcomes in:
 - cancer
 - coronary heart disease
 - mental health
 - older people
 - improving life chances for children
- improving the overall experience of patients
- reducing health inequalities
- contributing to the cross-government drive to reduce drug misuse

3.3 In each of these priority areas there are key targets for the next three years. These are shown in Appendix B. They are relevant to primary care as well as hospital services and will not be achieved without close co-operation between health and social services. Indeed many rely on achieving a better balance in local service provision with a greater emphasis on community-delivered services. Every health and social care community must plan to meet each of these targets in the next three years.

3.4 There are, naturally, a very large number of important services and needs not covered by these targets:

- local communities will have local priorities related to their local populations and local circumstances
- local government has priorities in other important areas of public services
- nationally, the NHS and social services will be supporting other areas of public services including, for example, neighbourhood renewal

And the world will not stand still over the next three years. There will for example be the new National Service Frameworks for Children and Renal Services and the delivery of that for Diabetes. (Critical milestones for diabetes are included in the targets set out here.)

3.5 Other than the targets in this document, arrangements for delivery will be a matter for local determination. Local organisations and communities will set their own timescales and milestones. They will be responsible for reporting to and accounting to their local communities for improving these services where necessary.

4. Building capacity

4.1 In order to deliver in the priority areas it will be necessary in most cases to have additional capacity available in terms of staff, facilities and equipment. In some cases this may mean involving new organisations in providing services and care.

- 4.2 Alongside the targets in Appendix B we have set out the national assumptions about the level of capacity that will be needed to deliver targets in each priority area. Organisations will take these into account in developing their plans. Whilst the targets themselves are not negotiable, local organisations and communities can work to different assumptions where these can be justified by local circumstances.
- 4.3 In addition each NHS organisation, working with its local councils and other local partners, will need to develop underpinning plans which show the total increases in capacity in the three key areas of:
- physical facilities
 - workforce
 - information management and technology
- 4.4 Nationally the NHS will be looking for significant increases and developments in each of these areas. The national requirements in each area for the three years are described in Appendix C.

5. Organisational responsibilities

- 5.1 Implementing these plans will depend on taking a whole system approach with each organisation playing its part in delivery. It will be important that there is local sharing of performance and financial data (particularly between PCTs and providers of health care such as acute hospital trusts and GP practices) to inform local planning. The planning process itself will need to involve all the relevant organisations and, most importantly, the front line staff who must make the vision happen. For example, staff in General Practices must be actively involved through improved engagement with PCTs.
- 5.2 Within the new planning framework a lead agency will be responsible for ensuring that the process of developing plans is robust to take responsibility for the quality of the final product. For the priority areas the division in leadership between the NHS and social services is:

| NHS lead | Joint lead | Social services lead |
|---|-------------------|-----------------------------|
| Access to services for emergency and planned care | Mental health | Life chances for children |
| Cancer | Older people | |
| CHD | | |
| Patient experience | | |
| Health inequalities | | |
| Drug misuse | | |

- 5.3 Where the NHS is in the lead, strategic health authorities will be responsible for ensuring the process and outcome of planning is robust, and similarly councils will take responsibility for the social care lead area. Where the lead is joint, PCTs and councils should locally agree the lead arrangements at the beginning of the planning process.

5.4 Within the NHS planning will be from the bottom up:

- PCTs (and relevant Care Trusts), as the lead planners, will be responsible for creating local plans which describe health and service improvement in their area. These will be developed using local clinicians' knowledge as well as patients and the public. They will address the needs of the community as a whole and incorporate the national priorities.
- each NHS Trust will be responsible for creating its own plan which shows how it will deploy its resources to deliver on both national and local priorities and fit within the plans of its PCT commissioners
- Workforce Development Confederations will work with the other organisations to contribute to these plans and support Strategic Health Authorities to create the workforce plan as part of the Local Delivery Plan.
- Strategic Health Authorities will bring together those PCT plans, as described in the next section, into a comprehensive Local Delivery Plan for their area
- taken together these plans will make up a coherent national picture

5.4 Councils should contribute to Local Delivery Plans as necessary. In particular, where they are leading on one of the joint priority areas, the plan they produce with the NHS should be built into the Local Delivery Plan for the area. Councils' planning for their lead priority on life chances for children should follow local government requirements taking account of any special arrangements agreed for the Local Government PSA as a whole. Both NHS organisations and Councils should consider how joint activity will be reflected in local PSAs and contribute to meeting them.

