Standards for Better Health

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Foreword from the Secretary of State

Patients have a right to take it as a given that every effort is made to ensure that their care and treatment is both safe and effective. We have already achieved a great deal with the spread of clinical governance throughout the NHS, the establishment of the National Institute of Clinical Excellence, and with the publication of National Service Frameworks. On the frontline, clinicians and managers have worked highly effectively and with dedication to create a modern, caring NHS which puts the needs of the public first.

Standards for Better Health has, at its heart, the development of safe high quality care as we continue to make progress in developing a modern National Health Service. We have made enormous progress with increasing capacity and ensuring that waiting times have fallen. The focus of NHS reform is now shifting to improving the quality of care patients receive. The NHS will develop into a health service rather than one that focuses primarily on sickness. There will be a sustained drive to reduce inequalities in health. There will be few national targets and greater scope for local organisations to tackle local priorities. We can now concentrate on delivering an NHS that is more qualitative and focused on what the public and patients want from a 21st century health system.

The standards will achieve two important things. First, they will set the foundations for a common high quality of health care throughout England. Second, they will clarify what the NHS can and should be reaching for in its ambitions, both for the public and for the people who work within it.

Improvements in the quality of care against these standards will be supported and rewarded by the Healthcare Commission's new assessment framework and by the assessments of the Commission for Social Care Inspection. The independent inspections will make sure that the incentive is there for continuing quality improvements.

I am confident that the new approach, building on the improvements we have achieved in the National Health Service and social care, will result in the development of a truly world class service with patients at the forefront.

John Reid
Secretary of State for Health

Introduction

1. This document was published formally as an integral part of *National Standards, Local Action* (July 2004) which set out the framework for all NHS organisations and social service authorities to use in planning over the next three financial years. It is made available in stand-alone for ease of reference and to reinforce the standards-driven approach to the NHS improvement programme.

2. *National Standards, Local Action*, the Health and Social Care Planning Framework 2005–08 set out priorities for the NHS and social care based on the Department's Public Service Agreement targets. In line with the standards-driven approach, there are fewer national targets in the Planning Framework, with a strong focus on health outcomes and patient experience, to give greater scope to address local priorities and targets and the flexibility for local flexibility and innovation.

3. From April 2005 there will be a new performance framework for the NHS and social care, driven by *Standards for Better Health,* which set out the level of quality all organisations providing NHS care will be expected to meet or aspire to across the NHS in England.

Why Standards?

4. The standards set out in this document have been developed with two principal objectives. First, they provide a common set of requirements applying across all health care organisations to ensure that health services are provided that are both safe and of an acceptable quality.

5. Second, they provide a framework for continuous improvement in the overall quality of care people receive. The framework ensures that the extra resources being directed to the NHS are used to help raise the level of performance measurably year-on-year.

6. The scope of the new quality programme which is emerging in the NHS is bold and broad-based. Underpinning this has been the concept of clinical governance – a unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect a change of culture in NHS organisations to one where:

> *"openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received."*
>
> (Sir Liam Donaldson, Chief Medical Officer)

Overall aims

7. *Standards for Better Health* sits at the heart of the new relationship between central Government and the NHS, under which it is the role of the Department of Health to set broad, overarching standards defining the Government's high level expectations of the health service. These should be comprehensive but at a level of detail that allows scope for local determination of what works best and for the new independent inspectorate to make judgments about what levels of performance are acceptable at any one time.

8. A strong underlying theme is the need to reduce the burden of unhelpful standards and guidance on the NHS over time. We are conscious of the large number of requirements that have (in the past) been set centrally, either directly from the Department itself or by its Arm's Length Bodies. Some of the Department's own standards are currently under review and the review of Arm's Length Bodies will provide an opportunity to rationalise either standards themselves or some of the reporting requirements that they currently impose. The development of the new high level standards set out here represents the first step toward simplifying and rationalising the expectations on the service. It also provides an excellent opportunity to reduce the burden of current requirements, although the process of doing so will necessarily take some time to evolve. While *Standards for Better Health* will synthesise a large number of existing rules and guidance, NHS bodies will continue to be subject to the wider regulatory framework, such as health and safety legislation.

