Department of Health

Autumn Performance Report 2007

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
December 2007

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Contents

Introduction

The Government set new priorities for public spending with significant extra resources in key services such as education and health. The Government also made a commitment to link this extra investment to modernisation and reform, to raise standards and improve the quality of services. The aims and objectives of the Department of Health are enshrined in the Public Service Agreement (PSA) which was published in the HM Treasury White Paper, *Public Services for the Future: Modernisation, Reform, Accountability*, in December 1998.

The 2000, 2002 and 2004 Spending Reviews (SRs) build on the success of the original Comprehensive Spending Review (CSR) by setting further challenging targets. The SR2002 set spending plans and measurable targets, the PSAs for 2003/04 to 2005/06. The SR2004 set spending plans and PSAs for 2005/06 to 2007/08.

These PSAs are set out in the White Papers:

- *2000 Spending Review: Public Service Agreements,* July 2000;
- *2002 Spending Review: Public Service Agreements,* July 2002; and
- *2004 Spending Review: Public Service Agreements,* July 2004.

In July 2004, the Department of Health published the planning framework, *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08.* This sets out the national targets for the NHS and social care that apply from April 2005. It also sets out the architecture of the new planning and performance system. Its main features are:

- a shift to a system in which standards of quality and care will be the key national driver for improvements;
- a reduced set of national targets to accelerate progress in a focused set of priority areas;
- headroom for local communities to address local priorities;
- financial and performance assessment incentives aligned to support improvements in the system; and
- local organisations taking a greater lead in service modernisation.

The Department of Health's aim and objectives that were agreed in SR2004 are set out below. There is then an analysis of progress against these targets. Also set out are SR2002 PSA targets that became standards in SR2004. These are followed by an analysis of progress against the Department's efficiency targets. Analysis of live PSA targets resulting from SR2002, SR2000 and CSR1998 is set out in Annex A and a summary of the latest National Audit Office (NAO) data quality assessment is set out at Annex B.

The Department of Health's aim and objectives (SR2004)

Aim

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

Objectives and performance targets

Objective I: Health of the population

Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.

1. Substantially reduce 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 deprivation indicators and the population as a whole;
   - from cancer by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
   - from suicide and undetermined injury by at least 20%.
2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.
3. Tackle the underlying determinants of 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;
   - 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 (joint target with the Department for Children, Schools and Families (DCSF) and the Department for Culture, Media and Sport (DCMS)); and
   - reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health (joint target with DCSF).

Objective II: Long-term conditions

4. Improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

Objective III: Access to services

5. Ensure that by 2008 no one waits more than 18 weeks from GP referral to start of treatment unless it is clinically appropriate to do so or they choose to wait longer.

6. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

Objective IV: Patient/user experience

7. Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:

    - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
    - increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

Departmental Public Service Agreement targets (SR2004) analysis

Further to the 1998, 2000 and 2002 Spending Reviews, the SR2004 continued the process of delivering improvements in services, through the innovation of PSA targets. The targets from that Review are laid out in the table below with updates on progress.

Objective I: Health of the population

PSA target	Measure	Progress
Target 1 Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.	**Life expectancy at birth for men and women in England.**	**Overall life expectancy – encouraging progress** In the period 2004–06, the life expectancy in England at birth was as follows: • male – 77.2 years; and • female – 81.5 years. These have risen from a baseline of 75.0 years for men and 79.9 years for women in the period 1997–99.
Substantially reduce 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 deprivation indicators (the Spearhead Group) and the population as a whole;	**Death rate from heart disease, strokes and related illnesses** among people aged under 75.	**Heart disease, stroke and related illnesses overall mortality – met early** The 1995–97 baseline figure for overall mortality for heart disease in people aged under 75 in England was 141.0 deaths per 100,000 population. In the period 2004–06, the rate had fallen to 84.2 deaths per 100,000 – a fall of 40.3%. Three-year average rates have fallen for each period since the baseline. The minimum target requirement has been met five years ahead of schedule. **Inequality dimension – on course** Three-year average rates have fallen in the Spearhead Group and England as a whole for each period since the baseline. During this period, the inequality gap has reduced from a baseline absolute gap of 36.7 deaths per 100,000 population in the period 1995–97 to 24.9 deaths per 100,000 population in the period 2004–06. (The target for 2010 is to reduce the absolute gap to 22.0 deaths or less per 100,000 population.) The gap has therefore reduced by 32.2% since the baseline, compared with the required target reduction of at least 40% by the period 2009–11.

Table 1. All circulatory diseases: 1995–97 to 2004–06

	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Mortality rate per 100,000 (under-75s)	141.0	135.1	128.3	121.6	114.5	108.1	102.8	96.7	90.4	84.2

Table 2. Circulatory disease, inequality dimension: 1995–97 to 2004–06

	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Absolute gap between England and Spearhead Group (rate per 100,000, under-75s)	36.7	36.4	35.2	32.7	30.8	29.0	28.7	27.6	26.4	24.9

PSA target	Measure	Progress
• 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 (the Spearhead Group) and the population as a whole;	**Death rate from cancer** among people aged under 75.	**Overall mortality – on course** The 1995–97 baseline figure for overall mortality for cancer in people aged under 75 in England was 141.2 deaths per 100,000 population. In the period 2004–06, the rate had fallen to 117.0 deaths per 100,000 – a fall of 17.1%. Three-year average rates have fallen for each period since the baseline. If the trend of the last 10 years were to continue, the target would be met. **Inequality dimension – ahead** Three-year average rates have fallen in the Spearhead Group and England as a whole for each period since the baseline. Following a small increase in the inequality gap in the first monitoring period, the gap has reduced slightly from a baseline absolute gap of 20.7 deaths per 100,000 population in the period 1995–97 to 18.1 deaths per 100,000 population in the period 2003–05. Although mortality rates continue to fall, for the period 2004–06 there has been a small increase in the inequality gap to 18.4 deaths per 100,000 population. (The target for 2010 is to reduce the absolute gap to 19.5 deaths or less per 100,000 population.) The gap has therefore reduced by 11.3% since the baseline, compared with the required target reduction of at least 6% by the period 2009–11.

