Performance Indicators for Assessment 2005/2006

National target indicators for primary care trusts

As part of the Healthcare Commission’s annual health check, we will be assessing primary care trusts (PCTs) against all of the national targets (as described in National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 – 2007/2008, published by the Department of Health in July 2004) using the following 28 indicators:

1. Access to contraception
2. Access to GUM clinics
3. Access to termination of pregnancy services
4. Blood pressure
5. Breast cancer screening for women aged 50 to 70 years
6. Cancer - Implementation of NICE Improving Outcomes Guidance (IOGs)
7. Cancer mortality rate
8. Cardiovascular disease mortality
9. Cholesterol levels
10. Commissioning of assertive outreach services
11. Community equipment
12. Community matrons
13. CPA seven day follow up
14. Diabetes: Management of blood sugar
15. Drug misusers sustained in treatment
16. Emergency bed days
17. GP recording of BMI status
18. Infant Mortality: Breastfeeding initiation rates
19. Infant Mortality: Smoking during pregnancy
20. Infection control
21. Number of drug misusers in treatment
22. Number of very high intensity users
23. Patient experience
24. Patients with coronary heart disease, diabetes or stroke who smoke, offered smoking cessation advice
25. Practice-based registers
26. Smoking status amongst the population aged 15 to 75 years
27. Teenage conception rates
28. Waiting times for MRI and CT scans
Performance Indicators for Assessment 2005/2006

Access to contraception

Target:
Reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.

Rationale:
The accessibility and range of contraceptive services available vary widely across the country. While general practice provides a considerable proportion of contraceptive care, about 1.2 million women attended community family planning clinics in 2003/2004. Of these attendees, 370,000 were teenagers and the provision of accessible and appropriate services for this age group is an important component of the National Teenage Pregnancy Strategy. Peak age for attendance at clinics is 16-17. Reducing unintended pregnancy rates is a key aim of the Sexual Health and HIV Strategy and specialist family planning services play a key role in achieving this. Although the majority of attenders at clinics are aged 24 and under access for women of all ages is important.

It is also important that these services offer the full range of contraceptive methods that are available so that the most appropriate methods can be chosen according to individual circumstances. The proportion of women choosing the intra uterine device (IUD), intra uterine system (IUS) and implant gives an indicator of the range of methods provided by each service. In addition, insertion and removal of IUDS and IUSs is a national enhanced service within the new general medical services (GMS) contract and many areas have adopted fitting and removal of implants as a locally enhanced service. PCTs should therefore consider GP activity in terms of uptake of these methods in conjunction with KT31 Returns.

Data source and period
DH prescription data (Financial year 2004/2005)
ONS (Calendar years 1998 and 2004)
KT31 returns (Financial year 2005/2006)
Performance Indicators for Assessment 2005/2006

Access to GUM clinics

**Target:**
Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.

**Rationale:**
Annual numbers of STIs diagnosed in GUM clinics in England rose by 43% between 1996 and 2002, with an overall increase in clinic workload of 79% for the same period. The White Paper, *Choosing Health*, included a number of commitments, including improved access to GUM clinics, and efficient and convenient screening services.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

**Data source and period**
New data collection
PCT Local Delivery Plans (2005/2006)
Access to termination of pregnancy services

Target:
Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.

Rationale:
The earlier in pregnancy an abortion is performed the lower the risk of complications. If women can access services before they are nine weeks pregnant, they can have a choice of an early medical or surgical abortion – medical abortion avoids the need for anaesthesia and surgery. The sexual health and HIV strategy highlighted that there are wide variations in access to NHS abortion services and the methods available, and that there is evidence that women who choose to seek an abortion can wait up to four or five weeks in some areas of the country. The strategy’s implementation action plan set a national standard that women who meet the legal requirements should have access to an abortion within three weeks of the first appointment with the referring doctor.

The Department of Health allocated pump-priming funding in 2003/2004 to those PCTs where 40% or more of NHS funded abortions were performed at ten weeks gestation or later. This funding was to improve access to abortion services and to help these PCTs achieve the recommended national standard.