9. The final but key aim of these standards is to underpin the delivery of high quality services which are fair, personal and responsive to patients' needs and wishes, which are provided equitably and which deliver improvements in the health and well-being of the population. This aim can only be achieved if these benefits are delivered to **all** groups within our society. The standards must therefore be interpreted and implemented in ways which:

- Challenge discrimination
- Promote equality of access and quality of services
- Support the provision of services appropriate to individual needs, preferences and choices
- Respect and protect human rights
- Further the NHS's reputation as a model employer
- Enable NHS organisations to contribute to economic success and community cohesion.

NHS Improvement Plan

10. The new standards reflect the direction set by the *NHS Improvement Plan*. In particular, the core standards will underpin patient choice by determining which health care organisations may provide care under the NHS.

11. Furthermore, the developmental standards describe the framework for quality improvement that have been taken forward in the *NHS Improvement Plan*. There is, in particular, a new focus on public health. These standards, in line with the *NHS Improvement Plan*, stress the importance of reducing inequalities and of organisations working together to provide a whole systems approach to care, tailor made for the individual patient. Raising standards in this way will deliver more personalised care and ensure that all patients, including those from disadvantaged groups, are able to benefit.

Taxonomy

12. A key element in simplifying and rationalising the approach to standards setting will be the adoption of a common framework for all matters related to performance and a common language so that terms such as "standards" have a clearly understood, shared meaning. It is our clear intention that the domain structure set out in this document should become the common framework, not only for standards set by the Department and for the inspection process itself, but also for the whole performance agenda whether national or local.

13. From now on, the Department of Health will define the most frequently used terms in the following way:

Standards

Standards are a means of describing the level of quality that health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.

Quality Requirements

Quality requirements will be established through the National Service Frameworks. They describe the care which clinicians and others will use to guide their practice.

Criteria

Criteria are ways of demonstrating compliance with, and performance relevant to, a standard. They establish specific, objective expectations, drawing on such evidence and indicators as the Healthcare Commission may establish.

Targets

Targets refer to a defined level of performance that is being aimed for, often with a numerical and time dimension. The purpose of a target is to incentivise improvement in the specific area covered by the target over a particular timeframe.

Benchmarks

Benchmarks are used as comparators to compare performance between similar organisations or systems.

Who the standards are for

14. The standards themselves will be taken into account by those providing NHS care directly, no matter what the setting, those managing the health service, those commissioning health care and, most importantly, for the general public.

15. The standards apply to the provision of all NHS services in the full variety of settings, including NHS Foundation Trusts, and the voluntary and private sectors insofar as they provide care to NHS patients.

16. They are also for the Healthcare Commission who have responsibility for assessing the quality of health and health care provided in England. The Commission's role is set out more fully below.

Response to consultation

17. The standards published here were subject to a full twelve-week public consultation. A summary of the main points made in response to the consultation will be available on the DH website – www.dh.gov.uk

How the standards framework is structured

18. The standards set out in this document are organised within seven "domains", which are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The domains encompass all facets of health care, including prevention, and are described in terms of outcomes. The seven domains are:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus

- Accessible and Responsive Care
- Care Environment and Amenities
- Public Health

Outcomes for each domain are specified.

19. Within these domains there are two types of standards, core and developmental.

Core standards

20. The core standards do not of themselves set out new expectations of the NHS, but are based on a number of standards or requirements that already exist. They describe a level of service which is acceptable and which must be universal. **Meeting the core standards is not optional. Health care organisations must comply with them from the date of publication of this document.**

Developmental standards

21. Service provision which only meets the core standards will be no more than acceptable at the date of publication of this document. The focus of attention, both on the part of the Healthcare Commission in its annual reviews and on Trusts themselves, will be on progress against the developmental standards. These are broad-based and comprehensive in their scope and are framed so as to provide a dynamic force for continuous improvement over time. Through the annual review process they will enable health care organisations themselves, health care professionals and, most importantly, the public to see progress made year-on-year.