6. Creating robust plans within a new planning process

- 6.1 A new NHS planning system has been designed to allow organisations to produce three-year plans. It is simpler and has fewer national requirements and national targets. The essence of the new system is for all the current national planning requirements for the NHS to be replaced by a single three year local delivery plan. This mirrors the recent changes for social care where there is already a reduction in the number of plans required to be submitted to the centre and further work being undertaken on simplifying local government planning requirements.
- 6.2 The Local Delivery Plan will be significantly different from previous plans. It will need to identify the expected progress or milestones for each priority area over the three year period (in programme management terms this means the "trajectory" of delivery). In general terms it will need to identify quarterly or annual milestones but in a small number of critical deliverables it may need to show planned progress on a month by month basis.
- 6.3 It will also need to be supported by a financial strategy and plan, taking account of the changes to the financial system during the period, and showing how resources will be deployed and value for money will be achieved.
- 6.4 The Local Delivery Plan will cover a whole Strategic Health Authority area but will be based on PCT level plans. It will need to take account of the various reforms to the systems which will be happening during this period, (eg on financial flows), and show how these will contribute to progress.

- 6.5 The Local Delivery Plan itself will be a “live” document which will be amended with, for example, corrective action taken if delivery goes off course or new initiatives taken when new opportunities arise. These adjustments will generally be made following quarterly and annual monitoring. There will not be an annual planning round to replace the current SaFFs process. However a new three-year plan will need to be developed within the third year.
- 6.6 The timetable is as follows:
- local planning started during the summer months following the briefing sessions which were organised nationally
 - technical guidance on the new process will be published shortly
 - a guidance and consultation document on the introduction of payment for results will be published shortly
 - the national project on Configuring Hospitals will be publishing an advisory framework during the autumn. (The focus of the framework is hospital configurations but it has been developed in the context of a whole systems approach to planning and delivering care.)
 - the three year financial allocations to PCTs will be announced in November, together with the national price tariff which will apply to the payment for results system. (In the meantime organisations will need to work to sensible assumptions about the amount of money available to them based on the national allocation.)
 - Strategic Health Authorities have been asked to produce capacity plans in October which identify how sufficient capacity will be brought into use during the three year period. These will be incorporated into the local delivery plans which are due in March. However some aspects of the capacity plans which are time critical eg for capital projects or key appointments will need to be actioned before March.
- 6.7 Whilst the final plans are required in March, all NHS organisations will need immediately to design their local planning processes, where they have not already done so. In addition there will need to be constant and continuing discussion between StHAs and the Department of Health over these plans throughout the next few months to ensure that they can be agreed before the start of the next financial year.
- 6.8 As part of this new planning process the Department of Health has set out the key priorities for the next three years. It will do everything possible to ensure that these are maintained and to minimise any changes which may result from unforeseen risks or events and changes in local or national circumstances. The vast majority of NHS resources will be in the hands of PCTs, thereby reducing the scope over this period for new initiatives and programmes.
- 6.9 However the three-year period will inevitably bring about some change. Where this happens, the Department will consult with Strategic Health Authorities, councils with social services responsibilities – and where possible with the NHS more widely – about how to introduce changes to this framework.

7 Arrangements for monitoring and NHS performance management

- 7.1 Under the new arrangements, it will be much more important for local organisations to have good monitoring arrangements in place so that they can amend their plans and take action where necessary during the course of these three years. Wherever possible individual organisations should be taking action themselves rather than waiting for intervention to be initiated by others.
- 7.2 The arrangements for monitoring and performance management in the NHS are that:
- each organisation will have its own system. In addition each organisation will need to make arrangements, as described in the next section, to report to their staff and public on performance.
 - PCTs will hold provider organisations to account for the delivery of services which they have commissioned
 - StHAs will hold all NHS organisations to account for performance
 - The Department of Health will hold StHAs to account for the performance of the NHS within their area.
- 7.3 Monitoring and performance management will focus on the targets for the next three years. There will be routine monitoring of national standards and past targets where appropriate to ensure they continue to be met.
- 7.4 During the year, SSI will track councils' progress against the local improvement plan. Monitoring information will continue to be used to contribute to the overall assessment of social services performance that leads to the award of star ratings.
- 7.5 As part of this system, new inspectorates are to be put in place for both health and social care. They will have the responsibility for assessing the overall performance of organisations and for the publication of performance ratings.