Data source and period
DH abortions database (Calendar year 2005)
**Performance Indicators for Assessment 2005/2006**

**Blood pressure**

**Target:**
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.

**Rationale:**
High blood pressure is a risk factor for heart disease and for stroke. Effective treatment for high blood pressure is primarily drug therapy, supported by lifestyle approaches including diet and exercise. Management of blood pressure through drug treatment will save lives and represents a more effective use of NHS resource (such as reducing unnecessary hospitalisation). At present we know there is significant room for improvement: this indicator would give added impetus to this process. It also has the potential to tackle health inequalities and obesity.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

**Data source and period**
QMAS/QPID (As at 31st March 2006)
PCT Local Delivery Plans (March 2005/2006)
Performance Indicators for Assessment 2005/2006

Breast cancer screening for women aged 50 to 70 years

**Target:**
Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

**Rationale:**
The International Agency for Research on Cancer (IARC) of the World Health Organisation (WHO) evaluated the evidence on breast cancer screening in March 2002. IARC concluded that trials have provided sufficient evidence for the efficacy of mammography screening of women between 50 and 70 years, and that the reduction in mortality from breast cancer among women who choose to participate in screening programmes was estimated to be about 35%.

Around 127,000 people die from cancer each year, of whom 63,000 are aged under 75. In 2003/2004, over 1.4 million women were screened for breast cancer in England, and over 11,200 cancers were detected. Latest available research shows that breast cancer mortality fell by over 21% between 1990 and 1998. A third of this fall is attributed to breast screening (Blanks et al, BMJ, September 2000).

**Data source and period**
Performance Indicators for Assessment 2005/2006
Cancer - Implementation of NICE improving outcomes guidance (IOGs)

Target:
Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

Rationale:
The establishment of multidisciplinary teams (MDTs) is a useful proxy for the implementation of NICE guidance as a whole as IOGs are centred on the establishment of designated specialist MDTs.

MDT working is vital for the improvement of outcomes for cancer patients. MDTs lead to improved communication between the professionals involved and as a result patients managed by an MDT are more likely to:

• be offered a range of effective interventions rather than investigations and treatments determined by an individual doctor's specialisation
• receive better coordination and continuity of care through all stages of their disease
• be treated in accordance with locally-agreed protocols and clinical guidelines
• be offered appropriate and consistent information
• have psycho-social as well as clinical issues considered thus improving the overall experience of care

In addition:

• staff working in MDTs are likely to develop higher levels of knowledge, skills, expertise and experience thus ensuring higher quality diagnosis, treatment and care for cancer patients
• establishment of MDTs tends to reduce the variation in management and outcomes around the country and in particular avoid individual 'outliers' who may provide sub optimal care.

We have a limited number of ways of ensuring that we achieve a reduction in mortality and improving treatment is one of the main ways. IOGs are the main driver for improving the treatment cancer patients receive. Implementing IOGs (and the establishment of MDTs as part of that) will play a key role in delivering the PSA target to reduce cancer mortality and reduce inequalities by 2010.

We will assess PCT performance against the multidisciplinary team line in the strategic health authority’s local delivery plans that are based on the cancer network improving outcomes guidance action plan.

This will be assessed at the cancer network level, with all PCTs in the network being scored the same.

Data source and period
New data collection
Cancer network IOG action plans
Performance Indicators for Assessment 2005/2006

Cancer mortality rate

Target:
Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

Rationale:
Cancer is one of the biggest killers in Britain. One in three people will be diagnosed with cancer in their lifetime and one person in four will die from cancer. The total number of new cases is increasing by 1.4% per annum. Around 130,000 people die from cancer every year of whom 65,000 are aged under 75. Cancer incidence and mortality rates are higher in socially disadvantaged areas and groups.

The White Paper on improving health, Choosing Health, recognises that taking effective action to tackle health inequalities is a top priority and one that will be very challenging.

All PCTs experience health inequalities in their population. PCTs should be addressing these inequalities through their service planning. The Government has given a commitment to faster improvement on life expectancy, cancer, cardiovascular disease, stroke and related diseases in the fifth of areas with the worst health and deprivation indicators. This target also supports each of the new public service agreement (PSA) targets on inequality in life expectancy.