22. The developmental standards are designed for a world in which patients' expectations are increasing. The levels of investment now being made in the NHS make achievements against these standards realistic. Progress is expected to be made against the developmental standards across much of the NHS as a result of the *NHS Improvement Plan* and the extra investment in the period to 2008. **The Healthcare Commission will, through its criteria for review, assess progress by health care organisations towards achieving the developmental standards.**

23. The core standards will therefore serve a platform or "bottom rung" for progress against the developmental ladder. They serve as a marker for where the service is now. They also serve to assure the public that all services, wherever provided, will be safe and of an acceptable quality.

National Service Frameworks and NICE Guidance

24. National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance are integral to a standards-based system. They have a key role in supporting local improvements in service quality. Organisations' performance will be assessed not just on how they do on national targets but increasingly on whether they are delivering high quality standards across a range of areas, including NSFs and NICE guidance.

25. We will continue to develop NSFs and other national strategies where these are needed[1]. There are forthcoming NSFs for children, renal services and long-term conditions, and a national strategy on sexual health. NSFs should be considered as part of the developmental standards. Over the course of the

1 There are already NSFs on coronary heart disease, diabetes, mental health, older people's services and paediatric intensive care, as well as the NHS Cancer Plan, the national strategy for sexual health and HIV, and a major programme of work to implement recommendations from the Shipman inquiry.

three-year planning period for the Planning Framework, the NHS together with Local Authorities will need to be able to demonstrate that they are making progress towards achieving the levels of service quality described in the NSFs and national strategies. Both the Healthcare Commission and CSCI will undertake thematic reviews of progress, jointly where appropriate.

26. In the consultation document we indicated that the development of comprehensive standards would provide an overarching framework in which the performance management, monitoring and assessment system would operate. The proposal to present an integrated approach to the performance regime received very strong support in the responses to the consultation. The new standards framework set out in this document now establishes the parameters for:

- The standards themselves;
- The independent inspection regime;
- Existing, new and future targets; and
- Performance ratings.

27. The Healthcare Commission will develop criteria to assess performance related to each of the standards, which will contribute to performance ratings. The Commission intends to consult on its proposed criteria later in 2004.

The inspection function

28. As well as establishing the power for the Secretary of State for Health to set standards, the Health and Social Care (Community Health and Standards) Act 2003 also established the Healthcare Commission and set out its functions. These include undertaking an annual review of the provision of health care by (and for) each NHS body in England, including Foundation Trusts. Its judgements will be based on criteria, which it is charged with developing and which have to be agreed with the Secretary of State. These criteria have to take account of the standards set out in this document.

29. In undertaking its reviews, the Commission will focus on achievement against the developmental standards. However, it will also need to be satisfied that all trusts are meeting the core standards. The Commission will be responsible for determining *how* it assesses core performance, although the process will need to take account of targets that the Department has set and which are now assumed to be achieved. For this reason, we are including one core standard (C7 f) that cross refers to a number of existing requirements (as listed in Apppendix 1 to these standards) which are currently being met and must continue to be met.

30. The outcome of the Healthcare Commission's review will therefore enable the public to identify progress against the standards by individual organisations. The reviews will also help to determine which Trusts are to be considered for Foundation Trust status. If, exceptionally, a Trust fails to satisfy the Commission that it meets the core standards, then consideration will need to be given to how performance should be improved. In such cases, it will normally be for the Trust to develop proposals for improvement in negotiation with its Strategic Health Authority. Exceptionally, the legislation gives powers to the Commission to recommend to the Secretary of State, or in the case of Foundation Trusts the Independent Regulator, that they take special measures in relation to any significant failings. It should be noted that the Independent Regulator has additional powers to intervene in the case of Foundation Trusts which are failing to discharge their responsibilities in other ways

First Domain – Safety

Domain Outcome

Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard

C1 Health care organisations protect patients through systems that

a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and

b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.