8 Improving NHS accountability and demonstrating added value

- 8.1 The NHS is transforming itself into an organisation which truly focuses on its patients, designs its services around them and offers them choice and involvement. Its success depends on the involvement of very many people and organisations and on the support of patients and the public.
- 8.2 PCTs have responsibility for publishing an annual Patient Prospectus which describes services and performance in their area. This will be a core document for the public. In addition, however, each organisation will continue to bear responsibility for its own communication and involvement of stakeholders. It is therefore essential that each NHS Board reviews its arrangements for involving and communicating with all its stakeholders – its patients, its public, its staff and its partners. It will need to involve these stakeholders in preparing and advising on the plans. It must also show in its plans how it will continue to involve and communicate with them and report on performance and progress for each of these groups.

- 8.3 The arrangements for reporting to stakeholders will, amongst other things, need to demonstrate how extra funding has been used to add value to services provided by or commissioned through the organisation, for example by investment in new facilities or in training or in extending the availability of services to people.
- 8.4 The precise way that an organisation demonstrates the value that is being added will depend on its activities and local circumstances. However, in every case the organisation should be able to demonstrate that it has added value at least to the level of any additional funding, that it has secured a minimum 1% increase in cost efficiency and a minimum increase in quality equivalent to 1% of its budget. Further guidance covering methodology will be issued to organisations in due course.

9 Conclusion

- 9.1 This document sets out the national requirements for local planning. Taken together these local delivery plans will show how the NHS, working with social services and other partners, will make visible improvements, expand and reform services over the next three years.
- 9.2 This national picture is very important. However, it is equally important that plans make sense locally and that they are understood and owned by all the local parties. Delivery of improvements will depend on the involvement and determination of front-line staff and the involvement of patients and the public in shaping services. PCTs, as fully inclusive organisations, must ensure that the plans produced as part of this process must be about local accountability and local action as much as being about national accountability and the delivery of national targets.

Department of Health
September 2002

DEPARTMENT OF HEALTH – PUBLIC SERVICE AGREEMENT

AIM: Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

Objective I: improve service standards.

1. Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to 3 months by 2008.
2. Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004; and reduce the proportion waiting over one hour.
3. Guarantee access to a primary care professional within 24 hours and to a primary care doctor within 48 hours from 2004.
4. 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.
5. Enhance accountability to patients and the public and secure sustained national improvements in patient experience as measured by independently validated surveys.

Objective II: improve health and social care outcomes for everyone.

6. Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40 % in people under 75; from cancer by at least 20% in people under 75.
7. Improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010.
8. Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30 % of the total being supported by social services at home or in residential care.
9. Improve life chances for children, including by:
 - improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area, and at least 15% of children in care attain five good GCSEs by 2004. (The Government will review this target in the light of a Social Exclusion Unit study on improving the educational attainment of children in care.);
 - narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted; and
 - reducing the under-18 conception rate by 50% by 2010.
10. Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
11. By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

Objective III: improve value for money

12. Value for money in the NHS and personal social services will improve by at least 2% per annum, with annual improvements of 1% in both cost efficiency and service effectiveness.

IMPROVE ACCESS FOR BOTH EMERGENCY CARE AND PLANNED CARE

Objective

The overall objective is to provide fast, safe and high quality emergency care and fast convenient access and patient choice for planned care.

Throughout the country, there will be:

- Universally high quality primary care services which are accessible and responsive to patients' needs and preferences.
- Integrated networks of emergency care involving health and social services that link together primary care, social care, hospital care, ambulance services, voluntary services and NHS Direct all of whom will play their part.
- Increasing separation of elective and emergency capacity.
- Efficient systems for booking appointments and admissions that offer patient choice and fast access to planned care.
- Local systems to ensure that guarantees to patients are met including the NHS Plan cancelled operations guarantee. (From 1 April 2003 this will apply to patients cancelled at "the last minute" and not just those cancelled "on the day of surgery".)