Table 3. All malignant neoplasms: 1995–97 to 2004–06

	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Mortality rate per 100,000 (under-75s)	141.2	138.4	134.9	132.0	128.7	126.5	124.0	121.6	118.9	117.0

Table 4. Cancer, inequality dimension: 1995–97 to 2004–06

	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Absolute gap between England and Spearhead Group (rate per 100,000, under-75s)	20.7	21.0	20.8	20.3	19.9	19.6	19.1	18.8	18.1	18.4

PSA target	Measure	Progress
• from suicide and undetermined injury by at least 20%.	**Death rate from intentional self-harm and undetermined injury** among people of all ages. Baseline is average of 1995, 1996 and 1997. (All using Office for National Statistics (ONS) mortality statistics age standardised to allow for changes in the age structure of the population.)	**Suicide and injury of undetermined intent – encouraging progress** The three-year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen and is now 10.0% below the baseline. The three-year average rate for the period 2004–06 fell to the lowest recorded rate of 8.3 deaths per 100,000 population. If current trends continue, the target for 2010 would not be met, though there are signs that the rate of decline may once again be increasing. An increased rate of decline must be sustained if the target is to be met.

Table 5. Intentional self-harm and injury of undetermined intent (excluding verdict pending): 1995–97 to 2004–06

	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Mortality rate per 100,000	9.2	9.3	9.6	9.7	9.3	8.9	8.6	8.6	8.5	8.3

PSA target	Measure	Progress
Target 2 Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.	**Mortality in infancy by social class:** the gap in infant mortality between routine and manual groups and the population as a whole. Baseline is average of 1997,1998 and 1999.	**Infant mortality – slippage** Data for the period 2004–06 show a further slight narrowing in the gap between the routine and manual groups and the population as a whole, compared with data for 2003–05 and 2002–04. However, over the period since the target baseline, the gap has widened, and the infant mortality rate among the routine and manual groups is now 17% higher than in the total population. This compares with 13% higher in the baseline period of 1997–99, although there have been year-on-year fluctuations in intervening years. The target is measured using an indicator of socio-economic groups defined only through the father's occupation because there are limited occupational data associated with sole registration by mothers. The current approach has remained consistent since the target was set.
	Life expectancy by local authority: the gap between the fifth of areas with the worst health and deprivation indicators (the Spearhead Groups) and the population as a whole. Baseline is average of 1995, 1996 and 1997.	**Life expectancy at birth – slippage** For men, in the period 2004–06 the relative gap in life expectancy between England and the Spearhead Groups was 2% wider than at the baseline period 1995–97, the same as in the period 2003–05. For women, in the period 2004–06 the relative gap in life expectancy between England and the Spearhead Groups was 11% wider than at the baseline period 1995–97, compared with 8% wider in the period 2003–05. In the period 2004–06, data show that two-fifths of Spearhead areas are on track to narrow their own life expectancy gap with England by 10% by 2010 compared with baseline for either men or women or both. Some 17% are on track for men only, with a further 13% on track for women and 11% on track for both.

PSA target	Measure	Progress
Target 3 Tackle the underlying determinants of 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;	**Smoking:** reduction in number of adult and routine/manual groups smokers. Prevalence from General Household Survey.	**Adult smoking rates – on course** The percentage of adults smoking has fallen by 3 percentage points since 2001. While 27% of the whole population smoked in 2001, this figure had fallen to 24% in 2005. **Reduction in prevalence among the routine and manual groups – encouraging progress** The routine and manual figures were 33% in 2001 and 31% in 2005.
• 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 (joint target with DCSF and DCMS).	**Obesity data system:** The Health Survey for England (HSE), which comprises a series of annual surveys beginning in 1991. The series is part of an overall programme of surveys commissioned by the Department of Health which are designed to provide regular information on various aspects of the nation's health.	**Obesity – not yet assessed** Annual performance on tackling obesity is measured by comparing HSE figures for aggregate three-year periods. Data for the period 2002–04 showed that the prevalence of obesity among children aged 2 to 10 years was 14.9%. Equivalent data for the period 2003–05 (published by the National Centre for Social Research) also showed a rate of 14.9%. Halting the increase in obesity would mean no statistically significant change in prevalence between the three-year periods 2005–07 and 2008–10. Non-aggregated data from the 2005 HSE recorded that 16.8% of boys and 16.9% of girls aged 2 to 10 years in England were obese, an increase from 9.6% and 10.3% for boys and girls respectively in 1995.

