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**Our vision for the NHS is to reapply its founding principles with vigour to meet the needs of the people of Scotland. Delivering for Health means a fundamental shift in how we work, tackling the causes of ill-health and providing care which is quicker, more personal and closer to home.**

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# Delivering for Health

## Foreword



As the NHS in Scotland changes and improves, one thing remains the same – the absolute commitment to comprehensive services available to all according to their clinical needs, and free at the point of delivery. This, the foundation of the NHS, remains my principal guide as we work to improve our health services still further.

Scotland is changing. While our population is becoming healthier, it is becoming more elderly too. Health technology and practices are advancing and there are new and better opportunities in the NHS for the people who work there. All of this change means that the way health services are provided has to change too. Not because we should do things differently just for the sake of it, but because now, more than ever, we can prevent people becoming unwell, treat them faster and better if they do, and more often than not, treat them close to their home rather than in a hospital.

In May, I received Professor David Kerr's report, *Building a Health Service Fit for the Future*. His prescription for an NHS that is proactive, modern, safe and embedded in communities is supported by Scottish Ministers. It also fits well with the conclusions emerging from our review of social work.

After extensive consultation across Scotland, a framework was set out for the way services need to change. Now, I want NHS Boards and Regional Planning Groups to use that framework to drive their service improvement programmes.

At a national level, we will continue to support greater integration within the health service and with other social services. We will seek improvements in the quality of health care and in productivity too. We want services delivered as locally as possible, when that can be done safely and sustainably, but with prompt access to specialised services when necessary.

Over the next few years, the changes that we are making in the NHS in Scotland will lead to increases in the diagnostic and treatment services available in local communities, and an end to unacceptable waits for more complex treatments. Our hospital services will work differently, with better rehabilitation and faster transfer back home or to community care services.

I also expect the changes that we are making will see the health of our population continue to improve, but I want everyone to have the same opportunity to experience that improvement. Currently there are stark differences in the healthy life expectancy of different communities across Scotland. This is unacceptable. Within this plan I commit to an emphasis on tackling health inequalities greater than Scotland has ever seen before.

We will prioritise preventive medicine and proactive care. We will be prepared to target our resources where they are most needed. We will equip the health service to encourage and secure health improvement and “wellness”, rather than just treating illness.

In his report to me, Professor David Kerr said: *‘The NHS in Scotland needs to change. Not because it is in crisis as some would have us believe – it is not; but because Scotland’s health care needs are changing and we need to act now to ensure we are ready to meet the future challenges.’*

We must make that change in the NHS happen.

The programme set out in this document describes in practical terms what action we must take to turn our vision into reality. It applies the findings of Professor Kerr’s framework in a national context, setting them alongside our existing initiatives and future plans.

This is a plan for the long-term. A plan for a national service that promotes our national health. A plan with patients at its core. A plan for action, a plan for change.

A handwritten signature in dark ink, reading "Andy Kerr". The signature is fluid and cursive, with the first letters of "Andy" and "Kerr" being capitalized and prominent.

**ANDY KERR, MSP**  
**Minister for Health and Community Care**

# Executive Summary



This report sets out a programme of action for the NHS, as we seek to shift the balance of care. We need to reduce our reliance on episodic, acute care in hospitals for treating illness, increasingly through emergency admissions. Instead, we need to move towards a system which emphasises a wider effort on improving health and well-being, through preventive medicine, through support for self care, and through greater targeting of resources on those at greatest risk, with a more proactive approach in the form of anticipatory care services.

Our aim is to improve the health of the people of Scotland, and to close the gap in life expectancy. We are working to encourage people to take greater control over their own health. We want the NHS and new Community Health Partnerships to tackle this challenge at local level, with local authorities and the community planning machinery contributing wholeheartedly.

The National Framework for Service Change assessed the changing needs for health care in Scotland. It highlighted the combination of an ageing population and the growth in long term conditions; the trend of rising emergency admissions to hospital among older people; the growing divergence in life expectancy, despite the general improvement for Scotland as a whole. It reinforces the clear evidence of public interest in the future of the NHS.

We want to respond to the wishes of the people of Scotland to have more local health care, a more responsive NHS, and a greater say in the way their NHS is run. And as we do so, we must address the unacceptable inequalities in healthy life expectancy across Scotland.

The National Framework for Service Change concludes that there needs to be a shift towards preventive medicine, towards more continuous care in the community, with targeting of resources and anticipatory care to reach out to those at greatest risk. By strengthening local services; with more support for self-care; more intensive case management for individuals with serious long term conditions; and with more capacity for local diagnosis and treatment, it is possible to reduce the rising trend of unscheduled hospital admissions. It also showed that much can be done to manage hospital admissions and discharges better.

The challenge of improving health care services in Scotland requires a national action plan with clearly defined commitments, clear responsibilities, effective mechanisms to hold the service to account, and objective measures of performance. It requires a culture that promotes innovation and redesign, but always with an ultimate focus on the delivery of better care for patients.

*Delivering for Health* describes the main actions we will take within current spending plans to implement the recommendations of the National Framework for Service Change, which have been widely welcomed. The pace of implementation will depend on the amount of resources that can be allocated for these purposes, from both the savings achieved through the Efficient Government programme and future public spending plans.

Box ES.1 shows the kind of changes patients and their families in Scotland should expect to see as we implement the actions contained within this paper.

We will deliver our plans through the continuing development of the NHS as an integrated service, so that patients experience a smooth and quick 'journey of care' wherever and however they may access services. The emphasis on integrating care will require multi-disciplinary team working. It will require collaboration and co-ordination between professionals and across organisational boundaries – in fact, a partnership approach

at all levels to achieve continual improvements in quality and value for money. It requires the NHS to deliver public health improvements by engaging with other public authorities for services such as transport, housing, education and leisure.

It is the job of our NHS to improve health and improve the quality of health care. But it also has a responsibility to improve efficiency and increase productivity, because by doing that we can offer more care with the resources available. By 2008, annual funding for the NHS will reach £10bn – that is double what it was in 1999, and well in line with health spending in Western European countries. Alongside that major investment and commitment the health service must use the money more effectively for the benefit of patients.

Organisational change is taking place within the Scottish Executive Health Department (SEHD) to ensure a sharp focus on the delivery of key priorities and targets, including the commitments in this plan. A new Delivery Group will draw together and strengthen the performance management function by agreeing annual Local Delivery Plans with each NHS Board, providing systematic monitoring of performance, and playing a more assertive role in supporting or intervening. A new Group for Primary and Community Care will help to prioritise the development of health care services in community settings and partnerships with social care services.





**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



Record levels of investment in NHSScotland over the last six years have yielded demonstrable improvements in the service we provide to the people of Scotland.

That investment has produced a sustained increase in staff numbers and modernisation of buildings and equipment. Improvements for patients include better survival rates for the killer diseases, shorter waiting times, the introduction of new treatments, and effective action to improve public health.

We must go further. Our collective aim should be to implement the proposals in this plan by engaging with, and winning the support of the people we serve.

The first section of this report describes this progress more fully. Section 2 addresses the big strategic challenges that face NHSScotland. Section 3 focuses on other implications of our ambition for an integrated approach to health care services.

## **BOX ES.1**

### **THE CHANGES PATIENTS WILL SEE**

More of their health care will be provided locally in GP practices, in community pharmacies or, increasingly, in Community Health Centres, with greater use of day case treatment.

If they stay in a less well-off area, their local primary care team will have dedicated resources to reach out and help people with higher risks of ill-health.

If they have a long-term condition, help and support will be available so they can play an increasing role in managing the condition themselves.

If they are older, frail or liable to frequent hospital admission, they will get co-ordinated care provided locally.

Carers will be treated as partners in the provision of care.

Patients will have access to their own Electronic Health Record and so will all the clinical staff who treat them.

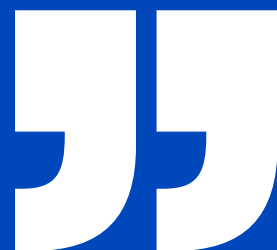
If they need specialist treatment in hospital they will get access to a good, safe service provided by the right person, even if that means they have to travel.

If they need to go to hospital, they will have quicker access; more tests will be done locally, and their length of stay will be planned and shorter.

If patients require care urgently, they will be able to see the right person, with the right skills, at the right time.

Patients will experience fewer cancelled appointments or procedures because of an emergency or because tests are not available.

If they stay in remote and rural areas, the NHS will provide them with a core set of services in Rural General Hospitals.



# Key Actions

WHAT?	HOW?
We will...	By...
<b>reduce the health gap</b> (the inequality in life expectancy across Scotland)	<ul style="list-style-type: none"> <li>▸ developing and delivering anticipatory care for those ‘at risk’ wherever they live</li> <li>▸ increasing health care services delivered in disadvantaged communities</li> </ul>
<b>enable people with long-term conditions to live healthy lives</b>	<ul style="list-style-type: none"> <li>▸ increasing support for self care</li> <li>▸ anticipating the needs of vulnerable people</li> <li>▸ identifying those people at greatest risk of hospital admission and providing them with earlier care to prevent deterioration of health and reduce emergency admissions</li> </ul>
<b>establish new health and social care services in communities</b>	<ul style="list-style-type: none"> <li>▸ prioritising investment in local services, including Community Health Centres that deliver diagnostic and day-case treatment</li> <li>▸ developing practitioners with extended roles</li> <li>▸ fully utilising the skills of all professionals through stronger teamwork in Community Health Partnerships</li> </ul>
<b>accelerate improvements in mental health services</b>	<ul style="list-style-type: none"> <li>▸ identifying priorities for investment in a delivery plan that builds on our <i>Framework for Mental Health in Scotland</i></li> </ul>
<b>build on recent progress on waiting times</b>	<ul style="list-style-type: none"> <li>▸ delivering our waiting time commitments for 2007</li> </ul>

WHAT?	HOW?
We will...	By...
ensure that wherever people need care, their medical history is available to the service provider	<ul style="list-style-type: none"> <li>› implementing a national information and communication technology system, including an Electronic Health Record</li> </ul>
streamline unscheduled (emergency) hospital care	<ul style="list-style-type: none"> <li>› delivering services locally in Community Casualty Units when it is safe to do so, and in well-resourced Emergency Centres when it is necessary to do so</li> </ul>
separate planned from unscheduled care	<ul style="list-style-type: none"> <li>› aiming to make day case surgery the norm</li> </ul>
remove bottlenecks in diagnostic services	<ul style="list-style-type: none"> <li>› delivering on our diagnostic waiting time commitments for 2008</li> <li>› increasing the range of locally available diagnostic services</li> </ul>
apply a systematic approach to decisions regarding the concentration of specialist services	<ul style="list-style-type: none"> <li>› basing our decisions on National Framework recommendations</li> </ul>
strengthen health care in remote and rural areas	<ul style="list-style-type: none"> <li>› establishing the Scottish Centre for Telehealth</li> <li>› identifying what services can be safely delivered in Rural General Hospitals</li> <li>› educating and training health care professionals with specialist skills for practice in those hospitals</li> </ul>
decide where national specialist services such as neurosurgery and neuroscience and tertiary paediatric services should be provided	<ul style="list-style-type: none"> <li>› aiming to make the best use of valuable specialist skills, and delivering services of the highest quality</li> </ul>

A smiling woman with blonde hair, wearing a blue and white striped sweater, is the background of the image. She is looking towards the camera and has a joyful expression.

“

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# Section one

## Where we are now

### 1.1 A POLICY FOR HEALTH

Our overarching aim is to improve Scotland's health. Policies and actions across the Scottish Executive support that central objective.

We are building an integrated approach to health that has the NHS at its core. The approach sets out to tackle determinants of population health, particularly through action to close the 'health gap' that blights the lives of people in our disadvantaged communities.

This plan is therefore about more than the future shape of our NHS. It also brings together elements of wider policy the Scottish Executive has been developing for a number of years that impact on Scotland's health.

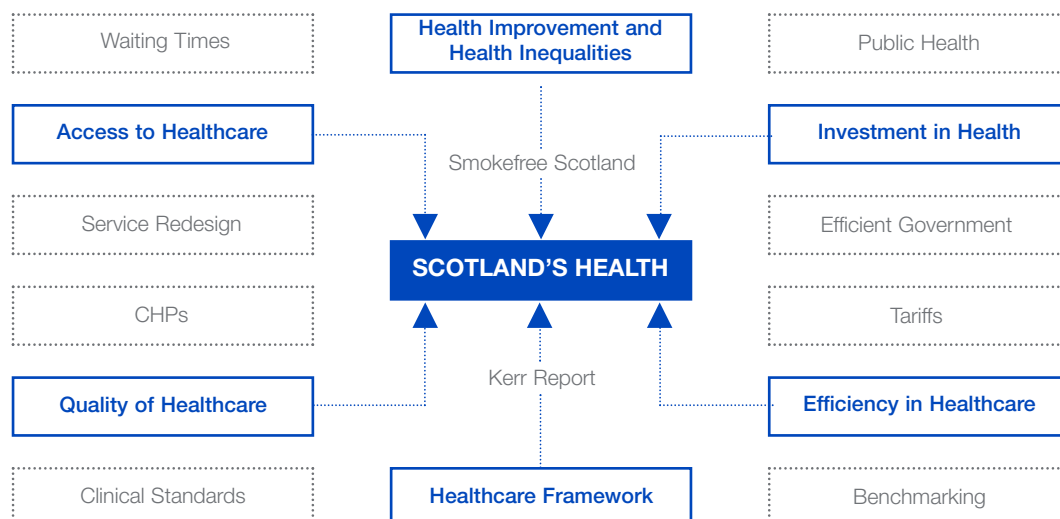
Health care makes an important contribution to health improvement. Our plans for the health service to reach out with earlier intervention (anticipatory care) make this link explicit, emphasising the importance of delivering health care that is fair to all and personal to each.

We expect the NHS to provide care that is tailored to the needs of the individual, drawing on the efforts of appropriately skilled members of the health care team. This means encouraging team members to get out of the 'service silos' that have for too long led to patients being passed from one service to another without proper co-ordination.

Figure 1.1 summarises the key elements of our broad approach to Scotland's health. It requires us to:

- reach out further with our health improvement programmes
- continue to reduce the longest waiting times
- improve access through service redesign
- improve the quality of health care by raising the standards of all to those of the best
- get best value from the £8bn we already spend each year on the NHS
- build on the Kerr Report to deliver an NHS fit for the future.

**FIGURE 1.1**  
Scotland's health policy





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## 1.2 PROGRESS

We have a good foundation on which to build. We are heading in the right direction, and can illustrate progress in five particular areas:

- › health improvement
- › reducing deaths from killer diseases
- › shorter waiting times
- › redesigning services around the needs of patients
- › improving patients' experiences of health care.

- › taking action on oral health, particularly for children and young people
- › launching a new *Plan for Action on Alcohol*
- › taking action on mental health through the *See Me* and *Choose Life* initiatives.

We put emphasis in the first phase of *The Challenge* on raising the profile of health improvement and getting effective structures in place. *We now need to sharpen the focus on delivery, ensuring that services are reaching those who need them most and that real health improvement is demonstrated, especially in our most disadvantaged communities.*

### 1.2.1 HEALTH IMPROVEMENT

*Improving Health in Scotland – The Challenge*, published in 2003, identified areas where action was required to achieve a more rapid rate of health improvement.

Among the main advances achieved over the last few years are:

- › enacting legislation to secure smoke-free, enclosed public spaces in Scotland from 26 March 2006
- › increasing smoking cessation services, targeting areas of disadvantage
- › appointing 600 active schools co-ordinators
- › encouraging healthier eating at school through the *Hungry for Success* programme
- › providing free fruit and drinking water in primary schools

### 1.2.2 REDUCING DEATHS FROM KILLER DISEASES

Coronary heart disease (CHD), stroke and cancer are the major killer diseases in Scotland. They are recognised among the national clinical priorities for NHSScotland.

We have devoted considerable resources to ensure progress is made in these areas. The formation of Managed Clinical Networks (MCNs) has enabled the redesign of services, raising standards and improving outcomes. We have set challenging national targets for these services and are making good progress.



## Coronary heart disease/stroke

Scotland has had considerable success in recent years in treating patients with CHD. The premature mortality rate has fallen by 43.6% since 1995.

But there are still around 500,000 Scots with CHD, with 180,000 being treated at any one time. Our target now is to reduce premature deaths by 60% (among people aged under 75) between 1995 and 2010, and progress to date suggests that this target is achievable. Figure 1.2 shows progress since 1980.

MCNs in each NHS Board have taken the lead in prioritising bids for funding under the CHD and Stroke Strategy. Extra national funding (£40m between 2003-2006) has been committed to CHD and stroke services to support rapid-access chest pain clinics, heart failure and cardiac rehabilitation services, and to develop stroke units. MCNs are developing primary and secondary prevention strategies, drawing on lessons from national projects such as *Have a Heart Paisley* and the *National Heart Health Learning Network*. These initiatives are aimed at reducing the incidence of CHD, with emphasis on promoting healthier lifestyles.

Mortality from CHD is higher in disadvantaged communities. We have consequently set an additional target – to reduce premature mortality by 15% above the national rate, for people in the most disadvantaged communities (see health inequality targets in section 2.3).

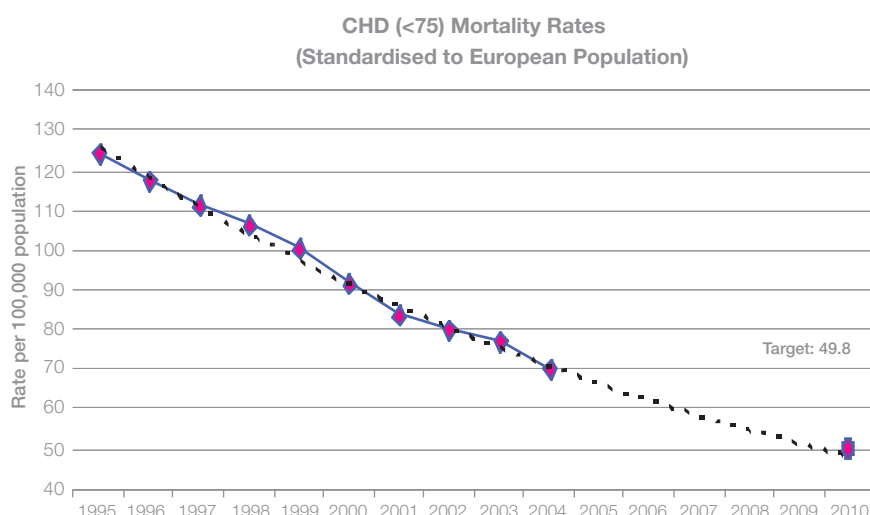
Progress is also being made in the prevention of stroke and the care and treatment of stroke patients. The number of people admitted to hospital with cerebrovascular disease has fallen by 13% since 1995.

Specialist stroke units providing acute and rehabilitative care are recognised as the way forward. These units now exist in most NHS Board areas and are integral to the stroke MCNs.

The national target is to reduce premature mortality for people aged under 75 by 50% between 1995 and 2010. Figure 1.3 indicates that we are on track, with a reduction of 40% to date.

**FIGURE 1.2**

**Age-specific mortality rates per 100,000 population: under 75s dying from CHD**





Cancer

Cancer continues to be one of the main challenges facing NHSScotland. We have the highest mortality rate for cancer in Western Europe. Each year, 26,000 people in Scotland are diagnosed with various forms of the disease, and 15,000 die.