Targets

For emergency care:

- Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by March 2004 for those Trusts who have completed the Emergency Services Collaborative and by the end of 2004 for all others. A target will be set relating to a reduction in the proportion of patients waiting over one hour, following consultation with the service over its precise definition.
- By December 2004 a single phone call to NHS Direct will be a one-stop gateway to out-of-hours healthcare, with callers passed on where, necessary, to the appropriate GP co-operative or deputising service.

For planned care:

- Ensure 100% of patients who wish to do so can see a primary health care professional within 1 working day and a GP within 2 working days by December 2004.
- Achieve a maximum wait of 4 months (17 weeks) for an outpatient appointment and reduce the number of over 13-week outpatient waiters by March 2004, as progress towards achieving a maximum wait of 3 months for an outpatient appointment by December 2005.
- Achieve a maximum wait of 9 months for all inpatient waiters and reduce the number of 6-month in-patient waiters by 40% by March 2004, as progress towards achieving a maximum 6 month wait for inpatients by December 2005 and a 3 month maximum wait by 2008, ensuring an overall reduction in the total list size and a reduction of at least 80% by March 2005 in the number of over 6-month in-patient waiters from the March 2003 baseline.
- Increase the level of choice in each year, offering routine choice of hospital provider at point of booking for all patients by December 2005 with 100% booking of day cases and two thirds of all first outpatient and inpatient elective admissions being pre-booked by March 2004.

National capacity assumptions

- Differential between growth in elective activity and GP referrals of 3% to ensure sufficient elective capacity to meet waiting time targets and offer choice.
- Day case rate increased to 75%
- Increased amount of activity taking place in primary and community settings to contribute to the national assumption of at least one million more outpatients appointments (around 10%) take place in the community rather than in hospital.
- Sufficient bed capacity (including critical care) to ensure that bed occupancy drops to a level consistent with admitting emergency cases without delay.
- Support and incentives for routine delivery of fast and convenient access to primary care services for all patients by increasing and targeted resources in those practices or other service providers with particular resource, management or other developmental needs.
- Increase the amount of elective activity undertaken in dedicated facilities (including DTCs) and non-NHS providers (including the private sector).

CANCER

Objective

The NHS Cancer Plan sets out a framework for services that will:

- Save more lives
- Ensure people with cancer get the right professional support and care as well as the best treatments
- Reduce inequalities
- Build for the future through investment in workforce and research for cancer

All patients should have access to prompt, high quality services for prevention, diagnosis, treatment and care for cancer as set out in the NHS Cancer Plan. Services should be developed through cancer networks (involving the Cancer Services Collaborative) and be provided in line with national cancer standards, taking full account of NICE appraisals and clinical outcomes service guidance. Providers should ensure full participation in national cancer comparative clinical audit, from 2003/04 for lung and breast cancer and from 2004 for colorectal and head and neck cancers.

Targets

- Maintain existing cancer waiting time standards and set local waiting time targets for 2003/04 and 2004/05 so that by the end of December 2005 there is a maximum of one month from diagnosis to treatment, and two months from urgent referral to treatment for all cancers.
- Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006
- Extend breast screening to all women aged 65-70 by 2004
- Set local targets to achieve compliance with forthcoming national standards on supportive and palliative care (to be derived from NICE supportive and palliative care guidance)
- Agree, implement and monitor local plans to improve the outcomes of cancer treatment, as evidenced by increasing compliance with NICE Improving Outcomes guidance and the associated national cancer standards

National capacity assumptions

- Increased investment in cancer services, to contribute to additional funding nationally of £570 million for cancer services by 2003/04 (baseline 2000/01)
- Increased access to radiotherapy and diagnostic services (including radiology, pathology and endoscopy) to enable cancer waiting times targets to be met, as demonstrated through increased staffing, improved facilities and equipment.
- Increased investment in specialist palliative care in line with NICE Supportive and Palliative Care Guidance and NHS Cancer Plan commitment, contributing to an extra £50m nationally by 2003/04 (baseline 2000/01)