Table 6. Smoking prevalence: 1998 to 2005

	1998	1999	2000	2001	2002	2003	2004	2005
All adults	28%	–	27%	27%	26%	25%	25%	24%
Routine and manual groups	–	–	–	33%	31%	32%	31%	31%

PSA target	Measure	Progress
	As set out in the Technical Note for this PSA target, levels of childhood obesity are measured by aggregate trend data available every three years. The delay between the end of the collecting period and when the data is published is around 12–15 months. Baseline: 14.9% – the three-year aggregate data from the HSE from the period 2002–04 latest outturn against trend. The first indication of progress against the baseline will be available later in December 2007.	The 2007 CSR included a new long-term ambition for obesity in national and local accountability frameworks: to reduce the rate of increase in obesity among children under 11 years, as a first step towards a long-term national ambition by 2020 to reduce the proportion of overweight and obese children to 2000 levels in the context of tackling obesity across the population. The Government has committed to go further and faster on its existing obesity policies and will be developing a comprehensive cross-government strategy on obesity, building on the evidence in the *Foresight* report. The focus on obesity will be enhanced by the creation of a cross-governmental Ministerial Group. A new joint Obesity Unit, supported by DCSF and the Department of Health, is being established to tackle obesity.
• reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health (joint target with DCSF).	**Teenage conceptions:** The under-18 conception rate is the number of conceptions to under-18s per 1,000 females aged 15–17. Baseline year is 1998 (ONS conception statistics).	**Teenage conceptions – slippage** The under-18 conception target is now a shared PSA target between the Department of Health and DCSF, in light of the move of the Teenage Pregnancy Unit to DCSF in June 2003. Teenage pregnancy rates are falling. Between the 1998 baseline year and 2005, the under-18 conception rate has fallen by 11.4%. The rate is at the lowest level for 21 years; however, progress needs to accelerate for the target to be met.

Table 7. Under-18 conception: 1998 to 2005

	1998	1999	2000	2001	2002	2003	2004	2005
Under-18 conception rate per 1,000 females aged 15–17	46.6	44.8	43.6	42.5	42.7	42.2	41.6	41.3

Objective II: Long-term conditions

PSA target	Measure	Progress
Target 4 Improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.	**Reduction in number of emergency bed days** as measured through Hospital Episode Statistics. Reduction in number of very high intensive uses of care.	**Reduction in number of emergency bed days – met early** Between 2003/04 and 2006/07, the number of emergency bed days decreased by 10.1%, from 32,457,517 to 29,183,638.

Table 8. Emergency bed days: 2003/04 to 2005/06

	2003/04	2004/05	2005/06	2006/07
Number of emergency bed days	32,457,517	31,902,650	30,699,595	29,183,638

Objective III: Access to services

PSA target	Measure	Progress
Target 5 By December 2008, ensure that no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks).	**18 weeks** We will know that the 18 week programme has succeeded when patients tell us that they are no longer concerned about waits and that their actual experience of the service they receive is a good one. We are now developing surveys to ask patients to give us their views on their experience of referral to treatment. The Department will continue to underpin this kind of evidence with NHS reported referral to treatment times. We have set some stretching milestones for delivery – by March 2008, 85% of admitted patients and 90% of non-admitted patients will start their treatment within 18 weeks of referral. There are a number of patients for whom it is not in their best interests clinically to start treatment in 18 weeks. There are also patients who make a choice to delay their progress – either explicitly by choosing convenient but later dates for their appointments or admissions, or because they forget or fail to	**18 weeks – on course** In the last quarter, we published for the first time the referral to treatment waits for patients whose treatment did not include admission to hospital ('non-admitted' patients). This showed that 76% of non-admitted patients waited 18 weeks or less. The results for admitted patients, which have been published each month since March 2007, showed that waits are coming down with an improvement from 48% in 18 weeks or less in March to 56% in August. In addition, the Department is now developing and piloting surveys to ask patients to give views on their referral to treatment experience. When this phase is complete, the Department will publish the findings and act on the results. Actions taken to support NHS progress towards delivering 18 weeks include: • mandating a Patient Tracking List (PTL) approach for admitted patients from July 2007; • offering intensive support to organisations that require it; • extensive engagement and communications activity at national and local level, including ministerial strategic health authority (SHA) events and the launch of NHS-facing End Waiting Change Lives campaign. Feedback from NHS staff is that they strongly support 18 week benefits; • 18 weeks delivery to be reaffirmed in the *NHS Operating Framework for 2008/09* and the necessary activity to deliver 18 weeks to be enshrined in operational plans and contracts between PCTs and providers; • guidance being issued to commissioners and providers to reach agreement on unbundled diagnostic prices (including corresponding adjustments to the outpatient tariff) where access to diagnostic services remains a block to 18 week delivery;

PSA target	Measure	Progress
	attend booked appointments. It is inevitable, therefore, that the statistics will never show literally 100% of patients in 18 weeks or less. Indeed, if we were to aim to achieve 100% it would mean denying some patients the ability to choose the appointments that are convenient for them. It would also be to ignore the clinical exceptions where the right care for the patient is that their treatment should not be started with 18 weeks. The proposed standards for delivery for the NHS from the end of December 2008 will therefore be 95% for non-admitted and 90% for admitted patients. This was confirmed in the *NHS Operating Framework for 2008/09*.	• implementation of 18 week compliant patient administration system (PAS) or local workaround solutions is a priority to ensure that solutions are in place by December 2007; and • making extensive good practice tools available to the NHS, including 35 good practice commissioning pathways.

PSA target	Measure	Progress
Target 6 Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	Annual returns from the **National Drug Treatment Monitoring Service (NDTMS)**, which provides details on the number of drug misusers entering into, successfully completing and sustaining treatment.	**Participation in drug treatment – met early** The results from the NDTMS reveal that there were over 195,000 people receiving structured drug treatment in England during 2006/07, an increase of 130% on the 1998/99 baseline of 85,000. **Effectiveness of drug treatment – on course** In addition, in 2006/07, 80% of those in drug treatment either successfully completed their programme or were retained in treatment for at least 12 weeks (measure of effectiveness). This is an increase from 76% in 2005/06 and means we remain on track to meet our target to increase year on year the proportion of drug misusers in treatment who either are being retained or successfully complete their treatment programme. A second indicator, which measured solely the proportion of those retained in structured treatment for at least 12 weeks following triage assessment, remained stable at around 75%.

