NHS SCOTLAND

BETTER HEALTH, BETTER CARE:
ACTION PLAN

healthier scotland
SCOTTISH GOVERNMENT

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FOREWORD

I launched the discussion about *Better Health, Better Care* in August 2007 with a group of patients, carers and their representatives in Glasgow. I promised them an Action Plan that would put their interests and their concerns at the centre of all that we do to improve health and health care in Scotland. This document begins to deliver on that promise.

I have been delighted by the response to the discussion paper. We saw over 2000 people face to face and received nearly 600 submissions. We made a specific effort to ensure that we heard views that reflected the diversity of Scotland's population.

We heard from the citizens of Scotland about the importance of communication, participation, being listened to and having the opportunity to play a stronger part within the NHS. For staff, the key issues were about feeling valued and there was a strong sense

that we seemed to be heading in broadly the right direction. For Boards, there was a wish for clarity about priorities and about stability. They want to be part of shifting care into communities, in raising quality and in reducing inequality. The Action Plan is built around those aspirations.

There is much to be proud of in our National Health Service. We have strong foundations on which to build as we seek to improve health in Scotland.

But I have been clear since taking on this position, that the best way to make progress on health and health care is by galvanising the people of Scotland with new rights and responsibilities. That is why this document sets out a new vision for the NHS. That vision is based on a shift from the current position where we see people as "patients" or "service users", to a new ethos for health in Scotland

that sees the Scottish people and the staff of the NHS as partners, or co-owners, in the NHS. I want us to move to a more mutual NHS where partners have real involvement, representation and a voice that is heard. We will also encourage patients and carers to be genuine partners in the delivery of their care through a commitment to patients' rights and active involvement in self management that suits their lifestyles.

A mutual NHS is more than an idea. This Action Plan contains a number of proposals that shift ownership and accountability to the people of Scotland and offer them the opportunity to take more control of their health. That brings with it responsibilities too. Our proposals for the development of a participation standard and a charter of mutual rights will enable us to maximise the opportunities that this brings. A mutual NHS is consistent with the founding values of the

NHS. I believe strongly in the principles of equal access on the basis of need, available free at the point of care. Neither will we change the funding model of the NHS. It will remain firmly in the public sector. In stressing public ownership through a more mutual approach, we distance NHSScotland still further from market orientated models.

Our Action Plan sets out an ambitious programme of work for the next five years. It is right to be ambitious. There is little that is as important to Scotland as our health and our NHS.
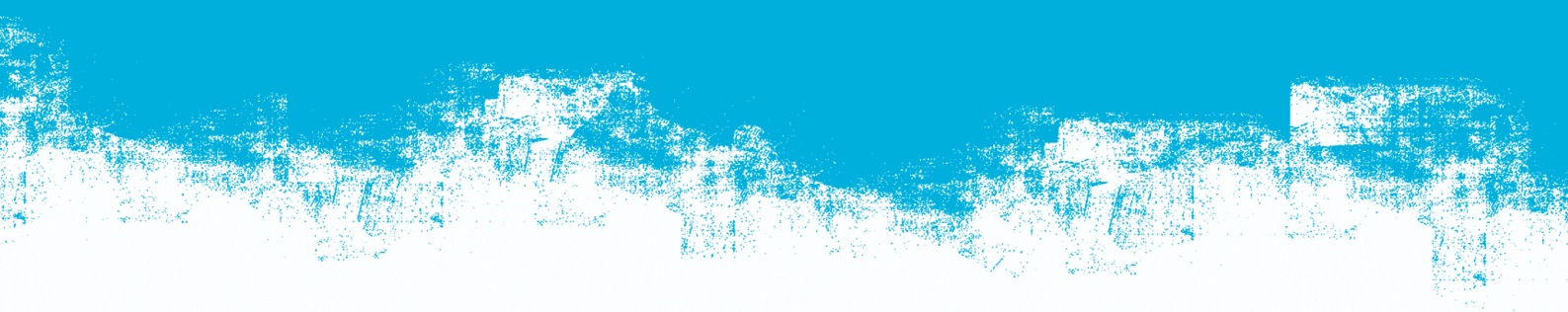
Nicola Sturgeon, MSP
Deputy First Minister and Cabinet Secretary for Health and Wellbeing

"Help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care"

INTRODUCTION

The new Scottish Government has set out its single overarching purpose and five strategic objectives as follows:

PURPOSE

To focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.

WEALTHIER & FAIRER – Enable businesses and people to increase their wealth and more people to share fairly in that wealth.

SMARTER – Expand opportunities for Scots to succeed from nurture through to life long learning ensuring higher and more widely shared achievements.

HEALTHIER – Help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.

SAFER & STRONGER – Help local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life.

GREENER – Improve Scotland's natural and built environment and the sustainable use and enjoyment of it.

NHSScotland, both alone and in conjunction with its partners, has a significant contribution to make to each of these ambitious objectives. Achievement will be assessed against seven high-level targets and 15 shared, national outcomes through a set of 45 supporting indicators which will be used to report progress to the people of Scotland over a 10-year period. This, in turn, will be underpinned by a range of performance management systems across the public sector, including NHSScotland, which will ensure that services and activities are aligned appropriately.

Better Health, Better Care is a significant step towards a 'Healthier Scotland' and its three main components of health improvement, tackling health inequality and improving the quality of health care. This Action Plan sets out a programme of comprehensive and targeted action to accelerate progress on each of these components.

On health improvement, we acknowledge the progress that has been made in tackling smoking but recognise that smoking is still the biggest cause of premature death in Scotland, especially in disadvantaged communities. We therefore commit to stepping up our efforts to reduce smoking across Scotland. We will also take action to tackle alcohol misuse and the rising problem of obesity and review our approach to improving mental wellbeing as well as physical health.

The Action Plan reflects work underway in the Ministerial Task Force on Health Inequalities to make improvements to health services and prepares the ground for its report to Cabinet in May 2008 on action to address the wider determinants of health. In particular, it sets out the Scottish Government's plans to extend anticipatory care approaches significantly and to develop early intervention programmes which invest in the health of pregnant mothers, babies and young children to break the link between early life adversity and adult disease.

Our Action Plan also sets out a range of measures to improve the quality of our National Health Service. It gives effect to our commitments to local care whenever possible, embedded in communities and tailored to people's needs. It gives effect to our commitment to care that is even quicker, even safer and even more efficient and effective than ever before. It recognises the excellent progress made by NHS staff over the last few years, and in the first months of this new Government. In the spirit of continuous improvement, our Action Plan seeks to accelerate that progress.

Our model of improvement is built around the existing strengths of NHSScotland – a collaborative, integrated approach built on our traditional values. We will therefore retain our unified Board structure and ensure that NHSScotland remains firmly in the public sector – a public service delivered in partnership with the public. Our Action Plan brings together our commitments to public participation, improving patient experience, patient rights and enhanced local democracy and expresses them in terms of a more mutual approach to healthcare. The Scottish people are more than consumers of NHS services. They share ownership of the NHS and that gives them rights and responsibilities which we discussed with the thousands of people who participated in our consultation and which we begin to set out in this Action Plan.

> **"**
> The NHS talks about patient focus and service users. It should talk about service owners
> **"**
>
> WORLD CAFÉ PARTICIPANT

SECTION ONE:

TOWARDS A MUTUAL NHS

1.1 TOWARDS A MUTUAL NHS

This section sets out actions to:

- Strengthen public ownership of the NHS by improving rights to participate

- Embed patient experience information in the performance management of the NHS

- Further strengthen the collaborative and integrated approach to service improvement that is the hallmark of Scotland's NHS

Mutual organisations are designed to serve their members. They are designed to gather people around a common sense of purpose. They are designed to bring the organisation together in what people often call "co-production". The concept of the mutual organisation sits extremely comfortably with the Scottish Government's commitments to stronger public involvement, improving the patient experience, clearer patient rights, enhanced local democracy - for example through direct elections to NHS Boards - and independent scrutiny of proposals for major service change. It also underpins the Government's commitment to partnership working, better staff governance and improving the NHS as a place to work.

For these reasons we intend to ensure that NHSScotland is based on a mutual ethos. This will not involve changes to the financial arrangements of the NHS. Nor will it require change to the overall structure of the NHS. On the contrary, it is entirely consistent with our existing approach of integrated care, based on the values of co-operation and collaboration delivered through unified Boards.

However, moving towards a mutual NHS will require new ways of thinking about health and health care. We need to move, over time, to a more inclusive relationship with the Scottish people; a relationship where patients and the public are affirmed as partners rather than recipients of care. We need to move towards an NHS that is truly publicly owned. We need to move towards an NHS where ownership and accountability is shared with the Scottish people and with the staff of the NHS. We need to move towards an NHS where we think of the people of Scotland not just as consumers - with only rights - but as owners - with both rights and responsibilities.

This is a process of evolution. A mutual NHS will require shifts in control, status and participation that cannot be achieved overnight. This strategy and Action Plan, however, sets out to embed the mutual philosophy in the way in which NHSScotland helps Scottish citizens to sustain and improve their health and takes action to improve the quality of health care services. It identifies a series of practical actions that will help bring the concept of mutuality to life for the citizens of Scotland and signal a new phase in the delivery of health care in our nation.

1.2 A SERVICE FOR THE PUBLIC

Introduction

NHSScotland is a public service, a service that is used for, and paid for, by the public. The *Better Health, Better Care* discussion process demonstrated both the willingness of patients and the general public to get involved in the design and delivery of health services, and the value that can be added by such participation. A mutual NHS gives the people we serve a greater say in their service and a chance for those working in health care to harness their knowledge and enthusiasm on a daily basis, as we make decisions about the shape and structure of services across Scotland.

Patient Focus and Public involvement

Community Health Partnerships (CHPs) have established Public Partnership Forums, which have made good progress in involving local communities in the design and delivery of health services. These forums played a significant role in shaping this strategy and we will work with them to produce a set of specific proposals during summer 2008 for strengthening their role still further. This will improve the way in which we engage with children, young people and the people who care for them and ensure greater involvement of the most vulnerable and seldom heard groups. Third Sector organisations have well established networks and connections across these communities and can play a vital role as partners in ensuring that our health services are fair for all.

Patient Experience

From 2008, *Better Together* – Scotland's new Patient Experience Programme – will encourage and empower patients, carers and health care staff in Scotland to work together in partnership to provide patient centred care and improve NHS services for the benefit of all. It will identify opportunities for improving patients' experience and enable patients, carers and staff to work together to redesign services and ensure that changes are implemented effectively. The programme will focus on redesigning the whole experience of care, rather than just internal systems and processes within NHS Boards. In doing so, the programme will make NHSScotland a world leader in involving patients in the design of health care services.

Patient Rights

A public consultation on the possible content of a Patients' Rights Bill will be launched by May 2008. A mutual NHS provides the context for a legal framework that sets out what patients have a right to expect from their service, including individual waiting time guarantees appropriate to individual needs. It will give us the opportunity to develop a charter of mutual rights – a charter that provides a clear statement of rights and responsibilities from the perspective of Government, staff and the public. It will provide patients with quick and efficient redress where problems occur, without the need for unnecessary and inappropriate legal action and litigation. It will also set out the right of patients to be treated as partners in their care and challenge all those who work for NHSScotland to respect the expertise of patients and their carers and improve the way in which we communicate and involve them in the decisions that affect them.

Independent Scrutiny

Independent scrutiny of proposals for major NHS service change provides local communities with the confidence that the available evidence has been assessed rigorously, all viable options considered and that their views have been sought appropriately and their interests taken fully into account. We have established independent scrutiny panels to consider proposals for service change in Lanarkshire, Ayrshire and Arran, and in the Clyde area and launched a consultation on options for embedding scrutiny in the future. This includes the potential to provide scrutiny through a decision conference, an independent body such as a local authority or an expert panel. We will respond to this consultation by April 2008, setting out a future model for independent scrutiny within the framework of a mutual NHS.

Elections to NHS Boards

Our consultation on the content of a Local Healthcare Bill will include consideration of direct elections to NHS Boards. The national discussion around *Better Health, Better Care* has identified the need to consider this issue alongside the functions of existing non-Executive directors, the role of independent scrutiny and other mechanisms for increasing accountability, including partnership working with Local Authorities and elected members at Board and community level. The Bill, which will be introduced in summer 2008, will address these concerns within the context of a mutual NHS.

Participation Standard

At present, the majority of public involvement exercises are evaluated against a set of criteria devised by the Scottish Health Council. This is extremely valuable, but we now need to integrate the level and quality of participation into our overall approach to quality improvement and the performance management framework for NHSScotland to ensure that patient focus and public involvement are core drivers of decision making and not an afterthought or side issue. We will therefore work with NHS Quality Improvement Scotland, the Scottish Health Council, Public Partnership Forums and other groups, including staff representatives, to agree a participation standard for all NHS Boards covering future involvement of patients, staff and the public more generally. This standard will reflect the needs of Scotland's diverse population. Boards will be asked to conduct an audit against this standard in order to collect systematic, comparable information on good practice and inform the future development of our approach to participation. We will include a target for performance against this standard amongst the key measures for NHS Boards by 2009.

Ownership Report

Our commitment to the concept of mutuality will be embodied in an annual ownership report. Distributed free of charge to all Scottish households, this will set out information on the rights and responsibilities of patients and their carers, alongside useful information about how to access local services, raise issues or complaints and get more involved in the design and delivery of local health services.

We will:

- Produce proposals in Summer 2008 to strengthen Public Partnership Forums

- Launch a public consultation on a Patient Bill of Rights by May 2008, including the right of patients to be treated as partners in their care

- Consult on the development of an NHS charter of mutual rights - a clear statement of duties and rights from the perspective of Government, staff and the public

- Produce proposals for independent scrutiny of major NHS service change proposals by April 2008 following a public consultation

- Introduce a Local Health Care Bill in Summer 2008

- Develop a Participation Standard for NHS Boards which reflects the needs of Scotland's diverse population

- Incorporate assessment of performance against the participation standard into NHSScotland's performance management system by 2009

- Produce and distribute an annual "Ownership Report" to all Scottish households

1.3 DELIVERING TOGETHER

Introduction

A mutual NHS requires us to clarify roles and responsibilities across the organisation and translate this into a clear set of expectations and ways of working. This begins with an explicit commitment to working with partners, at all levels, in the interests of the people of Scotland. It also requires a reappraisal of internal working practices and relationships. National NHS Boards should add value to the work of local Boards, help the organisation as a whole to avoid excessive costs and enable effective decision making at a local level. In turn, NHS Boards need to support the strategic direction of travel set out in this document and look for opportunities to collaborate with each other where this makes sense for patients and NHSScotland as a whole.

Performance Management

We recognise that targets that are poorly designed are an unnecessary distraction and can drive the wrong kind of behaviours and actions. However, all major organisations require clear targets and objectives to provide a sense of purpose, drive continuous improvement and focus the decisions they make.

The HEAT performance management system sets out the targets and measures against which NHS Boards are publicly monitored and evaluated. To support the delivery of our agenda, we will develop this system so that it:

- identifies and drives the contribution of NHSScotland to the overall strategic objectives of the Scottish Government

- links closely with the new accountability and performance arrangements that apply for local government and enables joint roles, responsibilities and actions to be agreed at local level through Community Planning arrangements

- demonstrates clear alignment between short term operational targets and the longer term strategic direction set out in this document.

The HEAT targets which will be addressed by NHS Boards in their local delivery plans for 2008/09 are listed in Annex A. They reflect a rebalancing of previous approaches to performance management, with a greater emphasis on health improvement, mental health, efficiency and anticipatory care, with a corresponding reduction in the number of access targets. From 2009, the new targets will embed evidence on the patient experience within the performance management framework of NHSScotland for the first time. This will provide greater impetus to efforts to extend the use of patient experience information in clinical as well as organisational performance management.

Our commitment to an NHS that is accountable and patient focused requires us to ensure that our approach to performance assessment and monitoring is strong and effective. We will therefore develop our arrangements for performance assessment and scrutiny in health in line with the five guiding principles set out in the Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland (2007). These are: public focus, independence, proportionality, transparency and accountability.

Community Health Partnerships

Community Health Partnerships (CHPs) offer the opportunity for NHSScotland and its partners to work together to tackle health inequalities, enhance anticipatory and preventative care, shift resources to community settings and provide a wider variety of services at local level. Our key priorities for health care require the drive towards locally provided services. The successful implementation of the waiting time target of 18 weeks from GP referral to treatment will, for example, require us to increase the availability of local diagnostic services which, in turn, requires development and investment plans for community hospitals and other facilities, including shared or joint premises wherever practicable.

Community Health Partnerships will increasingly be expected to shift the balance of care; improve access, manage demand, reduce unnecessary referrals to specialist services and provide better community care services. But in order to do this effectively they need to have a broader range of delegated resources and greater flexibility of decision making. We will therefore work with them to introduce an "integrated resource framework" which will build on the progress that has been made so far in devolving budgets to local levels and extend the responsibility and accountability of CHPs for delivering better outcomes by ensuring that resources follow the patient or client. This framework will support strategic joint commissioning and collaborative contracts to deliver local shifts in the balance of care.

Work is underway through the Strategic Partnership Group to develop a transparent resource framework that can be used locally to support the delivery of new service and care models. The approach may include the development of collaborative contracts, programme budgets and transitional funding as enablers of change.