CORONARY HEART DISEASE

Objective

The National Service Framework for Coronary Heart Disease set the framework for action to:

- prevent disease, save more lives and improve quality of life;
- deliver services that are responsive to the needs and choices of patients;
- reduce inequalities, through action to reduce the risk of CHD

All patients should have access to prompt, high quality care across the patient pathway, as set out in the NSF. Service development should build on the experience of the Primary Care and Coronary Heart Disease Collaborative Programmes, and should take full account of the results of comparative clinical audits. In particular all appropriate units should participate in national CHD comparative audits for paediatric and adult cardiac surgery and for myocardial infarction; and prepare to contribute to the planned national audit on angioplasty.

Targets

- Improve access to services across the patient pathway and increase patient choice by achieving the two week wait standard for Rapid Access Chest Pain Clinics; setting local targets to make progress towards the NSF goal of a 3 month maximum wait for angiography; and delivering maximum waits of 3 months for revascularisation by March 2005, or sooner if possible.
- 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.
- 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.
- Improve the management of patients with heart failure in line with the NICE Clinical Guideline due in 2003, and set local targets for the consequent reduction in patients admitted to hospital with a diagnosis of heart failure

National capacity assumptions

- Increased access to diagnostic and surgical capacity to enable waiting times targets to be met.
- More defibrillators commissioned in public places, working with the New Opportunities Fund, to contribute to national target of 3,000 by 2004.

MENTAL HEALTH

Objective

The Mental Health NSF and Suicide Prevention Strategy set out a modernisation programme to:

- reduce the suicide rate and deaths by undetermined causes by 20% by 2010
- improve access to general community Mental Health services

Services should be delivered in line with the standards in the Mental Health NSF, the Mental Health Implementation Guide, national Mental Health strategies and compliance with NICE appraisals/guidance. Comparative clinical audit and information from the Mental Health Minimum Data Set (which should be implemented in all Trusts by 03/2003) should be used to develop services, and the National Institute for Mental Health England will support development work. Modernisation will be supported by a new Mental Health Legislative framework. NHS and social services joint responsibility will be delivered through Local Implementation Team partnership.

The Children's NSF and its emerging findings will set out the standards and milestones for improvement in child & adolescent mental health services (CAMHS), including year on year improvements in access.

Targets

- Reduce the duration of untreated psychosis to a service median of less than 3 months, (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis by 2004.
- Offer 24-hour crisis resolution to all eligible patients by 2005.
- By Dec 2003, deliver assertive outreach to the 20,000 adult patients with severe mental illness and complex problems who regularly disengage from services.
- Increase breaks available for carers and strengthen carer support and networks to the benefit nationally of approximately 165,000 Carers of people on CPA by 2004.
- Improve mental health care in prisons so that all prisoners with severe mental illness have a Care Plan by April 2004 (approximately 5000 prisoners nationally) and ensure appropriate use of secure and forensic facilities by 2004, contributing to the national target of moving 400 patients from high secure hospitals by 2004.
- Ensure that by April 2004 protocols are in place across all health and social care systems for the care and management of older people with mental health problems.

National capacity assumptions

- Expanded service capacity in key services, to contribute to national requirements by 2004 of 335 crisis resolution teams; 50 additional assertive outreach teams; 50 early intervention teams; 140 new secure personality disorder places.
- Reduced pressure on acute inpatient units by reduction in bed occupancy rate
- All child and adolescent mental health services to provide comprehensive service including mental health promotion and early intervention by 2006
- Increase child and adolescent mental health services by at least 10 per cent each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment)

OLDER PEOPLE

Objective

The NSF for Older People sets out the framework for health and social care services that will deliver:

- Person centred care, respecting dignity and promoting choice
- The promotion of independent living and health and active life
- User satisfaction through timely access to high quality services that meet people's needs
- Partnership with carers

Services will be developed in line with the NSF standards and milestones. They will be provided in wider partnerships where appropriate, with the right professional support and care, to meet the full range of needs. The Information Strategy for Older People will be implemented and there will be systems in place to explore user and care experience. Councils will implement the policy of offering eligible individuals the choice of direct payments during assessment for community care services.