Objective IV: Patient/user experience

PSA target	Measure	Progress
Target 7 Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.	**The national survey programme** (under the administration of the Healthcare Commission) will gather feedback from patients on different aspects of their experience of care in NHS trusts.	**Improving the patient experience – on course** Since the first survey was conducted in 2001/02, well over 1.7 million patients have taken part in 18 surveys across eight different NHS care settings. PSA scores are an average score out of 100 – calculated by aggregating scores from five domains of patient experience: • improving access and waiting; • building closer relationships; • better information, more choice; • safe, high-quality coordinated care; and • clean, friendly comfortable place to be. An update on progress against the PSA target, including results from 2006/07 surveys, will be published in January 2008. To date, figures for three of the five domains covered by the PSA suggest small improvements. These improvements have been recorded in the: • adult inpatient survey (75.7 in 2003/04 to 76.2 in 2005/06); • primary care survey (76.9 in 2003/04 to 77.0 in 2005/06; 2005/06 results are obtained from a national survey conducted by the Department, and are marginally lower than the 77.4 recorded in the Healthcare Commission primary care trust (PCT) survey administered in 2004/05); and • community mental health services survey (74.2 in 2003/04 to 74.7 in 2004/05. Results for 2005/06 cannot be compared due to changes in question wording). There has been a small decline in the outpatient survey (76.9 in 2002/03 to 76.7 in 2004/05). Results from the emergency care survey cannot be compared due to changes to survey questions.

PSA target	Measure	Progress
		Full details of progress against the improving patient experience PSA target is available on the Department website at: www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/index.htm **2006/07 and future surveys** In 2006/07, the Healthcare Commission conducted an adult inpatient survey (results published in May 2007) and a community mental health services survey (published in September 2007). The results for each NHS organisation participating in these surveys – and nationally aggregated data – are available on the Healthcare Commission website at: www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys.cfm An update of performance against the PSA target will be published in January 2008. This will include these two recent surveys, and will be published on the Department website (see the web link above). In 2006/07, the Healthcare Commission also conducted a new trust-based survey among women who have recently used maternity services. Local and national results were published by the Healthcare Commission in November 2007, and are available at: www.healthcarecommission.org.uk/healthcareproviders/nationalfindings/surveys/healthcareproviders/surveysofpatients/maternityservices.cfm Confirmation of the 2007/08 survey programme is available at: www.healthcarecommission.org.uk/_db/_documents/NHS_staff_and_patient_experience_surveys_outline_draft_programme_for_2007_2008_200705104135.pdf

PSA target	Measure	Progress
Target 8 Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:		
• increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and	**Those being helped to live at home** are those who receive community-based services but are not in residential or nursing care. Only those who are care managed by social services, i.e. are assessed by social services and have a care plan, will be included in the target.	**Older people supported to live at home – on course** The baseline year for this target is 2005/06. The first national comparison is now available and shows a national increase averaging 0.9% compared with 2004/05. To recognise the crucial voluntary and community sector (VCS) contribution to non-intensive home care, a related data collection to assess the VCS contribution to this target has commenced this year.
• 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.	**Those people receiving more than 10 contact hours of home care and six or more visits per week** divided by the population of people supported by councils in residential care and nursing homes.	**Older people supported intensively to live at home – on course** In England, the number of older people supported intensively to live at home in 2005/06 shows a strong upward trend, increasing to 33.8% of the total supported by councils in residential care and in their own homes, 0.2 percentage points below the target of 34% by March 2008. The continual rise in the PSA value is due in part to the increasing number of households receiving intensive home care (i.e. the target has not been met simply by reducing numbers of care home residents). In September 2005, 98,200 households received an intensive home care service, a rise of 6% from the same period in 2004.

Departmental operating standards

Standard	Measure	Progress
Standard 1 Reduce to four hours the maximum wait in accident and emergency (A&E) from arrival to admission, transfer or discharge, by the end of 2004. Note: Following discussions with clinicians' representatives, a 2% tolerance was introduced during 2003 for the minority of patients that clinically require more than four hours in A&E. This meant that providers were performance managed to ensure that 98% of patients were seen, diagnosed and treated within four hours of their arrival at A&E. The target became an operational standard during 2005.	**Total time patients spend in A&E** from arrival to admission, transfer or discharge. This includes major A&E departments, walk-in centres and minor injury units.	**A&E total time – met (for 2006/07 as a whole) and sustained** Between July and September 2007, 98.3% of attenders at all types of A&E department in England were admitted, transferred or discharged within four hours of arrival. This continues the excellent performance level achieved for 2006/07 as a whole, where 98.2% of patients were seen, diagnosed and treated within four hours of their arrival at A&E, as well as the first quarter of 2007/08 where performance was above the 98% operational standard.
Standard 2 Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.	The Department's main measure for 48-hour GP access is now the national **GP Patient Survey**. PCT performance on both the 24-hour and 48-hour targets continues to be measured through the now quarterly **Primary Care Access Survey (PCAS).**	**Primary care access – met** The 2007 GP Patient Survey results indicated that 86% of patients are satisfied with the ability to get an appointment with a GP within the next two days the surgery is open. Since December 2004, PCTs have reported through PCAS each month that over 99% of patients could be offered an appointment within two working days to see a GP. Since April 2007, PCAS is now conducted quarterly and indicates a slight fall in performance to 98.3%. PCAS remains the only mechanism for reporting the 24-hour target. PCTs report that 98.3% of patients can be offered an appointment with a primary care professional within 24 hours.