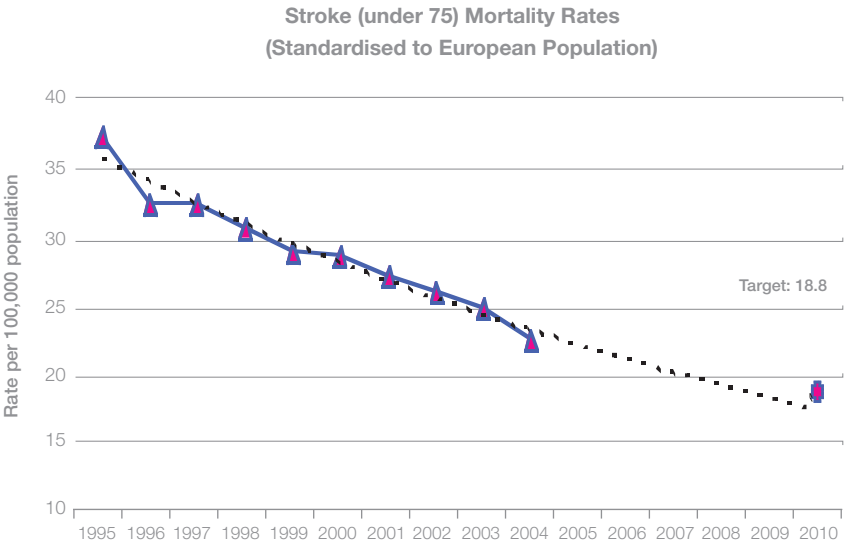
The national target is to reduce premature mortality from cancer by 20% between 1995 and 2010. The latest available data show a decrease of 14.8% (Figure 1.4), so this target still represents a considerable challenge.

In line with advice from the regional cancer MCNs, an additional £25m a year is being

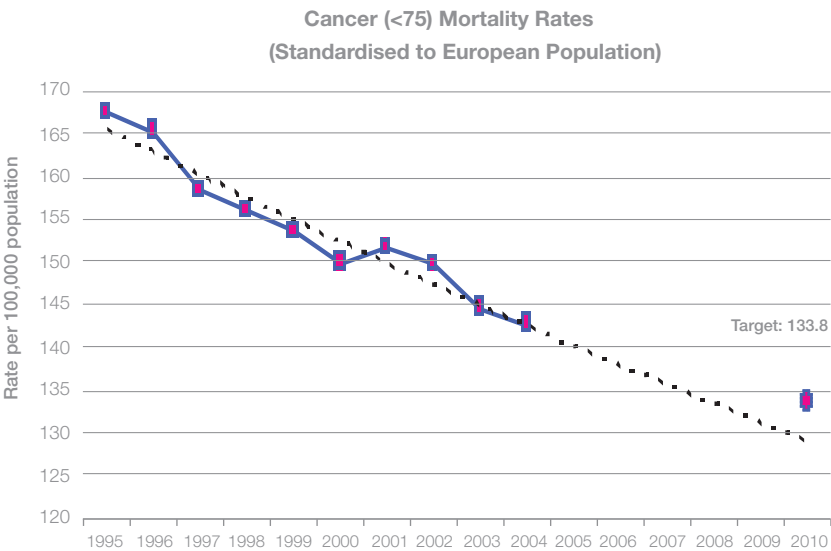
invested to improve cancer diagnosis, treatment and care through innovation and spreading good practice. Extra staff and equipment have also helped to reduce waiting times, but NHS Boards still need to achieve significant further reductions in waiting times, in accordance with the National Cancer Delivery Plan. This will require NHS Boards to improve management information in this area.

As is the case with Scotland’s other killer diseases, efforts to promote healthier lifestyles are being targeted at disadvantaged communities, where the incidence of cancer is particularly high.

**FIGURE 1.3**  
Age-specific mortality rates per 100,000 population:  
under 75s dying from stroke



**FIGURE 1.4**  
Mortality rates per 100,000 population:  
under 75s dying from cancer



### 1.2.3 SHORTER WAITING TIMES

Patients and their families want prompt access to services. Prompt access can also result in benefits in clinical outcomes through early diagnosis and treatment.

The majority of patients who require hospital inpatient or day case treatment are treated quickly. Almost 54% of patients treated in NHSScotland hospitals are admitted immediately and never join a waiting list. Of those who do wait, 41% are admitted within 1 month and almost 70% within 3 months. But for those who have to wait, it can be a period of anxiety and uncertainty. That is why reducing waiting times for patients is one of the Executive's key priorities for NHSScotland.

There is now a clear downward trend in the length of time people wait for hospital inpatient and day case treatment. The national maximum waiting time was reduced from 12 months to 9 months at the end of 2003, and will be further reduced to 6 months by the end of this year and to 18 weeks by the end of 2007. The latest available figures (for 30 June 2005) show that:

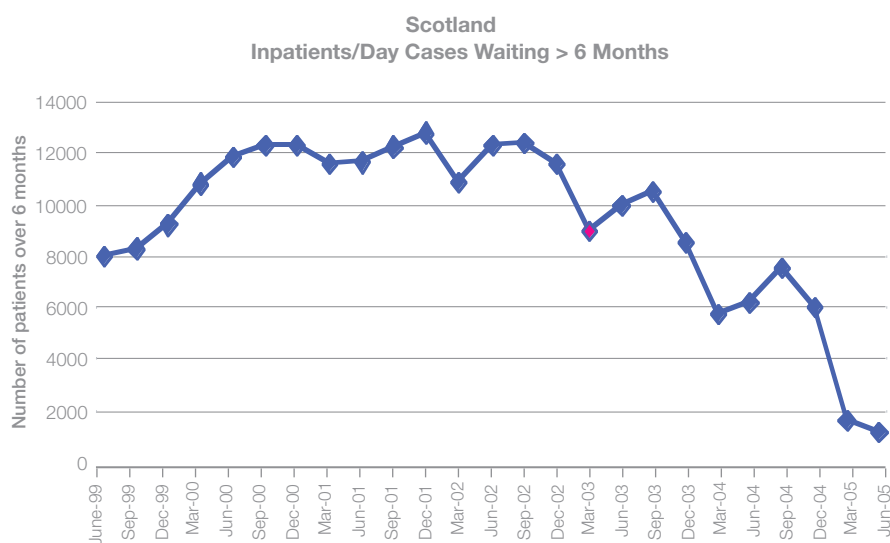
- the number of patients with a guarantee waiting over six months for inpatient and day case treatment is the lowest ever recorded, representing a fall of 30% from the previous quarter (figure 1.5), and a reduction of 82% from the previous year.
- for the fourth successive quarter, no patient with a guarantee waited more than 18 weeks for angioplasty or surgical graft for heart disease.

Our commitments on waiting times for inpatient and day case treatment and for cardiac revascularisation are firm guarantees to patients of the maximum time they will wait. If a patient's host NHS Board is unable to provide treatment within the target time, the patient must be offered treatment elsewhere in the NHS, in the private sector, or in exceptional cases, overseas.

The number of patients with a guarantee waiting more than 6 months for inpatient and day case treatment fell from 8,014 on 30 June 1999 to 1,121 on 30 June 2005. This performance is shown in the following graph.

**FIGURE 1.5**

**Number of inpatients/day cases with a guarantee waiting more than six months**





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On outpatient waiting times, the majority of patients referred by a GP or dentist for a first outpatient appointment at a consultant-led clinic are seen quickly, with nearly 54% of patients being seen with 9 weeks of referral and 66% within 13 weeks. For those who have to wait longer, we have set a national maximum waiting time target of 26 weeks from referral to consultation, by the end of 2005. This will be reduced to 18 weeks from the end of 2007.

To ensure performance is monitored effectively, *Partnership for Care* included a commitment to establish a national outpatient waiting list. Information on this list was published for the first time on 30 September 2004, and has been published quarterly since then. On 30 June 2005, 15,432 patients without an availability status code had waited more than 26 weeks for a first outpatient appointment – a reduction of 6,706 since 31 March 2005, demonstrating that NHSScotland is on track to deliver the commitment that no-one will wait more than 26 weeks by the end of this year.

*Fair To All, Personal To Each – The next steps for NHSScotland*, published in December 2004, set out the biggest and most comprehensive package of improvements promised by NHSScotland. In addition to setting maximum waiting times of 18 weeks for a first outpatient appointment and for hospital inpatient and day case treatment from the end of 2007, it included the following additional waiting times commitments to be delivered by that date:

- ▶ for patients with chest pain, a maximum wait of 16 weeks from GP referral, through a rapid access chest pain clinic or equivalent, to cardiac intervention, from the end of 2007
- ▶ for those patients not presenting with chest pain, a maximum wait of 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment
- ▶ a maximum wait of four hours from arrival to discharge, admission or transfer for A&E treatment
- ▶ a maximum wait of 18 weeks from referral by a GP or Optometrist to cataract surgery
- ▶ a patient entering a specialist orthopaedic unit for surgery, following hip fracture, will be operated on within 24 hours of admission.

In addition, in June 2005, maximum waiting times of 9 weeks by the end of 2007 were set for 8 key diagnostic tests – CT, MRI, Ultrasound and Barium scans and Upper Endoscopy, Cystoscopy, Sigmoidoscopy and Colonoscopy. This 9 weeks maximum waiting times commitment will be included within the maximum waiting times for outpatient consultations and inpatient and day case treatment – they are not additional.

We will ensure these commitments are delivered through the implementation of service redesign and new ways of working, increasing capacity, particularly at the Golden Jubilee National Hospital, and by working with the independent health care sector to increase NHS capacity further.

The Golden Jubilee National Hospital is a unique facility helping to reduce waiting times across Scotland, particularly for those experiencing the longest waits for treatment. Since the facility became part of NHSScotland the hospital has increased its activity from 2,500 procedures a year at the time of purchase to over 18,000 procedures in 2004-05, making a massive contribution to reducing patient waits.

*Fair To All, Personal To Each – The next steps for NHSScotland* includes a commitment to increase capital investment at the Hospital over the years 2007-2008 to bring all of the available floor space into intensive clinical use; the Executive will provide extra revenue funding to pay for the staff who will care for patients in these new wards. As a result, the Golden Jubilee is expected to be able to carry out 10,000 extra procedures annually by 2007-08 when all of the additional capacity and staff are in place taking the total number of procedures to 28,000 each year.

This expansion is now happening. Two state-of-the-art Orthopaedic operating theatres have been built and 3 Orthopaedic surgeons appointed, increasing orthopaedic activity from 360 in the first year to 1,800 now. A programme of upgrading the Hospital's diagnostic facilities by replacing or upgrading the ultrasound equipment, CT scanner, catheter lab and the MRI scanner has recently been completed. This has enabled

investigative procedures to increase from 7,200 in 2003/04 to over 13,000 in 2005/06.

NHS Greater Glasgow and NHS Lanarkshire are currently working with the Hospital on a proposal to establish a single-site West of Scotland cardiothoracic centre at the Golden Jubilee National Hospital.

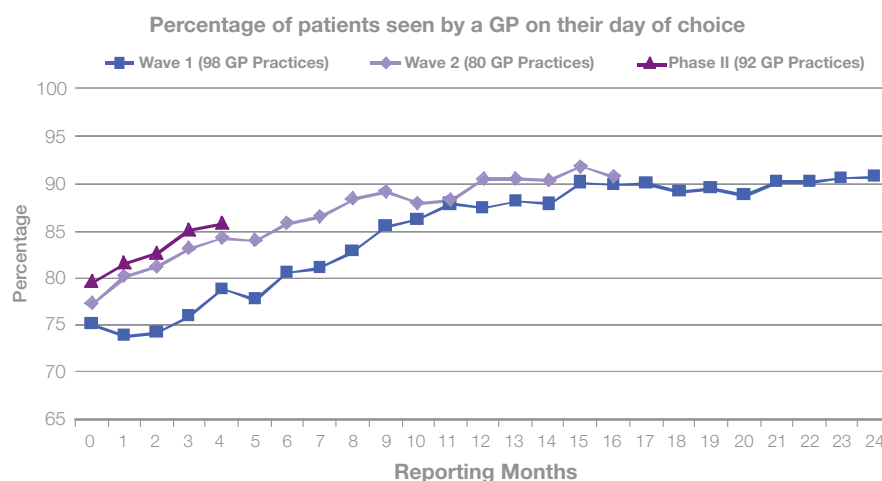
### Scottish Primary Care Collaborative

The NHS is working hard to improve access to local health care services. This year, 96.8% of GP practices have achieved the Scottish Executive Partnership Agreement target of guaranteeing access for patients to a member of the primary care team within 48 hours.

Almost 400 practices are currently involved in the Scottish Primary Care Collaborative, which works to improve access and outcomes for people with long-term conditions. The collaborative programme has improved clinical outcomes for patients with diabetes through proactive and systematic management and by adopting an integrated team approach. We are expanding this programme, so that by December 2005 almost 50% of practices will be involved.

Participating practices now aim to ensure that 90% of patients can access their health care professional routinely within one working day, and that patients can see a GP on a day of their choice (Figure 1.6).

**FIGURE 1.6**  
**Accessing GPs**



### 1.2.4 SERVICE RE-DESIGN

In setting out new waiting time targets, the Minister identified a number of key steps in delivering for 2007:

- › new and more efficient ways of working
- › better workforce planning – right skills, right place
- › more investment in capacity where it matters
- › more effective use of the independent sector

- › innovative Community Health Partnerships
- › more strategic and effective use of information and communication technology (ICT).

Much of the success already achieved has been made possible by frontline staff redesigning and improving the services they provide (see Box 1.1).



#### BOX 1.1 EXAMPLES OF REDESIGN ACTIVITY IN NHSSCOTLAND

##### Scottish Ambulance Service

All Scottish Ambulance Service (SAS) paramedics are now trained and equipped to provide pre-hospital coronary care and deliver thrombolysis, which reduces mortality from heart attacks and improves longer-term outcomes.

Training has been provided to address the needs of heart attack patients, diagnosis of acute coronary syndromes, use of thrombolytic agents and interpretation of 12-lead ECGs. A major component has been the introduction of the new 'Lifepak' defibrillator/monitor and ECG recorder and, linking to this, the development of five telemedicine decision-support centres which can transmit the pre-hospital ECG to the receiving hospital. In Lothian, where over 500 successful transmissions were made in the first two full months of

service, 22 were fast-tracked directly to the coronary care unit, 16 already having been thrombolysed prior to arrival.

##### Lung cancer treatment in Dundee

Doctors and clerical staff working with lung cancer patients in Dundee have made a number of simple changes to working practices that have reduced the time patients wait to be seen by a respiratory physician.

Radiology staff are now making direct referrals to the respiratory clinic after reporting a highly suspicious chest x-ray. Details of the results and the patient appointment are sent to the GP at the same time. Previously, patients waited an average of 23 days to be seen – this has now been reduced to an average of 10 days.

Innovation and service redesign also takes place where health improvement programmes link to health care. The *Have a Heart Paisley* programme, for example, has supported over 6,000 people through a range of local projects aimed at improving heart health. The programme uses coaching and mentoring to improve health, identify and tackle risk factors, and meet treatment needs that would otherwise be overlooked.

Innovation at local level is only the first step. We must spread good practice and promote a culture of innovation and redesign across the NHS, so staff and managers can learn from innovative, evidence-based schemes from elsewhere. We must ensure that this is done more systematically in the future than is the case at present.

### 1.2.5 IMPROVING PATIENTS' EXPERIENCE OF HEALTH CARE

Looking at patient satisfaction with services is a very important way to gauge the progress being made by NHSScotland.

A Scottish Executive survey of public attitudes to NHSScotland carried out towards the end of 2004 found that 90% of the 1,937 patients surveyed from all over Scotland were 'very or fairly satisfied' with the service they received (Table 1.1). Patient satisfaction was clearly linked to a number of factors, notably waiting, choice and generally having a greater say in their NHS.

These figures compare favourably with a similar survey carried out in 2000, with a marked increase in satisfaction with local GPs and inpatient services. We are tackling concerns about outpatient services, through targets to reduce waiting times and the Centre for Change and Innovation's Outpatient programme; and we are reviewing the provision of out-of-hours care in the light of the first year's experience of the General Medical Services (GMS) contract. We want to see further improvements in patient satisfaction, but it is encouraging to note that we start from a sound base, and are on a rising trend.

**TABLE 1.1**

**Patient satisfaction with services**

Service	'Very or fairly satisfied' percentage
Practice nurse	93
Own GP	93
Telephone consultation	91
Home visit	91
Another GP	90
Inpatient	90
Out of hours	88
Outpatient	86





“

Our vision for the NHS is to reapply its founding principles with vigour to meet the needs of the people of Scotland. Delivering for Health means a fundamental shift in how we work, tackling the causes of ill-health and providing care which is quicker, more personal and closer to home.

”

# Section two

## Making improvement happen



Health services have to change if they are to keep pace with population trends, patient needs and medical advances. That is why, since 1999, we have developed and implemented policies designed to improve the quality and productivity of NHSScotland. We have supported these policies with record levels of investment in the NHS workforce, in new equipment, and in modern buildings. Over the next three years, we have allocated:

- ▶ £135m for medical and diagnostic equipment
- ▶ £115m for primary medical and dental services
- ▶ £107m for information and communication technology (ICT).

We are also funding major hospital developments (see section 3.2).

National strategies or action plans are being delivered for the national clinical priorities (cancer, CHD/stroke and mental health), sexual health, oral health and dental services, and pharmaceutical care services. Strategies for eye care in the community and community hospitals are in preparation. A comprehensive set of national targets, including targets for waiting times, has been set out in *Fair to All, Personal to Each*.

We now need to make a decisive shift in the balance of care within the NHS. The *National Framework for Service Change* outlined the challenges of an ageing population, which will result in a growing number of people living with long-term conditions. The framework summarised the way in which the NHS needs to work to meet this challenge (Table 2.1) – **we endorse this model, which is central to our plans for the future.**

**TABLE 2.1**

The future model of health care

Current view	Evolving model of care
Geared towards acute conditions	Geared towards long-term conditions
Hospital centred	Embedded in communities
Doctor dependent	Team based
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventive care
Patient as passive recipient	Patient as partner
Self care infrequent	Self care encouraged and facilitated
Carers undervalued	Carers supported as partners
Low tech	High tech



To deliver this model of care we must:

- › *strengthen services in local communities* through more substantial Community Health Centres with diagnostic and treatment services, networked with GP practices
- › *adopt more proactive approaches to care for people with long-term conditions*, with resources targeted to where they are needed most and with greater support for self-care
- › *enable the NHS to play a full part in promoting good health through community planning*, giving greater emphasis to preventive medicine and earlier intervention ('anticipatory care'), especially in areas with the poorest health
- › *promote a more productive approach to specialist care in our major hospitals*, with shorter hospital stays and more resources targeted at pre-admission and rehabilitation services to enable quicker admission and discharge.
- › *shift the balance of care through CHPs* expanding the range of services available locally, determined by the needs of their communities.

There are four big priorities for investment and reform to reshape the NHS in this way:

- › **the NHS as local as possible**
- › **systematic support for people with long-term conditions**
- › **reducing the inequalities gap**
- › **actively managing hospital admissions.**

This section sets out a programme of actions under these important themes.

## 2.1 THE NHS AS LOCAL AS POSSIBLE

### Shifting the balance of care

Three factors will drive the Scottish population's changing need for health care over the next 10 years:

- › the growth in the number of older people, and in particular the number of relatively frail older people
- › the emergence of long-term conditions as the main challenge facing the health service
- › changing expectations from patients for more personalised care.

Extending the availability of locally responsive, community-based services will improve integration, quality and productivity by:

- › enabling a wider range of services to be delivered in community settings through a modern and collaborative primary care infrastructure
- › establishing a base for local diagnosis, treatment, advice and outreach in Community Health Centres
- › providing the opportunity to co-locate and more closely integrate health and social services
- › providing Community Health Partnerships (CHPs) with the tools they need to deliver a consistently good service to those at greatest risk in their communities.

No-one has challenged the case for extending and enhancing local health care services to build healthier communities. This is entirely consistent with our view that NHSScotland should be as local as possible. Hospitals should be our last resort for most health care needs, not our first port of call.

General practice and the development of Primary Care Teams are great strengths of the NHS. They have enabled us to deliver health care that is personal, continuous and local. They also perform a 'gatekeeper' function, managing patients' access to specialist care services.

To enhance primary care, we need:

- › to build stronger teams in appropriate facilities
- › GP practices to have access to shared resources, facilities and expertise in a collective mode
- › multi-disciplinary and multi-agency responses to tackle the determinants of ill health
- › to extend the roles of health care professionals.