Special Health Boards

Special Health Boards offer a unique resource for NHSScotland. They allow local Boards to concentrate resources and attention on front line treatment and care and deliver those services that can be offered more effectively and efficiently on a national basis. They have the additional potential to offer their services and expertise across the wider public sector as part of Efficient Government. To ensure that we make the most of this opportunity, we will work with them to ensure that their purpose, objectives and ways of working demonstrate the value they add in improving services, improving health, achieving economies of scale and minimising unnecessary duplication of investment and effort.

Service Planning

It has become clear during the discussion process that we need clearer health care planning arrangements across NHSScotland. Service planning needs to happen at three levels:

- National: To set the strategic direction for NHSScotland, performance manage NHS Boards on the basis of a focused set of targets and plan the delivery of specialist national services, where these are required, in order to provide sustainable services throughout Scotland

■ Regional: To develop plans where NHS Boards have decided that their local population would benefit from a collaborative approach to planning and commissioning services

■ Local: To plan and commission the vast majority of healthcare services as an integral part of local community planning processes.

We are committed to improving NHSScotland's healthcare planning system through the development of an agreed planning framework and by clarifying roles and responsibilities at each level, by the end of 2008. This will integrate previously distinct approaches to service, workforce and financial planning and will be supported by annual planning guidance and a co-ordinated timetable for planning across the service.

Implementing *Better Health, Better Care*

The revised set of HEAT targets and measures, has immediate consequences for the way in which we will manage the implementation of this programme as a whole. Wherever possible, we will use existing accountability arrangements and organisations to drive and support delivery across Scotland. This has the huge advantage of demonstrating that *Better Health, Better Care* is about the mainstream delivery of services and support, and not an additional project that can, in some way, be ring-fenced or isolated from the heart of our agenda. Any additional reporting on implementation will be streamlined and proportionate.

We will:

■ Ensure that NHSScotland plays a full part in cross Government activity to create a more successful country

■ Revise the HEAT performance management framework so that performance targets are better linked to long term strategy and integrated with other approaches to performance management across the public sector

■ Embed patient experience data in our targets for the first time

■ Develop an integrated resource framework to support joint commissioning and collaborative contracts within Community Health Partnerships

■ Review the purpose, objectives and ways of working of Scotland's Special NHS Boards

■ Review and improve the planning system within NHSScotland in 2008

■ Manage the overall implementation of this programme through existing processes and mechanisms wherever possible

1.4 CO-OPERATION AND COLLABORATION

Introduction

A mutual NHS enshrines our values of co-operation and collaboration in the very fabric of the organisation. We believe that co-operation and collaboration both across NHSScotland and between NHSScotland and its partners, is a more effective means of driving change than internal competition. Our national discussion has confirmed our belief that a public service, particularly one which supports people at some of the most emotionally testing times of their lives, should look to drive and sustain change on the basis of patients' needs and the expertise of our staff, rather than a reliance on market forces.

The values of co-operation and collaboration must be assertive rather than passive values. The challenge of implementation, is to create the structures and processes that support them in making a real difference to our services.

Staff Partnerships

Our staff are the agents of change. We cannot hope to bring about the improvements envisaged by this plan unless the people who will deliver these improvements are protected in their places of work, recognised and rewarded for their contribution to our success and given the opportunities to develop the skills and experiences they require. This commitment applies to staff at all levels and in all roles; from clinicians who work directly with patients, to the range of other professionals who work tirelessly behind the scenes to ensure that NHSScotland runs smoothly and that the public get best value for their annual investment of over £10 billion.

Over the past few years, NHSScotland has benefited greatly from its approach to partnership working with staff and their representative organisations. Partnership is not merely about good employee relations. It is invaluable in shaping and supporting service redesign, developing roles and ways of working and increasing capacity and skills across the service. It demonstrates trust, integrity and openness across all our activities and ensures that our values of co-operation and collaboration are realised in both our strategic direction and in the practical issues that affect people's working lives.

The concept of a mutual NHS reinforces and extends this commitment to partnership working and we will work through the Scottish Partnership Forum to continue the development of this concept at both a strategic and practical level. This will include joint working to incorporate staff involvement in the new participation standard for NHS Boards and to explore new opportunities to work together to support Scottish citizens in making healthy lifestyle choices and reinforce the reputation of NHSScotland as a professional, patient centred organisation.

Managed Clinical Networks

Managed Clinical Networks developed as mechanisms for linking groups of health professionals and organisations in the delivery of high quality services. The coverage of these networks now needs to be expanded. We will continue to encourage spontaneous initiatives from clinicians and the voluntary sector for the development of networks, where there are tangible benefits to patients from doing so, but we will also provide national leadership and resources to ensure the effective implementation of networks for respiratory and neurological conditions. Where appropriate, we will also strengthen the traditional model of Managed Clinical Networks so that they provide effective clinical leadership for action to plan and deliver national services against stretching targets. Such networks will recruit staff to network wide positions and enable us to sustain nationally networked services which balance the need for specialisation and local delivery of services wherever possible. In particular, they will lead the implementation of planned improvements to our specialist children's services, neurosurgery and laboratory services across Scotland.

Workforce Planning

Workforce planning is vital in order to meet the challenges of recruiting and retaining staff, particularly in remote and rural areas, in the face of an ageing population and intense competition for the best people from other sectors of the economy. This needs to draw effectively on the knowledge and experience of front line staff who understand the roles, responsibilities and opportunities that exist.

Over the next three years, a phased approach to workforce planning will support NHS Boards to develop their workforce capability, integrate workforce planning within the new overall planning framework and better integrate workforce planning with health care partners across the public and voluntary sectors. This will see greater collaboration in training provision, developed as part of a shared commitment to Best Value. Our strategic direction for developing workforce planning will be outlined in *Better Health, Better Care: Planning Tomorrow's Workforce Today.*

New Roles

Over the last 10 years, NHSScotland's workforce has grown by around 18%. The focus must now be on planning for new and extended roles arising from opportunities around the redesign and modernisation of services. This includes roles such as Rehabilitation Co-ordinators to support and enable self care, Physician Assistants and Assistant Practitioners in Child Health.

We want to see a model of nursing in the community that delivers effective nursing support to individuals, families and

communities. This, we believe, will support community based services that are proactive, modern, safe and which help people to realise their potential for health and wellbeing. However, during our national discussion, we heard some concerns about the current developments and it is therefore important that we test this new approach of community health nursing to demonstrate what works and to get it right for the future. We will therefore progress with work in four pilot sites and make a final decision about roll out, based on the outcomes of these projects in Spring 2009.

Third Sector

The value added contribution of Scotland's network of voluntary and community organisations is already significant, but more must be done to foster this important partnership. NHS Boards are required to work with local third sector organisations to understand and develop the potential contribution they can make to improving the effectiveness of health improvement and health care planning and delivery. Working together with Volunteer Development Scotland, we will refresh the strategy on NHS Volunteering, recognising the various roles played by the third sector and considering how best to recognise the role played by volunteers. We will then go further and require all NHS Boards to achieve the *Investing in Volunteers Standard* – the nationally recognised standard which guarantees a quality experience for volunteers.

Leadership Development

Leadership is central to improving performance, redesigning services and securing better outcomes for the people of Scotland.

Leadership at all levels, and in all disciplines, can make or break the delivery of this change programme. The Leadership Development Framework for NHSScotland and its subsequent delivery plan (2005) has served NHSScotland well over the past two years, but the plan needs to be reviewed during 2008 to clarify the leadership qualities and behaviours we require to deliver our new priorities.

We will continue to invest in staff skills, training and competencies to help improve services for patients, support team working and enhance Scotland's reputation as a base for leading health care science and research. This includes support for four demonstration projects in different NHS Boards which aim to illustrate the benefits of the National Career Framework in helping staff to plan and progress their careers, whilst at the same time providing NHS Boards with a valuable tool to help them plan workforce development around changing service needs and patient expectations.

Staff Experiences

One of the best ways of demonstrating the value we place on our staff is to invest in their health and wellbeing. We have already made good progress in addressing bullying, harassment and violence towards staff. Partnership Information Network policies have set minimum standards in relation to staff and employment issues. OHSXtra, a case management approach for fast track rehabilitation, including mental health, physiotherapy and Cognitive Behavioural Therapy services, has been piloted successfully in NHS Lanarkshire and NHS Fife and is now being tested in other areas. These initiatives are all encouraging, but we and our partners

can do more to provide working environments which minimise the risks to health and encourage and enable staff to take greater responsibility for their own health. This offers a practical demonstration of our commitment to mutuality as we work with staff to make NHSScotland a better place to work and ultimately improve the service we are able to provide for our patients. Understanding and reacting to the needs of individual staff is, of course, the stuff of good management. Nevertheless, as in many organisations, there is a need to take a regular snapshot of staff satisfaction through a survey and then use its findings to drive change. The next survey takes place in 2008 and we will ensure that each NHS Board works with its local partnership committees to identify problem areas, develop action plans to address problems and to show progress against previous results. Local Staff Governance Committees will be responsible for recommending actions and monitoring progress at a local level.

We will:

- Work with the Scottish Partnership Forum to develop the concept of mutuality as it applies to our staff

- Expand the coverage of Managed Clinical Networks and strengthen them, as appropriate, to implement improvements to neurosurgery, laboratories, and specialist children's services

- Move towards better workforce planning that directly supports the safe delivery of services in a way that is both affordable and sustainable

- Introduce phased improvements to workforce planning to help Boards develop their workforce capabilities and link more effectively with partners outside of NHSScotland

- Assess four pilots of a new model of nursing in the community and make a decision about roll out in Spring 2009

- Support four national demonstration projects around the National Carers Framework

- Refresh NHSScotland's strategy on volunteering

- Review the Leadership Development Framework during 2008

- Support staff in taking greater responsibility for their own health and ensure health protecting and enhancing working environments

- Hold a staff satisfaction survey in 2008 and take action on the results at national and local level

"...there is a need for a greater emphasis on joint working in order that NHSScotland, local authorities and partners can deliver on what is undoubtedly a shared agenda"

NATIONAL PROFESSIONAL REPRESENTATIVE ORGANISATION

SECTION TWO:

HELPING PEOPLE TO SUSTAIN AND IMPROVE THEIR HEALTH, PARTICULARLY IN DISADVANTAGED COMMUNITIES

2.1 IMPROVING SCOTLAND'S HEALTH

This section sets out actions to:

- Increase healthy life expectancy in Scotland

- Break the link between early life adversity and adult disease

- Reduce health inequalities, particularly in the most deprived communities

- Reduce smoking, excessive alcohol consumption and other risk factors to a healthier life

Introduction

Building a Health Service: Fit for the Future (2005) identified the main challenges to health and wellbeing as an ageing population, persistent health inequalities, a continuing shift in the pattern of disease towards long term conditions and growing numbers of people with multiple conditions and complex needs. *Better Health, Better Care* provides us with an opportunity to refresh our understanding of these challenges and reflect new insights that have emerged over the past few years.

The Scottish Population

Overall, Scotland's population is projected to rise from 5.12 million in 2006 to a high of 5.37 million in 2031. This represents an increase over the medium term of around 5%, driven largely by immigration. Over the longer term however, our population will start to decline, falling below 5 million by 2076.

Changes to the age profile of the population continue to present us with a particular challenge. The number of younger people is projected to decline, whilst the number of people of pensionable age is projected to rise

by around 31%, from 0.98 million in 2006 to 1.29 million in 2031.[1] The number of people aged 75 and over is projected to increase by around 81% from 0.38 million in 2006 to 0.69 million in 2031. These are the "baby boomers" of the post-war period.

In itself, an ageing population tends to increase the demand for healthcare, although its effects are being offset to a significant extent by the fact that our older citizens are on average healthier than they have ever been. The main impact of the age profile is therefore on the type of demand we face, since older people have a higher incidence of chronic disease and on average a greater number of long term conditions.

Long Term Conditions

The increasing number of people with long term conditions presents a major challenge for health and social care services and for society. According to *Scottish Household Survey* estimates, in 2005/06, 23.6% of adults aged 16 or over reported some form of long-term illness, health problem or disability. By the age of 65 nearly two-thirds of people have

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[1] Pensionable age is 65 for men, 60 for women until 2010; between 2010 and 2020 pensionable age for women increases to 65. Between 2024 and 2026 the pensionable age for both men and women increases to 66 and changes again, in two further steps, to 68 by 2046.

developed at least one long term condition, whilst 27% of people aged between 75-84 have two or more such conditions.[2]

Someone living in a deprived area is more than twice as likely to have a long term illness compared with someone in an affluent area, and people living with a long term condition are likely to be more disadvantaged across a range of social indicators such as employment, educational qualifications, home ownership and income. The impact of deprivation can also be seen in terms of mental health and wellbeing, with a recent Scottish survey reporting higher levels of mental wellbeing being associated with those on higher incomes.

Figure 1:
All-cause standardised mortality ratios (SMRs) in council areas.
Men aged 0-64 Scotland 2000-02.
Source: Medical Research Council[3]

SMR
- greater than 150
- 115-150
- 105-115
- 95-105
- 85-95
- less than 85
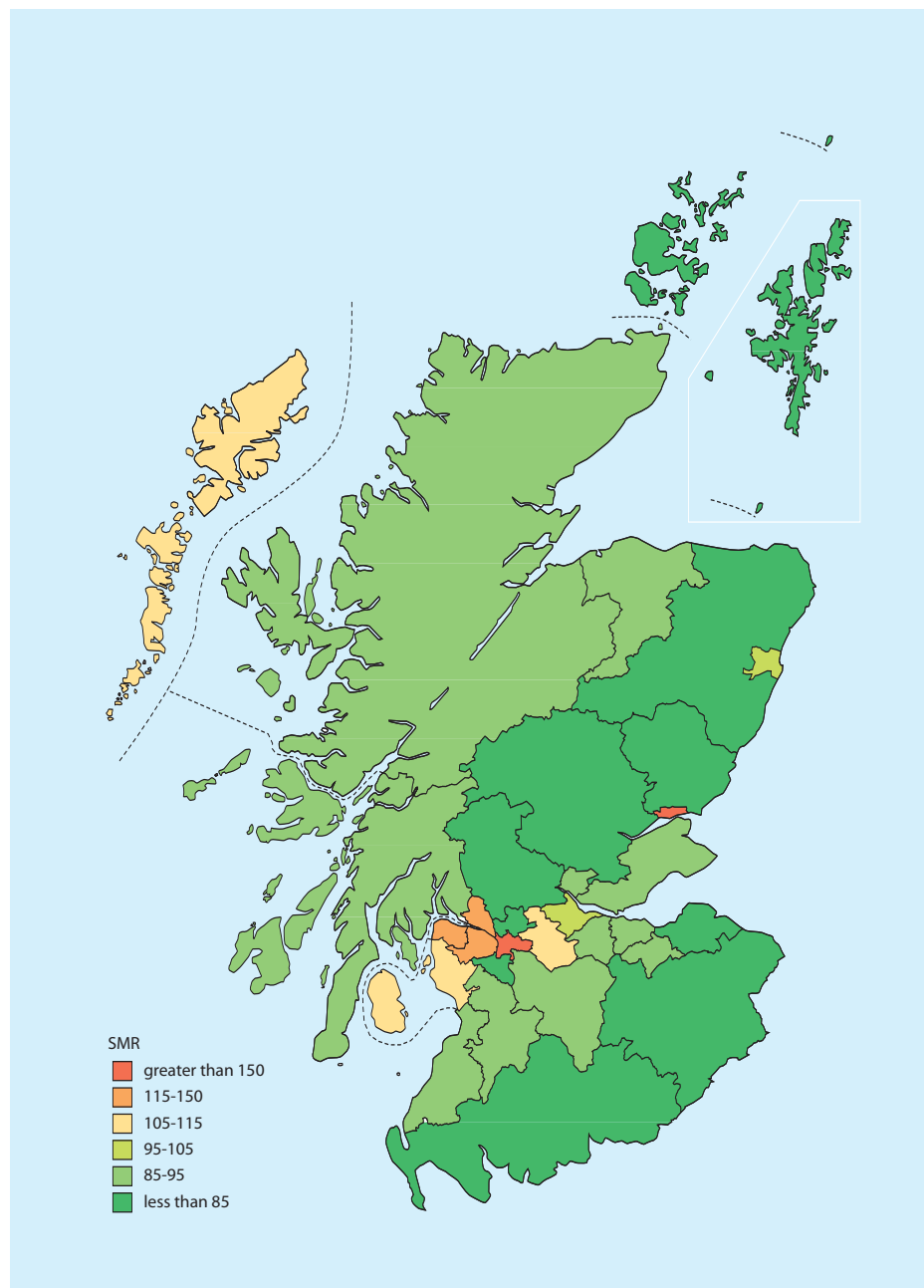
[2] Long Term Conditions Information Programme, ISD Scotland
[3] Leyland AH, Dundas R, McLoone P, Boddy FA. Inequalities in mortality in Scotland 1981-2001. MRC Social and Public Health Sciences Unit Occasional Papers no 16. Glasgow: MRC Social and Public Health Sciences Unit, 2007

Health Inequalities

Although people in Scotland are living longer than ever before, our life expectancy remains lower than that in most other Western European countries. Variations in life expectancy have increased consistently over the past 10 years. Men living in Scotland's least deprived areas now have a life expectancy of 10.7 years longer than men living in the most deprived areas, whilst for women, the life expectancy gap is 6.8 years. Figure 1 uses standardised mortality ratios[4] to show that the excess of 'premature mortality' in men is largely concentrated in the Clydeside conurbation and in Dundee city. A similar pattern can be found in premature female mortality, although the differences in mortality levels are not quite as large.