Standard	Measure	Progress
Standard 3 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 meet their needs.	**Department of Health monthly central data collection** measures the percentage of patients given the opportunity to choose the most convenient date from a range of dates. The booking data collection ceased at the end of March 2007 as the service is moving towards electronic booking through Choose and Book.	**Booking – met** Number of day cases booked – final figure: • March 2007 – 99.6%. The number of inpatient appointments booked (day cases and ordinary admissions) – final figure: • March 2007 – 99.6%. Outpatient booking – final figure: • March 2007 – 98.9%. **Electronic booking** The Choose and Book system was launched in summer 2004, and it enables patients to book initial hospital appointments at a time and place of their choice while in the GP surgery, or later either on the internet or by phone through the Choose and Book Appointments Line. **Choice** To monitor implementation of choice at referral, we are carrying out surveys to measure whether patients recall being offered choice when their GP referred them to hospital and whether they were aware of choice. These are carried out every two months. Latest published figures for July 2007 indicate that around 43% of patients who are eligible recall being offered choice. This is a slight decrease on end-of-year figures for March 2007, though the percentage of patients reporting awareness of choice has continued to rise and now stands at 38% for July 2007. Work is now ongoing to ensure the implementation of free choice from April 2008.

Standard	Measure	Progress
Standard 4 Improve life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis services and child and adolescent mental health services (CAMHS), and reduce the mortality rates from suicide and undetermined injury by at least 20% by 2010.	**Annual mapping of CAMHS to monitor success.** For **crisis services** there are two main forms of measurement: • number of home treatment episodes carried out by crisis teams per annum; and • number of crisis resolution teams established.	**Access to CAMHS** Progress towards this target is being measured by the percentage of PCTs that have care pathways to three essential elements of comprehensive CAMHS. The position as at June 2007 is set out below: • 24-hour emergency assessment: 98.7%; • CAMHS for children and young people with a learning disability: 99.3%; and • CAMHS for 16 /17-year-olds: 98.7%. It is anticipated that this standard will be fully met by the end of December 2007. **Access to crisis services** The key enabler for improving access to crisis services is the implementation of sufficient numbers of crisis resolution teams and their achieving the full caseload. The number of crisis resolution teams in place were as follows: • September 2002 – 62; • March 2003 – 102; • September 2004 – 137; • March 2004 – 179; • September 2004 – 212; • March 2005 – 343; • January 2006 – 343; and • March 2007 – 343.
		The number of home treatment episodes in the year (number of people receiving crisis resolution services up to year ending 2004/05) were as follows: • 2002/03 – 28,500; • 2003/04 – 45,800; • 2004/05 – 68,800; • 2005/06* – 83,800; and • 2006/07 – 95,400. In 2006/07, 95% of the national target (100,000 home treatment episodes) was achieved.

* In quarter 3 of 2005/06 the guidance was revised to record the number of home treatment episodes. Figures from 2005/06 are not comparable with previous years.

Gershon efficiency targets

Efficiency programme

The Gershon Report *Releasing Resources to the Front Line,* published in March 2004, committed the Department of Health to achieving the following targets as part of the SR2004:

- annual efficiency gains of £6.47 billion by March 2008, at least half of which should be cashable;
- a reduction in whole-time equivalent civil servants of 720 by March 2008; and
- the relocation of 1,030 whole-time equivalent posts out of London and the South East by March 2010 (reduced from 1,110 following transfer of some agencies to the Department for Constitutional Affairs, which has since been renamed the Ministry of Justice).

Efficiency gains

Programme structure

The programme comprises five workstreams on which progress is reported:

i) **Productive time:** modernising the provision of front-line services to be more efficient and also improving the quality of patient care, by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce.

ii) **Procurement:** making better use of NHS buying power at a national level to get better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies and other consumables and pharmaceuticals.

iii) **Corporate services:** ensuring that NHS organisations can rationalise and share back office services, such as finance, information and communications technology and human resources.

iv) **Social care:** improving commissioning of social care and other cash-releasing and non-cash-releasing gains from the design of social care processes by local authorities.

v) **Public funding and regulation:** reducing the operating costs of the Department of Health, arm's-length bodies, SHAs and PCTs through reducing processes and functions and restructuring, merging or abolishing existing organisations.

Measurement processes

Aggregate efficiency gains are assimilated through a large number of projects and business changes. Detailed measurement and assurance processes have been developed for each resulting efficiency gain. These have been verified and agreed with HM Treasury and the Office of Government Commerce (OGC). Details are provided in an Efficiency Technical Note (ETN) available on the Department of Health website at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124041

The Health Efficiency Programme continues to evolve to underpin gains up to and beyond 2008. During 2007, we have developed measurement processes to capture a number of outstanding areas of efficiency gain that were highlighted in the published ETN as planned or work in progress. These include measurement processes relating to variation in clinical interventions and GP and outpatient referrals, the reduction in SHAs and PCTs, and increased prescribing of generic drugs in place of branded equivalents.

In response to specific issues raised by the NAO, we have revised the calculation of hospital length of stay using a more statistically robust moving average calculation to resolve the issue of volatile baseline data (this will create a one-year time lag on final figures). We also removed the declared savings relating to reduced GP bureaucracy, as it was not cost-effective to undertake a new full validation survey on the savings previously agreed by a smaller group of GPs. These two changes reduced reported savings by just under £200 million (5%). The NAO did, however, also note within its report that some health efficiency calculations were more prudent than Gershon guidelines required, and also that the complexities of health processes and data availability can result in understated or incomplete reported efficiencies.

We have also identified other projects that were part of the original programme on which the £6.5 billion target was predicated, but where we are unable to verify robust attributable financial values within a strict definition of efficiency. We do not therefore include these within our reported Gershon savings but do recognise them as contributing to improved value for money

Where there have been established trends of increased activity driven by population and health needs changes, we have used counterfactual baselines to measure efficiency gains from the activity level that would have occurred had improvement actions not been initiated. This approach is consistent with Treasury guidelines for the CSR.