**We will respond to these challenges.**

Community Health Centres, whether in purpose-built facilities or housed in existing accommodation (such as large medical centres or community hospitals), can provide a wider range of local services such as specialist outpatient clinics, diagnostic tests (directly accessible by GPs) and day surgery. They provide a base for GPs and other practitioners with special interests and for NHS staff who will in future reach out into local communities (particularly disadvantaged communities) to provide anticipatory care.

### Primary care

Local GP surgeries will continue to provide most of the health care people need, working in partnership with community pharmacies, dental practices, optometrists, and NHS 24. They will also provide direct access to health care professionals for patients with acute illness and many long-term conditions. But local practices must become integrated with other community services as part of the whole NHS system of health care delivery.

Integration can be fostered by enabling health care professionals to work in Community Health Centres (including community hospitals), as well as in their practices. It will call for a shift in emphasis away from the independence of individual practices towards a more extended primary care team ethos. It will also need a radical review of the infrastructure in the community, particularly the premises from which services will be provided, and better use of integrated ICT to support patient care wherever it is delivered.

**The challenge is to make this vision happen. Examples already exist (see Box 2.1), and we will play our part in ensuring that primary care capital allocations support investment in this type of infrastructure, and that NHS Boards adjust their investment programmes to give priority to these changes.**

The new General Medical Services (GMS) Contract already provides a mechanism for NHS Boards to contract with GP practices to extend local services. The Quality and Outcomes Framework aligns GP services with the needs of local communities.

### BOX 2.1 EXAMPLE OF NEW LOCAL SERVICES.

In **Tayside**, the **Stracathro Diagnostic and Treatment Centre**, linked to a network of Community Resource Centres and Minor Injuries Units, provides the vast majority of acute care to the people of Angus within their communities.

The Centre contributes to a region-wide model of surgical care by providing minor and day case surgery, and is popular with staff and patients. When fully established within the next six months, the Centre will handle 20,000 care episodes that patients would otherwise had to have travelled to Dundee to receive. Services will include:

- a full diagnostic service, including CT scanning and MRI
- a network of outpatient clinics in all of the major specialties within Stracathro and in the Community Resource Centres.

In addition, Angus supports two Midwifery-Led Delivery Units in Arbroath and Montrose.

The Centre will be further enhanced over the next six months through a partnership with the independent sector. This will provide a surgical service for three NHS Boards – a good example of regional service planning and delivery.





**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



In forthcoming negotiations, **we will be looking to modify the GMS Contract to achieve the outcomes we have described. We will also begin to implement anticipatory care and local diagnostic services through NHS Boards and their CHPs.**

The arrangements for Primary Medical Services also allow NHS Boards to provide or commission services for particular patient groups where the traditional system may not be appropriate.

### **Community pharmacy**

Community pharmacists are key members of the primary care team. They are highly skilled professionals delivering important services to patients such as safely and efficiently dispensing the 72 million NHS prescriptions written in Scotland a year; advising patients on the appropriate use of both dispensed and purchased medicines; checking for drug interactions; and providing a convenient first port of call on the high street for advice on healthy lifestyles to the 600,000 members of the public who visit pharmacies in Scotland every day.

That is why **we are negotiating a modernised Community Pharmacy Contract to be implemented from 2006, which will reward pharmacists for the delivery of four main services:**

- the *Acute Medication Service* will continue to provide patients with access to the pharmacy of their choice for the dispensing of acute prescriptions and associated advice

- the *Minor Ailment Service* (already successfully piloted in Tayside and Ayrshire and Arran NHS Board areas) will enable patients who are exempt from prescription charges to register with a community pharmacy of their choice and have their common conditions treated by a community pharmacist on the NHS without the need to visit a GP
- the *Chronic Medication Service* will allow patients with long-term conditions to register with a community pharmacy and have their medicines supplied, reviewed, adjusted and monitored over a 12-month period as part of a shared care arrangement between patient, GP and pharmacist
- the *Public Health Service* will engage community pharmacy in the task of health improvement for individuals and local communities. The Public Health Service is designed to utilise the network of community pharmacies as healthy living walk-in centres and to encourage the involvement of pharmacists and their staff in supporting self care and promoting healthy lifestyles in order to help address Scotland's poor health record.

In addition, the Contract will promote the improvement and use of pharmacies as 'walk-in healthy living centres', where other care services can be provided.

The new ways of working are being underpinned by an extensive ePharmacy programme that exploits ICT to support patient care services. Building on early development work on the electronic transmission of prescriptions (ETP), the ePharmacy programme was established in 2003-2004 to develop a range of hardware, software and ICT initiatives to support the implementation of the new Community Pharmacy Contract. To date, some £11m has been invested in the programme.

The future roll-out of new technologies such as electronic prescribing and robotic dispensing systems in primary and secondary care will allow delivery of even safer pharmaceutical care services.

These improvements will be supplemented by our plan for a 50% increase in the number of non-medical prescribers by Spring 2008, through the provision of education and training programmes. Prescribing by health care professionals such as nurses, pharmacists and allied health professionals (AHPs) has allowed NHSScotland to make better use of all members of the health care team and improve patients' access to the right level of care first time.

### **The role of CHPs**

Community Health Partnerships (CHPs) will drive the shift in the balance of care we have outlined above. **They will need to identify specific and measurable service improvements, according to local needs, in the following areas:**

- › easing access to primary care services
- › taking a systematic approach to long-term conditions
- › providing anticipatory care
- › supporting people at home
- › avoiding hospital admissions
- › identifying opportunities for more local diagnosis and treatment
- › enabling appropriate discharge and rehabilitation
- › improving health and tackling inequalities
- › improving specific health outcomes.

### **We will continue to promote joint working with local authority services through:**

- › sustaining the focus of the Scottish Executive Health Department (SEHD) and the Convention of Scottish Local Authorities (COSLA) on measurable outcomes (and, if necessary, outputs from joint services) in the context of a framework of national and local targets
- › adopting a whole-systems approach based on common outcomes, and working within the community planning framework – the Joint Improvement Team we established in 2005 will help to ensure a focus on the key issues
- › accelerating the development of joint premises shared by NHS Boards and local authorities.

### **Extending professional roles**

We know that 90% of patients' interaction with the NHS starts and ends in primary care. We want to build on that by devolving further, rather than centralising.

We will support innovation which explores new approaches to delivering services. If we are to achieve a health care system that is genuinely embedded in local communities, we need to redesign services, extend roles and cut across some of the historical demarcation lines. But in doing so, we must seek to minimise clinical risks.

SEHD is already leading various initiatives to extend the roles of health care professionals (see Box 2.2). Work is under way to implement the frameworks for role development for AHPs and nurses. We will ensure that these frameworks also support the development of new and extended roles for community services.

AHPs have a vital role in rehabilitation, supporting people to remain at home, preventing unnecessary admissions and enabling patients to be discharged timeously from hospital. **SEHD will develop a rehabilitation framework to support services for older people, people with long-term conditions and people returning to work after a period of ill health.** The framework will promote a co-ordinated approach to delivering integrated care in community settings, focusing on the roles of AHPs. Our proposals will be published by May 2006.

**SEHD will also undertake a review of nursing in the community to develop a modern, redesigned community nursing service to support the future model of care we have described.** It will be published by May 2006.

### Practitioners with special interests

At present, a GP requiring specialist guidance on how to care for a patient has no alternative but to refer to a hospital-based consultant. GPs and other practitioners, who are trained in a special interest, can provide additional treatment options.

A Referral Management System, as described in Section 2.4, can help to determine the most appropriate service for some patients. The potential benefits are significant. For example, work done by the NHS Modernisation Agency in England has shown that up to 40% of orthopaedic referrals to outpatients can be treated by practitioners working in community-based practices.

We need to identify and develop the number of practitioners with special interests to achieve these kinds of service improvements. Already, we have supported the introduction of over 30 GPs with special interests (GPwSI), over 50 specialist nurses, and over 60 specialist practitioner AHPs in the CCI's Outpatient programme.

#### BOX 2.2

#### EXAMPLES OF EXTENDED HEALTH CARE PROFESSIONAL ROLES

##### NHS Fife

Physiotherapy-led orthopaedic outpatient services have proved very successful. They were introduced initially at the Victoria Infirmary in Kirkcaldy and have now been extended to the Queen Margaret Hospital in Dunfermline. The number of new patients being seen each month has doubled since October 2004 – 105 were seen in July 2005. Waiting times have been reduced from 715 waiting more than 26 weeks in October 2004 to only five in July 2005.

##### NHS Forth Valley

Three GPs with special interests (GPwSI) working alongside specialist nurses now run dermatology-linked care clinics in the community that aim to provide over 2,000 patient appointments a year locally. Instead of being referred to the acute hospital and waiting to see a consultant, patients can now see a professional with specialist knowledge

in the community. Waiting times are shorter for those needing to see a consultant, as the waiting list no longer contains the patients being seen locally.

##### NHS Argyll and Clyde

Physiotherapy assessment and treatment of self-referred (and GP-referred) patients presenting with low back pain is now available in four community locations. Specialist practitioner physiotherapists offer a self-referral, open-access service to patients with low back pain, assessing and treating patients according to protocols agreed by local GPs, consultants and AHPs. The service sees patients who may otherwise have been referred to the consultant, freeing up consultant appointments and reducing waiting times for other patients requiring more specialist procedures. Patients can self-refer for treatment, shortening the patient journey and allowing them to be seen closer to home.



The SEHD supports the continued development of practitioners with special interests. We will work closely with the RCGP, NES and QIS to ensure that the development of these roles continues, is driven by local need and is focused on the most clinically appropriate specialties.

We will give priority to the training of GPwSI with skills in:

- › long-term conditions
- › care of older people
- › services with demanding waiting time targets, such as orthopaedics and emergency medicine, particularly in more rural areas.

## **2.2 SYSTEMATIC SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS**

As Scotland's population lives longer, growing numbers of people will develop long-term conditions they will live with, probably for the rest of their lives.

Introducing a systematic approach to managing long-term conditions will improve integration, quality and productivity by:

- › matching more effectively the patient's need for care with the right level of response
- › managing someone's care needs as a whole when they have more than one condition
- › using information systems to deliver joined-up care
- › using the skills of the whole clinical team more effectively
- › developing systematic contact and support for patient self care and their carers
- › reducing emergency hospitalisation
- › ensuring a consistent approach and a spread of best practice across Scotland.

Evidence shows that:

- › growth in the number of people with long-term conditions will continue
- › an increasing number of people have multiple long-term conditions, which makes their care particularly complex
- › people in disadvantaged communities are more likely to have a long-term condition
- › a small number of people with long-term conditions account for a disproportionate amount of health care deployment
- › long-term conditions can be better managed through:
  - › increasing support for self care
  - › strengthening and extending primary care
  - › offering integrated and responsive specialist care
  - › managing vulnerable cases by anticipating needs
- › people with long-term conditions are significantly more likely to see their GP (accounting for up to 80% of GP consultations), to be admitted to hospital, and to stay longer in hospital following admission.

The prevalence of diabetes in Scotland, for example, is expected to increase significantly, perhaps even to double over the next 10-15 years. Diabetes can lead to a range of associated complications – increased risk of heart disease, kidney failure, sight loss and foot ulceration that can lead to amputation. Scotland has made considerable progress in the standards of treatment of diabetes through the development of the *Scottish Diabetes Framework*, and through the Scottish Primary Care Collaborative (see Box 2.3) An updated version of the framework will be published soon, and a national programme of diabetic eye screening to reduce blindness – one of the first in the world – will commence by March 2006.

## Population-wide prevention

Research evidence from the UK and elsewhere suggests that patients can be divided into three groups:

- ▶ the large majority of patients are usually able to manage their own conditions with the right advice and support
- ▶ a second group needs more professional care to, for example, avoid complications or slow the progression of their disease; there is a need for this group and care providers to work as partners
- ▶ a smaller group with particularly complex needs require a more intensive level of care, often referred to as 'case management' to signal the need for a co-ordinated and proactive approach.

The levels of care and corresponding service for patients are summarised in Figure 2.1.

The action the NHS needs to take to improve the quality of care for people with long-term conditions is set out in Box 2.4.

The pyramid as a whole includes all people with a long term health condition.

Level 1 is generally held to encompass 70-80% of all people with a long term condition, the appropriate model of care being "supported self care".

Level 2 covers 15-20% of patients with a higher level of risk and who require additional professional input.

Finally Level 3 covers a relatively small group of patients (no more than 3-5% of the population) who are at the highest level of risk with complex and often multiple conditions and who require intensive care management as the appropriate level of care.

### BOX 2.3 IMPROVEMENT IN DIABETES CARE

All Primary Care Collaborative practices are taking a more proactive approach to the care and management of patients with chronic conditions. This is evidenced by the improvements in outcomes for patients with diabetes made by those practices participating in Phase I

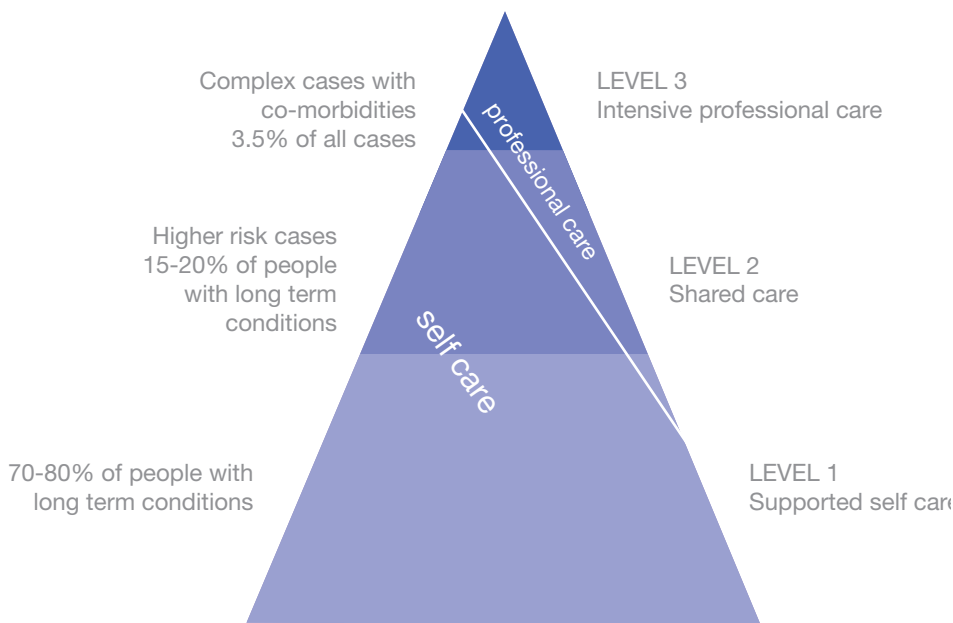
- ▶ 51% improvement in cholesterol levels

- ▶ 34% improvement in Blood Pressure levels
- ▶ 30% improvement in HbA1c levels (blood sugar)

Sharing this information with patients can encourage better self-care. It can also help to target early intervention (anticipatory care) to reduce the risks of hospitalisation.

**FIGURE 2.1**

**Patients with long-term conditions: self care and management**



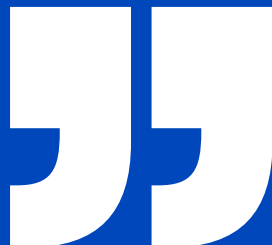
**BOX 2.4**

**THE KEYS TO MANAGING LONG-TERM CONDITIONS**

Effective long-term conditions management will:

- › focus on the whole person (holistic care)
- › involve people in their own care
- › provide care in the least intensive setting
- › aim to minimise unnecessary hospital visits and admissions
- › be co-ordinated in primary care
- › be provided by a multi-disciplinary team
- › integrate generalist and specialist care
- › integrate health and social care
- › use a population approach
- › use good information systems and intelligence
- › identify people with long-term conditions and place them on a general practice-based register, with their consent/authorisation
- › use a structured approach to call and recall
- › review care using evidence-based protocols and guidelines
- › focus on improving medicines management
- › use community and voluntary resources well, including support for family carers.

Source: *National Framework for Service Change*







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To support local health services in implementing this approach, SEHD will:

- develop and introduce a new approach to risk prediction
- promote a stratified approach to meet the care needs of patients with long-term conditions
- introduce a 'tool kit' to enable CHPs to benchmark the development of local services for those with long-term conditions.

These three actions are linked. The better we can predict the vulnerability of a patient and the risk of hospital admission, the more likely we are to be able to provide people with the right level of support.

We will ensure that service development for long-term conditions is taken forward in a systematic way. **We will establish a national strategy for the care of long-term conditions by convening an expert group to agree the development of the risk prediction and benchmarking tools and to identify more fully the implications of the stratified approach to the care of these conditions.** We will complete this work by June 2006.

This is a necessary first step in our strategy for long-term conditions, which has two parts. First, we will identify those people at greatest risk of hospital admission and provide them with earlier care to prevent the deterioration of their health. Second, we will equip people at all levels to manage their own health, enabling them to take greater control of their condition and of their life.

### **Risk prediction**

A number of NHS Boards have done work on risk prediction. NHS Ayrshire & Arran and NHS Tayside, for example, are each working on a screening tool that uses a range of criteria to predict vulnerable patients. The criteria include clinical indicators such as multiple chronic diagnoses, multiple prescribed drugs and significant impairment in activities of daily living, and criteria based on hospital attendance and admission.

We have also looked at models delivered in England and in the US. The evidence suggests that the better the predictive capacity of the tool used to identify high-risk patients, the more likely we are to secure better care without the need for hospital admission. **SEHD and NHS Quality Improvement Scotland will work with others to determine the optimal set of indicators. We will then make the use of this tool a requirement in NHSScotland for managing long-term conditions.**

## Intensive co-ordinated management

We will provide comprehensive, integrated care for those with the most complex health care needs and the greatest vulnerability to emergency hospital admission.

Holistic care of this nature is best delivered in the community by primary care teams. Research evidence indicates that GPs should take a particular interest in patients with the most complex health care needs, working with their practice teams to develop personalised care plans to meet their needs.

A member of the primary care team needs to be identified as a fixed point of reference for the patient. This person will take responsibility for the patient, co-ordinating the contribution of various professionals with an interest (including those in social care) and anticipating and dealing with problems before they lead to worsening health or hospitalisation.

A local decision should be taken on who is best placed to offer co-ordinated care. It may be a GP or a nurse, an AHP or social care professional. **We will ensure the care co-ordinator has the right skills, knowledge and contacts to provide the joined-up care required for the patient.**

The expert group on care for long term conditions will oversee the preparation of guidance for NHSScotland and primary care practitioners. **All NHS Boards will be providing care of this nature to the most vulnerable people with long-term conditions by the end of 2007.**

## Improving self management

Self care and self management have become increasingly important for people with long-term conditions as means of maintaining independence and enhancing well-being.

Supporting self care and self management means more than giving patients information about their condition. It also means that health care professionals must empower patients (and involve their family carers) to take greater control over their own care.

We will establish a Scottish Long-Term Conditions Alliance in 2006 to support self management. We will work with the Alliance to:

- › ensure that patients and their carers have the skills and knowledge they need, and someone they can contact if required
- › develop mentors and 'expert patients' to act as advisers and role models
- › pilot home-based information technology to support self management at home.

## CHP self-assessment tool kit

We want to be sure that the various changes proposed will actually make a difference to people with long-term conditions. For this reason, we have supported the creation of the CHP self-assessment tool kit to support each CHP to recognise whether it is delivering good, safe and responsive services for people with long-term conditions as locally as possible.

The tool kit, which has been piloted successfully in NHS Lanarkshire, will allow CHPs to benchmark their activities, identify areas of good practice and draw up action plans to improve services and fill gaps. It sets out clearly measurable criteria relating to four standards:

- › organisation of long-term conditions management
- › patient information and supported self care
- › multi-disciplinary and multi-agency working
- › inter-disciplinary education and training.

The format, which will be familiar through its use in the accreditation of MCNs, will also include outcome indicators being developed for CHPs.

**The tool kit represents an effective way of introducing generic approaches to long-term conditions in a way that helps promote consistency of approach across the whole of Scotland. Use of the tool kit will therefore be mandatory for CHPs.**

## Supporting unpaid carers

A central theme for future health care policy in Scotland is the recognition of unpaid family carers as key partners and providers of care, as embedded in the Community Care and Health (Scotland) Act 2002.