Between 1981 and 2001, there was a 62% fall in deaths amongst men from Ischaemic Heart Disease (IHD) and significant reductions in deaths due to lung cancer, cerebrovascular disease, chronic respiratory disease and accidents. Female mortality under the age of 65 declined by 33%, reflecting significant falls for IHD, breast cancer, cerebrovascular disease, accidents, chronic lower respiratory disease and for suicide. However, at the same time, we have seen a substantial increase in the number of deaths amongst both men and women under the age of 65 from chronic liver disease and increases amongst men in this age group from suicides (up 43%) and deaths linked to mental and behavioural disorders due to the use of drugs and alcohol. These increases are far more pronounced amongst people living in deprived areas and are having a major impact upon overall levels of inequality in mortality between social classes. They suggest a need for a sharper focus on inequalities within efforts to tackle alcohol and drug misuse and improve mental health and wellbeing across Scotland.

Scotland's Opportunity

The new Scottish Government moved quickly to streamline the Cabinet, creating new opportunities for cross-cutting working, in which every portfolio is challenged to contribute to health and wellbeing wherever, whenever and however they can.

The mutual benefits of working together across Government include:

- *Education and Lifelong Learning*: Shared actions to provide children with the best possible start in life, develop life skills, resilience and confidence, adopt a rights based approach to children's services, improve the way the curriculum addresses health and wellbeing and supports a whole school approach

- *Finance and Sustainable Growth*: working with local authorities to achieve shared outcomes, improving employment opportunities and opportunities to promote health in the workplace, developing local transport solutions and enhancing the role of the voluntary and community sector in the design and delivery of health-related services

[4] The standardised mortality ratio (SMR) is the ratio of the number of observed deaths to the number of deaths that would have been expected in a council area had the Scottish age-specific death rates for that year applied to that area's population. These are expressed such that an SMR of 100 indicates mortality in line with the Scottish experience. An SMR of 110 suggests that age standardised mortality is 10% above average and an SMR of 90 corresponds to a mortality rate 10% below average.

■ *Rural Affairs and Environment*: Shared approaches to the provision of sustainable models of service in remote and rural areas and ensuring the long term environmental sustainability of NHS services

■ *Justice*: Action to improve community safety, health services in Scottish prisons and tackling drug misuse.

By creating Scotland's first ever Minister for Public Health and expanding the health and wellbeing portfolio to include key determinants of health – such as sport and physical activity, housing, homelessness, poverty, social and financial inclusion and regeneration – we have laid the groundwork for a more radical and inclusive approach to achieving shared objectives. These include our goals to tackle poverty and disadvantage and to regenerate our most deprived communities, which are central to reducing health inequalities and meeting our aspirations for health improvement. In particular, it has provided us with the opportunity to make an impact on health and health inequalities, the key driver of these policies.

Key commitments include:

■ increasing the supply of good quality sustainable housing, as we work with local government and other housing providers towards a Scotland where everyone will have a secure, warm house at a cost they can afford. A total investment of £1.47 billion has been identified within the draft Scottish budget to support this ambition

■ launching a wide-ranging consultation on the future of housing in Scotland to consider how best to free up the supply of housing to buy and to rent, in order to create sustainable, mixed communities and provide a fair deal for first-time buyers, tenants and taxpayers

■ preventing and tackling homelessness by ensuring everyone who needs it is able to access appropriate accommodation, advice or support

■ ensuring that NHS Boards continue to make progress in achieving Health and Homelessness Standards

■ establishing a new fund amounting to £145 million a year within the local government settlement to be deployed by Community Planning Partnerships, to tackle poverty and deprivation and to help more people overcome barriers and get back into work

■ supporting a range of large-scale regeneration projects and working with local government and Community Planning Partnerships to target regeneration activities on tackling poverty in our most deprived communities

■ working with Community Planning partners towards the eradication of child poverty

■ building on work with Community Planning partners on suicide prevention and the delivery of local suicide prevention action plans

■ taking the opportunities offered by the Commonwealth Games in 2014 to develop sustainable and accessible community facilities and encourage wider participation in sport and physical activity.

2.2 AN ENABLING HEALTH SERVICE

Introduction

NHSScotland is uniquely placed to provide services and support which build people's capacity to improve their health and wellbeing. This is an enabling role: to help create the conditions in which people have the confidence, motivation and ability to make healthy choices and to provide professional support and advice when required. This has been recognised more clearly in the HEAT targets for 2008/09, which provide a clearer specification of the distinct contribution that NHSScotland will make towards the Scottish Government's strategic objectives and the national outcomes required to achieve a Healthier Scotland.

Mental Health and Wellbeing

Scotland is recognised internationally for some of its work in mental health legislation, services, improvement activities and supporting population mental health. There is, however, more to do to enhance, support and improve people's mental wellbeing so that they are able to flourish and have the confidence and capability to make healthy choices for their lives. We wish to build a country in which we understand that there is no health without good mental health and know how to support and improve our own and others' mental health and wellbeing. Our discussion document, *Towards a Mentally Flourishing Scotland*, offers an opportunity to shape our future agenda for promoting and improving mental health and wellbeing, preventing mental health problems, mental illness, co-morbidity and suicide and support improvements in the quality of life, social inclusion, health, equality and recovery of people who experience mental health problems or mental illness.

Further work is required to address the stigma, prejudice and discrimination that still exists around mental health problems and illness. Part of this approach will involve ensuring that key workers (social workers, teachers, healthcare staff, community workers, employment support staff and other key public services staff) are mental health and mental wellbeing literate, through, for example the roll out of the Mental Health First Aid Programme. This will enable mental health awareness to become an embedded part of their work and practice. Mental health and wellbeing literacy should also include a recovery-oriented approach, so that people with a mental illness are enabled to lead and direct their own wellbeing and recovery.

We are committed to delivering better outcomes for those people who suffer from depression by matching appropriate therapies to the specific needs of individuals. New quality standards will form the basis for the way in which everyone who enters the service is managed and treated. We will assess delivery, and support clinicians and service planners to tackle any inequalities in delivering care. Whilst antidepressants will offer the most appropriate help for some, for many others, particularly those with mild to moderate depression, anxiety and stress, a range of other interventions may be more appropriate and effective. We are therefore targeting NHS Boards to reduce the annual rate of increase of defined daily dose, per capita, of antidepressants to zero by 2009/10 and once achieved, deliver a 10% reduction in future years.

Smoking

We have helped people to quit smoking through the successful ban on smoking in public places and by increasing the minimum age for purchasing tobacco from 16 to 18 years. Our continuing commitment to the anti-smoking agenda will be demonstrated through the publication of a new smoking prevention Action Plan in 2008, supported by an additional £3 million per annum. Building on the key messages from our expert report *Towards a Future Without Tobacco* (2006) and the subsequent widespread consultation, the new Action Plan will set out national and local actions and focus on reducing the availability, affordability and attractiveness of tobacco products. We will continue to develop a network of smoking cessation services across Scotland, supported by continued investment of £11 million per annum, with NHS Boards being targeted to support 8% of its smoking population to quit successfully by the end of 2010/11.

Alcohol

The negative effects of excessive alcohol consumption continue to dominate the debate on health improvement in our country. Although many people drink sensibly, alcohol is responsible for significant levels of harm to individuals' health, to families and to our communities. Scotland's liver cirrhosis rates are now 2.5 times higher than in England and it is estimated that one Scot dies every six hours as a direct result of alcohol.

In Spring 2008, we will publish a strategy to tackle alcohol misuse, which will set out a series of long term outcomes for cross-Government action to tackle alcohol problems and help change the drinking culture in Scotland. The draft Scottish budget provides an additional £85.3 million over three years to reduce alcohol-related harm – the single largest investment ever in this area. We will drive forward a significant expansion of brief interventions to identify early and nip in the bud health harms from harmful and hazardous drinking. We will also significantly increase access to follow up treatment and support for those who need it, and increase the number of alcohol nurses in acute and primary care settings.

Drug Misuse

We are working closely with Justice Ministers and others on a new National Drugs Strategy to be published in Spring 2008. An action plan will be published alongside the strategy which will summarise the key actions with timelines. The strategy will be based on five themes: better treatment to promote recovery; better drugs education and information; more choices and chances for young people; better outcomes for children affected by family substance misuse; and better enforcement. In 2007/08, the Scottish Government provided £23.7 million to NHS Boards for drug treatment and rehabilitation services and we are working in partnership to ensure that the right structures are in place to support local delivery. The draft Scottish Budget includes a total of £94.3 million for NHS Boards to support drug treatment and rehabilitation services in the period 2008/11.

Diet, Physical Activity and Healthy Weight

In common with other countries we face a significant challenge from rising levels of obesity. This is influenced by a number of factors including diet and physical activity, but critically also psychological, cultural, environmental and global factors that require to be met by a long term and evidence-based approach. Rising levels of obesity bring with them increasing risks of a range of chronic diseases, particularly type 2 diabetes, stroke, coronary heart disease and cancer.

We have identified an additional £11.5 million in the draft Scottish Budget over the next three years to help people, particularly children, tackle obesity through diet and physical activity programmes. Our priorities are:

- Publication of a detailed Food and Health Delivery Plan during 2008 that will set out how we can encourage a healthier national diet in Scotland. This will complement the development of a national food policy for Scotland, that will include healthier food as one of its objectives.

- Work with NHS Boards to ensure consistent weight management strategies across Scotland, with whole community approaches to reducing childhood obesity, including a commitment to the development of sustainable transport solutions.

- Longer term work with our partners to address environmental influences on obesity in line with the best available evidence of effectiveness. This includes developing sustainable places that provide practical, safe and pleasant opportunities to significantly increase walking and cycling trips both for leisure and transport purposes.

Scotland's physical activity strategy *Let's make Scotland more active* (2003) continues to provide the primary driver for physical activity policy for the Scottish Government and our delivery partners. The Strategy sets a target that 50% of adults and 80% of children should be meeting the recommended levels of physical activity by 2022. This will be a challenge given 2005 data which suggest that 33% of women (16-74), 44% of men (16-74), 74% of boys (2-15) and 63% (2-15) of girls are meeting the target currently, but we aim to double our previous financial investment in this strategy. We also intend that the 2014 Commonwealth Games will act as an inspiration to Scots of all ages to think afresh about their participation in sport and other physical activity.

Sexual Health

Scotland's sexual health is poor. There are rising levels of sexually transmitted infections, particularly in young people under 25 and Scotland has, by Western European standards, high levels of unintended teenage pregnancies, particularly in areas of high deprivation.

Respect and Responsibility, Scotland's national Sexual Health Strategy, was launched in January 2005 with the aim of reducing the number of unintended teenage pregnancies and the number of sexually transmitted infections throughout Scotland. We remain committed to this strategy which will positively influence the cultural and social factors that impact on sexual health. We will support its implementation with annual funding of £5.2 million until 2010/11, to enable NHS Boards and their partners to increase testing and diagnosis, improve education, information and advice and provide local, easily accessible

services to patients. The draft Scottish Budget identified £1 million over two years to increase the availability of independent sexual health information in urban as well as rural settings.

Health Protection

The Scottish Government has already introduced to the Scottish Parliament legislation to modernise the law relating to public health to make it fit for purpose in dealing with emerging threats to public health such as SARS and pandemic flu. The Public Health Bill clarifies the roles and responsibilities of the different agencies involved in responding to threats, outbreaks and incidents, and brings Scotland into line with the requirements of the new International Health Regulations.

Levels of childhood immunisation in Scotland are already high, and we have committed to make available a new vaccine capable of preventing most forms of cervical cancer to all girls aged around 12-13 years, from Autumn 2008. In addition, a catch up campaign will make the vaccine available to all girls under 18 years at the time of introduction. Our draft budget commits to fully funding the implementation of the Hepatitis C Action Plan – including providing testing and treatment services to the significant numbers of people in Scotland with undiagnosed Hepatitis C. We have also announced expenditure of over £100 million over the next three years to increase Scotland's resilience against a flu pandemic, by more than doubling our stockpile of antiviral drugs, antibiotics, face masks and respirators.

Public Health

We need to strengthen the engagement of Scotland's public health community in decisions about how and where to invest

NHSScotland's resources to improve health and prevent disease. We will therefore review and clarify the role and expected contribution of Directors of Public Health in ensuring that the major service and financial strategies of NHS Boards meet these objectives, in line with NHS Boards' corporate responsibilities for protecting and improving public health. We will also ensure that Community Health Partnerships are able to call upon adequate professional public health support and advice and ensure that decisions about service change and investment across NHSScotland are more routinely informed by health impact assessment. To support this activity, we will facilitate the development of regional managed public health networks, supported by action to refocus and clarify the roles of special health boards in relation to public health. These networks will be responsible for providing leadership and professional development opportunities for staff working in public health and developing capability and capacity in public health across NHSScotland to ensure that major finance and service plans take full account of their potential impact on the health of the local population.

Social Marketing

Public information remains an important feature of our integrated approach to health improvement and we are working in partnership with NHS Health Scotland, NHS 24, Food Standards Agency (Scotland), and local NHS Boards to develop a more co-ordinated approach to the design and delivery of health improvement campaigns. This will focus on the priority health improvement areas in a targeted, coherent and joined-up way across all key partners and seek to empower and enable people to make changes in their lives.

We will:

- Address stigma, prejudice and discrimination around mental health

- Enhance the mental health literacy of key workers such as teachers, social workers, community staff, employment support officers and health care staff

- Publish a new smoking prevention Action Plan in 2008 supported by additional funding of £3 million per annum and continued investment in a network of cessation services

- Expand significantly access to treatment and support for those with alcohol problems as part of a new strategy for tackling alcohol misuse to be published in Spring 2008 and supported by additional investment of £85.3 million over three years

- Support drug treatment services and work with partners to introduce a new drugs strategy and delivery framework in 2008

- Improve Scotland's diet through a Food and Health Delivery Plan and the development of a national food policy for Scotland

- Tackle obesity by delivering consistent weight management strategies across Scotland

- Work with partners to address the environmental influences on obesity including the greater provision of opportunities for safe walking and cycling

- Implement Scotland's sexual health strategy and increase the availability of independent sexual health information

- Modernise health protection in Scotland by taking forward a new Public Health Bill in the Scottish Parliament during 2008

- Introduce an immunisation programme to combat cervical cancer available to all girls aged 12-13 years from Autumn 2008 and introduce a "catch up" campaign for girls aged up to 18 years at the time of introduction

- Enhance treatment and testing services for Hepatitis C

- Commit more than £100 million over three years to increase Scotland's resilience to a flu pandemic

- Review and clarify the role of Scotland's public health community to ensure that major financial and service strategies improve health and prevent disease

- Develop a coherent, integrated approach to social marketing covering key health promoting messages

2.3 THE BEST POSSIBLE START

Introduction

By getting it right in the early years and supporting good health choices and behaviours amongst children and young people, we can set them on a trajectory where they can sustain good health throughout their lives. Making the best possible start is therefore at the forefront of the future health agenda.

Setting a New Direction for Early Years Policy

The Scottish Government has announced its intention to work with local government and other partners to develop a long term early years strategy by Autumn 2008. This will establish a framework within which we will work together to deliver effective early years support for children and young people, taking a preventative approach and allowing any problems to be identified and tackled earlier and more effectively. This will provide an opportunity for action to give children the best possible start through integrated, cross-Government approaches which build parenting and family capacity, create supportive environments and develop professionals and ways of working that enable us to meet the individual needs of children and their families.

Getting it Right for Every Child

Getting It Right For Every Child is a national programme that is changing the way adults and organisations think and act to help all children, young people and their families grow, develop and reach their full potential. *Getting It Right For Every Child* is about universal services being pro-active in assessing and addressing the child's needs and providing, or arranging for the provision of, appropriate support for the child at an early stage. It puts children's needs, experience and wishes at the heart of the process. Parents, carers and those with a relevant interest who can contribute are engaged in assessment and planning as far as this is appropriate in each case.

Getting It Right For Every Child promotes the streamlining of assessment and decision making processes so that children and families do not experience duplication or confusing systems. It brings support to the child rather than the child or family having to navigate the maze of separate agency services. Given the impact of parenting and parental stresses on the quality of care and interaction with children, this needs to be effective at a family level and bring about a culture shift within children's services so that they focus on the overall needs of the child. Our main challenge is to re-engineer services so that they work together more effectively, by assessing and making changes to the cultures, systems and practices in NHSScotland and its partner organisations. In addition, we will work with adult services to help shift their outlook so that they focus more intently on the needs of children within the family unit.

Our Most Vulnerable Children

We need to ensure a particular focus throughout early years and childhood on children who we know to be the most vulnerable in terms of health and wellbeing. These include disabled children, children who offend, children in homeless families, who are looked after or accommodated, who live in substance misusing households, are at risk in situations of domestic abuse and violence or live with parents who have mental health problems or learning disabilities. In many instances, these risk factors overlap and are

strongly associated with poverty and deprivation. The new early years strategy will have a particular focus on improving outcomes for such groups and we will be working to ensure there is a continuum of care for vulnerable children and young people that supports them well beyond their early years.