We will assess PCT mortality rate per 100,000 (directly age standardised) population from cancer in people aged under 75 against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
PCT local delivery plans (Calendar Year 2005)
ONS (Calendar years 2003, 2004, 2005)
Performance Indicators for Assessment 2005/2006

Cardiovascular disease mortality

Target:
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.

Rationale:
Cardiovascular disease is the biggest cause of preventable death in England; 300,000 people have a heart attack each year and hundreds of thousands of people are living with angina or heart failure, and thousands die or experience severe disability due to stroke. These diseases are also a major clinical cause of health inequality. England has higher rates of the disease relative to comparable countries and, with cancer, is one of the government’s top priorities for health. Coronary Heart Disease (CHD) alone is estimated to cost the UK more than £7 billion each year.

All PCTs experience health inequalities in their population. PCTs should be addressing these inequalities through their service planning. The Government has given a commitment to faster improvement on life expectancy, cancer, cardiovascular disease, stroke and related diseases in the fifth of areas with the worst health and deprivation indicators. This target also supports each of the new PSA targets on inequality in life expectancy.

We will assess PCT mortality rate from heart disease, stroke and related diseases in people aged under 75 against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
ONS (Calendar Years 2003, 2004, 2005)
PCT local delivery plans (Calendar year 2005)
**Performance Indicators for Assessment 2005/2006**

**Cholesterol levels**

**Target:**
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.

**Rationale:**
High cholesterol is a risk factor for heart disease. Effective treatment, which includes diet and exercise, but will primarily be statin therapy, is available and increasingly well used. Optimum use will save lives and represent a more effective use of NHS resource, such as avoiding unnecessary hospitalisation. It also has the potential to tackle health inequalities and obesity.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

**Data source and period**
- QMAS/QPID (As at March 31st 2006)
- PCT Local Delivery Plans (March 2005/2006)
Performance Indicators for Assessment 2005/2006
Commissioning of assertive outreach services

Target:
Substantially reduce mortality rates by 2010 (from the Our Healthier Nation baseline, 1995-1997) from suicide and undetermined injury by at least 20%.

Rationale:
The priorities and planning framework sets out the national target of delivering assertive outreach to 20,000 people by December 2003.

As set out in standard four of the mental health national service framework, assertive outreach services should be in place for all individuals who may fail to take their prescribed medication and would then be at risk of depression, severe mental illness or suicide; for those who have a tendency to drop out of contact with services; and for those who are not well engaged with services.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
PCT local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

Community equipment

Target:
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

Rationale:
Equipment plays a vital role in enabling disabled people of all ages to maintain health and independence, and preventing inappropriate hospital admissions. Improving the service has links with both the National Service Framework for Older People and with Valuing People, the strategy for services for people with learning disabilities. The priorities and planning framework 2003/2006 stated that by December 2004 all community equipment for older people (aids and minor adaptations) would be provided within seven working days.

The Healthcare Commission is committed to work with the Commission for Social care Inspection (CSCI) over the next six months to agree new proposal for shared indicators of improvement which directly support the focus to support older people to live at home. We will expect to apply these new indicators from 2006/2007.

Data source and period
New data collection
Performance Indicators for Assessment 2005/2006

Community matrons

Target:
To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline) through improved care in primary care and community settings for people with long-term conditions.

Rationale:
Patients with complex long-term conditions who are not managed effectively in a primary and secondary care setting are more likely to become frequent unscheduled users of secondary care services. By managing this cohort of patients effectively, PCTs can contribute to reducing the number emergency bed days that this patient group will use.

The initial focus of the long-term conditions strategy is on proactive case management of Very High Intensity Users (VHIUs). There is a need to build upon the existing good practice of care for patients with long-term conditions. We would expect whole health systems to work together to deliver a more systematic care planning approach to better benefit all patients with a long-term conditions.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
PCT local delivery plans (2005/2006)
New data collection
Performance Indicators for Assessment 2005/2006

Care programme approach (CPA) seven day follow up

Target:
Substantially reduce mortality rates by 2010 (from the Our Healthier Nation baseline, 1995-1997) from suicide and undetermined injury by at least 20%.