The enormous contribution of carers was shown in the 2001 Census, which identified over 115,000 unpaid carers caring for 50 hours or more a week. Further evidence was supplied in the recent Care 21 report, *The Future of Unpaid Care in Scotland*, the most detailed study of carers to date. The report recommends that the NHS and local partners provide carers with the information and training they need for their caring role and build 'carer awareness' into professional training. **We will issue guidance later this year on the implementation of NHS carer information strategies to support this work.**

## 2.3 REDUCING THE INEQUALITIES GAP

There are unacceptable differences in healthy life expectancy in Scotland.

Figure 2.2 shows that Scotland's health is improving, but the improvement is greater in more affluent areas. The differences within Scotland in life expectancy and premature mortality are significant and widening.

In 2002, life expectancy at birth for men living in the most disadvantaged areas was 69.5 years, compared with 78.4 years in affluent areas; for women, it was 77.3 years, compared with 82.3 years in the most affluent areas (Figure 2.2).

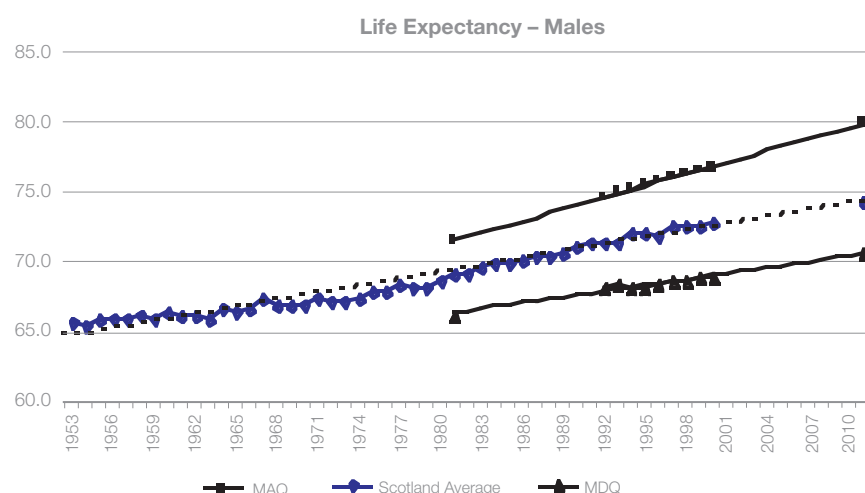
There is evidence that more people in disadvantaged parts of Scotland are living longer with illness. In 2001, 21% of women living in disadvantaged areas reported they had a limiting long-standing illness or disability, compared to 8% of women in the most affluent areas. The corresponding figures for men were 21% and 9%.

There is also clear evidence emerging of the gap between our most affluent and most deprived communities in more specific indicators of health, as set out in Figures 2.3.

The Executive's approach to closing the opportunity gap by tackling poverty and disadvantage in Scotland will benefit the health of people living in the most deprived communities, by addressing aspects of poverty such as improving people's employability, increasing young people's confidence and skills and regenerating the most disadvantaged neighbourhoods.

**FIGURE 2.2**

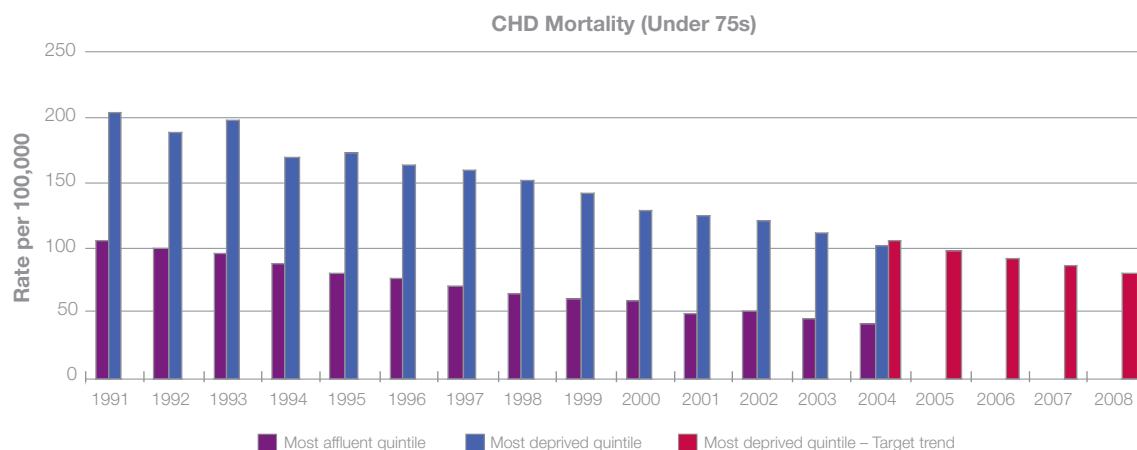
**Change in male life expectancy 1953-2001**



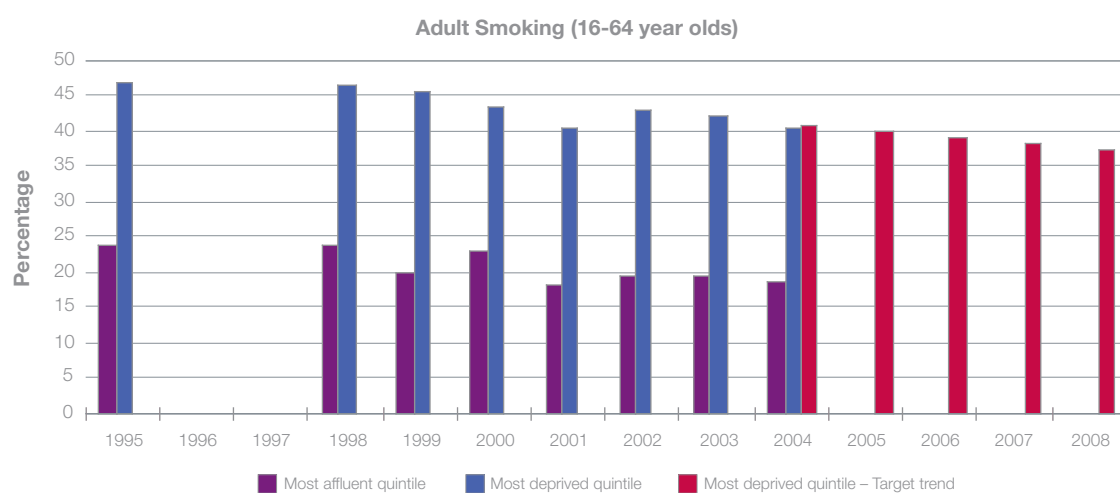
MAQ: 20% Most Affluent Areas

MDQ: 20% Most Deprived Areas

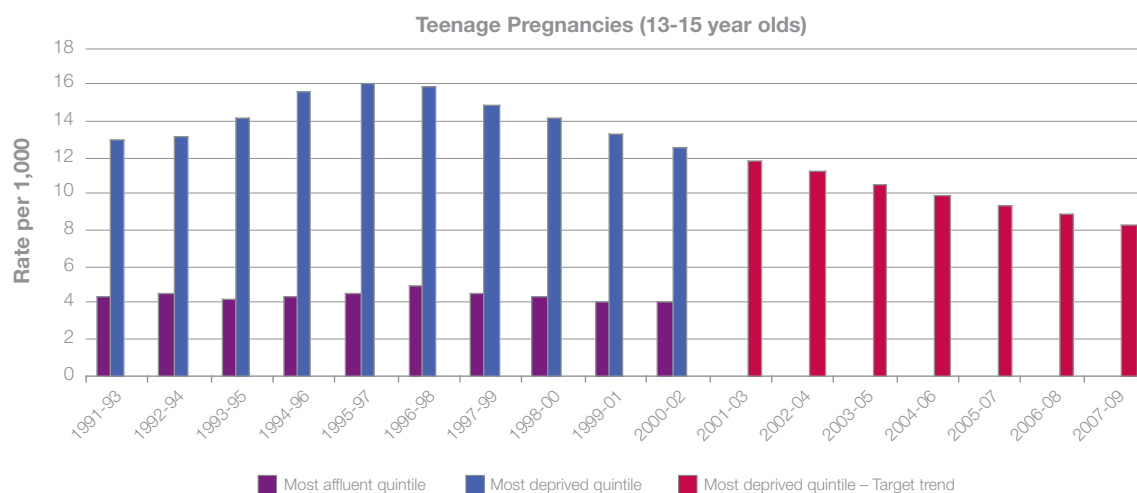
**FIGURE 2.3A**



**FIGURE 2.3B**



**FIGURE 2.3C**





**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



Much work is already being done across the Scottish Executive to address these issues.

The new £318m (2005-08) Community Regeneration Fund (CRF) will help Community Planning Partnerships achieve community regeneration of the most deprived neighbourhoods, through improvements in employability, education, health, access to local services and quality of the local environment. The fund has a specific focus on health inequalities and will support interventions across a range of health improvement measures including, for example, Public Health Nurses to undertake preventative health promotion in North Ayrshire, substance misuse services in East Renfrewshire and sexual health projects for young people in Dundee.

The Scottish Executive's Central Heating Programme is the biggest investment ever made in a home energy efficiency programme in Scotland. It is aimed at Scotland's most vulnerable households: those whose health or general wellbeing may be at risk from cold and damp housing. Approximately 65,000 householders will receive free central heating, insulation and other benefits under this scheme by March 2006 as a result of this £140 million investment.

We have also provided £64 million through the Warm Deal programme for home insulation grants for low income households and pensioners. This has ensured the insulation

of 218,000 homes, nearly one tenth of all of Scotland's housing stock.

The impact of these fuel poverty programmes on health is being assessed by the University of Edinburgh's Research Unit in Health. The report is expected in 2006.

We believe that NHSScotland can do more itself to break the link between deprivation and poor health. We need not only a sustained effort to promote good health and good health care, but also to target our resources at areas of greatest need. This will call for additional service activities to promote and support good health in our most disadvantaged communities and for the lessons learned to be translated elsewhere. An example of an effective health service response to health inequalities is shown in Box 2.5.

We have made clear our determination to achieve progress by setting targets to increase the rate of improvement across a range of health indicators – the incidence of CHD, cancer, smoking, teenage pregnancies and suicide – by 15% by 2008 for the most disadvantaged communities.

We believe the most significant thing we can do to tackle health inequalities is to target and enhance primary care services in deprived areas. Strengthening primary care teams and promoting anticipatory care in disadvantaged areas will reduce health inequalities by:

- › targeting health improvement action and resources at the most disadvantaged areas
- › building capacity in primary care to deliver proactive, preventative care
- › providing early interventions to prevent escalation of health care needs

This approach will ensure that people at greatest risk of ill health are actively identified and offered opportunities for early detection, advice and treatment, enabling earlier identification, prevention and treatment for conditions such as high blood pressure, type 2 diabetes and high cholesterol. Strengthening primary care services in these communities can improve health outcomes through preventive medicine, changing the focus to ‘anticipate and prevent’.

The approach requires:

- › primary care teams with dedicated resources aimed at identifying and recruiting ‘at risk’ populations
- › targeting identified populations for health checks, screening, advice or referral to community services or treatment
- › targeting ‘at risk’ populations for health improvement promotion and prevention services (putting primary care and CHPs at the heart of measures to promote health and well-being while tackling health inequalities)
- › targeting and designing services such as smoking cessation and alcohol and weight management to meet the needs of people most at risk
- › working with voluntary and other organisations which are close to local communities and which can therefore be a useful bridge to primary care services
- › systematic, regular monitoring and evaluation.

## BOX 2.5

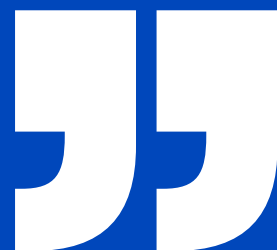
### AN EXAMPLE OF AN EFFECTIVE HEALTH SERVICE RESPONSE TO HEALTH INEQUALITIES

The Welsh GP Julian Tudor Hart advanced the ‘inverse care law’ – that the availability of good medical care tends to vary inversely with the needs of the population served – some thirty years ago. Given the unmet health needs in Scotland’s most disadvantaged communities, there is much we can learn from the model of anticipatory care and preventative medicine pioneered by Dr Hart.

Dr Hart provided proactive care for Glyncoirwg, a disadvantaged industrial village in South Wales with a population of less than 2,000 people, for 25 years. He began a programme of active search for health needs in his practice in 1968.

Statistics show that health outcomes, including mortality rates, were dramatically better in Glyncoirwg than in the neighbouring and socially similar Blaengwynfi. By the end of Dr Hart’s period in Glyncoirwg, age-standardised death rates under 65 were 28% lower than the neighbouring village. Perhaps even more striking is the fact that while Glyncoirwg was one of the five most disadvantaged of West Glamorgan’s 55 electoral wards, it ranked third for age-standardised mortality under 65, on a par with the most affluent areas in the region.

These dramatic improvements were the result of the system of anticipatory care and preventative medicine put in place by Dr Hart, built on proactive case finding, preventative interventions and regular follow-up and audit.







**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



To strengthen the capacity of primary care teams in these areas, we will examine the scope for new staffing developments to support general practice, in addition to key roles for practice nurses and AHPs.

Activity should be supported nationally by systems to enable patient identification and risk stratification, the development of new skills and roles, and evaluations of the success of interventions.

#### **We will:**

- › pilot this approach in 2006/2007 in up to five CHPs; this will allow us to generate evidence of what is most effective in achieving better health outcomes
- › place CHPs at the centre of work on tackling health inequalities
- › continue with tried and tested interventions in the high-risk areas of smoking, alcohol, diet and physical activity, in addition to treating key clinical needs
- › use the evidence gathered from pilots to inform more general and widespread application of the 'anticipate and prevent' approach elsewhere, for other people at risk through deprivation.

## **2.4 ACTIVELY MANAGING HOSPITAL ADMISSIONS**

There is now evidence of a sustained reduction in the longest waiting times in Scotland. Much of the progress has been secured through increasing capacity where required and by improving productivity. We can do more to reduce the need for planned hospital admission to ensure that this welcome reduction in waiting is maintained and challenging targets for the future are achieved.

**We will implement five simple changes across NHSScotland that will raise the performance of all NHS Boards to the standard of the best.** Implementing these five simple changes will improve integration, quality and productivity by:

- › enabling more care to be delivered locally, often by the primary care team
- › ensuring patient pathways are planned in advance, patients have a seamless experience and are informed about their programme of care
- › speeding access to care
- › sharing best practice and making NHS Boards accountable for raising their performance.

The changes are evidence based and draw on best practice from around the world. They have been tested on the frontline and have been shown to work. **We will ensure that NHS Boards implement all of the changes systematically.**

**We will require all NHS Boards to develop a three-year improvement plan to introduce these changes, beginning in 2006/2007, including the introduction of referral management centres for appropriate services.**

### **Change 1: Treat day surgery (rather than inpatient surgery) as the norm for planned procedures.**

Day surgery has grown over the last 20 years as a result of technological and medical innovations such as less-invasive surgery and improved anaesthesia. The benefits for patients are significant. Day surgery is less disruptive to patients and their families, and has proved to be the preferred option when available. It is frequently delivered in local hospitals or in Community Health Centres.

Day surgery has, however, not grown as quickly in all locations as might have been expected, due mainly to the way hospitals

are organised. Promoting day surgery will help to shift the balance of care. It will help to separate elective from unscheduled care, and so reduce uncertainty and disruption for patients. It can also release resources by increasing productivity – by transferring just 4,000 patients to day surgery, it is estimated that 5,600 hospital bed days would be released.

The rate of day case surgery as a percentage of the total will be a key measure reported by NHS Boards in the new Local Delivery Plans and used to monitor NHS Boards' progress in this area.



### **Change 2: Improve referral and diagnostic pathways.**

Evidence suggests that referral between primary and secondary care and access arrangements for diagnostic tests often create bottlenecks in the system. To tackle this, we will work with NHS Boards to improve access to eight key diagnostic tests in radiology and endoscopy in a two-year redesign programme running to December 2007 (see 'Diagnostic services' in Section 3.2 below).

Referral and diagnostic pathways must be defined with clear referral protocols, and implemented in practice, with:

- electronic referral to a central point
- referral to a service, not to a consultant (unless there are clear clinical reasons for referring to a named individual)
- direct referral from diagnostics to a specialist service (without the need to go back to the GP)
- waiting list management
- flexible and extended working days
- introduction of new roles with agreed competences
- protected time for reporting.







## **BOX 2.6**

### **REFERRAL MANAGEMENT AND BOOKING SERVICES.**

Referral Management and Booking Services will help to ensure that the patient is seen by an appropriate practitioner, in an appropriate setting, in the shortest possible time.

Traditionally when a GP is unable to diagnose or manage a patient's condition, he or she refers the patient to a named consultant in secondary care. The GP may not be aware of the range of services available on referral.

A Referral Management and Booking Service can accept referrals from appropriate members of the primary care team. The referral of a patient with a musculoskeletal problem, for example, can be vetted by the multi-disciplinary team and directed to the most appropriate practitioner with the shortest wait. Patients may also be offered their appointment at a choice of locations.



### **Change 3: Actively manage admissions to hospital.**

Where hospital admission is indicated, a team of health care professionals will work together to ensure best outcomes for the patient. Nurse-led pre-admission clinics, with support from anaesthetic services, are already being adopted for pre-admission assessment for surgery. Experienced nurses are able to discuss common procedures with the patient, answering questions, allaying concerns, and offering reassurance.

Pre-admission services provide many benefits. They improve the quality of care offered to patients, resulting in a lower cancellation rate and increased patient satisfaction. They also increase productivity by improving operating theatre efficiency and utilising bed resources more effectively.

Pre-admission clinics will also begin the process of planning patient discharges, agreeing with the patient the level of community support required and ensuring primary care and local authority colleagues are notified, even in advance of the operation date.

#### **Change 4: Actively manage discharge and length of stay.**

Evidence shows that there is scope for bringing down the average length of hospital stays, in line with best practice in high-performing hospitals or specialities. With effective management and the introduction of a dynamic discharge process, current bottlenecks within the system could be reduced, shortening hospital stays and improving patient experience.

One option is to introduce discharges at weekends. This would not necessarily require great capital outlay or create a greater burden for consultants; nurses and AHPs are already discharging patients, and this can be more widely implemented.



#### **Change 5: Actively manage follow up.**

Around 75% of failures to attend by outpatients are for follow-up appointments. We know that in some areas, outpatient clinics see on average around four follow-up cases for every new case. The scope to speed access to the first outpatient clinic is obvious, and reveals a need to review current follow-up processes.

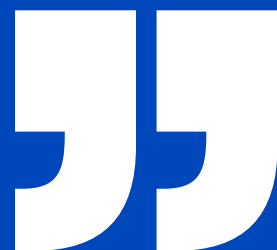
Patients should only receive follow-up appointments with a specialist where there is a clinical need. To maximise the potential for integrated care, any necessary follow up should be carried out in the right health care setting by the appropriate health care professional. NHS Boards should actively manage this shift.



### **BOX 2.7 FOLLOW UP APPOINTMENTS**

In 2004/05 there were almost **280,000** dermatology outpatient appointments in Scotland, two thirds of these were return appointments. Many of these patients require follow-up appointments for long term conditions. Traditionally these patients have been managed by consultants in an acute setting. In NHS Lothian specialist nurse practitioners have now been trained to

manage patients with chronic conditions such as psoriasis and acne. Around 400 patients are seen on a monthly basis by the nurses, benefiting patients through much shorter waiting times. The nurses also provide a telephone consultation service allowing patients to call for advice on their conditions without having to leave their homes.





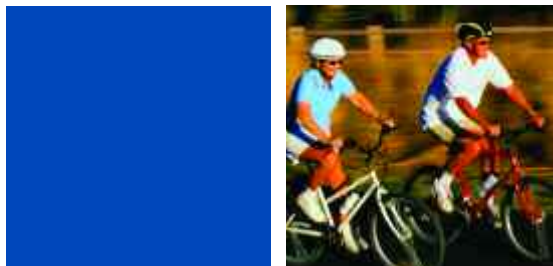
“

Our vision for the NHS is to reapply its founding principles with vigour to meet the needs of the people of Scotland. Delivering for Health means a fundamental shift in how we work, tackling the causes of ill-health and providing care which is quicker, more personal and closer to home.