Health for all Children (Hall 4) is a surveillance, assessment and need identification programme which provides NHS Boards with the foundation for working with young children, and the means of access to more intensive support for those with greater needs. We are working with NHS Quality Improvement Scotland to ensure its successful implementation and to support new ways of offering support through inter agency working.

We will work to ensure that our new strategies on drugs, alcohol and smoking prevention support the broader early years strategy and include approaches to protect children from the effects of substance misuse. This will, for example, include a commitment that NHS Boards will identify a lead maternity care professional to help mothers stop drinking or smoking during pregnancy. In addition, we will implement the recommendations of *Looked After Children and Young People: We Can and Must Do Better* to improve the emotional, mental and physical health of these children and ensure that NHS Boards provide the support that the children require, including access to primary care and dentistry. As part of this commitment, NHS Education for Scotland has been commissioned to develop a competency framework to support the training and development of specialist nurses for looked after and accommodated children's nurses.

Pre-Conception

Many women and teenage girls experience unintended or unwanted pregnancies. While pregnancy and parenthood are positive choices for some young people, for others unintended pregnancies and parenthood are associated with negative social and psychological consequences such as incomplete education, poverty, social isolation and low self-esteem. The Sexual Health Strategy, *Respect and Responsibility*, which contains a key aim to reduce the number of unintended pregnancies, recognises that ensuring success depends on involving parents, carers, young people and partners as well as key clinical services.

We need to ensure good clinical services and easy access to information throughout Scotland and that this is done in a context of promoting a positive and respectful approach to sexuality and sexual relationships.

Antenatal Care

NHSScotland's antenatal services mean that it is uniquely placed to develop early relationships with Scottish families and to identify risks and offer a preventative approach to health care. We need to strengthen antenatal care so that we get better engagement with families who are at higher risk of poor outcomes, paying particular attention to the needs of teenage mothers who have traditionally started antenatal support later and had less of an engagement with elements of the service such as antenatal classes.

Maternity Care

The Maternity Services Action Group is currently reviewing and updating the national maternity policy set out in The *Framework for Maternity Services* (2001) and the subsequent *Expert Group on Acute Maternity Services* (2002). We remain committed to the provision of women and family-centred services within a network of care, with the bulk of that care being offered as locally as possible by clinically competent professionals. The Keeping Childbirth Natural and Dynamic (KCND) programme is a 3–5 year programme which aims to provide evidence based care, reduce unnecessary intervention, ensure informed choice for women and introduce multi-professional antenatal, intrapartum and postnatal care pathways which will enable the service to better identify and support vulnerable women and families.

Supporting Parenting

Most of a child's needs in their earliest years are met by their parents, families and wider social networks. Children who live in families where parental capacity is high and which have strong family and social networks often go on to enjoy better outcomes later in life. Whilst most, if not all, parents require and value a degree of support as they begin parenting, some require additional help to build the resilience to support the development of their children. The early years strategy is putting a particular emphasis on building parental capacity and health services such as home visiting and community nursing will be a strong focus of this work.

One of the key areas where parents influence child health during pregnancy and the early years is infant nutrition. Our new Food and Health Delivery Plan which will be published in 2008 will therefore include actions to help promote nutrition in women of childbearing age and pregnant women and support breastfeeding and healthy weaning in infants. This includes the provision of free fruit and vegetables for pregnant women and pre-school children. NHS Boards will be targeted specifically to increase the proportion of newborn children who are exclusively breastfed at 6-8 weeks to 33.3% in 2010/11 and we will appoint an Infant Nutrition Co-ordinator to promote good infant nutrition at a national level.

Oral Health

Standards of oral health in children have a strong relationship with deprivation and can be a sign of wider issues related to the quality of care and support a child is receiving. There is clear evidence that young children with decay in their baby teeth are very likely to have problems with their adult teeth and that tooth decay can be prevented by establishing good habits in terms of diet and oral care at an early age. That is why we have introduced a new target for NHS Boards to ensure that

80% of all children aged 3–5 years are registered with an NHS dentist by 2010/11.

In December 2007, a new Schools-based preventative dental service was launched in NHS Fife. It will roll out to Tayside and Ayrshire and Arran in early 2008 and later to other NHS Board areas. Under the umbrella of the *Childsmile* programme, this will see fluoride varnish being applied to children's teeth during their first year at school and, in the second year, supplementing this with the application of fissure sealants as appropriate. Further support will be provided by expanding the current *Childsmile* programme aimed at very young children to the island NHS Boards and one other rural Community Health Partnership and a scheme in rural parts of Grampian which better integrates school and community based dental services in order to improve continuity of care.

Evidence Based Interventions

We will look at the evidence on what can be done to improve the wellbeing of children in deprived areas in the light of recent data published by UNICEF and studies linking child wellbeing with income inequality. Our first step will be to publish a review of available evidence, followed by a programme of work with NHS Boards to implement those evidence based interventions that will mitigate the effects of inequality on wellbeing. We will adopt a similar approach to early interventions, publishing a review of the current evidence on the effects that these might have on health outcomes and working subsequently with NHS Boards to begin putting new programmes in place by Summer 2009.

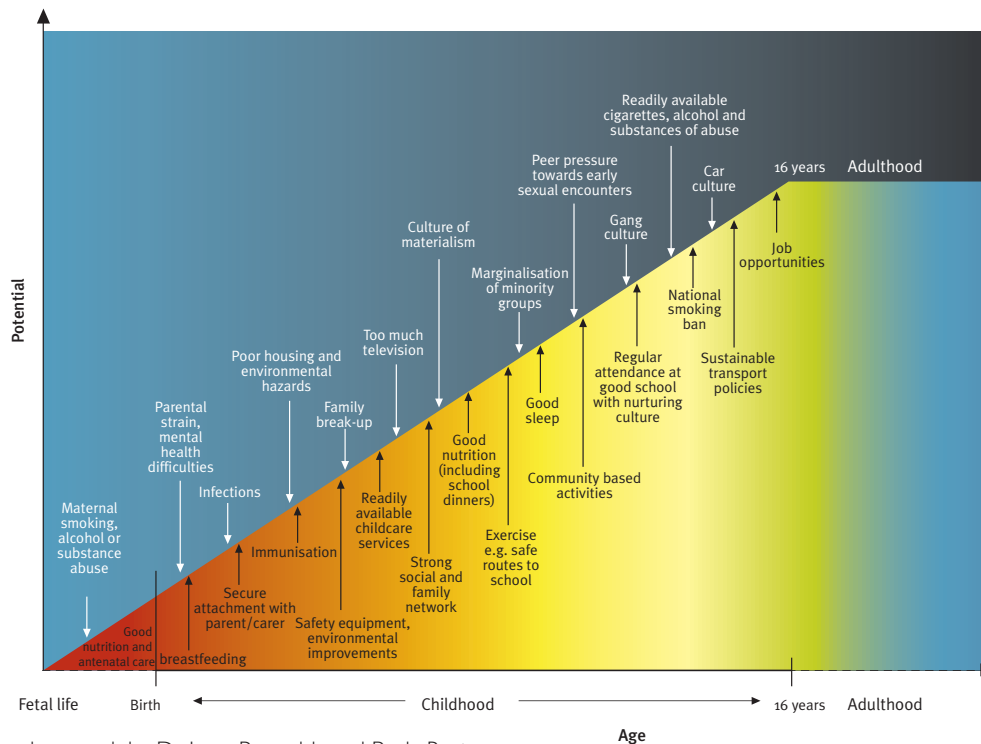## Integrated Children's Services Plans

Integrated Children's Services Plans have a vital role in ensuring that local authorities, NHS Boards and other relevant agencies and organisations come together to plan services and support for children and families, including the most vulnerable, in each local authority area in a co-ordinated way. They bring together a number of core statutory and other planning requirements for children and young people into a single plan. These include the relevant child health plans.

All local partners and relevant organisations are involved in preparing the plan, including, amongst others, the local authority education, social work and housing departments, NHS Boards, police, children's reporter services and voluntary organisations. The planning process determines local needs for services and support; how local agencies and organisations will work together to deliver and develop services in response to these needs; the most effective use of staff and other resources; and how services will be monitored and evaluated in terms of the outcomes for children, young people and their families. A shared local ownership of the Integrated Children's Service Plans and the planning process will ensure the best possible outcomes for children and families.

Child Centred Approaches

We want to see a child centred approach to the planning and delivery of children's services. This includes the rights of children to be heard and heeded as well as the right to privacy and confidentiality, health, education and safety.

Figure 2: Influences on Health from Conception to Adulthood

Source: Based on work by Dr Lucy Reynolds and Paula Barton

Schools

Health-promoting schools have developed in the context of community planning and Integrated Children's Services in recognition of the role that schools can play in promoting and sustaining the health of children and the wider community. The place of health promotion in schools and the importance of sound nutritional guidance to ensure accessible high quality food and drink within schools has now been enshrined in legislation with the passing of the Schools (Health Promotion and Nutrition) (Scotland) Act 2007. The Act places a duty on Scottish Ministers and local authorities to endeavour to ensure that schools are health promoting. The Act goes on to state that a school is 'health promoting if it provides on its own or in conjunction with health boards, parents or any other person, activities, an environment and facilities, which promote the physical, social, mental and emotional well-being of pupils'. Consequently, health promotion will permeate every aspect of school life.

We have already increased provision of free healthy school lunches to all Primary 1-3 pupils in our trial scheme in five Scottish Local Authority areas. In 2009/10, provided the evaluation of the trials is positive, legislation will be introduced to allow extension of the nutritious free school meals to all pupils in P1 to P3. Assuming the legislation is passed, local authorities will provide free school meals to all P1 to P3 pupils from August 2010. Subject to necessary legislation being passed, entitlement to free school meals will be extended to all primary and secondary pupils of families in receipt of both maximum child tax credit and maximum working tax credit from August 2009.

Through the *Curriculum for Excellence* children will have opportunities to take part in physical activities and learn about health and wellbeing and all teachers will have the responsibility of

promoting aspects of health and wellbeing from age 3-18. Our Active Schools initiative aims to promote healthy, active and well-motivated communities providing new opportunities to get involved in active pursuits. When combined with the benefits of the Reaching Higher sport strategy and attracting the 2014 Commonwealth Games to Glasgow, our young people will have increasing opportunities in sports.

There are further opportunities to provide more effective health care in schools through a range of agencies and health care professionals such as midwives, mental health nurses and Allied Health Professionals. We shall continue to work with our partners to carry out our duties to implement the Education (Additional Support for Learning) (Scotland) Act 2004 and to ensure that children with additional support needs receive appropriate support from health care staff. Healthcare support for schools and teachers will therefore be increased, starting in those areas with the highest concentrations of vulnerable children. Care will be delivered in partnerships involving children, families and teachers and using a multidisciplinary approach. This will be part of a continuum of care for children, young people and their families as they move through the school years, ensuring that transitions are as smooth as possible, and that those most vulnerable receive the services they require. Figure 2 sets out the influences on health from conception to adulthood and their possible impact on an individual's potential.

Child and Young People's Mental Health

The Scottish Government is committed to improving the mental health and wellbeing of children and young people through a wide-ranging programme of improvement across all aspects of care, services and support. We will implement the Mental Health of Children and Young People Framework for Promotion, Prevention and Care by 2015. We will also:

■ reduce the number of admissions of children and young people to adult beds by 50% by 2009

■ increase dedicated inpatient beds nationally from the current 44 to 56 beds by 2010

■ provide mental health training for all those working with, or caring for, looked after or accommodated children and young people by 2008

■ ensure that a named mental health link person is available to every school by 2008 to better inform all concerned and help identify needs at the earliest point

■ provide training for child psychotherapy through NHS Education for Scotland.

Specialist Children's Services

Delivering a Healthy Future: Action Framework for Children and Young People's Health in Scotland (2007) sets out a 10-year Action Plan to assist hospital and community-based health services to respond to the challenges of improving and maintaining children's health in the 21st century. In line with this framework, we will publish in 2008, a National Delivery Plan for specialist children's services. Managed Clinical Networks for children's services will define and develop services for children at a national, regional and local level and we are committed to developing new hospitals in Glasgow and Edinburgh by 2012 and sustaining four major children's hospitals across Scotland in Glasgow, Edinburgh, Aberdeen and Dundee.

We will:

- Work in partnership with local government and others to develop a long term early years strategy by Autumn 2008

- Work within the framework of *Getting it Right for Every Child* to change cultures, systems and practices in NHSScotland and its partner organisations

- Ensure the widespread implementation of *Health for All Children*, supported by NHS Quality Improvement Scotland, to enable intensive support for those with greatest needs

- Continue work to protect children from the effects of drugs, alcohol and smoking

- Implement the recommendations of *Looked After Children and Young People: We Can and Must Do Better*

- Develop a competency framework through NHS Education for Scotland to support the development of specialist nurses for looked after children

- Strengthen antenatal care to better engage with parents with higher needs, in particular teenage mothers

- Develop actions to promote infant nutrition within the new Food and Health Delivery Plan

- Target NHS Boards to improve breastfeeding rates and appoint an Infant Nutrition Co-ordinator at national level

- Roll out the new schools based preventative dental service

- Publish reviews of current evidence on early interventions, particularly those that will mitigate the effects of inequality on wellbeing and develop a programme of work that will implement them across NHS Boards

- Extend entitlement to free school meals, subject to legislation being passed

- Increase healthcare support for schools and teachers starting in those areas with the highest concentrations of vulnerable children

- Implement the Mental Health of Children and Young People Framework for Promotion, Prevention and Care by 2015

- Publish a National Delivery Plan for Specialist Children's Services in 2008

- Sustain four major children's hospitals across Scotland, including new hospitals in Glasgow and Edinburgh by 2012

2.4 TACKLING HEALTH INEQUALITIES

Introduction

Poor mental and physical health is both a cause and consequence of social, economic and environmental inequalities. Risk factors include individual behaviours such as smoking, alcohol misuse, diet and inactivity and also aspects of the wider social, economic and physical environments that shape such behaviours, including educational achievement, income / relative poverty, the work environment and unemployment. Inequalities can also cross the generations, with children born and brought up in disadvantaged families being more likely to experience poorer health in later life.

Ministerial Task Force

A Ministerial Task Force on Health Inequalities led by the Minister for Public Health has been established to identify and prioritise practical actions to reduce the most significant and widening health inequalities. Our national discussion provided an opportunity to inform the work of that Task Force and there was an enthusiastic response from all concerned. The key message was that effective action requires us to work across Government and in conjunction with our partners in the public, private and voluntary sectors in order to tackle both the causes and consequences of health inequalities. The outcomes agreed with local authorities provide a real opportunity to make significant progress with this shared agenda.

The Task Force will report to Cabinet in May 2008 with proposals that will:

■ reduce factors in the physical and social environments in Scotland that act to perpetuate health inequalities

■ build the resilience and capacity of individuals and communities to improve their health

■ enhance the contribution that public services can make to reducing inequalities.

The Task Force has adopted some key principles to drive its work. These are:

■ improving the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health

■ reducing people's exposure to factors in the physical and social environment that cause stress, are damaging to health and wellbeing, and lead to health inequalities

■ addressing the inter-generational factors that risk perpetuating Scotland's health inequalities, particularly focusing on supporting a good start in life for all children in Scotland

■ engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health, and promoting clear ownership of the issues by all involved

■ delivering health and other services that are both universal and appropriately prioritised to meet the needs of those most at risk of poor health, and that seek to prevent problems arising, as well as addressing them if they do

■ basing current and future action on the available evidence and adding to that evidence for the future, through introducing new policies and interventions in ways which allow for evaluating progress and success

■ ensuring that the range of actions we take now will achieve both short and long term impact and will address foreseeable future challenges.

The Task Force is setting priorities which include:

■ an emphasis on supporting families and children in the very early years

■ enhancing mental health, wellbeing and resilience

■ the importance of education and skills, income and employment status as factors underlying inequalities in health

■ a multi-agency approach in which public, private and third sectors work together, with strong Government leadership.

Delivering reductions in health inequalities will require a continuous improvement approach, with clear definition and performance management of outcomes. All Government policies will need to be assessed for their impact on health and demonstrate how they are contributing to reducing health inequalities and we will support this by the development and application of a systematic process for such assessments.

Staff and services need to engage the individuals and communities they work with if they are to build the resilience and capacity that are necessary for change. Community planning partnerships will be vital to local delivery and ensuring that resources are allocated on the basis of need.

Early Years

Our approach to providing children with the best possible start, described in the previous section, lies at the heart of the approach being considered by the Ministerial Task Force. This underpins our commitment to extending the entitlement to free school meals and introducing free fruit, vegetables, milk and vitamins for low income families.

Within the context of universal service provision, there is a clear need to increase the intensity of the support provided for particularly vulnerable children and families and work more effectively with partners as part of the forthcoming early years' strategy to address their needs in a holistic way. As detailed previously, NHSScotland will work with partners to identify our most vulnerable children and take action to scale up and replicate those interventions that we know can make a difference, such as smoking cessation services for pregnant women and programmes that encourage parents to play with their babies and promote wellbeing from an early age.