Rationale:
Reductions in the overall rate of death by suicide will be supported by arrangements for securing provision by PCTs of appropriate care for all those with mental ill health. This includes action to reduce risk and social exclusion and improve care pathways, it includes action to follow up quickly all those on enhanced CPA who are discharged from a spell of inpatient care. Guidance to support best practice, including the mental health national service framework and NHS Plan is available to support local planning and service delivery. Measures by mental health services to achieve a reduced risk of suicide are also set out in the National Suicide Prevention Strategy for England and Preventing suicide: A toolkit for Mental health services.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
CPA records through MHMDS (Calendar Year 2005)
PCT local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

Diabetes: Management of blood sugar

Target:
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.

Rationale:
Type 2 diabetes (this is the commonest type and has increasing prevalence) is a complex disorder, where blood sugar abnormalities are only one component of a ‘metabolic syndrome’ in which vascular disease (large vessel disease) is prominent and the main cause of death. Blood sugar levels (HbA1c) are a proxy for good systematic care of diabetes as a whole.

Data source and period
QMAS/QPID (As at March 31st 2006)
Drug misusers sustained in treatment

Target:
Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

Rationale:
Measuring the percentage of drug misusers discharged during the financial year, who were retained in treatment for 12 weeks or more, focuses on the effectiveness of the local treatment system in engaging drug users and minimising early drop out.

Evidence suggests that retention during the first 12 weeks significantly improves treatment outcome and is likely to impact on treatment retention and successful completion. At this point retention can only be measured by episodes in individual services. In future years it is anticipated that treatment effectiveness will be measured as a care pathway across services.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
NDTMS (NTA) (Financial year 2005/2006)
PCT local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

Emergency bed days

Target:
To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.

Rationale:
The provision of proactive and co-ordinated care in primary and community settings for the most at risk people should help to maintain their health and avoid unnecessary use of acute inpatient hospital services.

The focus of the long term conditions strategy is on proactive case management for very high intensity users (VHIUs). Whole health systems should work together to deliver more systematic care planning to better benefit all patients with long term conditions.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Hospital episode statistics (HES) data will be changing to financial year in 2006/2007.

Note, the HES calendar year 2005 file may be compiled from the January to March 2006 data from the 2005/2006 financial year file, and the quarterly extracts for quarters one to three 2005/2006. Further information will be provided in the early autumn.

Data source and period
HES (Calendar year 2005)
PCT Local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

GP recording of BMI status

Target:
Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

Rationale:
As a key priority of the White Paper, *Choosing health: making healthier choices easier*, tackling obesity is a national priority. This is also reflected in the LDP technical note on Childhood Obesity, but is further emphasised in relation to the wider strategy required.

This measure is intended to act as a proxy for prevalence of obesity in the population. SHAs should set plans linked to local PCT plans and activity towards delivery of the PSA and its associated national targets.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
PCT local delivery plans (2005/2006)
New data collection
**Performance Indicators for Assessment 2005/2006**

**Infant mortality: Breastfeeding initiation rates**

**Target:**
Reduce health inequalities by 10% by 2010 (from a 1997/1999 baseline) as measured by infant mortality and life expectancy at birth.

**Rationale:**
Infant mortality numbers are too small for setting plans. Breastfeeding initiation is a good proxy, and is much less prevalent amongst more disadvantaged groups. In general, mothers who do not initiate breastfeeding tend to be younger, less well educated and from lower income groups. Infants who are not breastfed are five times more likely to be admitted to hospital with infections in their first year of life. NHS staff should be following best practice in increasing initiation and duration of breastfeeding.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

**Data source and period**
LDPR standard collection (Financial Year 2005/2006)
PCT local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

Infant mortality: Smoking during pregnancy

Target:
Reduce health inequalities by 10% by 2010 (from a 1997/1999 baseline) as measured by infant mortality and life expectancy at birth.