C2 Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.

C3 Health care organisations protect patients by following NICE Interventional Procedures guidance.

C4 Health care organisations keep patients, staff and visitors safe by having systems to ensure that

a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;

b) all risks associated with the acquisition and use of medical devices are minimised;

c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;

d) medicines are handled safely and securely; and

e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Related Developmental Standard: **D1**

Developmental standard

D1 Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.

Second Domain – Clinical and Cost Effectiveness

Domain Outcome

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

Core standards

Related Developmental Standard: **D2**

C5 Health care organisations ensure that

a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;

b) clinical care and treatment are carried out under supervision and leadership;

c) clinicians continuously update skills and techniques relevant to their clinical work; and

d) clinicians participate in regular clinical audit and reviews of clinical services.

C6 Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Developmental standard

D2 Patients receive effective treatment and care that:

a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;

b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences;

c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and

d) is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

Third Domain – Governance

Domain Outcome

Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.

Core standards

C7 Health care organisations

a) apply the principles of sound clinical and corporate governance;

b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;

c) undertake systematic risk assessment and risk management (including compliance with the controls assurance standards);

d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;

e) challenge discrimination, promote equality and respect human rights; and

f) meet the existing performance requirements set out in the annex.

Related Developmental Standard: **D3**

C8 Health care organisations support their staff through

a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and

b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

Related Developmental Standard: **D7**

C9 Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Related Developmental Standard: **D6**

C10 Health care organisations

a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and

b) require that all employed professionals abide by relevant published codes of professional practice.

Related Developmental Standard: **D7**

C11 Health care organisations ensure that staff concerned with all aspects of the provision of health care

a) are appropriately recruited, trained and qualified for the work they undertake;

b) participate in mandatory training programmes; and

c) participate in further professional and occupational development commensurate with their work throughout their working lives.

C12 Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

Related Developmental Standard: **D3**

Developmental standards

D3 Integrated governance arrangements representing best practice are in place in all health care organisations and across all health communities and clinical networks.

D4 Health care organisations work together to

a) ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service;

b) implement a cycle of continuous quality improvement; and

c) ensure effective clinical and managerial leadership and accountability.

D5 Health care organisations work together and with social care organisations to meet the changing health needs of their population by

a) having an appropriately constituted workforce with appropriate skill mix across the community; and

b) ensuring the continuous improvement of services through better ways of working.

D6 Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.

D7 Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

Fourth Domain – Patient Focus

Domain Outcome

Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core standards

C13 Health care organisations have systems in place to ensure that

a) staff treat patients, their relatives and carers with dignity and respect;

b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and

c) staff treat patient information confidentially, except where authorised by legislation to the contrary.

C14 Health care organisations have systems in place to ensure that patients, their relatives and carers

a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;

b) are not discriminated against when complaints are made; and

c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Related Developmental Standard: **D8**

C15 Where food is provided, health care organisations have systems in place to ensure that

a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and

b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

C16 Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

Related Developmental Standard: **D9**

Developmental standards

D8 Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.

D9 Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are

a) encouraged to express their preferences; and

b) supported to make choices and shared decisions about their own health care.

D10 Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.

Fifth Domain – Accessible and Responsive Care

Domain Outcome

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core standards

Related Developmental Standard: **D11**

C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

C18 Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

C19 Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Developmental standard

D11 Health care organisations plan and deliver health care which

a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice;

b) maximises patient choice;

c) ensures access (including equality of access) to services through a range of providers and routes of access; and

d) uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

Sixth Domain – Care Environment and Amenities

Domain Outcome

Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standards

Related Developmental Standard: **D12**

C20 Health care services are provided in environments which promote effective care and optimise health outcomes by being

a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and

b) supportive of patient privacy and confidentiality.