Abolition of Prescription Charges

Prescription charges are a tax on ill health. The Scottish Government is therefore committed to abolishing these charges and ensuring that those who require medication,

particularly those suffering from long term conditions, are not deterred by cost. The charges will therefore be reduced significantly over the next 3 financial years, beginning in April 2008 and abolished completely by April 2011. Removal of this barrier to good health will support people to make choices which are good for their health and wellbeing. The draft Scottish Budget identifies £97 million to support these changes.

During this time the cost of prescription pre-payment certificates will also reduce significantly. This will benefit those with long term conditions, particularly those who require regular or large numbers of prescriptions.

Primary Care

The Ministerial Task Force has identified the need to place more emphasis on tackling health inequalities through primary care. This requires the allocation of resources to better reflect the additional workload required to meet the needs of people in disadvantaged areas. The new Scottish Enhanced Services Programme for Primary and Community Care reflects the Scottish Index of Multiple Deprivation and will therefore weight resources more significantly towards such areas than previous methods of resource allocation.

We will also look specifically at those areas of the GP contract that we believe do not adequately reflect the additional needs of GP practices in disadvantaged communities. In particular we will engage with the professions on future changes to the Minimum Practice Income Guarantee and Quality Outcomes Framework for GPs to ensure that the

distribution of existing and future resources better reflects the balance of workload that is required to help us tackle health inequalities in Scotland.

The new community pharmacy contract also offers opportunities to better target resources towards areas of greatest need. This is particularly true of the Public Health Service which could be used to improve access to smoking cessation or sexual health services or to promote the benefits of the *Healthy Start* and *Keep Well* programmes.

Anticipatory Care

The Task Force has already made it clear that it wants to see a more widespread application of anticipatory care approaches across Scotland. Working with partners within Community Health Partnerships, we need to pilot, assess and roll out if successful, a range of new approaches to tackle health care priorities such as reducing the risks of alcohol to the health of young people, improving the physical health of people with mental illness or a learning disability and supporting early intervention and rehabilitation for those with disabilities, multiple long term conditions and complex needs.

The Scottish Government will continue to support the *Keep Well* programme, so that it has the time to prove that it can reduce health inequalities in cardiovascular disease by the year 2010 by increasing the rate of health improvement among high risk groups, aged 45-64, living in the most deprived communities. This programme complements the commitment to extend screening and health checks, including the development of the "Life Begins" programme.

Keep Well NHS Lanarkshire

Keep Well NHS Lanarkshire is a primary care based anticipatory care programme providing health checks to individuals aged 45-64 years living in Airdrie, Wishaw and Coatbridge. Through a dedicated focus on better engagement between the NHS and service users, over 5,000 have been encouraged by letter, phone call or home visit to attend their *Keep Well* Health Check. This diverse one-stop assessment that identifies clinical, lifestyle and socio-economic needs has prompted access to a range of services across partner agencies, ranging from drug treatments for previously undiagnosed long-term conditions to joining of local weight management groups and smoking cessation classes.

Targeting Support

Where appropriate, we will take specific action to focus on the needs of particular groups. This will include, for example, action in partnership with Defence Medical Services Department and the charity Combat Stress to meet the mental health needs of serving and former armed forces personnel.

Effective approaches to reaching and engaging with the most vulnerable groups of people to improve their physical and mental health need to be identified and scaled up. This might include actions to support people in institutional settings, such as care homes or secure care, groups such as homeless people who may not otherwise be reached by traditional approaches or people who experience discrimination in whatever form. We will use proven approaches to continuous improvement to enhance the rate at which we identify and implement good practice across Scotland, with a particular focus on the supporting NHS Boards to deliver against the targets for tackling health inequalities that are included within the HEAT performance management framework.

Prisons and Offender Health Care

Offenders and ex-offenders tend to have poorer physical and mental health, lower standards of dental health, greater prevalence of substance misuse and higher rates of conditions such as Hepatitis C. Within a wide ranging strategy to tackle health inequalities, it therefore makes sense for NHSScotland to review its approach to the health and health care of offenders and ex-offenders and to consider what more can be done in prisons and custody settings to ensure continuity of care during the transition between prison and the community. Subject to the normal controls around patient confidentiality and consent, this requires us to improve the exchange of information between healthcare professionals working inside and outside of Scotland's prisons.

Employability

The workplace provides an ideal opportunity for the primary prevention of ill health and the promotion of health and wellbeing. We are determined to re-energise Scotland's healthy working lives agenda, working in partnership

with employers, unions, local authorities and other stakeholders such as HSE Scotland. We will support employers to ensure safe and health promoting environments and ensure that all NHS Boards adopt existing good practice in working with community planning partners and employability services to enable people to retain or return to work. The Ministerial Task Force on Health Inequalities is clear that all NHS Boards should commit to implement fully the recommendations of the *Framework for Adult Rehabilitation* which includes actions to improve vocational rehabilitation. A clear plan for action should be agreed by the end of 2008, which describes the unique contribution that NHS Boards can make at local level to help people return to work as part of local Workforce Plus partnerships.

Third Sector

The Scottish Government is committed to improving the capacity of the third sector to reduce health inequalities. We are continuing to implement the recommendations of the 2006 report of the community-led task group, by supporting commissioners and funders on the one hand and community-led services on the other, to work better together in achieving shared outcomes. Throughout the national discussion we heard from people working in, or benefiting from, third sector organisations and initiatives, who were concerned about their ability to provide or receive these services over the longer term. We will therefore establish a national review of the way in which NHSScotland supports these organisations to explore ways in which we can enhance the sustainability of programmes that demonstrate a clear benefit for patients and their carers.

Health Promoting Health Service

Given the proportionately greater use of acute services by patients from deprived communities, health promotion in acute care settings offers a major opportunity to improve health and reduce health inequalities. We will therefore build on existing good practice by identifying some simple but effective actions that can be taken to improve the health of patients, staff and visitors. This includes screening accident and emergency patients for harmful or hazardous drinking and encouraging them to cut down, promoting breastfeeding and providing healthier food and drinks. There is unique opportunity to develop this agenda in partnership with staff organisations, building, for example on the success of *Nutrition Now*, the Royal College of Nursing's clinical campaign, developed in conjunction with patient groups to raise standards of nutrition and hydration in hospitals.

A Corporate Citizen

NHSScotland has a huge opportunity to act as a force for change in shaping and influencing healthy environments far beyond hospital settings. It is a major employer and investor, has a huge influence on the built environment and, through its approaches to issues such as travel, energy consumption and waste disposal can make a significant contribution to the Scottish Government's objective of securing sustainable economic growth. Innovative employment and investment schemes in particular can act as a major source of regeneration in some of our more deprived areas. By offering pre-employment training and first destination work opportunities, particularly for those on benefits, NHS Boards can directly support individuals to improve their prosperity and their prospects for better health and wellbeing. Within the next 12 months we therefore expect NHS Boards to participate in a network of pre-employment services for people on benefits who require support to return to work.

NHS Lothian Health Care Academy

NHS Lothian is part of the consortium behind the Edinburgh City Jobs Strategy. This aims to increase the rate and speed of disadvantaged groups moving into sustained employment within the city. The Health Care Academy is a six week pre-employment course that helps prepare people for a clinical position and a career in the NHS. The course runs three days a week and includes two clinical placements, practice interviews and training on issues such as basic life support, communication and confidence building. In the past two years, 79 people have been trained through the Academy. 64% achieved permanent employment in the NHS, voluntary or social care sectors whilst a further 7% went on to Higher or Further education.

We will:

- Publish cross-Government proposals from the Ministerial Task Force on Health Inequalities in May 2008 to tackle Scotland's most significant and widening health inequalities

- Phase out prescription charges and abolish them completely by 2011

- Work with partners to reform the GP contract to ensure that it adequately reflects the needs of GPs working to improve patient services in deprived areas

- Extend the use of the Community Pharmacy Public Health Service to improve access to support and advice in deprived areas

- Pilot, assess and roll out new approaches to anticipatory care

- Support the roll out of the *Keep Well* programme to reduce inequalities in cardiovascular disease

- Introduce a programme of "Life Begins" health checks

- Work with partners to meet the mental health needs of serving and former armed forces personnel

- Strengthen our ability to assess and replicate proven approaches to tackling health inequalities in both physical and mental health across Scotland

- Review NHSScotland's approach to the health and healthcare of offenders and ex-offenders

- Ensure that all NHS Boards implement the *Framework for Adult Rehabilitation,* and work with partners to support people in returning to work

- Improve the capacity of the third sector to reduce health inequalities

- Roll out simple but effective health promoting interventions within acute care settings

- Work with staff groups to support and encourage NHSScotland's staff and their families to make healthy choices

- Support NHS Boards to participate in a network of pre-employment services for people on benefits who require support to return to work

- Implement a systematic process for assessing the impact on health and health inequalities of health and work with partners to extend this approach to all Government programmes

> **improvement can only be achieved through shared ambition and effective joint working**
>
> **NHS BOARD**

SECTION THREE:
ENSURING BETTER, LOCAL AND FASTER ACCESS TO HEALTH CARE

3.1 IMPROVING QUALITY

This section sets out actions to:

- Enable and support patients to be partners in their care

- Make health care in Scotland safer still and a world leader in this area

- Make access to primary care more flexible through re-designing services

- Spread best practice in care for people with long term conditions

- Bring a more systematic approach to clinical effectiveness, for example by reducing variation in practice

- Modernise the NHS through better use of technology

- Deliver the quickest treatment ever available in Scotland's NHS

By virtually any measure, the NHS in Scotland is improving. Waiting times are shorter and mortality from the major killer diseases is reducing. Therefore, this is exactly the right time to seek to accelerate the pace of that improvement. The Scottish people need and deserve care that is safer, more reliable, more anticipatory and more integrated, as well as being quicker still. The key to improving quality will be to meet all of those public requirements.

In its seminal report "Crossing the Quality Chasm" (2001), the Institute of Medicine identified that a health care system that achieved major gains in six dimensions of quality would be far better at meeting patient needs. The six dimensions are as follows:

Patient centred	providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions
Safe	avoiding injuries to patients from care that is intended to help them
Effective	providing services based on scientific knowledge
Efficient	avoiding waste, including waste of equipment, supplies, ideas, and energy
Equitable	providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
Timely	reducing waits and sometimes harmful delays for both those who receive care and those who give care

This section details actions to improve each of these aspects of quality.

3.2 PATIENTS AT THE CENTRE

Introduction

NHSScotland should deliver patient centred care which is respectful, compassionate and responsive to individual patient preferences, needs and values. Throughout the national discussion we heard first hand experiences – good and bad – which challenged us to think about what really matters to patients and design and deliver services that meet their needs and expectations. Patients and carers are after all, the real experts in what it feels like to receive care from NHSScotland. Our task is to listen to them, think afresh about the ways in which we involve and engage them in shaping their care and work in new and different ways which challenge traditional boundaries both within and between organisations.

Improving Your Experience of Care

Better Together, our programme to improve patient experience will involve work with patients and staff across Scotland to find out what is really important to them in the delivery of a good quality health service. It uses surveys, focus groups, interviews and analysis of the complaints we receive to tap into real life experiences and use them as the basis for a programme of continuous improvement to deliver high quality, safe and effective patient centred care. We will implement the programme with an initial focus on inpatient care, GP services and long term conditions. Preliminary improvement work is being carried out to improve the experiences of cancer patients.

Supported Self Management

Supported self management requires support, advice and information to be provided to someone who is managing symptoms that can affect the quality of their everyday life. Of course, everybody self manages to a certain extent, but some people will require a far greater degree of support from care services than others. This might vary over time, as a condition changes through relapses or recoveries, but it might also reflect differences in our ability to learn or manage, or the barriers we face in accessing the information and support that is available.

The Long Term Conditions Alliance Scotland, supported by the Scottish Government, is developing the concept of supported self management and identifying policies and initiatives that might strengthen its role within healthcare in Scotland. Maintaining this 'grass roots' approach is essential in realising the potential of self management to transform the quality of people's lives, reduce pressure on the NHS and change the culture of health and healthcare.

The Alliance suggests there are five key stages where support from professional and voluntary organisations is particularly important:

- at the point of diagnosis

- living for today

- as the condition changes and progresses

- transitions between services, such as between paediatric and adult services or adult and old age care

- end of life.

At each stage along this pathway, our challenge is to ensure that patients and their carers receive accessible, plain, clear, appropriate and timely information. We need to enable

patients to ask questions of the professionals they see, provide them with the support and contacts that are most appropriate to their current situation and support them as they think about what they can do for themselves and make the right choices for themselves around treatments, lifestyles and their relationships with those around them.

Self Management Framework

Self management cannot be supported by the NHS alone. Voluntary organisations, Local Authorities, social and community care all provide support to people with long term conditions, their families and carers and have a key part to play in providing and signposting support.

Health and social care professionals need quick access to information and to have the

skills to use the knowledge appropriately. Despite good local examples, there is no standard referral system between NHS and non-NHS organisations. A self management framework, based for example on figure 3, is therefore required in each area to identify existing support systems and provide a map for staff and the public. It will include details of the different kinds of support available in a particular area, or for a particular condition at each stage of the patient journey, including details on group activities, condition specific and generic self management programmes, mental health services, motivational coaching; carer and family support and telecare support. This will be supported across Scotland by the launch of a Managed Knowledge Network in April 2008 which will provide resources for patients and carers to help them to self manage their condition.

Figure 3: Self Management Framework for Long Term Conditions
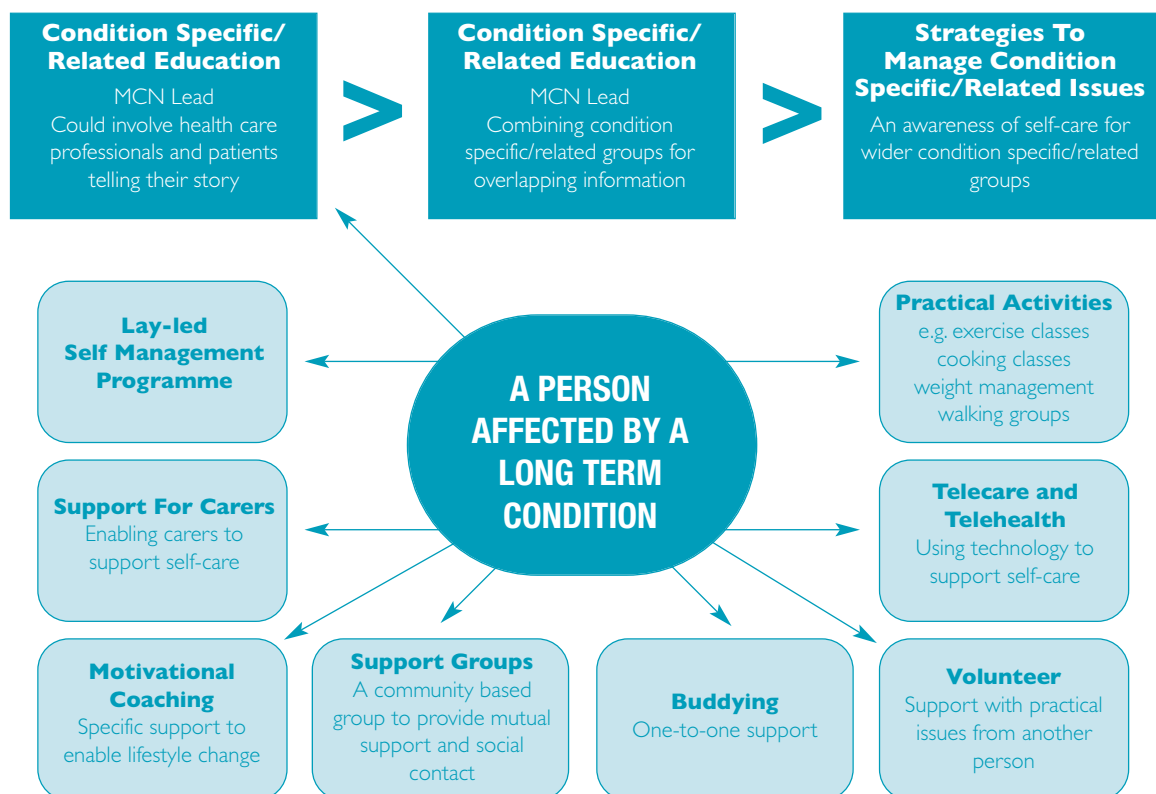
Information for Patients

NHS Boards have developed a range of information for patients and carers about conditions and procedures. Much of this is well presented and of good quality, but it is not necessarily consistent or widely available, and may not, in all cases, meet quality standards or be written from a patient's perspective. There may also be unnecessary duplication with material produced by the voluntary sector.

We are committed to working in partnership with the voluntary sector to ensure that patients, the public and carers get the information they need, when they need it and that this information is clear, accurate, up-to-date and presented in a way which meets their needs. By April 2009 we will introduce a National Health Information and Support Service to provide a single shared health information online resource which brings together quality assured local and national information from the NHS and other sectors, a national health information helpline available and a network of branded health information support centres, embedded in local communities. This will involve:

- a consistent approach to produce high quality patient information across NHSScotland

- information partnerships with key national voluntary organisations to maximise the benefit to patients from the high quality, patient focused information they produce

- clearly signposted access points where people can get support to find the information they need; understand the information provided and develop the skills and confidence to use it effectively in order to become an active partner in their own care

- a particular focus on meeting the needs of those communities and individuals who have traditionally found it harder to engage with health services.