Rationale:
This is a vital measure to deliver the national health of the population target to reduce health inequalities. Infant mortality numbers are too small for setting plans. Smoking during pregnancy is the best proxy for low birth weight and is much more prevalent amongst young mothers, and those that are from more disadvantaged groups. In general, mothers who smoke tend to be younger and more disadvantaged.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
LDP (2005/2006)
LDPR standard collection (Financial year 2005/2006)
Infection control

Target:
Achieve year on year reductions in MRSA levels, expanding to cover other healthcare associated infections as data from mandatory surveillance becomes available.

Rationale:
Tackling healthcare associated infection cannot be left to clinical staff alone; senior management commitment, local infrastructure and system are also vital. Winning ways: Working together to reduce healthcare associated infection in England makes clear that each organisation should have a director of infection prevention and control to:

- oversee the implementation and monitoring of infection control policies
- be responsible for the infection control team within the healthcare organisation
- report directly to the chief executive and the board and not through any other officer
- have the authority to challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions
- assess the impact of all existing and new policies and plans on infection and make recommendations for change
- be an integral member of organisation’s clinical governance and patient safety teams and structures
- produce an annual report on the state of healthcare associated infection in the organisation(s) for which they are responsible and release it to the public

NICE guideline G2: ‘Infection Control’ sets out how PCTs should deal with the prevention of healthcare associated infection in primary and community care.

Data source and period
New data collection
Performance Indicators for Assessment 2005/2006

Number of drug misusers in treatment

Target:
Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

Rationale:
Improving drug treatment is recognised by ministers as the lynchpin of the national drugs strategy; this is based on evidence showing the dramatic effects that access to effective drug treatment can have for the individual and in reducing crime. These benefits include substantial financial savings within both the criminal justice system through reduced offending and the NHS through reduction in blood-borne diseases in drug misusers, and also the other associated health costs that a chaotic drug misuser will account for.

Reducing drug misuse is one of the key priorities in the planning and priorities framework (PPF) 2003/2006. PCTs have a key role, with other partners, in commissioning integrated treatment and prevention programmes and implementing national guidance. The PPF includes the PSA target to increase the participation of problem drug users in treatment programmes by 100% by 2008 (from a 1998 baseline).

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
NDTMS (NTA) (Financial year 2005/2006)
PCT local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

Number of very high intensity users

**Target:**
To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.

**Rationale:**
Patients with complex long term conditions who are not managed effectively in a primary and secondary care setting will become frequent unscheduled users of secondary care services. By measuring and managing this cohort of patients effectively, we will have a direct positive impact on the emergency bed days target.

The initial focus of the longterm conditions strategy is on proactive case management of very high intensity users (VHIUs). There is a need to build upon the existing good practice of care for patients with long-term conditions. We would expect whole health systems to work together to deliver a more systematic care planning approach to better benefit all patients with longterm conditions.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

**Data source and period**
PCT local delivery plans (2005/2006)
New data collection
Performance Indicators for Assessment 2005/2006

Patients’ experiences

Target:
Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys. The experience of black and minority ethnic groups will be specifically monitored as part of these surveys.

Rationale:
The *NHS Plan* requires each NHS trust and PCT to obtain feedback from patients about their experience of care. Pending new arrangements for surveying patients in primary care, performance indicators for 2005/2006 will be drawn from a national survey conducted among patients with diabetes in every PCT. To ensure comparability with previous PCT patient surveys, a nationally representative sample of PCT patients will be carried on centrally. This will track performance at national level only and will attribute to individual organisations.

Data source and period
Healthcare Commission diabetes survey (Fieldwork to be undertaken Spring 2006)
Performance Indicators for Assessment 2005/2006

Patients with coronary heart disease, diabetes or stroke who smoke, offered smoking cessation advice

Target:
Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.

Rationale:
Guidance on the quality and outcomes framework (QOF), issued in August 2004, highlighted the information set that GPs are required to collect data on, by disease type. The provision of stop smoking advice is an indicator that is found in a number of disease data collections, including the set for patients with CHD, diabetes and those who have suffered a stroke.