”

# Section three

## An integrated NHS for the whole of Scotland



Our objectives of high-quality services and better productivity will be achieved by promoting the integration of services. Service co-location will support the aim of integration, but much more important are the development of a culture and the creation of working practices that enable co-operation and teamwork.

At the heart of our programme to promote integration is a strategy to increase sharing of information, with unified databases, effective communication links and standardised protocols.

We set out below the national eHealth strategy for the application of information and communications technology, built around an Electronic Health Record.

Our objective also requires a clear understanding of the way different services interact, especially in the way resources – hospital facilities and health care professionals – have to be mobilised to meet distinctive needs.

In this section, we therefore:

- ▶ address the challenges of managing unscheduled (including emergency) care and elective (planned) care
- ▶ outline opportunities for reshaping specialist services in hospitals, applying them to specific patient groups such as those who access rural health services, mental health services, children's health services and neurological services

- ▶ outline our plans to link service redesign with workforce planning as it develops in line with our *National Workforce Planning Framework*, published in August 2005.

### 3.1 eHEALTH STRATEGY

A common information and communications technology (ICT) system is essential if NHSScotland is to deliver the integrated care services we require. Health care providers around the world recognise the opportunity for faster, safer, more efficient and more patient-centred services that ICT offers. International evidence suggests that an Electronic Health Record can address many current problems for patients and services. For instance:

- ▶ one in seven hospital admissions occurs because care providers do not have access to previous hospital records
- ▶ 20% of laboratory tests are requested because the results of previous investigations are not accessible
- ▶ 15% of hospitalisations are complicated by medication error.

*A comprehensive health information system built around an Electronic Health Record is vital to achieve the shift away from reactive, crisis-management, acute-oriented care towards anticipatory, preventative and continuous care.*

Delivering the eHealth agenda will be extremely challenging. Many changes will be necessary, such as adhering to more rigorous record-keeping standards and ensuring that communications are marked properly with the patient's Community Health Index (CHI) number to enable clinical information to be safely and securely shared in an electronic environment. Wherever possible, clinical staff will record their interventions directly into Electronic Health Records, rather than transcribe to written records. Adherence to security standards will be built in so that patients and clinicians can be confident that records remain confidential.

Clinical staff will be increasingly involved in agreeing the criteria for Electronic Health Records. A degree of local configurability is necessary, but only the adoption of rigorous technical and information standards will ensure that patient information is available and reliable at the point of need. Previous freedoms to procure and implement systems locally will be curtailed to ensure that local systems align with the move to Electronic Health Records.

Much work is already underway in Scotland (see Box 3.1 for an example).

The general effort can be split into two streams.

**Stream 1** of the work focuses on the short to medium term and includes the elements set out in Table 3.1.

**Stream 2** consists of planning and implementing the **Electronic Health Record**. Planning work has now begun. Deployment of a new system is expected to start in 2007, and will be completed in 2010.

We will complete procurement by June 2007 and will only authorise developments that are consistent with and support the migration to a single record.



### **BOX 3.1 EXAMPLE OF WORK UNDERWAY IN SCOTLAND**

**The Ayr Hospital** has implemented a **Hospital Electronic Prescribing and Medicines Administration (HEPMA)** system that allows on-line prescribing and administration of medicines to inpatients.

The system has reduced or abolished many errors such as those associated with legibility of the prescription. It is being evaluated very carefully in advance of any national roll-out so that the requirements and dependencies of implementation are understood, as was urged by Audit Scotland. A single drug record shared across delivery sectors will be a vital element of the record.

The national budget for eHealth will increase almost threefold over the next three years, from £35.3m in this year to £100.3m in 2007/2008. Much of this resource will support the local infrastructure required for the Electronic Health Record. NHS Boards will be obliged to demonstrate that existing local IT budgets are planned for growth over the same period to ensure that NHS staff across all Board areas have the right IT tools, support and training to deliver beneficial changes to patient care in line with the eHealth strategy.

A second element of Stream 2 will be the establishment of a **Scottish Centre for Telehealth**. The Centre will provide practical help to NHS Boards as they seek to realise the potential of telehealth development projects (see Box 3.2 for an example). Following evaluation of development projects, approved National Telehealth Reference Solutions will be brought to the attention of NHS Boards, and we will promote the development of standardised solutions.

The core functions of the Scottish Centre for Telehealth will be to:

- provide a centre of expertise to define and disseminate best practice and develop inter-operable standards, protocols and processes to support telehealth solutions
- provide practical and informed support to telehealth projects in their development phase and to NHS Boards implementing National Telehealth Reference Solutions
- co-ordinate the evaluation of projects capable of evolving into National Telehealth Reference Solutions and support the process of awarding funds to projects.
- evaluate the impact of telehealth solutions on service redesign

The Centre will harness the skills and expertise of key groups across Scotland from medicine, operational management, and telehealth technology and impact evaluation. NHS Grampian will provide the hub for the Centre, building on local experience of telemedicine.

### **BOX 3.2**

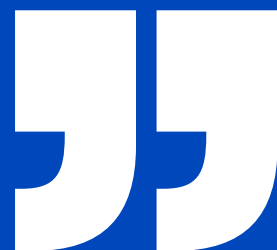
#### **EXAMPLE OF A SCOTTISH TELEMEDICINE PROJECT**

The **Scottish Paediatric Telemedicine Project** has been established to improve clinical and education links between hospitals where ill children are managed.

The system is currently in Yorkhill, Ayrshire, Wishaw, Ninewells, Edinburgh Royal Hospital for Sick Children, Simpson's Centre for Reproductive Health (Edinburgh), the Princess Royal Maternity Hospital (Glasgow), Kirkcaldy and Paisley and will be rolled out imminently to Aberdeen, Inverness and Stirling.

It was intended initially to provide telemedicine links for the assessment and discussion of ill children with cardiac or surgical problems, and this has been very successful. Of the first 19 surgical consultations, 10 transfers were prevented.

An exciting development has been the wide range of uses made of the network – foetal medicine, psychiatric, renal and genetic consultations have been performed, in addition to regular broadcasts of teaching sessions from Yorkhill Hospital. Even job interviews, case conferences and a variety of administrative meetings have been facilitated, with great savings in staff time.



**TABLE 3.1****Stream 1 activities**

<b>Community Health Index (CHI) number uptake</b>	The reliable identification of the patient's record is a prerequisite for composite Electronic Health Records. Identification must be founded on the CHI number, which is a unique patient identifier. We will achieve universal uptake of the CHI number by June 2006.
<b>Picture Archiving and Communication Systems (PACS)</b>	The clinical case for a national PACS service to enable electronic transfer of digital records such as X-rays and scans is strong, and the savings on film costs are compelling. National roll-out will be completed by June 2007.
<b>Emergency Care Summary (ECS)</b>	A single, national ICT record system that contains key information from GP records such as current medication and allergies is being developed. Complete roll-out to out-of-hours services and NHS 24 will be achieved by June 2006. Content will be then enhanced and access extended to A&E Departments and the Scottish Ambulance Service. Access and the ability to contribute to the Emergency Care Summary Record will also be considered for other groups, such as Community Pharmacists.
<b>National A&amp;E System</b>	This software program is used to support all aspects of the patient's A&E journey. It includes an online A&E attendance card initiated by reception staff, which flags to triage staff that the patient is waiting, and other facilities for staff to record times and relevant information. It also links to electronic referral systems, including the Scottish Ambulance Service, and allows transmission of attendance letters to the patient's GP. It helps staff to access information already held about the patient and to check Child Protection status. Comprehensive analysis of A&E waiting times from electronic information systems will start in January 2007. NHS Boards must implement the National A&E System or demonstrate that existing software can fulfil national requirements.
<b>ePharmacy</b>	<p>The ePharmacy programme (see Section 2.1) is an ambitious programme that will:</p> <ul style="list-style-type: none"> <li>› connect all community pharmacies to the NHS Net</li> <li>› design and build a generic architecture and infrastructure to underpin identified e-applications to support future delivery of core pharmaceutical care services</li> <li>› develop a central patient registration system</li> <li>› establish training and support programmes for community pharmacists and their staff on the use of new systems</li> <li>› develop more efficient payment processing systems.</li> </ul> <p>It is a major initiative that will deliver more efficient and safer working practices in pharmacies, enabling community pharmacists to devote more time to patient care. The development and phased implementation of the electronic infrastructure and support for the community pharmacy strategy and the new Contract will be delivered as follows:</p> <ul style="list-style-type: none"> <li>› Minor Ailment Service April 2006</li> <li>› Public Health Service April 2006</li> <li>› Acute Medication Service April 2007</li> <li>› Chronic Medication Service April 2007.</li> </ul>



## 3.2 HOSPITAL SERVICES: PLANNED AND UNSCHEDULED CARE

Our planned investment in Scotland's hospitals will enable us to deliver care that is quicker, safer and more reliable, whether the patient requires emergency or planned care. The programme includes:

- › two 'walk-in' hospitals in Glasgow (at Stobhill and the Victoria Infirmary)
- › the renewal of the Southern General Hospital in Glasgow
- › a new Children's Hospital in Glasgow
- › a new hospital for Forth Valley at Larbert, with associated walk-in hospitals at Stirling and Falkirk
- › the partial rebuild and refurbishment of the Victoria Infirmary in Kirkcaldy and the redevelopment of the Queen Margaret Hospital in Dunfermline.

Many smaller developments are also under way, including:

- › redevelopment of Ailsa Hospital in Ayr
- › development of Ayrshire Community Hospital
- › Phase 2 of Glasgow Royal Infirmary
- › refurbishment of wards at Dumfries and Galloway Royal Infirmary
- › redevelopment of Chalmers Hospital in Grampian.

These developments are consistent with the models for hospital care described in the *National Framework for Service Change*.

**We will require NHS Boards to:**

- › **plan all subsequent hospital developments to be consistent with these models**
- › **organise existing services to promote the separation of unscheduled and planned care**
- › **work together on a regional basis, and with the Scottish Ambulance Service, to ensure effective networks of hospital care are in place.**

## Unscheduled care

The rise in emergency admissions to hospital in recent years is striking. It has been accompanied by a significant increase in the proportion of bed days occupied by emergency patients: in 1983, 59% of bed days were occupied by emergency patients, compared to 80% today.

Welcome changes to the training of doctors and the gradual implementation of the Working Time Regulations by 2009, when weekly working limits of 48 hours will apply (to support patient safety by ensuring that doctors achieve sufficient rest), mean that the model of unscheduled care must be reviewed. We will therefore develop other parts of the service to prevent emergency admissions, while acting to maximise the input from trained doctors and to develop a multi-disciplinary approach that makes best use of contributions from other members of the clinical team.

The need for unscheduled care can be reduced through the actions we set out in Section 2. There will, however, always be some patients identified by general practitioners, or who seek help by calling the emergency ambulance service, or who present at A&E departments, who require immediate admission. **We intend to redesign the model of unscheduled care throughout Scotland, building on the National Framework and the Unscheduled Care Collaborative Programme.**

Developing a stratified unscheduled care system will improve integration, quality and productivity by:

- › maintaining care at local level for the majority of unscheduled cases through multi-disciplinary teams working in Community Casualty Units
- › allowing a greater separation of planned and emergency care wherever possible to protect capacity in both
- › reducing the number of appointment cancellations for patients, and reduce waiting times
- › achieve a more efficient use of limited facilities and specialist staff across the country.



**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



NHS 24 has a key role to play in supporting NHS Boards to deliver unscheduled care in the future. The recent review of its activities has produced a detailed report with recommendations. NHS 24 will work with its partners across the NHS to implement the changes that will allow a sustained improvement in performance. As that review makes clear, an effective service requires a responsiveness to local needs and good systems to distinguish genuine emergencies from routine calls.

We will:

- ▶ begin the implementation of new, accredited models of unscheduled primary care based on multi-disciplinary care teams from 2006
- ▶ continue to invest in the Scottish Ambulance Service to ensure delivery of the key eight-minute response target by the end of March 2008, and require it to develop proposals for the development of its services, consistent with the National Framework, by September 2006
- ▶ develop hospital unscheduled care in line with the model of the National Framework, separating planned and unscheduled care where appropriate
- ▶ use telemedicine to integrate the various levels of the unscheduled care system; this will help to avoid inappropriate referrals and unnecessary travel for patients by fostering better communication among health care professionals

- ▶ support the development of networks of Community Casualty Units linked to appropriately staffed and resourced Emergency Centres
- ▶ allow emergency specialists to concentrate on dealing with complex cases by focusing key medical resources in well-staffed and resourced Emergency Centres
- ▶ plan emergency admitting services on a regional basis to ensure the most appropriate distribution of services and staff for the needs of the Scottish population in the 21st Century

NHS Boards and Regional Planning Groups have begun to work on these issues. They will be required to report their conclusions by the end of 2006. Our objectives are clear – to deliver urgent care that is tailored to individual needs locally if possible, but always safely.

### **Planned care**

We set out some of the practical measures NHS Boards will take to manage demand for planned care in hospitals in Section 2. Our principal objective for the improvement of planned care remains a further reduction in waiting times, with specific national targets set (see page 6).

NHS Boards need to work together in the Regional Planning Groups to insulate elective care from the impact of emergency care and to retain most elective procedures in local facilities.

Streaming of planned care will improve integration, quality and productivity by:

- › improving predictability of workflow and facilitating the matching of supply and demand
- › reducing cancellations
- › making best use of facilities
- › improving access for patients.

Benefits realised through the focus on planned care in cardiac and orthopaedic services at the Golden Jubilee National Hospital in Clydebank illustrate what can be achieved, particularly in relation to improving productivity and reducing inpatient waiting times for inpatient and day case treatment.

## National Tariff

**We will introduce a national tariff for hospital procedures to increase transparency in how the NHS uses its money.** The national tariff will form the set price list for activity carried out by one NHS Board on behalf of patients who reside in another NHS Board area.

The objective of the national tariff policy is to:

- › create a set of standard prices for most procedures to simplify the process for service level agreements between Boards
- › create a system that is transparent and fair, and takes into account both volume and case-mix complexity
- › create an incentive for efficiency by encouraging benchmarking among Boards, and
- › improve the accuracy of financial data by ensuring better recording of both cost and activity data.

The application of the national tariff to cross-boundary activity will be phased in starting in 2005-6, using a selection of specific procedures. NHS Boards have been asked to agree financial flows for this activity using the national tariff by the end of November 2005. The range of procedures to which the tariff will apply will be increased progressively over the next two financial years.

The Executive will monitor the implementation of tariffs, closely benchmarking Boards' performance against the tariff and ensuring that data quality is improved over time.

## Independent sector

The long-term relationship between the NHS and the independent health care sector can help to deliver faster access and innovative solutions to some of the challenges identified in the Kerr report. It can support our objectives for a greater separation of elective and emergency work and for faster access to diagnostic services.

We have pledged £45 million over 3 years to negotiate contracts with the independent sector to enable NHS patients to receive their operations more quickly where clinical quality and value for money can be guaranteed. Such a commitment can help to build capacity and bring down prices.

There are three strands to our independent sector purchasing strategy:

- › Effective use of existing private sector health care capacity within Scotland, with strict rules on additionality and value for money.
- › Use of mobile diagnostic facilities.
- › Creation of fast track diagnostic and treatment centres.

During 2004/5, the Executive, through the National Waiting Times Unit, allocated £10m to NHS Boards in Scotland to purchase additional capacity from the independent sector. A further £10 million has been allocated for 2005/6. This has enabled patients throughout Scotland to be treated more quickly in specialities such as orthopaedics, urology, ENT, plastic surgery, ophthalmology and general surgery.

Independent sector 'see and treat' initiatives have been successful in both Greater Glasgow and Tayside, where patients were assessed as outpatients and if treatment was required, operations were provided. Further examples are in Box 3.3.

We may also see the adoption of more short term mobile solutions over the next year, in specialties such as ophthalmology, general surgery and MRI.

## Diagnostic services

Diagnostic services are a key part of inpatient, outpatient, primary care and emergency care pathways. The wait for diagnostic tests, however, often presents a bottleneck in the care pathway and leads to uncertainty and heightened anxiety for patients.

The CCI's Diagnostics Programme is supporting NHS Boards to address bottlenecks by matching capacity and demand through the application of basic redesign tools and best practice waiting-list management approaches. We will improve patient access to the eight key diagnostic tests for which national targets have been set (see page 6).

### We will take a number of steps to redesign diagnostic services:

- regional and national oversight of service planning to ensure a rational distribution of services, including specialist services
- an information system with a nationally agreed dataset used consistently across Scotland
- extension of the working day to reflect the pattern of demand for services
- systematic planning of key equipment replacement across Scotland on a rolling basis to avoid the creation of backlog of outdated equipment.

### BOX 3.3

#### EXAMPLES OF COOPERATION BETWEEN NHS AND INDEPENDENT SECTOR

NHS Lothian undertook a pilot mobile facility for 100 ENT cases during August. Given the success of this initiative it may be extended to include other specialties during the remainder of the year.

Funding has also been made available towards reductions in diagnostic waiting time targets, some of which will be within the independent sector. NHS Forth Valley have recently contracted with Alliance Medical for a new five day MRI scanning facility which will also achieve reductions in waiting times for cancer patients.

As a pilot to develop longer term contracts with the independent sector to achieve better value for money, the use of Stracathro Hospital as a Regional Treatment Centre, to be run in partnership with the independent sector, will contribute significantly to delivering waiting times targets for 2007/08 and beyond. It is anticipated that the contractual arrangements with a preferred provider will be in place early in 2006 and will run for a period of three years initially.

With planned investment of £50m over three years, we will minimise waiting times, within a maximum waiting time of nine weeks for eight key diagnostic tests, including MRI and CT scan, by December 2007.

There will be inevitable growth in demand for certain services as a result of Scotland's demographic trends, and requests for complex imaging, including CT, MRI, ultrasound and, in the near future, PET (positron emission tomography) are increasing in preference to standard x-rays. We will proactively plan for the changing nature of demand for diagnostic services and will keep the configuration of services under continuous review.

Management of diagnostic services must focus on the needs of patients by providing services when there is a need for them. While many hospitals have 24-hour x-ray services in or near A&E departments, most provide very limited 24-hour laboratory services, leading to the unnecessary admission of patients who might otherwise be discharged. As new techniques emerge and the uptake of existing technologies accelerates, point-of-care testing should expand considerably as part of the drive towards a more patient-centred service, but not at the expense of the quality assurance of diagnostic tests.

The roll out of digital imaging (PACS) across Scotland will bring major benefits. PACS captures, stores and displays digital images such as radiology images, x-rays and scans. It is an efficient way to acquire and store images which also allows flexibility in display. When linked to a single CHI-based Electronic Health Record, PACS allows separation of image acquisition, scanning of the patient and analysis and reporting on the scan. This means the patient and reporter do not need to be in the same place, avoiding the need for patients to travel to a specialist centre for some scans. Separating the reporter from the likelihood of interruptions during the process will also improve quality and efficiency.

We will investigate the feasibility of centrally co-ordinated on-call services for radiologists, and will consider if the new national MCN for Pathology should be used as a model to develop further regional and national MCNs for diagnostic services across Scotland.

## Managed Clinical Networks

Managed Clinical Networks (MCNs) are now a well-established part of NHSScotland's approach to the management of long-term conditions, promoting integration of services and patient focus through the strong involvement of patients and clinicians.

Bringing health care professionals together in these networks can also support collaborative working between hospitals and between a hospital and a Community Health Centre. Box 3.4 illustrates recent progress in Tayside in promoting such collaboration.

All NHS Boards have MCNs for cardiac services, stroke and diabetes, which support locally the implementation of our national strategies for these conditions. Many NHS Boards have established (or are setting up) a MCN office as a generic administrative resource to support a number of networks.