C21 Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Developmental standard

D12 Health care is provided in well-designed environments that

a) promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and

b) are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections.

Seventh Domain – Public Health

Domain Outcome

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standards

C22 Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by

a) co-operating with each other and with local authorities and other organisations;

b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and

c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

Related Developmental Standard: **D13**

C23 Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Related Developmental Standard: **D13**

C24 Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

Developmental standard

D13 Health care organisations

a) identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role;

b) implement effective programmes to improve health and reduce health inequalities;

c) protect their populations from identified current and new hazards to health; and

d) take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

Appendix 1: Existing commitments to be maintained

Commitments due to be achieved before March 2005

- Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge.
- Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.
- All ambulance trusts to respond to 75% of Category A calls within 8 minutes.
- All ambulance trusts to respond to 95% of Category A calls within 14 (urban)/19(rural) minutes.
- All ambulance trusts to respond to 95% of Category B calls within 14 (urban)/19(rural) minutes.
- Maintain a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.
- Maintain a maximum two-week wait standard for Rapid Access Chest Pain Clinics.
- 3 month maximum wait for revascularisation by March 2005.
- From April 2002 all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days or fund the patient's treatment at the time and hospital of the patient's choice.

Note: The underlying definitions for these standards – and the split between rural and urban services – will be clarified later in 2004, as part of the current ambulance review.

Commitments due to be achieved after March 2005

- Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005, and a comprehensive Child and Adolescent Mental Health service by 2006.
- Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four to five different health care providers for planned hospital care, paid for by the NHS.
- Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005.
- Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005.
- 800,000 smokers from all groups successfully quitting at the 4-week stage by 2006.
- 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.
- A minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy by 2006, and 100% by 2007.
- Achieve a maximum wait of 3 months for an outpatient appointment by December 2005.
- Achieve a maximum wait of 6 months for inpatients by December 2005.
- 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.
- Delayed transfers of care to reduce to a minimal level by 2006.

Appendix 2: Glossary

Access:	the extent to which people are able to receive the information, services or care they need.
CHAI:	The Commission for Healthcare Audit and Inspection was established by the Health and Social Care (Community Health and Standards) Act 2003 and is now known as the Healthcare Commission.
CHI:	The Commission for Health Improvement was, until April 2004, the independent, inspection body for the NHS. Its functions were transferred to the Healthcare Commission.
Clinical audit:	a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in health care delivery.
Clinical governance:	a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.
Clinical network:	connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience.
Clinician:	professionally qualified staff providing clinical care to patients.
Controls assurance standards:	standards covering buildings, land, plant and non-medical equipment; catering and food hygiene; decontamination of re-usable medical devices; emergency planning; environmental management; financial management; fire safety; fleet and transport management; governance; health and safety management; human resources; infection control; information management and technology; management of purchasing and supply; medical devices management; medicines management; professional conduct and liability; records management; risk management; security management and waste management. Full details can be found on http://www.hcsu.org.uk
Crime and disorder reduction partnerships:	partnerships between the police, Local Authorities, probation service, health authorities, the voluntary sector, and local residents and businesses which work to reduce crime and disorder in their area.
Criteria:	criteria devised and published by the Healthcare Commission, and approved by the Secretary of State, with reference to which the Healthcare Commission must, each financial year, conduct a review of the provision of health care by and for each English NHS body, and each cross-border SHA.
Cross-border SHA:	a special health authority performing functions in respect of both England and Wales.

English NHS body: a Primary Care Trust, Strategic Health Authority or NHS Trust, all or most of whose hospitals, establishments and facilities are situated in England, or an NHS Foundation Trust or special health authority performing functions only or mainly in respect of England.