Carers

Under the Community Care and Health (Scotland) Act 2002, NHS Boards are required to develop and implement Carer Information Strategies. These strategies, in place since May 2007, should improve carer identification, information and training to help carers continue in their caring role. The draft Scottish Budget identified a total of £9 million over the next three years to support NHS Boards in implementing these strategies and the Scottish Government is also investing a further £280,000 over two years to pilot carer training and help carers, particular new carers, to gain the knowledge and skills they need to care effectively while looking after their own health.

Our approach to young carers aims to ensure that their interests are addressed in mainstream support. This is particularly appropriate for supporting children living in drug misusing households who almost inevitably have some caring responsibilities. Such carers are often hidden from the services designed to help them, and their mental, physical and emotional health suffers as a result. We are investing £183,000 (spread over two years) in the development of a national young carer forum, which will give young carers a national voice and raise their profile within Scottish society. If this initial event is successful, funding will continue to make this forum an annual event.

Palliative Care

End of life, or palliative care, is an integral part of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable disease. It is not just about care in the last months, days and hours of a person's life but includes support to enable someone to live with a life threatening condition and maintain, as far as possible, a decent quality of life for their families and themselves.

We are committed to the delivery of high quality palliative care to everyone in Scotland who needs it, on the basis of clinical need not diagnosis, and according to established principles of equity and personal dignity.

By March 2008 we will therefore publish a plan setting out how we will implement the recommendations of the Scottish Partnership for Palliative Care's report: *Palliative and End of Life Care in Scotland: the Case for a Cohesive Approach*. For the first time, this will bring a single, comprehensive approach to the provision of palliative care across Scotland.

As part of this approach we will expand the use of the high quality generalist palliative care standards in all care settings, so that more people can live and die well in the places they choose and encourage a uniform approach to achieving the goals of the Liverpool Integrated Care Pathway for the Dying Patient in all care settings. We will support Community Health Partnerships (CHPs) and Managed Clinical Networks to better integrate specialist palliative and primary healthcare teams in order to enable patients to remain at home during the terminal stages of their illness should they wish to, and if it is possible for them to do so. We will ensure that we integrate statutory services with ideas and initiatives from the voluntary sector where they are valued by patients and have demonstrated their effectiveness and sustainability.

Tayside Ambulance Pilot

NHS Tayside, Marie Curie Cancer Care and the Scottish Ambulance Service have launched a dedicated ambulance, specially designed to transport people with life-limiting illness across Tayside. The Scottish Ambulance Service is operating the service as part of a two year pilot, with funding from Marie Curie Cancer Care as part of its Delivering Choice Programme. The ambulance's first priority is to deliver a quick response for patients nearing the end of their lives and transport them to their preferred place of care – which is usually their home. The ambulance is specifically designed for palliative care patients and is fitted out with specialist equipment and other features to help patients feel relaxed and comfortable during their journey. It is operated by two trained ambulance care assistants who can deal with the specialist needs of palliative care patients. Healthcare professionals can refer their patients to the service by calling a dedicated phone line.

Transport

Many participants in the national discussion, particularly those in remote and rural areas, identified transport as a key factor in their overall experience of the care we provide. NHS Boards have a responsibility to ensure that transport issues are taken into account in designing and delivering health services and are required to deliver operational travel plans by April 2008. Travel Plan Co-ordinators are increasingly being appointed by Boards to take on this responsibility and ensure that patients are provided with appropriate advice and support if required to travel to receive care. All plans must reflect local and regional travel strategies and incorporate sustainable travel policies which address the demand as well as the supply for travel, providing greater encouragement to the use of public transport, cycling and walking wherever possible.

We are committed to establishing a national approach to travel management to realise the potential patient benefits and operating efficiencies that can come from greater co-ordination between local NHS Boards, the Scottish Ambulance Service and the logistical capabilities of NHS National Services for Scotland. As part of this national approach, we will strengthen our engagement with Regional Transport Partnerships to ensure our patients benefit from the statutory obligation on such Partnerships to develop regional transport strategies which address access to health care facilities.

Hospital Evening Visitor Scheme

Discussions with communities across Glasgow identified a range of concerns about transport to and from the city's key hospitals, including difficulties in reaching our sites by public transport and fears about travelling at night. These were particular issues for older people, disabled people, parents with young children and people on low incomes. In response to these concerns, NHS Greater Glasgow and Clyde, Community Transport Glasgow, the City's five Community Transport Operators, Glasgow City Council and Strathclyde Partnership for Transport got together to launch a dedicated Evening Visitor Scheme in October 2006. This offers partners, families and friends the opportunity of reaching six Adult Acute Hospitals within the city via a dedicated evening, door-to-door transport system five days a week. In November 2007 the service was expanded outside the city boundaries, with the inclusion of new partners in East Dunbartonshire Council, East Renfrewshire Council, East Renfrewshire CHP, South Lanarkshire CHP and two further Community Transport Providers. The service has now carried over 4500 visitors to hospital and covered more than 30,000 miles.

We will:

- Implement the Patient Experience Programme with an initial focus on inpatient care, GP surgeries and long term conditions

- Ensure that a self management framework is available in every CHP by end 2008

- Launch a Managed Knowledge Network in April 2008 to provide patients and carers with resources to support self management

- Develop an integrated National Health Information and Support Service by April 2009

- Invest a total of £9 million over the next three years to support Carer Information Strategies

- Introduce a national young carer forum in 2008

- Publish delivery plans for implementation of recommendations of Scottish Partnership for Palliative Care's report by March 2008

- Extend the use of high quality generalist palliative care standards in all care settings

- Develop a national approach to travel management and ensure that NHS Boards publish operational transport plans by April 2008

3.3 PATIENT SAFETY

Introduction

The NHS in Scotland is safe by UK and international standards, but our priority is to make it safer still. Improving safety standards and ensuring a safety culture within NHSScotland requires us to remain at the forefront of international action on this issue. It demands action by a range of stakeholders and the deployment of tested, evidence based interventions across Scotland.

Considerable concern was expressed throughout our discussions about the risks of MRSA and other hospital acquired infections. We heard examples of patients discovering poor and unacceptable standards of cleanliness and cleaning practice in our main hospitals and a widespread demand for greater accountability for safety within care settings, allied to a willingness on the part of patients and the public to play their part.

Scottish Patient Safety Alliance

The Scottish Patient Safety Alliance brings together the Scottish Government, NHSScotland, the Royal Colleges and other professional bodies, the Scottish Consumer Council and the Institute of Healthcare Improvement in a partnership to achieve:

- significant reductions in healthcare associated infections; adverse surgical incidents, and adverse drug events

- demonstrable improvements in critical care outcomes, care on hospital wards and organisational culture through leadership which is focused on patient safety.

The Alliance will build upon the success of the current Safer Patients Initiative which is already improving safety standards in NHS Ayrshire and Arran, NHS Dumfries and Galloway and NHS Tayside. With evidence suggesting that one in 10 patients admitted to Scottish hospitals will be unintentionally harmed and that 50% of these incidents are avoidable, the significance and importance of this work is obvious. The Alliance's task is to extend the learning and success achieved in these NHS Boards to every NHS Board in Scotland. Front line staff will be empowered to ensure focused improvements are made wherever they interact with patients, be that at the bedside, the operating theatre or clinic, whilst the systematic application of key interventions will support effective multidisciplinary learning across NHSScotland.

Medication Safety: NHS Tayside

Ensuring every patient gets the correct medicine in hospital can be a complicated process. When individuals are admitted with a range of medical conditions, a variety of treatments may be involved. This issue can be further complicated when patients are admitted to hospital without their individual list of medicines - until now. NHS Tayside has introduced, as part of the hospital patient safety programme, a matching process for all medications for each patient. This process of medicine reconciliation (matching) involves making a list of medications on admission and referring to that list (in addition to the prescription chart) for all changes and transfers within the patient journey. Reconciliation is undertaken on admission, during all transfers, and on discharge home. The list is also consulted when any change to the medicine regime is undertaken. The introduction of this process has improved medicine safety by 85% in the first two years of the programme. As part of the Scottish Patient Safety Alliance early in 2008 this process will be introduced to every participating site across NHSScotland.

NHS Boards will be charged with ensuring that all acute hospitals take action to:

- ensure early interventions for deteriorating patients through, for example, rapid response teams

- deliver reliable, evidence based care for acute myocardial infarction to prevent deaths from heart attack

- prevent adverse drug events by implementing medication reconciliation

- prevent central line infections by implementing a series of interdependent, scientifically grounded steps

- prevent surgical site infections by delivering the correct perioperative antibiotics at the proper time

- prevent ventilator associated pneumonia by implementing a series of interdependent, scientifically grounded steps

- prevent pressure ulcers by reliably using science based guidelines for their prevention

- reduce *staphylococcus aureus* (MRSA plus MSSA) infection by implementing scientifically proven infection control practices reliably

- prevent harm from high alert medications, beginning with a focus on anticoagulants, sedatives, narcotics, and insulin

- reduce surgical complications by reliably implementing a range of surgical safety approaches

- deliver reliable, evidence based care for congestive heart failure to reduce readmissions

- drive a change in the safety culture in NHS organisations by engaging NHS Board members, senior clinicians and managers.

By March 2010 we will:

■ see significant, measurable improvement in outcomes at all major NHS hospitals in Scotland through the implementation of these specific evidence based interventions

■ ensure, through NHS Quality Improvement Scotland and the Institute for Health Improvement, that robust quality improvement methodologies are widely implemented in major NHS hospitals

■ develop and build a quality improvement and patient safety culture in our hospitals underpinned by the capability and capacity required to sustain this culture over the long term.

Healthcare Associated Infection

We will introduce new measures to tackle Healthcare Associated Infection (HAI) from 2008/09 and provide over £50 million to support their implementation through the HAI Task Force. The Task Force will be responsible for ensuring that NHS Boards have the right tools at their disposal, follow all the correct

nationally recognised procedures and are better equipped to deal with situations where infection is a serious risk. This will support the work of NHS Boards in meeting their target of reducing all *staphylococcus aureus* bacteraemia, including MRSA, by 30% by 2010.

Priorities for action include new work to:

■ target skin and soft tissue infections

■ develop and implement evidence based 'care bundles' aimed at *Clostridium difficile*, central and peripheral vascular catheters; ventilator associated pneumonia; surgical site infections; hand hygiene and urinary catheterisation

■ renew hospital cleaning standards

■ introduce a pilot MRSA screening programme in 2008/09 and a national programme from 2009/10

■ reduce bloodstream infections

■ ensure that additional surveillance information is gathered and put to practical use in the targeted areas of general medicine and the care of the elderly.

We will:

■ Support the Scottish Patient Safety Alliance to deliver significant improvements to safety in all major NHS hospitals in Scotland

■ Introduce new measures to tackle hospital infection and provide £54 million for them and a national MRSA Screening Programme from 2009/10

3.4 EFFECTIVENESS

Introduction

Scotland's healthcare challenges require us to continue to shift the balance of care towards community based services which enable ongoing, continuous care to be delivered at home or within the local community. It requires a greater emphasis on anticipatory rather than reactive care and action to develop the services offered in primary care and community hospitals. It also requires more flexible opening hours among GP practices and provision of walk-in access to a wider range of services through community pharmacies.

Improving Access to Primary Care

At present, the General Medical Services (GMS) contract defines opening hours for GP practices as 8 am to 6.30 pm, Monday to Friday. Typically, routine appointments are scheduled for between 9 am and 5.30 pm. Only very few GP practices offer evening, early morning or lunchtime appointments. Whilst this pattern suits those who do not have work commitments, many participants in the national discussion told us that they wanted general practice opening hours to reflect the demands of their day to day lives. There is no substantial demand for GP services to be available 24/7, but many patients, especially those who commute, would prefer to attend

on Saturday mornings or before or after work. Early morning, evening or weekend sessions would be particularly popular for routine, planned or ongoing care. We must also, as we make clear later in this document, ensure that primary care resources are targeted in a way that reflects levels of need.

We will work with the Scottish General Practitioners Committee of the BMA, the Royal College of General Practitioners, NHS Boards and individual GP practices to provide an accessible service which fits in with the day to day lives of their patients. This will mean:

- guaranteed access to see a member of the GP practice team within 48 hours

- advanced booking arrangements that allow patients to book ahead with a GP of their choice

- as appropriate, early morning (from 8 am) and later (up to 6.30 pm) appointments, with premises remaining open throughout the day and throughout the week

- discussions with the GP profession about an enhanced service to extend the opening period of practices in weekday evenings or at weekends

- innovative methods of increasing access to services including more effective use of telephone consultations and email communication (within the guidelines on patient confidentiality and consent) to allow for the differing commitments of patients

- through the national Improving Patient Experience Programme and the framework for GP practice based patient experience surveys, develop a robust evidence base to support the drive to improve access and patient experience.

Community Pharmacy

Community pharmacies offer convenient access to primary care in busy high streets and other community settings. The new Community Pharmacy contract provides opportunities to build further on the role of the community pharmacist and work has begun on pilot projects in five NHS Boards (NHS Grampian, NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Lothian and NHS Tayside) that will test and evaluate walk-in access to a wider range of services through selected community pharmacies. The pilots will offer a different mix of services in suitable locations, such as major shopping areas and main commuter points, or where there is an identified local need. They will also open at more convenient times, such as early evening and at weekends. Over time, the services provided will include, for example, nurse-led minor injury treatments, sexual health screening, simple diagnostic tests, and some adult immunisations. The pilot sites are expected to be up and running by the end of March 2008 and their work will be fully evaluated with a view to the wider development and spread of walk-in services.

Long Term Conditions

There are many good local examples of integrated case or care management approaches delivering holistic care and real benefits to those with long term conditions. Our aim is to make such approaches more consistent and widespread across Scotland and to balance this professional care, on the basis of need, with the enhanced support for self management described earlier in this document. The implementation of our long term conditions strategy is being overseen by a steering group led by the Chief Medical Officer for Scotland and we are determined to ensure that, as it does so, it is driven by the experiences of those who live with these conditions either directly or in a caring role. A delivery plan for the next stage of this work will be published in 2008. The Long Term Conditions Alliance Scotland and the individual organisations it represents have led the development of our approach to date and we are committed to supporting the organisation in the future and, in particular, to enabling them to develop the concept of a long term conditions 'hub', which can act as a valuable resource for smaller member organisations.

The Scottish Patients at Risk of Readmission and Admission (SPARRA) risk-prediction tool offers NHS Boards the opportunity to identify those people who are at greatest risk of emergency admission or readmission to hospital. At present it concentrates on people aged 65 and over, but we will extend its scope to encompass all high risk people by June 2008 and have commissioned work to develop a separate predictive tool for mental health patients. By the end of 2008, SPARRA will be extended further to identify those judged to be of medium risk of emergency admission and who have yet to enter the cycle of repeat emergency admissions. This will allow NHS Boards, and their partners locally, to support these people with preventive models of care and support that can help avoid unnecessary and potentially traumatic admissions to acute hospitals. All Boards will be required to use SPARRA unless they can demonstrate that they have a more effective predictive tool available.

A new, dedicated, Long Term Conditions Collaborative, is being developed to support NHSScotland deliver sustainable

improvements in patient centred services. The three year national programme will engage all 14 territorial NHS Boards and have work streams on self care, specialist care and complex care. The focus will be on clinical systems improvement to improve access, reliability, safety and patient experience. There will be a regional management infrastructure to support the use of technical and behavioural management tools and techniques. These teams will work closely with other improvement programme teams for the Mental Health Collaborative and 18 weeks Referral to Treatment Time programmes and others including Rehabilitation Co-ordinators.

As we develop integrated case and care management across Scotland, we will enhance the level of emotional support provided to patients and carers within their package of care and rehabilitation. This will be achieved by:

- ensuring that people with long term conditions are treated as people, not a collection of symptoms

- making sure that they are made aware of the full range of information and support available to them, especially around the time of diagnosis, especially the contribution that the voluntary sector can make

- recognising the psychological dimension to long term conditions management by providing better psychological support through counselling and techniques to raise self-esteem.

Nairn Anticipatory Care Project

In Nairn, the Anticipatory Care Project has led to the development of Anticipatory Care Plans for around 300 people who are assessed as being at greatest risk of admission to hospital or who currently enjoy Residential and Nursing care. Case Managers seek out these patients and ask a series of questions about their carer or cared for status, preferences for treatment, progression of disease, referred place of care and resuscitation status. The team is also looking at general health status and action that might be taken on issues such as nutrition, financial matters and help with the demands of daily living. This has seen it take action to ensure that paths are gritted, working with the local authority to ensure that the elderly person is exempt from taking the bins to the gate and reduce the risk of falls. Such interventions improve the quality of life of some of our most vulnerable people and have a direct impact on the number of days that people have to spend in hospital. In Nairn for example, with less than 3% of the list receiving a more managed approach to their care they are on target for a 15% reduction in occupied bed days, based on last year.