At regional level, cancer MCNs are key to the implementation of Scotland's Cancer Plan, and there are MCNs for neurological conditions such as epilepsy. There is also a small (but growing) number of national MCNs, such as those for cleft lip and palate and for mentally disordered offenders.

*It is time to take stock of the MCNs' role in the light of experience gained to date and the developments signalled in this report.*

**SEHD will produce revised guidance by summer 2006 on MCNs aimed at strengthening their authority and increasing their influence over the way in which resources are allocated for services,** particularly for service developments identified as a priority. The guidance will also deal with issues such as the way CHPs should link to MCNs, and how the networks fit with the generic approach to long-term conditions.



## Transport

The Transport (Scotland) Act 2005 provides for the creation of regional transport partnerships, which will develop regional transport strategies. These strategies will have regard to, amongst other things, the transport needs of health care services including people accessing those services and the wider health impact of transport policies. Health Boards will be statutory consultees for regional transport strategies and will have to act in accordance with them as far as possible. The work by NHS Greater Glasgow, as part of its Hospital Modernisation Programme, in conjunction with other public authorities illustrates this kind of joint working in practice. At a national level we will also consider transport and health issues in the context of the forthcoming National Transport Strategy.

As we refine the shape of planned and unplanned hospital care, we will need to review NHS transport arrangements, particularly those that relate to inter-hospital transfers. At present, there are some 73,000 inter-hospital transfers each year. Only 10% of the transfer work is classified as 'emergency', but two-thirds are carried out by front-line emergency resources. **By December 2005, the Scottish Ambulance Service will prepare proposals for a dedicated inter-hospital transfer service that will:**

- ▶ free paramedics and other practitioners in the emergency service to develop their emerging role as providers of mobile health care in the community
- ▶ improve performance on front-line emergency and non-emergency ambulance services
- ▶ improve integration of national, regional and local services
- ▶ support NHS Boards as they redesign hospital services in accordance with the National Framework for Service Change.

### BOX 3.4

#### EXAMPLE OF COLLABORATIVE WORKING BETWEEN HOSPITALS

NHS Tayside has made a commitment to retaining Perth Royal Infirmary (PRI) as an acute hospital, linked to the teaching hospital in Dundee, in effect creating a single hospital campus between PRI and Ninewells Hospital and Medical School for Tayside.

The centres are physically joined by a regular transport network for patients, visitors and staff, are 'virtually' joined by technological developments including enhanced digital communications, and are operationally joined through increased staff mobility and sharing of key resources.

The approach across the region has been based on building safe, sustainable and affordable services to the people of Tayside, providing services locally wherever possible and only asking patients to travel when there is a clear clinical requirement to do so.

The project will see the repatriation of an estimated 15,000 episodes of care back to Perth from Dundee, including:

- ▶ the development of a satellite renal dialysis unit
- ▶ the development of oncology and haematology facilities at PRI
- ▶ provision of an enhanced range of investigative and diagnostic services, including MRI
- ▶ increasing the volume and range of general, specialist and orthopaedic surgery undertaken at PRI

significant expansion of specialist outpatient clinic provision, including the expansion of endoscopy services.

PRI has also established a Midwifery-Led Unit for Perth. Deliveries in the first year were greater than planned, with the unit dealing with 135 deliveries from January 2005 to the present day.

### 3.3 HOSPITAL SERVICES: AS SPECIALISED AS NECESSARY

We endorse the National Framework for Service Change as the basis for NHS Boards to take future decisions on the reconfiguration of specialist health care services. It reflects considerable professional and patient input and records the substantial consensus that was achieved on these difficult issues.

#### Volume and outcomes

We will continue to develop a better evidence base about the relationship between the volume of a complex health care intervention and the quality of outcome for the patient. We now know that, across a range of procedures, there is variation in the relationship between increasing volume and improved outcome (reduced mortality and/or improved recovery). We also know that:

- › for a condition that is not common and is relatively complex, the improvement tends to be greater: the more operations of a particular type a surgeon performs, the better the outcome
- › for a more common, less complex condition, the improvement in outcome is greater initially, but tends to level off: after some threshold level of activity is met, outcome benefits do not continue to grow.

The pattern for many services lies between these ranges, with the precise position being determined by a number of factors. Figure 3.1 shows this relationship.

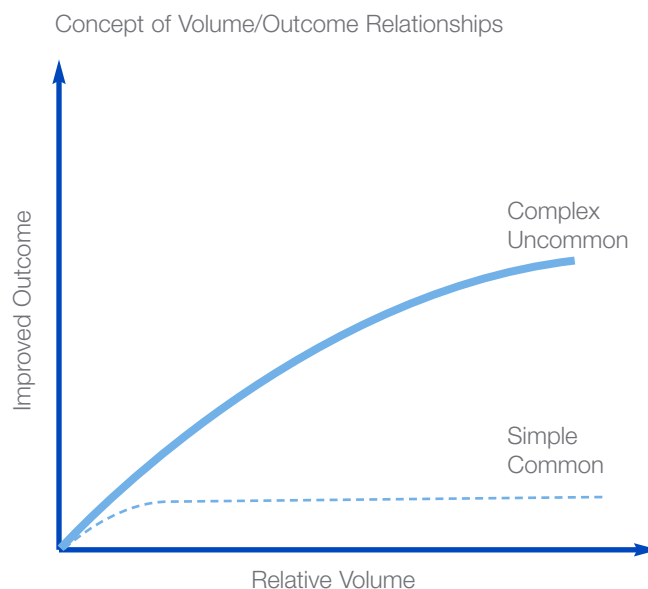
There is a strong case for ensuring volume is maintained in complex cases. In a country the size of Scotland, that can only be done by offering those procedures in a few locations. Clinicians (and their teams) should undertake common procedures locally, provided there are sufficient cases to maintain clinical skills and it represents a good use of public resources.

But it is the area between the two lines in Figure 3.1 that remains problematic. For some disorders, even though the evidence is less abundant and the effect not so dramatic, the consequences may still be important. For example, a reduction of a few per cent in mortality from myocardial infarction (heart attack) could be associated with many lives being saved in Scotland.

In general, it would be reasonable to suggest that there may be a very small extra risk (increased complications, slightly poorer outcomes) by keeping some treatments local. To inform our future decision making, we need to do more audit, data collection and evaluation to collect information we can use to compare and contrast outcomes according to individual clinicians' and hospitals' workload, improving the quality of our own health care and contributing to the international debate on specialisation. **We will establish an expert group to examine this issue and will publish the early results by December 2006.**

**FIGURE 3.1**

**Acute Interventions: volume and outcome**





In taking future decisions about service changes, the Scottish Executive will approve proposals where:

- › there is evidence of improved clinical outcomes
- › there are resource or workforce constraints and it can be demonstrated that:
  - the services are highly specialised and a clinical benefit will result, or
  - the services include 24-hour receiving of seriously ill patients, or
  - the services involve care for medically unstable patients through the night, and
  - service redesign will not achieve a sustainable outcome.

### 3.4 RURAL HEALTH SERVICES

One in five people in Scotland lives in a remote and rural area. Service models that are effective in urban areas may be unsuitable in such locations. **We will respond by developing a framework of care specifically for remote and rural communities.**

#### Community health care

The framework will maximise the role of local health care services, especially of GPs, pharmacists and community health teams. This will involve GPs and local primary care teams taking on extended roles (see Box 3.5). The work to develop an accredited programme for GPs and practitioners with special interests, referred to in Section 2, will be an important element, for example in specialties such as:

- › dermatology
- › ear, nose and throat
- › ophthalmology
- › musculoskeletal medicine.

CHPs will have a role to play in overseeing the distribution and co-ordination of these skills to serve appropriate populations. That will also mean local practices working collaboratively to provide a range of services for local populations.

The efficiency of visiting clinicians must be maximised. That means co-ordination between visiting consultants and local GPs with special interests to ensure that specialists are concentrating on the most complex cases while also providing support and education for local clinicians.

Community Hospitals will play a key role, treating patients who cannot be cared for at home but who do not require the specialist care provided by a more distant hospital. Their services should include pre-admission and routine testing, outpatient and specialist clinics, day surgery, convalescence, rehabilitation and palliative care. Community Hospitals will remain a key resource if they can refocus their services to meet the changing needs of the population.

#### BOX 3.5 GPS AND MINOR SURGERY

Some GPs in Grampian have been trained to provide minor surgery such as vasectomies and the removal of skin lesions. These GPs now work in a number of community hospitals, maintaining and extending the

range of services provided locally in Grampian. As a result, waiting times for the general surgery clinic in one community hospital fell from 22 to eight weeks.

## Out-of-hours services

As a local Community Health Centre, Community Hospitals can provide a base for out-of-hours care. Many presentations of illness outwith the normal working day can be dealt with properly in the local community. Community First Responders, drawn from the local community and supervised by the local health systems, can also contribute (see Box 3.6).

Rural communities should have immediate access to emergency triage and dispatch for out-of-hours emergencies. There should also be access to appropriate diagnostic facilities when diagnosis cannot be made at the incident. This could be provided at a Community Hospital or a Rural General Hospital, allowing the most serious cases to be transferred to a specialist trauma centre.

A key requirement in bringing all this together is transport. The Scottish Ambulance Service, NHS 24 and NHS Boards will work collaboratively at regional level to ensure that a resilient transport system for urgent cases is in place.

## Rural General Hospitals

Collaboration through, for example, MCNs and greater use of eHealth systems will be needed to ensure that Rural General Hospitals (RGHs) function efficiently and effectively. They must have defined links with neighbouring RGHs and with larger hospitals. This network of hospitals must share responsibility for ensuring that the bulk of remote communities' health care needs (both unscheduled and planned care) is met locally.

Rural General Hospitals cannot be maintained through providing only trauma and acute illness care. A range of planned services should be provided to maintain local services and consultant skill levels. Each RGH should examine what level of elective service it can safely support, based on guidance on day case surgery as a starting point and looking at how this might be appropriately extended through MCNs. The North of Scotland Planning Group is taking the lead in agreeing a list of safe core services for RGHs that will comprehensively reflect health care needs in rural communities.

### **We will establish a group that includes NHS Education for Scotland, the Scottish Medical Royal Colleges, NHS Boards and other partners to:**

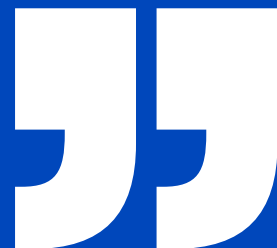
- ▶ consider the evidence around standards of care in remote and rural areas by December 2006
- ▶ consider operational issues associated with the delivery of health care in remote and rural areas, including how staffing can be assured and clinicians' skills maintained in low-volume procedures, and report in December 2006
- ▶ develop appropriate training for remote and rural practitioners and report by June 2007
- ▶ consider how this training can best be incorporated into posts in these areas and report by June 2007.

**The group will also develop a proposal for a virtual School of Rural Health care by the end of 2006** to build on existing initiatives and develop world class approaches to the development and training of the rural workforce.

## **BOX 3.6 COMMUNITY FIRST RESPONDERS.**

A Community First Responder is a local volunteer who agrees to undertake training to be able to provide life-saving treatment in the first few minutes, prior to the arrival of an ambulance, to people who are critically injured or become ill within the community.

We know that if certain simple but critical interventions can be performed within those first few minutes, life can be saved and disability reduced. This is especially pertinent for heart attacks, choking and injuries that have caused loss of consciousness.



### 3.5 MENTAL HEALTH SERVICES

Mental health remains one of our three national clinical priorities. Good mental health improves the quality of life for people with serious physical illnesses and may contribute to longer life. Of older adults who have physical illness such as heart disease, stroke, cancer and arthritis, about 25% may also be depressed.

The structure and organisation of care is as important in mental health as it is for other services delivered by the NHS, and the messages of the National Framework apply. Integrated and well-organised care, based on up-to-date research and accurate information about the patient, delivered in appropriate settings by teams of professionals, is our shared objective.

The policy context for mental health since 1997 has been the *Framework for Mental Health Services in Scotland*. It remains relevant, but there is a need for greater clarity about the changes required to deliver a modern and effective mental health service.

**We will collect our work to improve mental health services in a national Delivery Plan, to be published by the end of 2006.**

#### Population health

The National Programme for Mental Health and Well-being will continue its focus on population health. This is about promoting well-being and resilience and tackling stigma and discrimination to reduce the risk of mental illness and increase the likelihood that people with mental illness will seek and receive help and support. Specifically, we will implement the report on *Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care*, and interim targets will be identified to allow us to track progress by 2008 and 2010.

We will focus on improving the physical health and well-being of those with mental illness through work on smoking cessation, diet and physical activity.

#### Primary care

Up to 30% of GP time is spent in consultations with patients presenting with mild to moderate symptoms of depression, sleeplessness and stress. If we can become more effective in working with this patient cohort, we have the possibility of offering a better, more patient-focused service and of freeing up resources to enable primary care services to play a greater role in long-term conditions management.

We will do this by producing an evidence-based practice guide on depression for primary care in 2006, together with proposals for how the approach can be rolled out across Scotland. This will be based on the lessons from the Centre for Change and Innovation's *Doing Well by People with Depression* programme (see Box 3.7).

#### Community services

Expectations of the success of treatments and the possibility of recovery from mental illness has improved in recent years with new medications and therapies, but for many people, mental illness continues to be a long-term condition. Good quality services, such as assertive outreach, enable those with severe and enduring mental illness to remain in the community and live more productive and fulfilling lives.

Evidence shows that crisis services can reduce the need for admissions and enable more people to remain in the community. The Scottish Executive has already provided £575,000 to deliver a range of new crisis services across Scotland. We will take the learning from the crisis pilots and our work on out-of-hours services to develop a national standard for such services in 2006.

National standards will be developed for Integrated Care Pathways (ICPs) for the main diagnoses (schizophrenia, bi-polar disorder, dementia, depression and personality disorder) by late 2007. Implementation of the standards will be accredited by NHS Quality Improvement Scotland.

## General and specialist services

We will develop, by the end of 2006, a national and regional analysis of specialist service needs and the action required to meet those needs, including the implications for service redesign.

We will continue to support the development work of the Forensic Managed Care Network to put in place delivery of new medium secure units, in the west and north-east of Scotland, with redevelopment at the State Hospital by 2009.

### 3.6 CHILD HEALTH SERVICES

Scottish Ministers have already agreed a high-level vision for children and young people in Scotland:

*'...we want them to have ambition for themselves and to be confident individuals, effective contributors, successful learners and responsible citizens. All Scotland's children and young people need to be nurtured, safe, active, healthy, engaged in learning, achieving, included, respected and responsible if we are to achieve our ambition for them.'*

#### Delivering improvements in child health

We have already clarified responsibilities from local to national level, strengthening the role of SEHD in setting the child health agenda and improving links among the new Children and Young People's Health Support Group (CYPHSG), regional planning groups and NHS Boards. We have also asked NHS Boards and local authorities to draw together their existing planning for children and young people into a single Integrated Children's

Services Plan, which describes local improvement objectives and delivery strategies across universal and targeted services for children and young people.

Now that infrastructure issues are being addressed, the CYPHSG will focus on supporting implementation and delivery of improvements in health services for children.

**We have asked CYPHSG to produce an Action Framework for Children and Young People's Health Services, which will focus on measurable improvements in health outcomes and health care services.** This will be issued for consultation by the beginning of 2006.

We have already started with the publication of guidance on the implementation of *Health for all Children* (Hall4) in April of this year. This focuses on the local delivery of health surveillance and screening, health promotion and redesign of contacts with primary care to ensure that families with greatest need get better access to services.

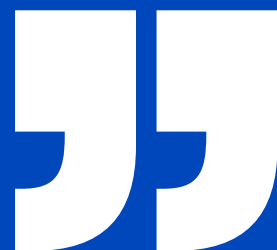
#### Children and young people's mental health

Mental health affects children and young people's behaviour, learning and physical health. We must ensure that services and approaches are in place to promote children's mental health, prevent mental illness, and support those children and young people with mental health problems more effectively.

### BOX 3.7 DOING WELL BY PEOPLE WITH DEPRESSION

Within the programme *Doing Well by People with Depression*, one key area of activity has been the development of directories of self help materials. The information comes in a variety of formats which includes written materials, cd rom based information, audio and web based. This approach has been used with patients accessing the service in

Glasgow. The materials are all quality controlled and made easily accessible. This approach helps patients to deal more effectively with a current episode of depression and provides them with key actions they can take on how to prevent its recurrence.



We are committed to the strategic direction set by the Scottish Needs Assessment Programme (SNAP) report on children and young people's mental health published in 2003. We want to develop and increase capacity within mainstream children's services for mental health promotion and identification of potential mental health problems. We also want to ensure that specialist services are available and accessible for those children and young people who need them.

We have been working closely with CYPHSG and our national project for children and young people's mental health, *HeadsUpScotland*, to develop a framework that will help local agencies deliver the strategy. We have also been undertaking workforce planning to support delivery, and have committed £1m over two years (to 2006) for workforce development and training. We will work with NHS Boards to support implementation of the framework and to monitor progress.

### **Specialised acute care for children**

The current pattern of specialist paediatric services in Scotland has developed through a process of evolution – it was not designed. In future, decisions on the provision of these services will be taken on a whole-Scotland basis. The current fragmented approach will be transformed to create an integrated service that improves access and equity of care.

We have already agreed funding of £100m to relocate the Royal Hospital for Sick Children in Glasgow as a centre of national expertise in specialist children's services. It will be co-located with maternity and adult services, providing a 'gold standard' children's hospital. The hospital is planned to open in 2010, once the decision on its new location has been approved by Ministers.

We also initiated a review of specialist children's services in 2003 which will inform future plans. Four pilot reviews covered cancer services, complex respiratory conditions, gastroenterology and neurology. Main recommendations from these reviews included:

- › development of MCNs at regional and national level
- › redesign of services using a four-level model of care describing how services could be provided and organised at local, District General Hospital, regional and national levels
- › an increase in specialist staff to meet Working Time Regulations and service gaps
- › development of specialist/consultant roles for nursing and AHP staff
- › development of regional and national planning and commissioning of services.

The focus now is on implementation of the recommendations from the reviews that have been completed.

The development of children's cancer services is a helpful model for other specialist paediatric services. Clinicians will work as a managed network, and specialist centres will operate as one service for Scotland. The model means that children with cancer will receive the highest quality of specialist care, and will be able to access routine care in a local setting.

CYPHSG will lead a process to undertake an option appraisal to determine the future shape of cancer services over the next 12 months.

The continued provision of paediatric intensive care (PIC) and high dependency care (HDC) is an immediate issue for NHSScotland in the light of trends in activity and case mix that may not be sustainable within current provision. The National Framework report recommended continuation of PIC units in both Edinburgh and Glasgow and that the service should be national, commissioned by National Services Division (NSD) for at least the next five years.



We accept these recommendations, and the service will be nationally designated by 2007 at the latest. The two PIC units will adapt over time, depending on the relative balance of specialist paediatric service provision in the two centres. There will be integrated planning of PIC, HDC and neonatal surgical intensive care (NSIC) services. HDUs in Aberdeen, Dundee, Edinburgh and Glasgow will support the provision of a wide range of services, while clear procedures will be put in place for the escalation of the intensity of care, including rapid intensive care transfer to and from the lead PIC units in Glasgow and Edinburgh.

A two-year audit of HDU care will be undertaken by NSD. This will provide information on the future need for dedicated HDUs and how these will relate to the PIC units in Edinburgh and Glasgow. This will commence as soon as possible.

An example of the kind of integrated care we envisage is shown in Box 3.8.

### Maternity services

The framework and strategic direction for maternal health in NHSScotland is detailed in *A Framework for Maternity Services*, published in 2001, and the report of the *Expert Group on Acute Maternity Services* which followed in 2003. We will continue to implement the conclusions and recommendations of these reports to improve services for Scotland's families, mothers and their babies. The *National Framework for Service Change* reiterates the central principles of both documents, and we accept the recommendations it makes.

We will establish a National Maternity Services Support Group which will oversee implementation of the national strategy. They will do this by linking with regional support structures, identifying priorities for action and negotiating national work with a range of bodies such as NHS Quality Improvement Scotland and NHS Education for Scotland.