The ETN has recently been updated and expanded so that it reflects fully the final scope of contributing programmes and projects, the additional or amended measures, and the service quality and data assurance processes introduced by the OGC in 2006.

Reported gains to date

The following gains have been recorded for 2004/05, 2005/06, 2006/07 and up to quarter 2 of 2007/08:

Table 9.

Workstream	2004/05 (£m)	2005/06 (£m)	2006/07 (£m)	2007/08 Q1 (£m)	2007/08 Q2 (£m)
Productive time	508	963	1,787	2,036	2,638
Procurement	333	1,319	2,397	2,595	2,685
Corporate services	14	38	57	58	65
Social care	0	179	390	518	518
Public funding and regulation	13	77	270	317	526
Total health	**868**	**2,576**	**4,901**	**5,524**	**6,432**

Note:
Productive time calculations have been revised to reflect agreed changes to length of stay formula.
In-year figures include some estimates that are subject to year-end reconciliation.
Q2 productive time includes first reported benefits for outpatient appointments and surgical interventions for which data were not previously available.

Of the total reported gains, £3,793 million (59%) are cashable.

(Note: savings attributable to reducing the cost of patient stays which would require local capacity planning changes to realise the savings as cash are counted as non-cashable.)

Assurance of reported gains

For each separate efficiency project or area of gain, we are required to demonstrate that service quality has at least been maintained. We have developed balancing quality measures appropriate to most individual workstreams and projects, and these are set out in the ETN. The latest position on agreed quality measures is as follows:

Table 10.

Workstream	Quality measures
Procurement	Maintained or improved product quality standards are inherent in procurement contracts and specifications. NHS organisations will choose not to purchase if standards are not maintained. Drug price savings are for named drugs for which quality must be unchanged.
Productive time	Patient satisfaction improved by an average of 0.5% (latest data 2006). Inpatient waiting times improved from 12.4 to 6.9 weeks and outpatient waiting times from 7.9 to 6.9 weeks (2007). Main PSA targets delivered or on track. Post-inpatient mortality reduced from 1.76% to 1.69% (2005). Hospital readmissions increased from 9.0% to 10.1% (2006).*
Social care	Quality assurance of individual projects by councils not reported to central government. Performance on each of five key performance (performance assessment framework) indicators and overall star ratings for councils show improvement since 2004 (2006).
Corporate services	Shared services – no evidence of Service Level Agreement breaches or penalty payments. ESR – awaiting results of independent Gateway 5 review in 2008.
Public funding and regulation	Main NHS PSA targets delivered or on track (quality measure for the Department and SHA restructuring as these functions support NHS delivery). Arm's-length bodies are meeting Service Level Agreements and the basket of service quality indicators. Also awaiting conclusions of forthcoming NAO report on delivery of programme.

* Patient readmissions have been rising since 1999. The Department is confident that the rise reflects changes in the way that long-term condition patients are treated (shorter periods of stay) together with less ill patients being treated outside of hospitals. Critically, post-inpatient mortality rates are falling. Independent commissioned research considered a wide range of potential factors but was inconclusive. Further, more detailed analysis is under way and its findings will be reported when complete.

We are now required to differentiate total reported benefits under two classifications:

- status of gains – whether they are subject to change based on data availability; and
- data assurance – how robust the calculation is based on data reliability.

The breakdown of quarter 2 2007/08 reported gains is as follows. Detailed definitions of these classifications are provided in the ETN.

Status of gains	Preliminary	Interim	Final
	£76 million	£592 million	£5,764 million
Data assurance	Partial	Substantial	Full
	£358 million	£2,315 million	£3,759 million

Progress highlights

1. Productive time

- The average length of stay for hospital in patients has reduced by over 20% since March 2004 as a result of service redesign and more effective management of patient treatment pathways. The reduced average cost of hospital stays has cut costs by over £700 million per year since the start of the productive time programme.
- There has been a reduction of over 3 million emergency bed days per year since March 2004 and this continues to increase as the strategies for treatment of long-term conditions and *Our Health, Our Care, Our Say* (keeping patients out of hospital) are fully embedded.
- Emergency care practitioners treating emergency patients in situ have reduced the number of A&E admissions, saving over £35 million per year following their introduction in 2004.
- The trend of an increase in outpatient appointments of 2.6% per year has been reversed, saving over 1 million appointments and costs of over £100 million per year.
- Over 10 million patient appointments in GP surgeries were administered by nurse practitioners in the last year, freeing GPs to spend more time with patients suffering more urgent and complex illnesses.
- Improving medical techniques, technology and associated process redesign means that an increasing number of treatments are being carried out as day cases. Almost 73% of all planned procedures are now done in this way, reducing treatment costs by over £60 million in the last year and enabling more patients to go home earlier.
- NHS organisations are now provided with quarterly performance information on key measures of service efficiency. This enables them to benchmark their performance against similar providers and identify further potential opportunities for improvement. The metrics are supplemented by productivity guidance setting out the best practices associated with high efficiency performance. This benchmarking process has helped to deliver significant further gains in the year since their introduction.

2. Procurement

- A second wave of national procurement contracts for NHS supplies and services has increased savings from this programme to £340 million.

- By the end of 2007, procurement hubs will be established in all SHAs except London and South West SHAs, both of which have informal collaborative processes, prior to implementing formal hubs during 2008/09. Savings from hubs now exceed £150 million per year.
- The contract with DHL has been operational for one year. Following initial embedding of operations, we expect significant procurement savings over the next three years.
- We have achieved annual savings on generic prescribed drugs of £300 million in 2006 and an additional £300 million in 2007 through the annual negotiation of the pharmacy contract.