Foundation Trust: a public benefit corporation established by the Health and Social Care (Community Health and Standards) Act 2003 which is authorised to provide goods and services for the purpose of the health service.

Governance: a mechanism to provide accountability for the way an organisation manages itself.

Healthcare Commission: established in April 2004 as the independent body encompassing the work of the Commission for Health Improvement (CHI). It will inspect health care provision in accordance with national standards and other service priorities and will report directly to Parliament on the state of health care in England and Wales.

Health care organisation: English NHS bodies, cross-border SHAs and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients and the public.

Health care professional: a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Health care: services provided for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

Health care associated infection: all infections acquired as a direct or indirect result of health care.

Health inequalities: differences in people's health between geographical areas and between different groups of people.

Health promotion: includes the provision of information on healthier lifestyles for patients, and how to make the best use of health services, with the intention of enabling people to make rational health choices and of ensuring awareness of the factors determining the health of the community.

Local Strategic Partnerships: non-statutory bodies intended to bring together the public, private, voluntary and community sectors at a local level. Their purpose is to improve the delivery of services and quality of life locally.

Medical devices: all products, except medicines, used in health care for diagnosis, prevention, monitoring or treatment. The range of products is very wide: it includes contact lenses and condoms; heart valves and hospital beds; resuscitators and radiotherapy machines; surgical instruments and syringes; wheelchairs and walking frames.

National Service Frameworks:

NSFs

- set national standards and identify key interventions for a defined service or care group;
- put in place strategies to support implementation; and
- establish ways to ensure progress within an agreed timescale.

The NSFs published to date cover:

- mental health
- cancer
- coronary heart disease
- older people
- diabetes

NSFs on children, renal services and long-term conditions (focusing on neurological conditions) are in preparation.

NICE:

the National Institute for Clinical Excellence is a special health authority for England and Wales. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

NICE guidance:

guidance covering three areas of health:

- **Clinical guidelines** cover the appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales.
- **Technology appraisals** cover the use of new and existing medicines and treatments within the NHS in England and Wales.
- **Interventional procedures** cover the safety and efficacy of interventional procedures used for diagnosis or treatment.

Patient:

those in receipt of health care provided by or for an English NHS body or cross-border SHA.

Primary care:

first-contact health services directly accessible to the public.

Primary Care Trust:

a local health organisation responsible for managing local health services. PCTs work with Local Authorities and other agencies that provide health and social care locally to make sure the community's needs are being met.

Public health:

Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. Public health functions include:

- Health surveillance, monitoring and analysis
- Investigation of disease outbreaks, epidemics and risk to health
- Establishing, designing and managing health promotion and disease prevention programmes
- Enabling and empowering communities to promote health and reduce inequalities
- Creating and sustaining cross-Government and inter-sectoral partnerships to improve health and reduce inequalities
- Ensuring compliance with regulations and laws to protect and promote health
- Developing and maintaining a well educated and trained, multi-disciplinary public health workforce
- Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities
- Research, development, evaluation and innovation

- Quality assuring the public health function

Public Service Agreement: The PSA for the Department of Health sets out the priorities for the Department's spending programme and, for each priority, the target(s) it is expected to achieve.

Quality assurance: a systematic process of verifying that a product or service being developed is meeting specified requirements.

Research governance framework: defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards and applies to all research undertaken within the remit of the Secretary of State for Health.

Risk management: covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

Service user: an individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

Star rating: the Healthcare Commission's performance ratings system places NHS Trusts in England into one of four categories:

- Trusts with the highest levels of performance are awarded a performance rating of three stars
- Trusts that are performing well overall, but have not quite reached the same consistently high standards, are awarded a performance rating of two stars
- Trusts where there is some cause for concern regarding particular areas of performance are awarded a performance rating of one star
- Trusts that have shown the poorest levels of performance against the indicators or little progress in implementing clinical governance are awarded a performance rating of zero stars.