### 3.7 NEUROSURGERY AND NEUROSCIENCE

The National Framework team chose neurosurgery to help focus its consideration of the way in which highly specialised services should be designed in future.

An options appraisal carried out as part of the review indicated that Scotland should move from its current configuration of four neurosurgical centres towards a single centre for neurosurgical intervention for adults and children, as part of a service model that would provide local outpatient and rehabilitation services as well as pre- and post-operative care and diagnosis.

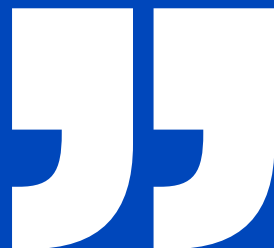
The review, which took full account of the views of patients, described a future service in which adult and paediatric neurosurgery will be co-located at a teaching hospital with other neuroscience specialties. The service will be integrated across specialist, secondary and primary care using the Managed Clinical Network model, and will be provided as locally as possible, with explicit standards of care across the integrated care pathway.

#### BOX 3.8 EXAMPLE OF INTEGRATED CARE

Currently, some patients have to travel with their parent for three hours or more to get a simple blood test carried out before returning home. Although children will still have to travel for very specialist care such as bone marrow transplantation, it is hoped that more routine care, including chemotherapy and monitoring of their condition, can take place closer to home. Professionals should be able

to access advice at diagnosis and different stages of care more easily through telemedicine and better links with specialist centres.

This is already happening in some areas such as Highland and Argyll, and other areas have indicated their willingness to develop services to meet this need.



Sub-specialisation should continue, but on a planned and managed basis. Paediatric neurosurgery should be concentrated in one prime site co-located with paediatric intensive care. Unplanned neurosurgical activity would be managed locally within the model, which supports local unplanned care and subsequent transfer to specialist services through agreed pathways.

Taking a national approach to planning highly specialised services will improve integration, quality and productivity by:

- › ensuring that services are developed sustainably
- › ensuring that we utilise effectively the distinctive skills of clinical teams providing services
- › enabling links between highly specialised services to be managed
- › ensuring that the quality of patient outcomes is the prime consideration.

The model therefore is for a single, nationally organised service on three levels (Figure 3.2). Within the model is a new concept – Level N1 – that is designed to promote local access to neurological teams when needed, supported by nurse-led clinics and rehabilitation teams. The service at this level will be focused through CHPs, Community Casualty services and GP practices.

**SEHD will establish a national implementation team to take forward this work.** Specific components of the work now needed include:

- › the development of the national model based on the three levels of service set out in Figure 3.2 and using a Managed Clinical Network approach
- › a needs assessment for neurosciences
- › the development of explicit standards for the neurosurgery service, including mechanisms for assessment of performance against the standards and action plans to address areas of improvement
- › the creation of a common minimum dataset and a planned audit programme for the service
- › a wide-ranging public consultation on the options for change.

This programme will be completed by December 2007.

## 3.8 SERVICE CHANGE AND THE NHS WORKFORCE

### Workforce planning

This plan will be delivered by putting in place the workforce that can make it happen. Workforce planning flows from service planning and must be fully integrated with it.

We need:

- › Regional Workforce Plans to be produced by January 2006 and each September thereafter; NHS Boards in each region will work together to produce a Regional Workforce Plan that addresses those services which serve populations beyond individual NHS Board areas
- › NHS Board Workforce Plans to be produced by April 2006 and April thereafter; these will be part of local health planning processes and will provide assessments of the workforce NHS Boards need to underpin strategic service plans, in alignment with the relevant Regional Workforce Plan
- › a National Workforce Plan to be produced in December 2006 and each December thereafter; this will be informed by the bottom-up evidence obtained from regional and NHS Board workforce plans on their future demands for staff, and allow decisions to be made on training numbers which will effectively align supply with the projected demand.

The overall aim of the workforce planning framework is to ensure NHSScotland is maximising the efficiency and effectiveness of its use of the workforce. It allows assessment of the numbers of staff we need for the future, the type of staff required, how they will work differently, and changes in education, training and regulation we will need to make to address future needs.



## FIGURE 3.2

### Model of service for neurosurgery

#### ➤ LEVEL N1

Focused through CHPs, Minor Injury Services and GP practices, this level will promote access to neurological teams supported by nurse-led clinics and rehabilitation facilities. It will be able to refer to Level N2 and directly to Level N3. It will provide:

- simple tests
- referrals
- decision support
- pre-admission clinics
- local neurology

#### ➤ LEVEL N2

Focused through District General Hospitals, this would be supported by neurologically trained A&E resuscitation staff and specialist outreach and follow-up clinics with rapid access to deal with urgent neurological emergencies. It will provide:

- all Level N1 services
- CT/MRI, with image transfer
- rehabilitation
- stroke medicine
- general neurology
- neurophysiology (linked to Level N3 centre)
- local orthopaedic service
- outpatient neurosurgery
- post-operative care for neurosurgery (supported by education and training from Level N3 centre)
- general intensive care

#### ➤ LEVEL N3

The specialist neurosurgical centre co-located with all neurosciences specialties and the major specialties of a teaching hospital. Provides a comprehensive range of sub-specialty expertise and national sub-specialties. It will provide:

- all Level N1 and N2 services
- complex medical and surgical management
- CT/MRI/CTA/MRA/angiography
- interventional neuroradiology
- neuro critical care
- inpatient neurosurgery
- emergency surgery
- paediatric neurosurgery



We will ensure that the workforce planning framework reflects the implications of service changes for the workforce and identifies actions to be taken at national, regional and NHS Board levels to secure the workforce required.

To ensure that we maximise the contribution of the whole health care team, and consequently improve the effectiveness and efficiency of the service, we will:

- ▶ implement the new training arrangements for doctors, *Modernising Medical Careers*, starting with the Foundation Programme Year 2 in August; programme-based, competency-assessed training will ensure that training arrangements are more effective and that time to train is used more efficiently to ensure future doctors are able to meet patient and service needs.
- ▶ build on the publication of frameworks for role development in nursing and the AHPs, focusing on the development of key clinical roles that will support the delivery of actions on unscheduled care, long-term conditions, out-of-hours and emergency services, orthopaedic services and diagnostic waiting times
- ▶ review nursing in the community to develop a framework to ensure that community nurses are equipped to provide significant input to the care and treatment of vulnerable people
- ▶ ensure that nurses, midwives and AHPs are equipped with core skills and competencies to deliver a modern maternity service, including extending roles for sonographers and preparing midwives as lead professionals for low-risk births
- ▶ agree new terms and conditions for Staff and Associate Specialist doctors to support their needs and maximise the valuable contribution they make to the delivery of services
- ▶ work with NHS Boards to support service redesign through, for example, the 'Hospital at Night' initiative, which allows for sustainable and effective services that also address the requirements of Working Time Regulations
- ▶ put in place a contractual framework for GP practices in 2006/2007 (and beyond) that helps deliver the priorities outlined in this plan, including anticipatory care for high-risk sections of the population, management of long-term conditions in local settings, and greater collaborative working in primary care.

## Pay modernisation

Pay modernisation (the new General Medical Services Contract, the new Consultant Contract and *Agenda for Change*) is a powerful tool for achieving modernisation and service change by providing a platform for new ways of working, the creation of new and extended roles through the development of new skill sets, and better organisation and management of staff capacity. It benefits patient care by providing more motivated staff, working more flexibly and more productively. In essence, pay modernisation is a means to reward, motivate and enable staff to deliver improved services to patients.

Our aim for future pay modernisation will be to deliver new pay systems which directly support the achievement of our priorities for improving services to patients, whether through attaining waiting time targets, better managing chronic disease, or pursuing our health improvement objectives. The new contracts will allow the NHS to:

- › manage workloads in a way that improves the working conditions and productivity of staff;
- › reward staff fairly;
- › replace outdated demarcations;
- › provide opportunities for staff to progress by taking on new responsibilities, allowing NHS jobs to be designed around patient and staff needs;

- › promote clinical leadership that contributes effectively to NHS objectives; and
- › provide a platform for new ways of working that will help deliver seamless care centred around patient needs.

We have already asked NHS Boards to draw up Pay Modernisation Benefits Delivery Plans outlining how they will achieve benefits to services from the new contracts through working in partnership with staff to support redesign and improvements in services. These initial plans have been developed and will now be implemented. They will be updated on a regular basis as part of a process of continuous improvement and modernisation.

This package of workforce measures builds on initiatives mentioned elsewhere in this report such as the integrated care physician, practitioner with special interest and remote and rural physician and provides an integrated workforce response to service change.



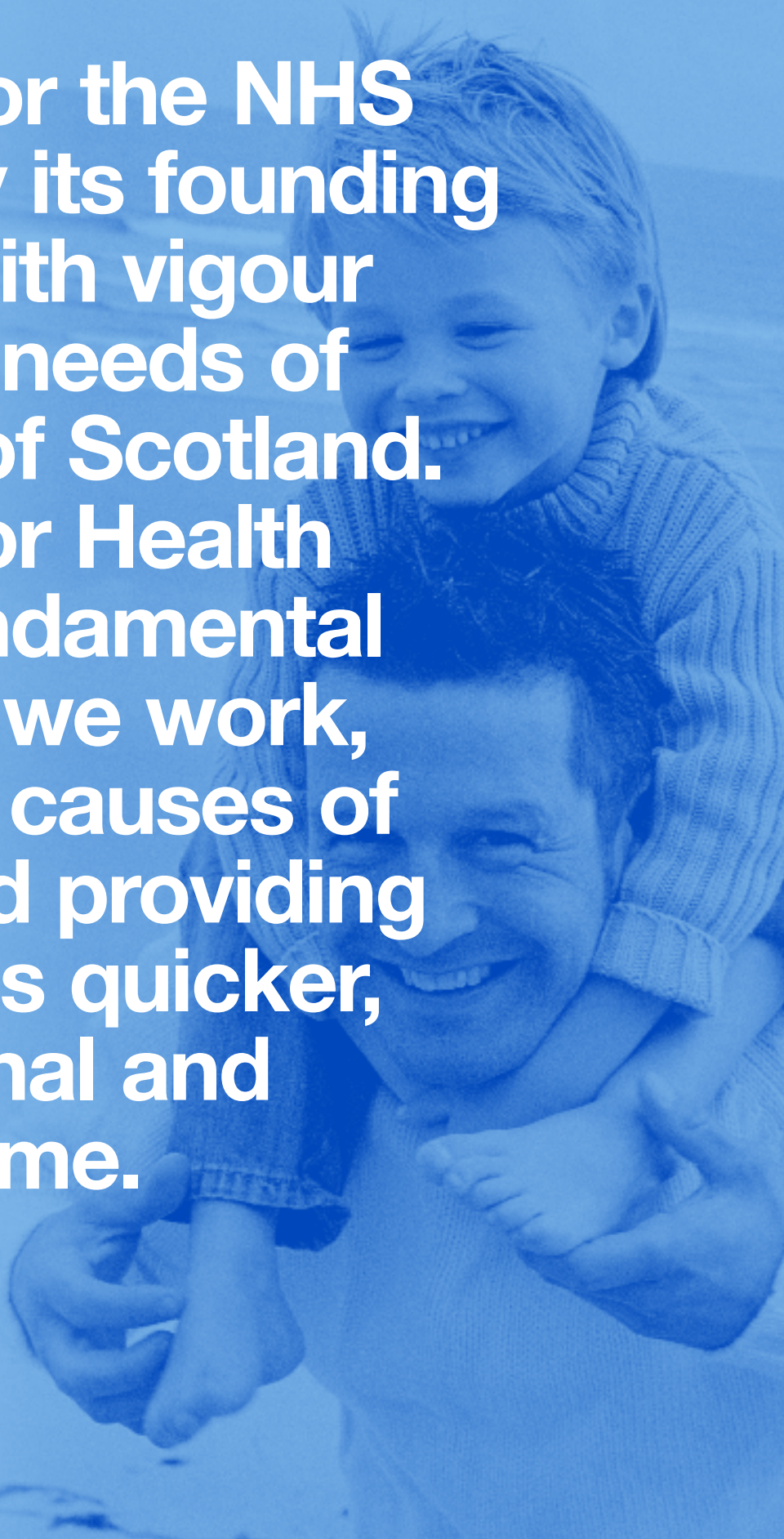
**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



“

Our vision for the NHS is to reapply its founding principles with vigour to meet the needs of the people of Scotland. Delivering for Health means a fundamental shift in how we work, tackling the causes of ill-health and providing care which is quicker, more personal and closer to home.

”





# Section four

## Making it happen



### Delivery

The NHS in Scotland is accountable to the Minister for Health and to the Scottish Parliament. In practice, the Minister holds the leaders of NHS Boards to account for their performance in meeting the health needs of their area, and for the implementation of national policies, including the commitments in this national action plan.

We outlined plans in July 2005 to set up in the SEHD a new Delivery Group to support the Minister in this role, with a view to:

- ▶ ensuring a renewed and explicit focus on key objectives, targets and measures across the health portfolio
- ▶ strengthening performance management arrangements between each NHS Board and the Scottish Executive by introducing local delivery plans consisting of agreed, sharply focused, quantified local actions
- ▶ working with more timely and reliable management data, enabling accurate tracking of NHS Boards' performance against all the agreed local delivery plan targets
- ▶ making specific interventions to support and improve performance where the need arises.

In setting up the Delivery Group, we recognise that we need better long-term planning and a clearer approach to ensure that NHS Boards are able, and supported, to deliver on those plans. We have established within the SEHD a new Group for Healthcare Policy and

Strategy to ensure we have the capacity for long-term planning. We have also established a Group for Primary and Community Care to ensure we can drive the strategic shift in favour of locally delivered services responsive to the growing level of long-term conditions.

We will issue guidance on local delivery plans for 2006/2007 shortly. The guidance will require local delivery plans to maintain a 'line of sight' from strategy through to delivery on the ground. It will describe how local delivery plans link to resource planning and change management.

NHS Boards will use local delivery plans to demonstrate how they will deliver key targets for all their patients within the resources available. By including clear performance milestones, these plans will help to set and track the pace of change and ensure the delivery of objectives is affordable and sustainable.

For some of the commitments in this national action plan, there will be performance measures in the local delivery plans (e.g. extent of day case surgery) that allow direct monitoring of their implementation. More generally, the new Delivery Group will monitor implementation of the full set of commitments in Delivering for Health, and will publish progress reports.



**Our aim is to improve the health of the people of Scotland . . . with a shift towards preventive medicine and more continuous care in the community. Our strategies, policies and actions are intended to support that key objective.**



### **Culture, consensus and leadership**

Reform of our planning and performance management processes will not be enough. If the changes we plan are to happen, we need to create a culture and climate for change. We need to recognise the nature and the scale of the health challenge which we face in Scotland, and to encourage the NHS to work with other bodies, especially local authorities, to tackle that challenge. In presenting his report, Professor Kerr was clear that the NHS needs to be transformed to meet the challenges of the future.

The huge consensus in support for the direction of change signalled in the National Framework provides us with an opportunity to build a commitment across the NHS for the practical measures set out in this plan. For that to happen, we need to put patients first and set aside professional differences. If people in Scotland want the high quality health care that is within our grasp, we all have to accept that change is required. We need to maintain consensus, requiring NHS Boards to engage in genuine dialogue with the patients and communities they serve.

We will therefore work with NHS Boards to ensure that there is a constant effort to ensure not only that the interests of patients are paramount in the redesign of services but that every reasonable effort is made to explain the impact of service changes for both patients and local populations, and to involve patients and the public in the consideration of options for change.

We will continue to give patients an influential voice in the future of the health service and in their own individual care. NHS Boards will be asked to demonstrate how they are working to achieve year-on-year improvements by involving the public in service delivery and in individual decisions about their personal health care. The new Scottish Health Council will have a central role, holding the NHS to account for its performance on patient and public involvement.

Our collective aim should be to implement the proposals in this plan by engaging with, and winning the support of, the people we serve.

## Section 2.1 – Shifting the Balance of Care

# Annex A

Detailed plans for the various actions identified in this report are set out below, to facilitate the reporting of progress

NATIONAL				OUTCOMES	
2006	2007	2008	2009		
Determine the optimal set of indicators to identify those high-risk patients who would most benefit from intensive case management. (SEHD working with NHS Boards)	Establish a national strategy for care of long-term conditions and establish a Scottish Long Term Conditions Alliance. (SEHD)	Use the evidence gathered from the pilots to inform more general and widespread application of the 'anticipate and prevent' approach elsewhere. (SEHD)			
Develop a national programme for GPs with special interests (GPwSI). (NES, RCGPs)	Pilot Reducing Health Inequalities approach in 2006/2007 in up to five CHPs by continuing with existing methods in high risk areas of alcohol, smoking, diet and physical activity. (SEHD)				
Introduce a 'tool kit' to enable CHPs to benchmark the development of local services for those with long term conditions. (SEHD)	Implement five simple changes across NHS Scotland that will raise all NHS Boards to the standard of the best. (SEHD)				
				<ul style="list-style-type: none"> <li>Increasing support for self care.</li> <li>Strengthening and extending primary care.</li> <li>Offering integrated and responsive specialist care.</li> <li>Managing vulnerable cases by anticipating their needs.</li> <li>Reducing emergency inpatient bed days for people aged 65 and over by 10% by 2008.</li> </ul>	

REGIONAL			
2005	2006	2007	2008
		Ensure compatibility with regional plans for streaming of unscheduled and planned care and development of community health centres.	

LOCAL			
2005	2006	2007	2008
Development of an action plan for the care of older people to ensure the following outcomes: <ul style="list-style-type: none"> <li>greater integration of health and social care provision</li> <li>fit-for-purpose technology used to support and monitor the care of older people at home</li> <li>enhanced community based rehabilitation. (CHPs).</li> </ul> CHPs to apply self-assessment framework to implement improved management of long-term conditions. (CHPs).		Intensive co-ordinated case management for all those in Scotland with the most complex health care needs and vulnerability to emergency hospital admission. (NHS Boards).	
		NHS Boards to demonstrate use of primary medical services and community pharmacy to extend local care.	
		Develop collaborative budgets across primary and secondary care, linking where appropriate with managed clinical networks. (CHPs)	



## Section 2.4 – Diagnostics

NATIONAL				
2005	2006	2007		2008
	Agree core radiology data set for NHS Scotland. (SEHD).	Strategic Review of the development and implementation of molecular diagnostic services using the model of the Scottish Molecular Genetics Consortium. (SEHD).		Provision of electronically embedded evidence-based guidance for referring healthcare professionals at the time of referral to reduce inappropriate demand. (SEHD).
	Feasibility study into development of an ultrasound programme open to non-radiographers including AHPs and assistant practitioners (NES).	Dissemination of Capacity, Demand, Activity Analysis methodology. (SEHD).	Purchase of Glasgow PET Scanner (SEHD Phase 1)	
	Comprehensive Scotland-wide application of a fit for purpose Radiology Information System (RIS). Benchmark and monitor performance using data collected through RIS. (SEHD).	Replacement of Aberdeen PET Scanner (SEHD Phase 1). Establishment of departmental advisory group to assess potential future developments in light of experience.		

### OUTCOMES

- › **9 weeks** from referral to provision for any MRI or CT scan and other key diagnostic tests.
- › Radiology Information System with agreed definitions applied nationally providing the basis for service management, delivery, planning and modernisation.
- › Digital imaging at the heart of clinical services.
- › A patient-centred service operating when demand dictates.
- › Ensures effective access across Scotland to specialist services.
- › Optimises use of resources, especially the workforce.

REGIONAL			
2005	2006	2007	2008
	Review of non-NSD funded specialist services in Lab. Medicine should be undertaken to provide national oversight (RPGs).	Review configuration of imaging and lab. services in light of emergency and planned care proposals and review of non-NSD funded specialist services. (RPGs).	
	Feasibility study into development of regional teams including regional consultants deployable throughout the region. (RPGs).		
	Explore opportunities to separate image acquisition/ testing and reporting (RPGs).	Establish Managed Diagnostic Networks building on the model of the Scottish Pathology Network. (SEHD/RPGs).	