3. Shared services

- The Shared Services Joint Venture Company established in 2005 has over 100 NHS organisations contracted for financial services by April 2006. A payroll processing service is now operational. Additional organisations continue to be recruited.

4. Public funding and regulation

- Gross operating cost savings of over £230 million are now being reported by SHAs and PCTs following downsizing and restructuring of the sector in 2007. Although savings this year are offset by restructuring (mainly redundancy) costs, from March 2008 they will be net savings.
- Arm's-length body operating costs reduced by over £180 million in 2006/07 and are on track to deliver annual savings of £250 million from March 2008.

5. Social care

- Local councils with responsibility for social services have continued to deliver significant efficiency gains through their specific local efficiency programmes. In addition, the Care Services Efficiency Delivery Team is working closely with local councils, Government Offices for the Regions and the Association of Directors of Social Services to promote five major efficiency opportunities based on leading-edge practices.
- Delivery of these national initiatives, together with local specific opportunities, has resulted in £518 million of annual savings by the end of 2006/07. Councils are collectively forecasting annual savings by March 2008 of £745 million, £60 million more than were targeted in the Gershon programme.
- The established efficiency programme, including the five major initiatives, will continue to deliver further significant gains during the next Spending Review period from 2008/09.

Final forecast delivery

At quarter 2 2007/08, £6,432 million (99%) of the £6,470 million target has been achieved. Further savings will be reported until quarter 2 2008/09 to take account of data time lags for most projects.

The results of key efficiency initiatives, particularly in productive time and social care, together with the full year effect of the latest savings secured in generic prescribed drugs, mean that it is likely that final efficiency savings will be in the range of £7,000 million to £8,000 million, significantly in excess of the original target.

Major programmes in productive time, procurement and social care will continue to adapt and expand, and will underpin continued significant value for money gains over the next three years, enabling the NHS to maximise service and health outcomes within a tight budget settlement.

Reduced Civil Service headcount

The Department committed to a gross reduction of 1,400 full-time equivalent civil servant posts through its change programme launched in early 2003. This reduction was based on our budgeted headcount prior to the start of our change programme. Just under half (680) of the overall planned reduction came from planned transfers to other NHS bodies and 720 were from net reductions as defined in the Gershon target.

The change programme enabled a net headcount reduction of 700 to be achieved by March 2004. Headcount remained broadly constant over the next two years. Since 2006, reductions in central administration budgets across central government, and the requirement for further reductions over the next three years, have led to further permanent reductions in staffing levels. A voluntary exit scheme run in spring 2007 resulted in 52 leavers. As a result, net departmental headcount has reduced by 827 from its 2003 pre-Gershon level, exceeding the original target by more than 100.

Lyons relocations

The Department and its arm's-length bodies are committed to the relocation of 1,030 posts out of London and the South East by March 2010. (Eighty out of the original target of 1,110 have transferred to the Ministry of Justice which has assumed responsibility for the Mental Health Review Tribunal.)

By September 2007, 794 relocations had been completed. Between September 2006 and September 2007, main relocations comprised the General Social Care Council (28 posts to Rugby), NHS Professionals (27 posts to Wakefield) and the National Institute for Health and Clinical Excellence (58 posts to Manchester).

The Department has plans to relocate further posts from London to Leeds by 2010 as part of its accommodation strategy which will result in London staff being housed in only three main locations instead of the current five. Further relocations are pending from the General Social Care Council. Additional relocations will be secured from other agencies whose existing London leases are due for renewal. We therefore expect to meet our 1,030 target by March 2010.

Annex A

Departmental Public Service Agreement targets (SR2002) analysis

Targets 2, 3, 4 and part of 7 have been adopted into the SR2004 operating standards. Targets 5, 6, 8, 9, 10 and parts of 7 and 11 have been subsumed into SR2004 targets. Information on the remaining targets, 1, 12 and part of 11, is provided below.

Objective I: Improve service standards

PSA target	Measure	Progress
Target 1 Reduce the maximum wait for an outpatient appointment to three months and the maximum wait for inpatient treatment to six 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 three months by 2008.	**Number of patients waiting.**	**Outpatient waiting times – met** Number waiting more than three months (13 weeks) – quarterly figures: • September 2002 – 257,613; • September 2003 – 160,745; • October 2004 – 72,464; • October 2005 – 28,374; • October 2006 – 161; and • October 2007 – 93.*

* Of the 93, 41 were English residents waiting in Welsh hospitals.

PSA target	Measure	Progress
		Inpatient waiting times – met Number waiting more than six months – monthly figures: • October 2001 – 258,945; • October 2002 – 242,516; • October 2003 – 163,230; • October 2004 – 69,948; • October 2005 – 24,847; • October 2006 – 353; and • October 2007 – 18.* Number waiting more than three months: The extension of the inpatient stage of treatment target to a maximum of three months has been overtaken and rendered irrelevant by the referral to treatment target of 18 weeks.

*2 Of the 18, 2 were English residents waiting in Welsh hospitals.