New patterns of consultation in primary care need to be developed continuously to support a person centred approach, enabled by relevant systemic change. This could, for example, offer people with more than one long term condition different types of appointments, such as "one stop clinics", which could improve both efficiency and the patient experience. Such an arrangement could include the consultation, any necessary investigations, interventions from a range of appropriate health care professionals and advice on health improvement and health protection in order that their total needs can be assessed and managed in the round.

Rehabilitation

Rehabilitation is a process of enablement geared to supporting individuals in achieving personal autonomy. The emphasis is on aspects of daily life considered important by the patient or service user and their family and carers. Access to rehabilitation can be a key determinant of an independent life, lived to the full, including being economically active. *The Delivery Framework for Adult Rehabilitation* (2007) sets out a model for how such services can be delivered across health, social care and the voluntary sector. This enabling approach will support older people and those with long term conditions to remain active and independent within their communities. It will also be key to avoiding unnecessary admissions to hospital and supporting people to return home after a period of ill health.

Community Care

Community care outcomes are often delivered jointly between the NHS and local authorities, and other partners – particularly the third sector – and form a key component of shifting the balance of care. For example, effective community care increases the number of people with complex care needs who can be cared for at home, reduces dependency on hospital based services, and enhances the quality of life of the people who depend on these services.

Over the last 15 years, there have been very significant increases in the number of older people, and adults with learning disabilities and mental health problems, living at home or in community settings rather than acute hospitals. Partnership working and investment of around £30 million per year has reduced the number of patients inappropriately delayed in hospital for more than six weeks by over 80% in the last six years. The introduction of Free Personal and Nursing Care has enabled many older people to access care services free of charge, and the extensive investment in care home fees has enabled vulnerable people to access better quality care services. Recent legislation has also strengthened support for adults at risk of harm.

The draft budget builds on these achievements and links them to an agreement via the Concordat with local authorities in respect of care home quality, free personal care and respite for carers. We have made significant new investment in housing and tackling poverty and deprivation, and are committed to sustaining and developing joint working between local authorities and NHSScotland, to secure further improvements in key areas including user satisfaction, faster access, better support for carers, the quality of assessment and care planning, identifying those at risk of admissions, and moving services closer to users/patients.

Community care aims to enable everyone in the community to enjoy sustained health and wellbeing, especially those in disadvantaged communities. We are therefore committed to supporting carers to look after their own health, including working with local government to develop local agreements to make progress towards delivering 10,000 more respite weeks annually and to ensure the effective implementation of Carers Information Strategies. We will enhance the delivery and sustainability of Free Personal and Nursing Care by supporting Lord Sutherland's Review and up rating levels of payment. Standards will be raised through effective regulation; we will implement our commitments in *All our Futures*; and we aim to reduce delayed discharges to nil by the end of March 2008, and to sustain this achievement thereafter.

The Single Shared Assessment remains a key part of these plans. We have heard concerns about its implementation during the national discussion. We are developing new standards, with stakeholders, for users' and carers' assessment and for care plan reviews and will revise the National Standards to set standards for the time to make an assessment and the time between assessment and service delivery. By 2009, we will also ensure that every partnership has the capability to share information electronically, based on the Single Shared Assessment. We are also committed to providing greater inclusion for people with learning difficulties, autistic spectrum disorders and sensory impairment.

Health in Care Homes

Care home residents have the same rights to access primary care services, such as doctors, dentists, chiropodists and opticians, as anyone else in the community. Due to the complexity of their needs, many older people in care homes also need access to specialists such as a Consultant in Old Age Psychiatry.

However, the Care Commission has raised concerns that the contribution of doctors, other professionals and specialist services for older people can be limited in some care homes. Alzheimer Scotland has concluded that a significant number of older people in care homes with dementia may not have received a diagnosis and may not, therefore, be receiving access to appropriate treatments.

Access to effective primary care and specialist health care services for people in care homes, including the frail elderly, can assist in reducing inappropriate hospital admissions and help maintain people in the community.

As part of our commitment to shift the balance of care and to providing more personalised and integrated care services, we will work with care providers and NHS professionals to ensure that people in care homes have appropriate access to both primary and specialist health care services.

National Clinical Priorities

The national discussion served to reconfirm the continuing importance of identifying cancer, coronary heart disease (CHD), stroke and mental health as the national clinical priorities. The success we have enjoyed in recent years in the treatment of cancer and in reducing premature mortality from coronary heart disease and stroke suggests the benefits of this approach, but we agree with those people in the discussion who argued that there is no room for complacency. Scottish mortality rates for CHD and stroke remain high by western European standards and there are still unacceptable disparities due to health inequalities. We are therefore committed to revising our national strategies for each condition, to put greater emphasis on prevention and tackling those issues that have hitherto been neglected such as inherited cardiac conditions. Updated strategies will be published in Summer 2008.

From 2008, dementia will be regarded as a national priority. This will be reflected in a new target from 2009 which will focus NHS Boards on this condition and allow us to build national approaches based on new standards for an integrated care pathway for dementia that will be published by NHS Quality Improvement Scotland in December 2007. We are committed to developing guidance and support tools to help make all primary care buildings dementia friendly, identifying and building upon examples of good practice across Scotland and developing a competency framework to support training and development of mental health nursing for older people.

Forth Valley Dementia Project

The Forth Valley Dementia Project is an improvement programme run by the Dementia Service Development Centre with funding from the Scottish Government. It aims to identify the needs of people with dementia in the Forth Valley area, establish what services are available and identify practical ways to improve the care of people with dementia.

The programme began in April 2007 and has delivered an extensive programme of training for nursing staff to help raise their understanding of dementia and offer problem solving advice for coping with difficult situations involving patients. Training has also been provided to police officers given that they come into contact with people with dementia in a variety of everyday situations. The programme has also produced an information booklet, *Memory Loss: Finding your Way Through the Maze* which provides information on dementia services in the Falkirk area.

Mental Health Services

The new Government is fully committed to the successful implementation of the action plan, *Delivering for Mental Health* (2006). NHS Quality Improvement Scotland has developed a set of standards for depression, dementia, schizophrenia, bi-polar and borderline personality disorder, which will provide the framework around which mental health services, particularly in primary care will operate and in January 2008. We will also publish guidance on the physical health needs of people with severe and enduring mental health problems covering both primary and secondary care. In April 2008, we will launch the Mental Health Collaborative to share good practice and drive the delivery of new and emerging commitments on antidepressant prescribing, readmissions and dementia.

The Scottish Recovery Indicator provides a method of assessing the extent to which practice in mental health services is focused around factors which are known to promote recovery. This focuses on 'strengths' rather than looking for negative aspects of an individual's illness. The tool is currently being piloted in four NHS Boards to test its validity and evaluate its impact on changing practice, promoting the concept of recovery and improving the quality of life of those who suffer from mental illness. Our aim is to roll out the use of this tool across all mental health services in Scotland by 2010.

We know that it will take time to grow the numbers of staff we will need to be able to deliver the range of psychological interventions that are required but we believe that such an investment of time and resources is worth it. Working with local NHS Boards and NHS Education for Scotland we will work to enhance the skills of current professionals in this area and train new staff in different interventions, whilst ensuring that they all have the appropriate supervision to practice safely and effectively. At the same time we will be funding a national mental health improvement programme that will work for the next three years with NHS Boards, Local Authorities and users and carers to drive forward the delivery of our mental health targets and change the way in which we care and treat individuals. An early output will be to work with NHS24 to explore and pilot telephone based Cognitive Behavioural Therapy in 2008.

Organ Donation and Transplantation

Organ transplantation is one of medicine's great success stories, but there is an acute, and growing, shortage of donor organs for transplantation. Although 29% of our population now have their names on the NHS Organ Donor Register, our donation rate is one of the lowest in the EU. We believe that organ donation should be regarded as a usual, not an unusual, event and that discussions about donation should be a normal part of end-of-life care for appropriate patients. We fully support the work of the UK wide Organ Donation Task Force and will ensure that Scotland plays its part in contributing to the 50% increase in organ donation which the Task Force believes is possible over the next five years. We will also encourage a wide public debate on the issue of presumed consent for organ donation.

Dental Services

A number of steps are underway to improve access to dentistry in Scotland, including:

- grants and allowances are in place to attract practitioners to Scotland and to encourage existing practitioners to expand their practices

- an undergraduate bursary scheme where students commit to work in NHS dentistry for up to five years following qualification

- funding under the Primary and Community Care Premises Modernisation Programme to provide new or substantially improved premises to support the delivery of NHS dentistry in areas with gaps in provision.

Furthermore, we have signalled our intention to open a third dental school in Scotland by expanding the Aberdeen Dental Institute. It is intended that the first group of students will enter the dental school in October 2008.

We will:

- Work with Health Boards and GP practices to provide an accessible service which fits in with the day to day lives of their patients

- Establish pilots in five NHS Boards to evaluate walk in access to a wider range of services in community pharmacy

- Publish a delivery plan for the next stage of our work on long term conditions in 2008

- Extend the scope of the SPARRA risk prediction tool from identifying those aged over 65 and high risk to all high risk individuals by June 2008; and to medium risk individuals by end 2008

- Launch Long Term Conditions and Mental Health Collaboratives in 2008

- Work with Local Authorities to secure further improvements in community care and enhance their deliverability and sustainability of personal and nursing care

- Roll out the Scottish Recovery Indicator by 2010

- Reduce delayed discharges to nil by the end of March 2008

- Ensure that people in care homes have appropriate access to primary and specialist health care services

- Ensure that all partnerships can share information electronically by 2009 based on the single shared assessment

- Revise our strategies for the national clinical priorities by Summer 2008 and include dementia in these priorities from 2008

- Establish a dental school in Aberdeen, aiming for a first student intake in 2008

3.5 EFFICIENCY

Introduction

A recent Commonwealth Fund report compared the UK health care system to five international examples (Australia, Canada, Germany, New Zealand and the USA) and found that the UK was the most efficient provider of services. The UK system as a whole performed well in terms of the relatively low number of individuals who presented as emergencies with conditions which could have been treated earlier by another health care professional and in areas such as the deployment of multi-disciplinary teams in primary care.

Nevertheless, we all recognise that NHSScotland, as an organisation that accounts for over £10 billion of public money every year, must strive to become ever more efficient in everything it does. In particular, it needs to draw on the expertise of staff and ideas from patients at every level in order to identify and take opportunities to ensure that resources are deployed in the most appropriate way in order to support front line patient care.

NHSScotland Efficiency and Productivity Programme

Over recent years, a range of initiatives and programmes around measuring and improving efficiency and productivity in NHSScotland have emerged. These include national improvement programmes, benchmarking, measurement of output and quality, unit costing/tariffs, programme budgeting and work towards achieving greater integration of finance, workforce and service planning in Boards' Local Delivery Plans.

The NHSScotland Efficiency and Productivity Programme has been established to bring greater coherence to this landscape within NHSScotland. A Steering Group will be established, chaired by a senior figure within the service, which will provide governance, direction and advice on a programme designed to assist Boards in identifying local improvements and efficiency savings. In particular, it will take forward further work on:

- national tariffs that reflect the value of procedures carried out by one NHS Board on behalf of another and act as a spur to greater efficiency

- pay modernisation to better reward and recognise staff, improve recruitment and retention and facilitate service changes that improve patient care

- release and reallocate valuable consultant time in conjunction with the Scottish Association of Medical Directors group

- Whole System Benchmarking to help NHS Boards to track the timing and sources of efficiencies and productivity, safeguard against double counting and improve the transparency of reporting by providing clearer standards against which the public can judge the performance of their local services

- improving the way in which we measure quality and productivity in line with the work of the Atkinson Review (2005) commissioned by the Office for National Statistics

- ensuring that service improvement programmes and the application of Lean principles are fully integrated with NHSScotland's overall approach to efficiency and productivity.

The national discussion and our determination to support the overarching purpose for

Government also challenges us to develop a shared agenda around Best Value in conjunction with local authorities and other public sector partners. This needs to cover the nine dimensions of that model, namely:

- sound governance at a strategic and operational level

- responsiveness and consultation

- commitment and leadership

- use of review and option appraisal

- joint working

- sustainable development

- equal opportunities

- sound management of resources

- accountability, including public performance reporting.

The NHS Efficiency and Productivity Programme will consider how we pursue these dimensions as part of the wider range of work.

Key Targets

The focus of action to improve efficiency and productivity is upon improving outcomes for patients in terms of clinical success, experience of care and, ultimately, quality of life. To achieve such outcomes however, it is essential that we concentrate on the way in which our services are designed and delivered.

The new HEAT performance framework contains a number of new targets aimed specifically at improving efficiency throughout NHSScotland. These include:

- universal utilisation of CHI, the unique patient identification number

- a sickness absence rate of 4% from 31 March 2009

- all employees covered by Agenda for Change to have an agreed personal development plan in line with the Knowledge and Skills Framework by March 2009

- delivery of agreed efficiency improvements for first outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011

- NHS Boards operating within agreed revenue resource limits, capital resource limits and their cash requirements

- meeting NHS Board cash efficiency targets

- increase the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 95% from December 2010.

Evidence Based Clinical Practice

Action to tackle significant variations in current practice across NHSScotland will be taken forward on the basis of an explicit commitment to the delivery of evidence based clinical practice which will ensure appropriate decision making and action across clinical and planning communities. It will enable us to ensure that investment is driven by clinical evidence and allow us to target other known variations in practice. In an initial phase this work will focus on:

- variations in referral from GP practices to emergency care

- variation in day surgery rates

- variation in theatre utilisation

- variation in length of stay.

Reducing Our Carbon Footprint

All NHS Boards are required to contribute to an annual national environment report which demonstrates performance in gas omissions, energy usage, water consumption, production of clinical waste and increased levels of recycling. This focuses the whole organisation on building on 38.7% reduction in carbon dioxide emissions we have achieved since 1989/90 and we propose to expand the scope of the report to embrace the wider sustainability agenda. In particular, we are keen to ensure that in designing new facilities, NHS Boards give full consideration to both design quality and the impact of design on the environment. This will be supported through the framework agreement with Architecture and Design Scotland that runs until September 2009.

NHS Grampian: Carbon Management

NHS Grampian was identified as a UK pilot in the carbon trusts study into carbon footprint reduction measures. NHS Grampian, recognising the direct and harmful influence of carbon dioxide emissions on climate change and mindful of its responsibility as a large public sector organisation agreed to this pilot study with the Carbon Trust the aim of which is to bring about sustainable reductions in the Board's CO_2 emissions. The Board has set targets of reducing its carbon impact by 2% year on year and by a minimum of 15% over five years. In meeting those targets over 10 years NHS Grampian would save £6.9 million and avoid emissions of 61,000 tonnes of CO_2.

eHealth

High quality information is crucial to the delivery of safe and effective health care. We will build on our work to put in place a modern and efficient information and communications system to ensure that the right information is available at the right time, in the right place, to enable staff to provide the best possible care. We also need to ensure that the benefits which information technology brings to patients and health care professionals, such as improved co-ordination of care, are delivered within a culture which respects, values and keeps secure patients' data.

Significant progress has been made over the past few years in developing eHealth that meets the needs of patients and facilitates efficient and effective working across NHSScotland. The Emergency Care Summary now contains key clinical information for over 5.1 million patients and is currently used around 25,000 times per week, if the patient explicitly consents, by clinicians in Out Of Hours GP services, A&E Departments and NHS24. Use of the Community Health Index (CHI) number on the 10 key clinical documents for communication between GPs and acute hospitals has increased from 70% in November 2006 to 94% in December 2007 and it now used on 94% of community-held case records, up from 86% in April 2007.

The Scottish Government is determined to build on these achievements and add fresh impetus to our national strategy in order to realise the opportunities that exist for improving the quality of patient care across Scotland. In Spring 2008, we therefore intend to publish a new eHealth strategy that will demonstrate how we intend to bring together

existing information and systems throughout a patient's journey of care and spread good practice between areas and clinical functions, whilst ensuring a continuing focus on protecting the confidentiality and security of patient information. The strategy will address the cultural issues we face in implementing new technology and above all will prioritise future investment on IT on the basis of its potential to improve our patient's experience of care.

Key features of the Strategy will be:

- action around the three themes of supporting safe, effective, timely and efficient patient care, contributing to equitable, patient centred care and improving eHealth capacity

- a vision of ever diminishing paper and increasing use by clinicians of secure IT to access the right information in the right place at the right time

- a clear focus on patient safety, safeguarding confidentiality, evidence based care and more efficient management of the patient's journey through care

- a new emphasis on 'Patient eHealth', initially focused on long term conditions, with trials of patient/carer online access to their records along with knowledge to promote self and collaborative care.

We have made progress to date by introducing incremental improvements that produce clear benefits to patients and the service. Our strategy will continue to be built on this approach. We do not plan to produce some large single database of patient information, but will join up systems where there are clear benefits from doing so.

Telehealth

Telehealth offers a range of care options remotely via phones, mobiles and broadband, often involving videoconferencing. Deployed effectively, it can improve the patient's experience of care by reducing the need for travel to major cities and hospitals to receive care and treatment. It has already been used successfully to provide treatment around conditions such as dermatology, cardiology and neurology.