Strategic Health Authority: responsible for:

- developing plans for improving health services in its local area;
- making sure local health services are of a high quality and are performing well;
- increasing the capacity of local health services so they can provide more services; and
- making sure national priorities are integrated into local health service plans.

Systematic risk assessment: a systematic approach to the identification and assessment of risks using explicit risk management techniques.

Appendix 3: Extracts from the Health and Social Care (Community Health and Standards) Act 2003

The "Duty of Quality":

45 Quality in health care

(1) It is the duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.

(2) In this Part "health care" means-

(a) services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

(b) the promotion and protection of public health.

(3) In subsection (2)(a), "illness" has the meaning given by section 128(1) of the 1977 Act.

The Power for the Secretary of State to prepare and publish standards, and the duty of upon every English NHS body and cross-border SHA to take account of the standards:

46 Standards set by Secretary of State

(1) The Secretary of State may prepare and publish statements of standards in relation to the provision of health care by and for English NHS bodies and cross-border SHAs.

(2) The Secretary of State must keep the standards under review and may publish amended statements whenever he considers it appropriate.

(3) The Secretary of State must consult such persons as he considers appropriate-

(a) before publishing a statement under this section;

(b) before publishing an amended statement under this section which in the opinion of the Secretary of State effects a substantial change in the standards.

(4) The standards set out in statements under this section are to be taken into account by every English NHS body and cross-border SHA in discharging its duty under section 45.

CHAI's annual reviews, reviews and investigations, their use of set criteria and the requirement upon CHAI to take into account the standards:

50 Annual reviews

(1) In each financial year the CHAI must conduct a review of the provision of health care by and for-

(a) each English NHS body, and

(b) each cross-border SHA,

and must award a performance rating to each such body.

(2) The CHAI is to exercise its function under subsection (1) by reference to criteria from time to time devised by it and approved by the Secretary of State.

(3) The CHAI must publish the criteria devised and approved from time to time under subsection (2).

(4) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

51 Reviews: England and Wales

(1) The CHAI has the function of conducting reviews of-

(a) the overall provision of health care by and for NHS bodies;

(b) the overall provision of particular kinds of health care by and for NHS bodies;

(c) the provision of health care, or a particular kind of health care, by and for NHS bodies of a particular description.

(2) If the Secretary of State so requests, the CHAI must conduct-

(a) a review under subsection (1)(a);

(b) a review under subsection (1)(b) of the overall provision of a kind of health care specified in the request; or

(c) a review under subsection (1)(c) of the provision of health care, or health care of a kind specified in the request, by or for NHS bodies of a description so specified.

(3) The Secretary of State must consult the Assembly before making a request under subsection (2).

(4) In conducting a review under this section in relation to any health care the CHAI must take into account-

(a) the standards set out in statements published under section 46, where the health care is provided by or for an English NHS body or cross-border SHA;

(b) the standards set out in statements published under section 47, where the health care is provided by or for a Welsh NHS body.

52 Reviews and investigations: England

(1) The CHAI has the function of conducting other reviews of, and investigations into, the provision of health care by and for English NHS bodies and cross-border SHAs.

(2) The CHAI may in particular under this section conduct-

(a) a review of the overall provision of health care by and for English NHS bodies and cross-border SHAs;

(b) a review of the overall provision of a particular kind of health care by and for English NHS bodies and cross-border SHAs;

(c) a review of, or investigation into, the provision of any health care by or for a particular English NHS body or cross-border SHA.

(3) The CHAI has the function of conducting reviews of the arrangements made by English NHS bodies and cross-border SHAs for the purpose of discharging their duty under section 45.

(4) If the Secretary of State so requests, the CHAI must conduct-

(a) a review under subsection (2)(a);

(b) a review under subsection (2)(b) of the overall provision of a kind of health care specified in the request;

(c) a review or investigation under subsection (2)(c), or a review under subsection (3), in relation to the provision of such health care by or for such body as may be specified in the request.

(5) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.