Targets

- Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.
- Each year there will be less than 1% growth in emergency hospital admissions and no growth in re-admissions.
- By December 2004: all assessments of older people will begin within 48 hours of first contact with social services and will be completed within four weeks, (with 70% within two weeks); following assessment, all social services will be provided within four weeks, (with 70% within two weeks); all community equipment for older people (aids and minor adaptations) will be provided by social services within seven working days.
- By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.
- By April 2004 all general hospitals caring for people with stroke to have a specialised stroke service, and all health and social care systems to have established an integrated falls service by 2005.

National capacity assumptions

- Intermediate care capacity expanded to meet the NHS Plan targets of an increase in the number of intermediate care beds by 5000 and the number of people benefiting from intermediate care by 220,000, in 2004 compared with 2000. By 2006 councils increase their intermediate care places to benefit an extra 70,000 people a year.
- Service capacity increased in other key services which support people at home so that in 2006: 30,000 more people a year receive care packages involving 5 hours or more a week of home care; 500,000 more pieces of community equipment are provided; there are 6,900 more extra care housing places. An increase of 6000 in the number of people in care homes supported by councils over the three years to 2006.
- An additional 130,000 carers a year receive services in 2006, using the increased investment in the existing carers special grant.
- As a result of investment in extra capacity and the introduction of reimbursement of the NHS by councils, delayed transfers of care reduce to a minimal level by 2006.

LIFE CHANCES FOR CHILDREN

Objective

Ensure the NHS and local government work together to improve life chances for children by:

- promoting the secure attachment of children to carers capable of providing safe and effective care for the duration of their childhood;
- enabling looked after children to gain maximum life chance benefit from educational opportunities, health care, social care and other services;
- addressing issues identified in the Kennedy Report including preparation for and implementation of the first module of the Children's NSF once this is published; and
- engaging fully with the ongoing development of cross-agency preventive work to support children and families, including local prevention strategies, and the continued development of Sure Start and Children's Centres.

Targets

- Improve the educational attainment of children and young people in care by increasing to 15 per cent by 2003-04 the proportion of children leaving care aged 16 and over with 5 GCSEs at grade A*-C, and maintain this level up to 2006. (N.B. The Government will review this target by the end of 2002 in the light of a Social Exclusion Unit study on improving the education attainment of children in care.)
- Improve the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004, and maintain this level up to 2006.
- Reduce by 2004, the proportion of children aged 10-17 and looked after continuously for at least a year who have received a final warning or conviction, by one third from September 2000 position. (Reduce the proportion from the 2000 national figure of 10.8 per cent to a local maximum of 7.2 per cent.) Maintain this reduction up to 2006.
- Maintain current levels of adoption placement stability (as measured by the proportion of placements for adoption ending with the making of an adoption order) so that quality is not compromised whilst increasing the use of adoption as follows:
 - By 2004-05 increase by 40 per cent the number of looked after children who are adopted, and aim to exceed this by achieving, if possible, a 50 per cent increase by 2006, up from 2,700 in 1999-2000. All councils will bring their practice up to the current level of the best performers (band 4 or 5 on PSS PAF indicator C23).
 - By 2004-05 increase to 95 per cent the proportion of looked after children placed for adoption within 12 months of the decision that adoption is in the child's best interests, up from 81 per cent in 2000-01, and maintain this level (95%) up to 2006, by locally applying the timescales in the National Adoption Standards, taking account of the individual child's needs.

National Capacity Assumptions

- All Local Authorities to have in place robust mechanisms for partnership working with relevant agencies to achieve targets.
- Improvement in the stability and quality of placements for looked after children including through recruitment/retention and support to foster carers over this period to support targets in line with the Choice Protects Review.

IMPROVING THE PATIENT EXPERIENCE

Objective

The NHS will be transformed through better engagement with patients, the public and staff. By regularly seeking out and acting on local feedback, the NHS will create patient responsive services that people perceive to be improving.

The 5 key dimensions for a good patient experience are:

- Improving access and waiting
- More information, more choice
- Building closer relationships
- Safe, high quality, co-ordinated care
- A clean, comfortable, friendly environment

Patients and the public will hold their local NHS to full and proper account for delivering improvements. They will expect updates on progress through formal patient and public involvement structures, and an annual guide to local health services.