LOCAL			
2005	2006	2007	2008
	Review of the equipment status and requirements of all Imaging. Pathology and Laboratory Medicine departments and identification of an appropriate rolling capital budget for equipment purchase and renewal. (Boards in conjunction with relevant RPGs).		
	All NHS Boards to demonstrate "matched clinical change" in any proposals to change or develop referring systems to avoid creation of diagnostic bottlenecks. (Boards).		
	All laboratory departments should participate in the UK National Benchmarking scheme organised by the University of Keele. (NHS Boards).		

# Section 3.1 – eHealth

NATIONAL					
2005	2006	2007	2008		
Telecommunications: upgrades and extension of connections consequent to new 'N3' contract. Fund migration and upgrade for GPs, community pharmacist connections and critical upgrades for hospitals. End 2005. (SEHD)	'New Ways Waiting Times Definitions.' Define IT system changes required, support system modifications. (SEHD)	ePharmacy, development and implementation of electronic infrastructure and support for the Community Pharmacy Strategy. April 2007. (SEHD)  Procurement of a single information technology system for NHSScotland with the following key features: <ul style="list-style-type: none"><li>➤ electronic health record available to all those who require it to provide patient care across the NHS</li><li>➤ patient access to the record and facility to update it</li><li>➤ Picture Archiving and Communications (PACS).</li><li>➤ electronic prescribing</li><li>➤ electronic booking</li><li>➤ evidence-based decision-making support at the front end of electronic requesting systems for diagnostic tests. (SEHD)</li></ul>	<table><tr><td>National coverage for PACS, June 2007. (SEHD)</td><td>Establishment of a Scottish Centre for Tele-health based in Aberdeen to develop nationally applicable approaches to tele-health. (SEHD)</td></tr></table>	National coverage for PACS, June 2007. (SEHD)	Establishment of a Scottish Centre for Tele-health based in Aberdeen to develop nationally applicable approaches to tele-health. (SEHD)
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## OUTCOMES

- ▶ Improving networking.
- ▶ Universal use of CHI number in clinical communications.
- ▶ Fully implementing existing products (SCI Store, SCI Gateway, A&E)
- ▶ Filling gaps (PACS, Generic Clinical System, Single Sign-on).
- ▶ Implementing rigorously information standards.
- ▶ Acquiring and implementing a product set for single patient record, jointly managed by patients and professional NHS staff with security of access governed by patient consent.

LOCAL																			
2005	2006	2007	2008																
	<table border="1"> <tr> <td>A single national patient IT record system which contains key information from GP records such as current medication and allergies. Known as the <i>Emergency Care Summary</i> system, access with the patient's consent will be available to out-of-hours services and NHS 24. June 2006. (NHS Boards)</td><td>A single patient IT communication system known as <i>Gateway</i> used by GPs to send electronically 90% of referrals to hospitals. June 2006. (NHS Boards)</td><td>Ensure local preparedness for PACS. (NHS Boards)</td><td></td></tr> <tr> <td></td><td>CHI Number uptake. June 2006. (NHS Boards)</td><td></td><td></td></tr> <tr> <td></td><td>A&amp;E System in place. June 2006. (NHS Boards)</td><td></td><td></td></tr> <tr> <td></td><td>"New Ways Waiting Times Definitions." Commission and implement required modifications. (NHS Boards)</td><td></td><td></td></tr> </table>	A single national patient IT record system which contains key information from GP records such as current medication and allergies. Known as the <i>Emergency Care Summary</i> system, access with the patient's consent will be available to out-of-hours services and NHS 24. June 2006. (NHS Boards)	A single patient IT communication system known as <i>Gateway</i> used by GPs to send electronically 90% of referrals to hospitals. June 2006. (NHS Boards)	Ensure local preparedness for PACS. (NHS Boards)			CHI Number uptake. June 2006. (NHS Boards)				A&E System in place. June 2006. (NHS Boards)				"New Ways Waiting Times Definitions." Commission and implement required modifications. (NHS Boards)				
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	A&E System in place. June 2006. (NHS Boards)																		
	"New Ways Waiting Times Definitions." Commission and implement required modifications. (NHS Boards)																		
	A single patient IT record system known as <i>SCI Store</i> in each NHS Board area which gives staff caring for patients online access to test results and clinical letters. June 2006. (NHS Boards)																		

# Section 3.2 – Unscheduled Care

NATIONAL				
2005	2006	2007	2008	2009
	Enhance skills of paramedics in key communities to improve locally available medical resources and improve emergency response times. (SAS).	Produce competency-based education frameworks to support the Kerr Report's unscheduled care recommendations. (NES).		
	Develop a specialist service to support high-dependency transfers which includes the full and active participation of intensive care specialists and specialised nursing staff. (SAS).			

REGIONAL				
2005	2006	2007	2008	2009
	Review emergency receiving services on a regional basis in conjunction with plans to develop regional planned care centres. (RPGs).	Implementation of regional review findings to secure appropriately staffed and resourced Emergency Centres; and distribution of core emergency admitting services determined by 21st Century demands. (RPGs).		

LOCAL				
2005	2006	2007	2008	2009
	Audit and feedback on referral patterns to emergency centres from other parts of the system. (NHS Boards, CHPs)			
	Develop community-based services (including Community Casualty Units) taking account of regional review of emergency receiving services and planned care centres; considering opportunities to integrate with Community Health Centres and out-of-hours services. These services should be linked to other levels of the unscheduled care system using modern ICT including tele-medicine links. (NHS Boards)			

## OUTCOMES

A stratified unscheduled care system which:

- Allows emergency specialists to concentrate on dealing with complex cases by focusing key medical resources in well staffed and resourced Emergency Centres.
- Maintains care at the local level for the majority of unscheduled cases through multi-disciplinary teams working in Community Casualty Units.
- Uses tele-medicine to integrate the various levels of the unscheduled care system. This will assist in the avoidance of inappropriate referral and unnecessary travel for patients by fostering better communication between health care professionals.
- Plans emergency admitting services (including such sub-specialised services as vascular surgery, urology, burns and plastic surgery) on a regional basis to ensure the most appropriate distribution of services and staff, given the needs of the Scottish population in the 21st Century.
- Delivers on the target of **4 Hours** from arrival for A&E Treatment by December 2007.

# Section 3.2 – Planned Care

NATIONAL				
2005	2006	2007	2008	2009
	Establish a list of day case procedures, measure and act on variation between NHS Boards in rates of day case surgery for these procedures. (SEHD)	Develop minimum expectations for surgery time and throughput for all surgical specialities. (SEHD/Royal Colleges)	Radiotherapy Activity Planning Review. (SEHD)	
		Radiotherapy: achievement of 25 modern Linear accelerators for Scotland: <ul style="list-style-type: none"> <li>▶ Glasgow 11</li> <li>▶ Edinburgh 6</li> <li>▶ Aberdeen 3</li> <li>▶ Dundee 3</li> <li>▶ Inverness 2</li> </ul>		

REGIONAL				
2005	2006	2007	2008	2009
	Produce plans for regional Planned Care Centres in conjunction with review of emergency admitting services. (RPGs)	Begin work to establish Planned Care Centres on a regional basis. (RPGs)		

LOCAL				
2005	2006	2007	2008	2009
Undertake a rigorous review of emergency and elective workflows and synchronise these to available resources. (NHS Boards)	Implement five simple changes in planned care. (NHS Boards, CHPs)	Ensure achievement of minimum standards for surgery time and throughput for all surgical staff. (NHS Boards)		

## OUTCOMES

### By December 2007:

- ▶ Target – **18 weeks** from GP referral to a new outpatient appointment.
- ▶ Target – **18 weeks** from a decision to undertake treatment to start of treatment for inpatients and day cases.
- ▶ Target – **18 weeks** from referral to completion of treatment for cataract surgery.
- ▶ Target – **24 hours** from admission to transfer to a specialist unit for hip surgery following fracture.
- ▶ Target – **16 weeks** from GP referral via rapid-access chest pain clinic or similar to cardiac intervention.

# Section 3.4 – Rural Health Care

NATIONAL				
2005	2006	2007	2008	2009
Review of current first responder schemes. (SAS)	Establish a Virtual School for Rural Health Care to ensure appropriate workforce development. (NES)	Development of local access programmes to attract people in R&R communities into health care careers with most education delivered locally. (SEHD/NES)		
	Review HEMS and, if necessary, enhance in remote and rural areas. (NES)			
	Rural general surgeons and physicians recognised as specialists with appropriate training (NES) and career pathways. (SEHD)	Implementation of a co-ordinated structure for GPsws/SLs. (RCGP/NES)		

REGIONAL				
2005	2006	2007	2008	2009
	Co-ordinate provision of services from all suppliers in R&R out-of-hours hubs.	Develop the RGH model expressed by Kerr: 1. North of Scotland Regional Planning Group in collaboration with the West Group to establish a strategic network to oversee the development of the RGHs. 2. Formalise links to specialist centres to deliver range of services specified as appropriate in RGHs. (NoSRPG)		
	Undertake feasibility study on national system of triage and service co-ordination in out-of-hours hubs. (RPGs)			

LOCAL				
2005	2006	2007	2008	2009
	Audit and feedback on referral patterns to emergency centres from other parts of the system. (NHS Boards, CHPs)			

OUTCOMES	
A safe and sustainable range of services in remote and rural areas based on:	
<ul style="list-style-type: none"> <li>Maximising the role of local health care services, GPs, pharmacists and community health teams.</li> <li>Primary care teams taking on extended roles, supported by the development of an accredited programme for GPs and practitioners with special interests.</li> <li>Local practices working collaboratively to provide a range of services for local populations.</li> <li>Community hospitals remaining a key resource if services can be re-focused to include: pre-admission and routine testing, outpatient and specialist clinics, day surgery, rehabilitation etc.</li> <li>Rural General Hospitals networked with larger teaching hospitals, providing the suite of core services which reflect health care needs in remote and rural communities.</li> </ul>	

# Section 3.5 – Mental Health Services

NATIONAL				
2006	2007	2008	2009	2010
Publication of National Delivery Plan for Mental Health, December 2006. (SEHD) Production of evidence based practice guide on depression and proposals to take forward doing well by people with depression work. (SEHD) Develop a national standard for crisis services. (SEHD) National and regional analysis of specialist service needs and implications for service redesign, December 2006. (SEHD)	Develop National Standards for integral care pathways for schizophrenia, bi-polar disorder, dementia, depression and personality disorder. December 2007. (SEHD and NHS QIS)	Report on interim progress in delivery of CAMHS Framework. (SEHD)	Redevelopment of State Hospital at Carstairs. Report on progress on National Delivery Plan. (SEHD)	Report on interim progress in delivery of CAMHS Framework. (SEHD)

## OUTCOMES

- Improvement of primary care response to people presently with mild to moderate and anxiety and depression.
- Standards in place for the management of care for those with severe and enduring mental illness.
- A hospital estate that meets the needs of forensic patients under the Mental Health (Care and Treatment) (Scotland) Act 2003.
- A National Plan for services that sets clear objectives for improvement that will be subject to performance management.
- Better national and regional management of specialised services.
- Improved crisis and out-of-hours services to reduce unnecessary patient admissions.

REGIONAL				
2006	2007	2008	2009	2010
	Stobhill Medium Secure Unit open.	Dykebar Medium Secure Unit open	North of Scotland Medium Secure Unit open.	

LOCAL				
2006	2007	2008	2009	2010
Start implementation of the local elements of the CAMHS Framework (NHS Boards)	Development of local action plans based on National Delivery Plan. (NHS Boards)	Development of local ICPs to meet National Standards. (NHS Boards)		



# Section 3.6 – Child and Maternal Health

NATIONAL				
2005	2006	2007	2008	2009
<p>Establish CYPHSG &amp; develop an Action Framework for Children and Young Peoples Health (AF).</p> <p>Establish Expert Group on maternity services to review and update existing policy.</p> <p>NES to develop training programme to deliver core skills and competencies for staff working with children.</p>	<p>Development of care pathways for the 10 commonest acute conditions for children.</p> <p>Initiate reviews of adolescent care and general surgery services for children and produce action plan for implementation.</p> <p>Agree workforce plans for child health staff and initiate scoping exercise for childrens nursing which defines future models of delivery and roles.</p>	<p>Support delivery of the AF and specific service frameworks for CAMHS and Emergency Care.</p> <p>QIS to carry out specific visits to local NHS systems.</p>	<p>Agree delivery of specialist acute hospital provision in children's hospitals.</p>	

OUTCOMES
<ul style="list-style-type: none"> <li>Redesign of child health services at a national, regional and local level ensuring equity of access and quality of care by 2010.</li> <li>Establish care pathways for 10 commonest acute conditions for children by 2008.</li> <li>Improve uptake of screening and surveillance contacts to 90% of population by 2008 through the implementation of Hall4.</li> <li>Improve care for adolescents by 2010 for example new children's hospitals in Glasgow and Edinburgh.</li> <li>Development of a workforce with the core skills and competencies to treat children and young people.</li> <li>Comprehensive care arrangements in place for children with complex care needs.</li> <li>Expansion of adolescent psychiatric inpatient sector to at least 56 places by 2010.</li> </ul>

REGIONAL			
2005	2006	2007	2008
<p>Establish Child Health Regional Planning Groups.</p> <p>Regional Planning for expansion of the adolescent psychiatric inpatient sector.</p>	<p>RPGs to develop workforce projections for children's services.</p> <p>RPGs to produce action plans for the delivery of acute care at a local and regional level.</p>	<p>Implement action plans for the provision of surgery on a regional basis with hub and spoke models and regular training courses for surgeons and anaesthetists by the specialist centres. Agree standards for paediatric surgery.</p> <p>Implementation of psychiatric adolescent inpatient proposals in regional planning areas to be completed by 2010.</p>	

LOCAL			
2005	2006	2007	2008
<p>Agree Local Integrated Children Service Plans including which include acute services.</p> <p>Issue guidance and agree local delivery mechanisms for Hall4.</p>	<p>Start implementation of the local elements of the Hall4 and the CAMHS and Emergency Care Frameworks.</p> <p>NHS Boards to review models of care for children with complex care needs.</p> <p>NHS Boards to produce local workforce plans to include services for children services.</p>	<p>Implement local aspects of AF, adolescent care and children's surgery review and establish care pathways for the 10 commonest acute conditions.</p>	<p>Implement key worker model for children with complex needs at a local level.</p>

# Section 3.6 – Tertiary Paediatric Care

NATIONAL				
2005	2006	2007	2008	2009
<p>Produce map of MCNs at national, regional and at local level with phased programme for MCN development over five years.</p> <p>Develop capacity for planning specialised paediatric services. (SEHD working with RPGs and CYPHSG).</p> <p>Define workforce requirements for specialist paediatric services.</p>	<p>National commissioning of the PICU Service for a period of five years.</p> <p>Establishment of the national critical care network. (SEHD)</p>	<p>Support the delivery of MCNs and specialist paediatric services at a regional and local level.</p>	<p>2008</p>	<p>2009</p>
	<p>Development of a National Managed Clinical Network for paediatric critical care. (SEHD)</p>			
	<p>Implementation of MCN strategy for specialist paediatrics including national MCN for children's cancer services.</p>			

## OUTCOMES

- › Delivery of specialist paediatric services at a national level with clear care pathways for specific conditions with DGH and primary care services.
- › Provision of acute services for children and young people in appropriate accommodation.
- › Development and implementation of standards for providing specialist care.
- › Delivery of care through MCNs for specialist children's services that define service provision at a local, regional and national level.
- › Establishment of a national paediatric intensive care network including high dependency care by 2007.

REGIONAL				
2005	2006	2007	2008	2009
	<p>Implementation of specialist paediatric MCN strategy with an emphasis on proposals of those services already reviewed for example children's cancer services, gastroenterology, complex respiratory, neurology.</p> <p>Development of the High Dependency Units (HDU) in Aberdeen, Dundee, Edinburgh and Glasgow as regional lead HDU centres within the national network.</p> <p>Development of the two Paediatric Intensive Care Units (PICU) in Edinburgh and Glasgow as the lead national PIC centres within the network operating as a single PIC on two sites.</p> <p>RPGs and SAS to ensure that:</p> <ul style="list-style-type: none"> <li>– The child is taken to the most appropriate hospital determined by need.</li> <li>– Rapid and reliable transfer arrangements are in place to escalate the level of support when needed.</li> <li>– Return transport arrangements are available as part of agreed discharge protocols. (RPGs/SAS).</li> </ul>	<p>Plans brought forward for the provision of age appropriate care at DGH and for specialist services.</p>		

# Section 3.7 – Neurosurgery and Neuroscience

NATIONAL					
2005	2006	2007	2008	2009	
Establish a working group to advise on implementation of recommendations. (SEHD)	Working Group begins needs assessment for neurosciences. Work starts on: <ul style="list-style-type: none"> <li>▶ service model (MCN), including integrated care pathways</li> <li>▶ standards for neurosurgery</li> <li>▶ minimum dataset and audit arrangements</li> <li>▶ sub-specialisation arrangements</li> <li>▶ implications for wider services, including neurology and neurophysiology.</li> </ul>	Working Group submits proposals to SEHD. Identify preferred prime site for paediatric and adult neurosurgery. (SEHD) Identify other preferred sites for sub-specialist adult neurosurgery. (SEHD)	Undertake consultation on proposals. (SEHD)		

## OUTCOMES

- ▶ **QUALITY**: to make sure that present quality of service can be improved, by a more sustainable approach to specialisation and sub-specialisation within a coherent framework.
- ▶ **INTEGRATION**: the new model will promote integration between services in the community and secondary and tertiary services through an MCN approach based on clear referral protocols which reflect integrated care pathways.
- ▶ **PRODUCTIVITY**: the new model will make use of scarce human resources including consultant neurologist and nurse specialists in the most efficient way.

REGIONAL					
2005	2006	2007	2008	2009	
	Consider regional appointments to new service model. (RPGs)				

LOCAL					
2005	2006	2007	2008	2009	
CHPs and primary care teams work with JNCS to scope Level N1 of the single service. Work on unplanned neurosurgical activity in conjunction with community casualty service.					

# Annex B

## List of acronyms used in the document

A&E	– Accident and Emergency
AHP	– Allied Health Professionals
CHD	– Coronary Heart Disease
CHI	– Community Health Index
CHP	– Community Health Partnerships
COSLA	– Convention of Scottish Local Authorities
CT	– Computed Tomography
CTA	– Computed Tomography Angiography
CYPHSG	– Children and Young People's Health Support Group
ECG	– Electrocardiogram
ECS	– Emergency Care Summary
ENT	– Ear, Nose and Throat
ETP	– Electronic Transmission of Prescriptions
GMS	– General Medical Services
GP	– General Practitioner
GPwSI	– General Practitioners with Special Interests
Hall4	– Health for all Children
HDC	– High Dependency Care
HEPMA	– Hospital Electronic Prescribing and Medicines Administration
ICP	– Integrated Care Pathway
ICT	– Information and Communication Technology
MCN	– Managed Clinical Networks
MRA	– Magnetic Resonance Angiogram
MRI	– Magnetic Resonance Imaging
NES	– NHS Education for Scotland
NHS	– National Health Service
NoSRPG	– North of Scotland Regional Planning Group
NSD	– National Service Division
NSIC	– Neonatal Surgical Intensive Care
PACS	– Picture Archiving and Communications Systems
PET	– Positron Emission Tomography
PIC	– Paediatric Intensive Care
PRI	– Perth Royal Infirmary
QIS	– NHS Quality Improvement
RCGP	– Royal College of General Practitioners
RGH	– Rural General Hospital
SAS	– Scottish Ambulance Service
SCI	– Scottish Care Information
SEHD	– Scottish Executive Health Department
SNAP	– Scottish Needs Assessment Programme

# Annex C

## Bibliography

### **Building a health service fit for the future: a national framework for service change in the NHS in Scotland (“The Kerr Report”)**

by Scottish Executive Health Department

Edinburgh: Scottish Executive, 2005

URL: <http://www.scotland.gov.uk/Resource/Doc/924/0012112.pdf>

ISBN: 075594545X

### **Framework for mental health services in Scotland: perinatal mental illness/postnatal depression hospital admission and support services**

by Scottish Executive Health Department

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