The QOF guidance highlights that 'there is strong evidence that stopping smoking reduces the risk of myocardial infarction in patients with CHD', that 'inferences can be drawn from the findings of primary prevention trials that cessation of cigarette smoking should be advocated' (for patients who have suffered a stroke of transient ischaemic attack), and for patients with diabetes mellitus 'simple advice to stop smoking given by a doctor, a nurse or a counsellor has a small but significant effect on helping smokers to quit. Health professionals involved in caring for patients with diabetes should advise them not to smoke'.

Data source and period
QMAS/QPID (2005/2006)
Practice-based registers

Target:
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.

Rationale:
The establishment of registers of at risk patients in all practices is an NSF standard: ‘general practitioners and primary health care teams should identify all people at significant risk of cardiovascular disease, but who have not yet developed symptoms and offer them appropriate advice and treatment to reduce their risks’.

Commission for Health Improvement (CHI) and Healthcare Commission local reviews have found implementation to be patchy. Primary care teams will be better able to offer systematic care to all patients to maximise their quality of life, to minimise their incidence of disease, and to predict future service requirements if they have an effective means of identifying (and intervening with) patients at risk - registers are the means by which these patients will be identified.

Effective disease prevention in at risk patients will make an important contribution to the overall PSA mortality target.

We will assess performance against PCT plans for 2005/2006, as set out in the local delivery plan.

Data source and period
New data collection
PCT local delivery plans (2005/2006)
Performance Indicators for Assessment 2005/2006

Smoking status among the population aged 15 to 75 years

Target:
Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.

Rationale:
This will provide a proxy measure, in support of obtaining information on the prevalence of smoking. Smoking is a major contributor to ill health, including coronary heart disease and cancer. Plans that will reduce the level of smoking in the population will assist in the delivery of a wider strategy to tackle inequalities and address specific targets in support of the PSA.

PCTs should have plans that support the reduction of smoking, including consideration of accurate identification of smokers and provision of stop smoking advice and services. They will need to be provided in the context of an overall policy to tackle smoking, including for example increased prescribing of stop smoking products and encouragement of more smoke free local public/workplaces, particularly in the NHS. Plans should target at risk groups, including those with comorbidity and groups with higher prevalence rates.

We will assess PCT performance against PCT plans for 2005/2006 as set out in the local delivery plan.

Data source and period
PCT local delivery plans (2005/2006)
New data collection
**Performance Indicators for Assessment 2005/2006**

**Teenage conception rates**

**Target:**
Reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.

**Rationale:**
Britain's teenage birth rates are the highest in Western Europe. Teenage mothers are more likely to suffer poor health outcomes. The teenage pregnancy strategy seeks to halve the under-18 conception rate by 2010 through a wide ranging programme of coordinated activity, including improved advice and contraceptive services for young people. The *NHS Plan* also set an interim target of achieving a 15 percent reduction in the under 18 conception rate by 2004.

In addition to national targets, local under 18 conception rate targets have been agreed with teenage pregnancy partnership areas, which are co-terminous with top tier local authority areas in England. These local targets range between a 40% to 60% reduction by 2010. Each PCT is signed up to the target for their teenage pregnancy partnership area.

**Data source and period**
ONS (Calendar years 1998 and 2004)
**Performance Indicators for Assessment 2005/2006**

**Waiting times for MRI and CT scans**

**Target:**
To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.

**Rationale:**
The *NHS Improvement Plan* set out the target of a maximum 18 week start to treatment waiting time by December 2008 and for the first time the target includes waiting for diagnostics. Providing fast, convenient access will ensure that waiting times for treatment will have been reduced to the point that they are no longer the major issue for patients and the public.

The indicator set for new national targets in 2005/2006 contains only one of the six trajectories included in the local delivery plan 2005/2008. There are no indicative milestones for the remaining data lines until March 2007.

We will work with the Department of Health to identify an additional indicator based on data quality in relation to diagnostics, to supplement this MRI and CT scan indicator. Details of this will be published in autumn 2005.

**Data source and period**
New data collection