Targets

- Improve the 5 key dimensions of the patient's experience as evidenced by increasingly positive local annual survey results, and other patient focused performance indicators, including those developed for the star ratings system. Agree, implement and jointly monitor local improvement plans as a result of surveys, with Patient Forums, as they come on stream during 2003.
- Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient & Public Involvement in Health, and annual publication of a patient prospectus covering local health services.
- Set local targets to contribute to national target of reducing the value of NHS building backlog maintenance by 25% by 2004.
- Introduce bedside TV and telephone systems in every major hospital by December 2003.
- Eliminate Nightingale wards for older people by April 2004.
- Introduce ward housekeepers in hospitals by 2004 and appoint modern matrons to all remaining posts by April 2004.

National capacity assumptions

- Active Patient Advisory & Liaison Service
- Regular and systematic approach to obtaining, analysing and responding to local patient and public feedback about services
- Partnership working with Patient Forums

REDUCING HEALTH INEQUALITIES

Objective

To reduce inequalities in health outcomes across different groups and areas in the country. Initially the focus is on reducing the gap in infant mortality and life expectancy at birth, and on reducing teenage pregnancies.

NHS improvement, expansion and reform should narrow the health gap by:

- ensuring that the distribution of health benefit from service expansion and development consistently favours individuals and communities that have been traditionally under-served,
- ensuring that service planning is informed by an equity audit and supported by an annual public health report by the Director of Public Health
- tackling the wider determinants of health - agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and neighbourhood renewal programmes, and ensuring the NHS makes a full contribution to support the *Sure Start* programme
- building capacity for public health improvement and protection in PCTs

Targets

- Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole by 2010, starting with children under one year.
- Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups.
- Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets.
- Contribute to a national reduction in death rates from CHD of at least 25% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of CHD.
- Contribute to a national reduction in cancer death rates of at least 12% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of cancer.
- Achieve the target of 70% uptake in influenza immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy.

National capacity assumptions

- Improved access to services for disadvantaged groups and areas, particularly:
 - Early antenatal service booking
 - Antenatal and child health screening services
 - Sexual health services, and breast/cervical screening.
 - Strengthened primary care services through increased numbers of health professionals and improved facilities in under-served and deprived areas.

DRUG MISUSE

Objective

To contribute to delivery of the National Drugs Strategy by reducing the harmful effects of substance misuse.

This will be achieved through expansion and improvement of drug treatment services, and by contributing to the Strategy target to reduce the use of Class A drugs, and frequent use of any illicit drug by young people.

This will include:

- Agreement through the local DAT of arrangements for commissioning integrated drug treatment and prevention programmes jointly with other partners.
- Implementation of the NTA guidance on maximum waiting times for drug treatment, Models of Care, prescribing guidance and action plan on drug-related deaths.

Targets

- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 (against 1998 baseline), and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
- Reduce drug-related deaths by 20% by 2004 (against 1999 baseline).

National Capacity Assumptions

- An increase in access to general medical services for all problem drug users (irrespective of prescribing needs), and GP participation in training programmes on treatment of drug users.

PHYSICAL FACILITIES**Objective**

To create a clean, comfortable, well-maintained physical environment which is fit to deliver modern, convenient care. This includes delivering sufficient physical capacity in the right place to implement the NHS's key priorities, increasing diversity of provision through use of non-NHS providers where appropriate, and ensuring that physical facilities are modernised in line with the vision set out in the NHS Plan.

National capacity requirements

- Introduce new providers from the independent sector and overseas to offer patients a greater choice over where they obtain diagnosis and treatment.
- Trusts with major capital schemes: achieve financial close on 29 schemes for new hospitals announced in February 2001 by June 2005, or sooner if possible.
- Improve GP premises, to contribute to national target of 3000 GP premises refurbished or replaced by the end of 2004.
- Establish new one-stop primary care centres, to contribute to national target of 500 centres by the end of 2004, 125 more by 2006, and a further 125 by 2008.
- Establish additional inpatient beds and hospital capacity to meet access and clinical priority targets.
- Establish new Diagnosis and Treatment Centres operational in time to make a contribution to meeting 2005 waiting targets.
- Plan for at least 40% of the total value of the NHS estate to be less than 15 years old by 2010.