Objective II: Improve health and social care outcomes for everyone

PSA target	Measure	Progress
Target 11 By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.	**Mortality in infancy by social class:** the gap in infant mortality between routine and manual groups and the population as a whole. **Life expectancy by local authority:** the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. Baseline year is average of 1997, 1998 and 1999.	**Infant mortality – see SR2004 PSA target 2** **Life expectancy at birth – slippage** For men, in the period 2004–06 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 1% higher than at the baseline period 1997–99, compared with 1% lower than at the baseline on revised data for the period 2003–05. For women, in the period 2004–06 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 11% higher than at the baseline period 1997–99, compared with 7% higher on revised data for the period 2003–05. (Figures for the period 2003–05 were revised to take into account revised population estimates for 2002–05 published by ONS in August 2007.) In addition, for health inequalities in life expectancy please see progress report under **SR2004 PSA target 2.**

Objective III: Improve value for money

PSA target	Measure	Progress
Target 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.	**Value for money based on unit costs of procedures and services**, adjusted for quality, underlying inflation and mix of cases. Service effectiveness element of target based on quality indicators published by the Department.	**Value for money – not known. This is final reporting for this target** The progress of this target cannot be assessed due to the lack of a measure which incorporates both cost effectiveness and service effectiveness. However, the cost efficiency improvements can be measured, and the latest figure for 2005/06 met the target of 1% annual improvement with an improvement of 1.2%.

Departmental Public Service Agreement targets (SR2000) analysis

The majority of SR2000 targets were subsumed within the SR2002 targets and details were given in previous performance reports. For the three targets that were not carried forward, final reporting took place in the *Autumn Performance Report 2003* and *Departmental Report 2007*. Responsibility for target 7 now lies with DCSF.

Departmental Public Service Agreement targets (CSR1998) analysis

Targets 1, 2, 5, 13 and 20 were subsumed into SR2002 targets. Final reporting took place in the *Autumn Performance Report 2003*, *Departmental Report 2004* and *Departmental Report 2007* with regard to the majority of the other targets. Information on those that remain live, targets 3 and 4, is given below.

Objective I: To reduce the incidence of avoidable illness, disease and injury in the population

PSA target	Measure	Progress
Target 3 Reduction in the death rate from accidents by at least 20% by 2010, from a baseline of 15.9 per 100,000 population for the three years 1995–97.	**Death rate from accidents.**	**Death rate from accidents – slippage** Data for the period 2004–06 show a rate of 15.9 deaths per 100,000 population – a rise of 1.0% from the baseline period 1995–97.

Table 11. Accidents: 1995–97 to 2004–06

	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Accident mortality rate per 100,000	15.8	15.9	16.0	15.9	15.9	15.9	15.9	15.9	16.0	15.9

PSA target	Measure	Progress
Target 4 Reduction in the rate of hospital admission for serious accidental injury by at least 10% by 2010, from a baseline estimate of 315.9 admissions per 100,000 population for the financial year 1995/96.	**Rate of hospital admission for serious accidental injury** requiring a hospital stay of four or more days.	**Rate of hospital admissions for serious accidental injury – slippage** These data are single financial year figures, available annually. Single year data for 2005/06 show a rate of 335.5 admissions per 100,000 population – an increase of 6.2% from the 1995/96 baseline estimate.

Table 12. Hospital admissions for serious accidental injury: 1995/96 to 2005/06

	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
Hospital admission rate for serious accidental injury per 100,000	315.9	319.3	314.3	319.1	324.9	313.4	312.7	327.9	330.1	332.5	335.5

Annex B
National Audit Office assessment of data quality

The NAO report on the quality of the data systems underlying PSAs, the *Fourth Validation Compendium Report*, examines the data systems used by 11 departments to monitor and report progress against their 2005–08 PSA targets. Overall results for Department of Health PSAs follow; analysis was undertaken in 2006.

Key

Rating	Meaning
Green (fit for purpose)	The data system is fit for the purpose of measuring and reporting performance against the target.
Green (disclosure)	The data system is appropriate for the target and the Department has fully explained the implications of limitations that cannot be cost-effectively controlled.
Amber (systems)	The data system is broadly fit for purpose, but needs strengthening to ensure that remaining risks are adequately controlled.
Amber (disclosure)	The data system is broadly appropriate, but includes limitations that cannot be cost-effectively controlled; the Department should explain the implications of these.
Red	The data system is not fit for the purpose of measuring and reporting performance against the target or will not be put in place within the PSA 2005–08 period.
White (not established)	The Department has not yet put in place a system to measure performance against the target.
White (too early to form a view)	The Department has established a system but it is too early to form a view on its fitness for purpose.

Departmental Public Service Agreement targets (SR2004)

Target		Rating
1	Substantially reduce mortality rates by 2010: • from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole; • from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and • from suicide and undetermined injury by at least 20%.	**Green (fit for purpose)**
2(a)	Reduce health inequalities by 10% by 2010 as measured by infant mortality.	**Green (fit for purpose)**
2(b)	Reduce life expectancy at birth.	**Green (fit for purpose)**
3	Tackle 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 the routine and manual group to 26% or less; • 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 (joint target with DCSF and DCMS); and • reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health (joint target with the DCSF).	**Green (disclosure)** **White (too early to form a view)** **Green (fit for purpose)**
4	Improve health outcomes for people with long-term conditions by: • offering a personalised care plan for vulnerable people most at risk; and • reducing emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.	**Red (not fit for purpose)** **Amber (disclosure)**
5	Ensure that by 2008 no one waits more than 18 weeks from GP referral to start of treatment unless it's clinically appropriate to do so or they choose to wait longer.	**Amber (systems)**
6	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year on year the proportion of drug users successfully sustaining or completing treatment programmes.	**Amber (systems)**

Target		Rating
7	Secure sustained national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.	**Amber (disclosure)**
8	Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by: • increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and • increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	**Amber (systems)** **Green (disclosure)**

Departmental operating standards

Target		Rating
1	A four-hour maximum wait in A&E from arrival to admission, transfer or discharge.	**Green (fit for purpose)**
2	Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.	**Amber (disclosure)**
3	Every hospital appointment booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meet their needs.	**Amber (disclosure)**
4	Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to: • crisis services; and • a comprehensive CAMHS.	**Amber (systems)** **Green (fit for purpose)**

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