Over the next five years the Scottish Centre for Telehealth will support and guide the development of telehealth for clinical, managerial and educational purposes across Scotland. This involves working across boundaries with industry, Local Authorities and NHS Boards to develop recognised models for redesigning care. The focus will be support for long term conditions (with an initial emphasis on COPD), paediatrics, and unscheduled care and in remote and rural areas. The Centre will provide support and advice to NHS Boards and help evaluate the potential benefits of new technologies, with the aim of making Scotland a recognised global leader in telehealth.

Tele-endoscopy for head and neck cancer assessment

The incidence of head and neck cancer is increasing and is particularly noticeable for oral cancer where the age standardised rates have increased by 35% in males and 44% in females over a 10 year period. Tele-endoscopy for head and neck cancer assessment uses remote diagnostic technology to facilitate the examination of an airway with symptoms of tumour growth.

The first stage of the pilot involves the delivery of a remote diagnostic service from Aberdeen to Shetland to provide patients with local access to a specialist opinion. Two local doctors and two local nurses have been trained to facilitate the clinical service which now runs every month. Future phases will involve the delivery of a remote diagnostic service from Inverness to Stornoway and a remote review appointment service to a local community hospital for patients who have had surgery, radio or chemotherapy for head and neck tumours.

We will:

- Bring greater coherence to NHSScotland's efficiency and productivity efforts through the NHSScotland Efficiency and Productivity Programme and meet the key efficiency improvements described in the HEAT performance framework

- Target variation across NHSScotland as part of an explicit commitment to evidence based clinical practice

- Further develop the existing Benchmarking Programme to help NHS Boards identify areas for improvement

- Publish the Balanced Scorecard for Mental Health to allow benchmarking of services

- Promote the lessons from the NHS Grampian carbon management pilot study

- Extend the scope of the NHSScotland Environment Report to embrace the wider sustainability agenda

- Publish a new eHealth Strategy in Spring 2008

- Support the Scottish Centre for Telehealth to focus on telehealth applications in the areas of long term conditions, paediatrics, unscheduled care and remote and rural health care

3.6 EQUITY

Introduction

It is important that we understand and respond to the needs of the different groups and communities we serve. It is not enough to provide a uniform service and expect that patients and the public will be able to take advantage of that service equally.

A lot has been achieved in NHSScotland already but it is critical that every part of the service considers whether the services it provides, and the way in which they are provided, support equity.

Remote and Rural Health Care

Building a Health Service: Fit for the Future recognised that a one size fits all approach can not meet the challenges of providing health care in remote and rural areas and established a national steering group to develop a framework for the provision of services in those areas. A further group was established to develop specific training for doctors working in remote and rural areas. Both groups have now reported and we will issue guidance on how we expect their recommendations to be implemented early in 2008.

The proposed framework presents a model for sustainable remote and rural services which maximises the contribution of each member of the health and social care team, and encourages further integration of services. Primary care teams are recognised as the bedrock of the health care system. Recommendations are made to extend, as far as is possible, the range of diagnostic tests and specialist support available to those teams to prevent unnecessary onward referral and travel for patients. The potential to upskill

members of those teams to provide more local services - for example through the development of GPs with special interests - is also recognised.

The Framework describes a suite of safe and sustainable core services for Scotland's Rural General Hospitals, supported by a modern staffing model which secures quality of care for patients. Rural General Hospitals will develop formal networks between one another, and with larger hospitals in urban centres, which will include agreed specialist clinical links. The current practice of visiting specialists will be reviewed and extended where appropriate. This will allow local decision making to be informed by access to specialist opinion, peer group support, training and education, the development of shared protocols and pathways across and between different facilities and opportunities for staff rotation that can help maintain and develop necessary skills.

It is clear that we can do much more to exploit the opportunities offered by eHealth and particularly telehealth in remote and rural areas. Travelling to a central point can be avoided through the use of videoconferencing, telephone or email, whilst digital data such as blood tests, ECGs, and images can be transferred from remote sites to other points to enhance diagnosis. This requires protocols and agreed service standards and the Scottish Centre for Telehealth will be a critical source of information and advice for NHS Boards as they start to deploy these technologies more effectively.

The Medical Training Pathways group has applied an understanding of the service requirements within remote and rural areas to develop educational standards for doctors

within a multi-disciplinary team, specifically considering Anaesthetists, Physicians, Surgeons and General Practitioners. The report makes recommendations on a competency framework for each of these key medical specialities, adapting the general training curricula for each specialty when required.

Fair for All

Our *Fair for All* agenda seeks to understand the needs of different communities, eliminate discrimination in the NHS, reduce inequality, protect human rights and build good relations by breaking down barriers that may be preventing people from accessing the care and services that they need. It aims to address inequalities by recognising and valuing diversity, promoting a patient focused approach and involving people in the design and delivery of health care.

A vast amount has been achieved already, with guidance now being available to help staff understand and meet their responsibilities under the Disability Discrimination Act, support NHSScotland in implementing the Gender Equality Duty, assess progress in achieving race equality outcomes and provide information and good practice examples of LGBT people using NHS services. Guidance on religion/belief and issues relating to age are due to be launched shortly. A new Directorate of Equalities and Planning is being created in NHS Health Scotland to bring together this work and to be the focus of support, advice and expertise to NHSScotland in addressing diversity and reaching excluded communities.

We are committed to continuing and further developing our *Fair for All* approach across NHSScotland. We will therefore ensure that we equality impact assess this action plan throughout its implementation. We will do this, not just because it is a legal requirement. It is right to do so and we believe that it will lead to services that are equitable and fair for all the communities we serve.

Disabilities

NHSScotland has been working in partnership with the Equality and Human Rights Commission through our *Fair for All – Disability* initiative to raise awareness of disability issues and deliver more responsive services for people with a disability. *Fair for All – Disability*, which is now housed within NHS Health Scotland, supports NHS Boards directly and with guidance to ensure health services strive for best practice that goes beyond compliance with the law and promotes the rights, independence, choice and inclusion of disabled people as health service users and members of the community. *Achieving Fair Access* – good practice guidance – has been launched to assist health staff to understand and meet their responsibilities under the Disability Discrimination Act.

We are working to address the barriers which disabled people[5] have told us they face, including the need for better information, providing suitable opening and appointment times and improving the accessibility of the buildings, including support for helping finding your way around buildings. Barriers to access can very often be easily remedied by offering simple adaptations to existing services such as making appointments by email, providing treatment information in large print, on tape or in easy read. The use of colour in signs and

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[5] We use the term disabled people, as recommended previously by the Disability Rights Commission, now part of the new Equality and Human Rights Commission, to best reflect the social model of disability. We are aware that not all disabled people accept this terminology.

as guide-lines on walls or floors can help visually impaired people to find their way around large clinics and hospitals. Disability awareness training for NHS staff at all levels of the service is helping to ensure that staff are confident and competent in dealing with a range of impairments and disabilities and are aware of the potential barriers which might prevent disabled people from accessing services.

We recognise that disabled people and carers may need more flexibility with appointment systems and we will continue to work towards the following:

■ the opportunity to book longer appointment times

■ appointments at a time of day that is best for them, e.g. to fit in with medication routines and carer availability

■ provide a written summary of discussion and outcomes from NHS interventions in an accessible format so that patients have a note to take away

■ advocacy and communication support, e.g. British Sign Language interpreters available when and where required.

The NHS in Scotland will continue to strive to provide a supportive attitude as well as creating an environment that is both welcoming to, and inclusive of, disabled people. They are significant users of NHS services, and listening and responding to their feedback is an essential mechanism to improve experiences. Monitoring these improvements will be central to 'Better Together' the Scottish Patient Experience Programme.

National Statement and Action Plan on Race Equality

The development of a National Statement and Action Plan was one of the recommendations made following the Executive's comprehensive and wide ranging review of race equality, which reported in November 2005. These will be launched in Spring 2008 following a further period of consultation and will set out the vision, basis and direction for our future work on race equality, and the actions the Scottish Government will take to support ethnic minorities in the labour market, Gypsies/Travellers, race equality in rural areas, and refugee integration.

We will:

■ Publish guidance in early 2008 on the implementation of the Remote and Rural Steering Group's Report

■ Establish a Directorate of Equalities and Planning in NHS Health Scotland

■ Publish a National Statement and Action Plan on Race Equality by Spring 2008

■ Equality impact assess the implementation of this action plan

■ Seek to reform the GP contract to better meet the needs of all of our citizens

■ Address the barriers young disabled people face in accessing health services

3.7 TIMELINESS

Introduction

From December 2007, all patients will be seen in an outpatient clinic within 18 weeks of being referred by their GP, and if an operation is needed, all inpatients and day cases will be treated within 18 weeks of being placed on a hospital waiting list. By the end of 2007, we will have abolished Availability Status Codes (hidden waiting lists) and delivered against a number of other waiting time targets which will then be embedded as patient access standards.

Whilst these are significant improvements, there must be no let up in our efforts to reduce waiting times. Shorter waits can:

- lead to earlier diagnosis and better outcomes for many patients

- reduce unnecessary worry and uncertainty for patients

- reduce inequalities by addressing variations in waiting times between NHS Boards or individual hospitals

- save the time, energy and resources that are wasted in the bureaucratic task of managing queues and backlogs for diagnosis and treatment.

18 Weeks Whole Journey Standard

From December 2011, 18 weeks will become the maximum wait for treatment following referral by a GP for non-urgent patients. Most patients will be seen more quickly than this.

The 18 week target is different from previous waiting time targets. It does not focus on a single stage of care, such as the time from referral to first outpatient appointment, or the time from being put on a waiting list until treatment starts. Instead, the 18 week Referral To Treatment (RTT) standard will address the whole patient care pathway, from receipt of a GP referral, up to the point at which each patient is actually admitted to hospital for treatment. This approach has the added advantage of introducing a single standard for access which is well understood by patients and clinical teams alike. As a milestone towards this goal, we will reduce the longest permitted waits for first outpatient consultations to 15 weeks, diagnostic tests to six weeks and inpatient or day case treatment to 15 weeks by end March 2009.

Achieving an 18 week pathway will challenge NHSScotland to improve patient access to hospital services, and, in so doing, increase the effectiveness of clinical care through faster access to outpatient consultation, diagnosis and treatment. Importantly, this will give added impetus to shifting the balance of care from acute hospitals into locally delivered, primary care diagnosis and treatment services. Where it is needed, extra activity will be commissioned by NHS Boards to achieve this standard, supported with additional investment by the Scottish Government Health Directorates. We will publish our delivery

strategy in Spring 2008 setting out our approach to the inter-related elements of:

- planning: action to plan and invest in effective and efficient reduction in patient access times locally, regionally and nationally

- redesign: to make the best use of current capacity, improve efficiency and bring best practice to systems and health care delivery

- information: to develop and use information and technology to support faster access to diagnosis and care

- performance management: to ensure clear targets are set, and service improvement momentum is maintained between 2008 and 2011.

The Scottish Government will support NHSScotland in delivering the 18 week target with an investment of an additional £270 million over three years to improve the range and quality of services for patients across the country. A three year Service Transformation Programme will engage with NHS Boards and their clinical teams, building on best practice both internationally and within NHSScotland and addressing the changes to behaviour that will be required across the service to deliver service transformation of this magnitude. Collaborative work will support NHS Boards to develop quicker access to services whilst improving patient safety and reducing health care inequalities.

Urology services in NHS Tayside

Although a one stop service for frank haematuria (blood in urine) was available in Ninewells Hospital in Dundee, it was not provided in Perth Royal Infirmary or Stracathro Hospital in Angus. In Perth Royal Infirmary, patients waited up to 96 days to receive a clinical management decision. A Rapid Improvement Event using Lean methodology was held in February 2007, in which a multidisciplinary team of 16 people examined current processes, spoke to staff and patients about their experiences and developed a four week action plan to improve the journey for frank haematuria patients across NHS Tayside. One stop services for patients in Perth and Stracathro were introduced in March and May respectively. The average waiting time for patients to receive a clinical management decision in Perth now stands at 11 days.

Unscheduled Care

When someone experiences a health emergency or crisis they need to have access to the right response, the right form of emergency care as quickly as possible. A good system of unscheduled care is one that responds promptly when it is called upon, but also one that responds in a way that is appropriate to patient needs.

We will respond to the challenges set out in the Audit Scotland report on primary care out of hours services (2007) and continue to develop a more integrated approach to the delivery of unscheduled care in each local area. We will therefore increase the use of "see and treat paramedics" so that patients can be supported without an unnecessary journey to hospital, extend access to primary care, use joint "rapid response" services, build on recent improvements in the services of NHS24 and ensure that we improve the experiences of patients through whichever route they receive unscheduled care. This approach can be further supported through the wider use of the Scottish Patients at Risk of Readmission and Admission tool to enhance preventative care in local communities, better use of the Emergency Care Summary to ensure joined up care and increasing the use of remote consultation and diagnostics through telemedicine and telecare. Such an approach will enable us to ensure that patients get the services they need, in the places that they need them, whilst also ensuring that we use our emergency care resources as efficiently as possible.

Our overall approach to unscheduled care, also requires us to ensure that we have the infrastructure in place to support crises that might occur for people with mental health problems. Crisis Standards have already been published and other work such as the development of the standards for integrated care pathways, the development of out of hours crisis teams or intensive home support services are also having a positive impact. More, however, requires to be done. In 2008 we will publish a tool, developed in partnership with SAMH and the Mental

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Unscheduled and Out of Hours Care: Integrated Emergency Response

This proposed service will bring together the dispatch functionality of NHS24, SAS and the Lanarkshire Out of Hours HUB and will also incorporate a Lanarkshire wide bed bureau. A single team is envisaged with all team members having the ability to access all the clinical and demographic information currently only provided to NHS24 through the Emergency Care Summary. In addition to accessing out of hours services and traditional ambulance services, the service will have access to 'see and treat paramedics' and also outpatient and GP next day slots to prevent A&E attendance and possible hospital admission. The emergency response team should be in operation 24 hours but it is acknowledged that the team will be able to access different levels of resource at different times of the day.

Health Foundation that will assist NHS Boards and their partners in evaluating and improving current services. This will be further supported by the development of a risk prediction tool to help identify those people who have a mental illness and who are at most risk of being re-admitted to hospital and assist care providers, particularly GPs and other community staff, to offer appropriate support to these individuals.

Improvement and Support

The Improvement and Support Team, working alongside partners such as NHS Quality Improvement Scotland, will support the implementation of *Better Health, Better Care* by helping NHS Boards to develop an overarching culture and capability for continuous improvement. From 1 April 2008, the National Improvement Programmes will be restructured to reflect the priorities with programmes to support work on achieving the 18 week whole journey time, mental health, long term conditions and implementing proven improvement approaches to new areas such as health improvement and productivity. Performance support programmes will also be developed to help Boards meet the challenges of the refreshed HEAT Performance Framework. This will offer access to improvement education, rapid improvement events and, where Boards need intensive performance support, tailored performance support programmes.

We will:

- Abolish ASC codes (hidden waiting lists) by December 2007 and introduce a new system of defining and measuring waiting times which is more transparent, consistent and fair to patients
- Publish a National Framework for achieving the 18 week Referral To Treatment (RTT) standard in Spring 2008
- Reduce the longest permitted waiting times for first outpatient consultations to 15 weeks, diagnostic tests to six weeks and inpatient or day case treatment to 15 weeks by end March 2009
- Publish comprehensive performance statistics from 2010 showing our progress towards the 18 week RTT target
- Achieve an 18 week RTT standard across Scotland by end 2011
- Establish a local NHS24 service in every mainland Board area
- Ensure that people can gain access to appropriate care first time by better linking the ambulance service, NHS24 and other health providers
- Continue to expand the Emergency Care Summary in order to ensure that care is joined up

ANNEX A

2008/09 HEAT targets

HEALTH IMPROVEMENT (7)
Reduce mortality from Coronary Heart Disease among the under 75s in deprived areas
80% of all three to five year old children to be registered with an NHS dentist by 2010/11
Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.
Through smoking cessation services, support 8% of each NHS Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 – 2010/11
Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010
Increase the proportion of newborn children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11

EFFICIENCY AND GOVERNANCE (7)
NHS Boards to achieve a sickness absence rate of 4% from 31 March 2009
NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement
NHS Boards to meet their cash efficiency target
NHS Boards to deliver agreed improved efficiencies for first outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011
NHS Boards to ensure that all employees covered by *Agenda for Change* have an agreed KSF personal development plan by March 2009
Universal utilisation of CHI
To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 90% from December 2010

ACCESS (7)
To respond to 75% of Category A calls within 8 minutes from April 2009 onwards across mainland Scotland
Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours
The maximum wait from urgent referral to treatment for all cancers is two months
As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks from GP referral to a first outpatient appointment from 31 March 2009
As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks for inpatient or day case treatment from 31 March 2009
As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than six weeks for one of the 8 key diagnostic tests from 31 March 2009
NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment

ANNEX A

TREATMENT (9)
By 2008/09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient two or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008
To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11
Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years
Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over seven days by 10% by the end of December 2009)
Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with dementia by March 2011
QIS clinical governance and risk management standards improving
To reduce all *staphylococcus aureus* bacteraemia (including MRSA) by 30% by 2010
Increase the level of older people with complex care needs receiving care at home
Improvement in the quality of health care experience

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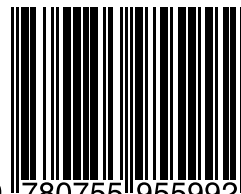www.scotland.gov.uk

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