WORKFORCE

Objective

To support delivery of NHS priorities by ensuring there are sufficient numbers of appropriately trained, motivated staff working in the right locations. The HR Strategy for the NHS sets out a managed programme for a rapid expansion in the NHS workforce, introduction of more flexible ways of working and improving the working lives of staff. Delivery of this strategy is absolutely central to the achievement of other NHS Plan priorities. Workforce Development Confederations will need to work on behalf of Strategic Health Authorities to develop a local delivery plan for workforce which:

- ensures sufficient increases in workforce to meet delivery priorities
- makes optimum use of the new contractual arrangements
- delivers the changes set out in *“HR in the NHS Plan”*
- addresses critical issues, particularly implementation of the Working Time Directive

National capacity requirements

- Increase the number of nurses employed by the NHS by 20,000 by 2005 (from a 2000 baseline), and plan to achieve increase of 35,000 by 2008 (from a 2001 baseline).
- Increase the number of consultants by 7,500 and the numbers of GPs by 2,000 by 2004 (from a 1999 baseline); increase the number of GPs and Consultants employed by the NHS by 10,000 by 2005 (from a 2000 baseline); plan to achieve increase of 15,000 doctors by 2008 (from a 2001 baseline). This will include: 1,000 cancer consultants by 2005; and increasing total numbers of cardiologists to 685 and cardiothoracic surgeons to 217 by 2004, (enabling single handed cardiologist posts to be eliminated).¹
- Increase the number of therapists and scientists employed by the NHS by 6,500 by 2004 (from a 1999 baseline), and plan to achieve an increase of 30,000 by 2008 (from a 2001 baseline).
- Increase the number of health care assistants employed by the NHS by 27,000 by 2005 (from a 2002 baseline).
- By 2004 expand the mental health workforce by: 1,000 new graduate workers in primary care; 500 community mental health “Gateway” workers; 700 more staff to support carers; 300 prison in-reach staff to ensure prisoners with severe mental illness have an appropriate care plan and care co-ordinator on release; 400 staff to support secure step-down.
- By 2006 expand the mental health workforce by: 300 extra prison in-reach staff, 500 community development workers for black and minority ethnic communities; 200 staff and 6 outreach teams for personality disorder and training of 3000 Support, Time and Recovery Workers (STR).
- Increase workforce capacity and productivity through skill mix and continuing professional development; moving work from doctors to other healthcare professionals and from healthcare professionals to the support workforce, supported by pay modernisation, and service redesign.

¹ Further explanation of these baselines and national requirements for increasing the number of doctors will be issued with the technical guidance

IM&T

Objective

To provide information management and technology to support delivery of fast, seamless and convenient care to patients. IM&T will facilitate greater patient choice, giving patients better information about options for their care. At the same time it will improve working lives for staff by reducing paper-based bureaucracy, enabling more effective communications between professionals and provide support for clinical and management decision-making. There will be a nationally-led programme for IM&T and all NHS organisations as part their Local Delivery Plans will need to implement the National Strategic Programme, (described in the document "Delivering 21st Century IT Support for the NHS"). In the years 2003-06 the elements to be delivered involve infrastructure, records, prescribing and booking.

National Programmes

- infrastructure - deliver broadband access to NHS net for NHS clinicians and support staff by April 2004. This will be a single national procurement of a new NHS network. StHAs and trusts should be aware of the national procurement and make arrangements for local networks.
- booking - implement electronic booking by December 2005. The chosen architecture is decided upon and early adopters (enterprise communities) are developing. Local communities should respond to the national roll out programme.
- national prescriptions service - this will be 50% implemented by December 2005 and 100% by December 2007 with full clinician and patient functionality. Pilots are being conducted in order to define a specification for a national programme. Local communities will need to respond to the national programme.
- electronic records - implement key elements of electronic records by December 2005. There will be a national health records infrastructure accessible nationally for out-of-hours reference and an electronic staff record. Existing systems and new procurements will need to be made part of the Integrated Care Records Service, the specification of which is out to consultation. A central advisory group is being set up to evaluate and answer questions about current procurements.