NHS SCOTLAND

FAIR TO ALL, PERSONAL TO EACH

The next steps for NHSScotland

healthier scotland
SCOTTISH EXECUTIVE

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Chapter I Executive Summary

1. Executive Summary

This paper reiterates the fundamental principles of healthcare in Scotland; outlines progress to date in key areas; and introduces specific plans to tackle waiting. The paper also points to further work on specialised NHS services, on clean hospitals, and on performance management of the NHS.

1.1 Healthcare and health are vital to Scotland as a nation and to the opportunities we enjoy now and will enjoy in the future. People in Scotland now live longer and enjoy better health than in previous generations, and clear progress has been made, for example, in reducing infant mortality and premature deaths from heart disease and cancer. But in comparison to our European neighbours the health of our people is not as good as it should be.

1.2 While health is improving for the vast majority of Scotland's people, it is improving fastest for those who are most affluent. This means that, even though things are getting better across the board, the health gap is not closing. So, for example, the most affluent of us enjoy life expectancy which is comparable to the rest of Europe, but the most deprived of us have a life expectancy that is still too low. Tackling health inequalities matters. We all want to stay healthy longer, and we should all have the chance to do so.

1.3 The Executive accepts its responsibility to help promote healthier lifestyles. Our intention to legislate for a ban on smoking in public places demonstrates our commitment to improving population health, continuing the direction set by, for example, our actions on diet and exercise.

1.4 But key decisions affecting our health lie in our own hands. The Government can't make us eat more healthily or give up smoking. Each of us needs to take responsibility for our own health by choosing a healthier lifestyle and the Government can help by providing appropriate opportunities and ensuring services are accessible and available.

1.5 Prevention is better than cure, and the NHS helps people sort out health problems early, spotting potentially serious health issues when effective treatment can be given quickly and easily. But the NHS also supports people in managing chronic and long-term conditions. And when people do become acutely ill or suffer an injury, it is the NHS that is there for us, caring and saving lives, and keeping families together for longer.

1.6 It follows that maintaining and improving NHS services is central to our commitment to high quality public services in Scotland. The founding principles and core concepts of the NHS – comprehensive services, available to all according to clinical need, and free at the point of use – are a part of our national fabric. These principles are strongly supported by the vast majority of people in Scotland.

1.7 These are our values. And we are committed to supporting and improving the NHS for the benefit of patients, and to helping the Service overcome the challenges which it faces as health technology advances and expectations and demands on services increase.

1.8 Our vision for the NHS is to apply its founding principles with vigour to meet the needs of the 21st century. Patients should be at the centre of the delivery of responsive care and treatment, with more convenient services delivered more quickly at each stage. Services should be as local as possible, and as specialised as necessary.

1.9 For the vast majority of us, our contact with the NHS starts and finishes in the GP surgery and local pharmacy. For some of us, contact will continue to diagnostic tests and investigations, to seeing a specialist at an outpatient clinic, and getting inpatient or day case treatment where that is necessary. Every step of that way should be safer, quicker and more accessible. We cannot begin to meet individual needs when people are waiting too long for their diagnosis or their treatment. When someone waits 18 months for an operation or a first outpatient appointment that someone else is getting in 18 weeks in another part of the country, the system isn't equal or fair.

1.10 The principal focus of this paper is on that crucial measure of the delivery of NHS services, waiting times. Driving down waiting times for inpatients, day cases and outpatients is the critical next step to improve clinical outcomes and give better quality of

care and service to patients. We also intend to move on and tackle those conditions which affect the quality of life for so many people and deal with other issues of immediate concern to people in Scotland. Where their health services are, and the cleanliness of our hospitals are of critical importance to them. This paper points to the further action we are taking on these.

Quicker, better care

1.11 We are continuing to respond to the increasing demand for healthcare and to public priorities by boosting investment in the NHS. We have invested record sums since 1999, increasing financial investment by 63% in 5 years and continuing the trend for the next 3 years. This sustained investment means more staff, providing more services, using more modern equipment in more suitable buildings. It has laid the foundation for further progress and for better, quicker services for patients.

1.12 But investment must deliver results. In the 2003 Partnership Agreement, we pledged to ensure that no-one with a guarantee waited more than nine months for hospital treatment by the end of 2003, and more than six months by the end of 2005. We are keeping this pledge for nine months, and the annual trend shows that we are on course to meet the six month pledge. Our recent pledges on heart treatment are also being met.

1.13 It is important to remember too that the majority of people using the NHS in Scotland don't wait at all.

1.14 There have been big falls over the last year in the number of patients with a guarantee waiting over 6 months for hospital treatment in a number of specialities:

- 38% for general surgery;
- 40% for ophthalmology; and
- 46% for cataracts.

For coronary heart disease, our targets of 12 weeks (soon reducing to 8) for angiography and 18 weeks for angioplasty/coronary artery bypass graft have led the way across the UK.

1.15 This context is important – we are building on success. But we are dissatisfied and intend not just to go further and faster, but to work in a new way.

1.16 So to ensure that patients get the best and quickest treatment possible from the NHS, we are setting the following new targets:

By the end of 2007,

- no patient will wait more than 18 weeks from GP referral to an outpatient appointment
- no patient will wait more than 18 weeks from a decision to undertake treatment to the start of that treatment – down from the current 9 month maximum wait guarantee
- patients will be able to rely on shorter maximum waits for specific conditions –
  - 18 weeks from referral to completion of treatment for **cataract surgery**
  - 4 hours from arrival to discharge or transfer for **accident and emergency treatment**
  - 24 hours from admission to a specialist unit for **hip surgery** following fracture
  - and 16 weeks from GP referral through a rapid access chest pain clinic or equivalent, to **cardiac intervention**

1.17 These are radical improvements to the time required for the patient's journey through the system. In addition, for the first time we will set new standards for patients waiting for diagnostic tests and procedures, and we will announce these in spring 2005.

1.18 We are also changing how waiting times are defined and measured to make them clearer, more consistent, and fairer to patients. The new definitions will balance the responsibility of the NHS to provide care and treatment quickly with patients' responsibility to make sure they attend for appointments.

1.19 We will achieve this unprecedented improvement in waiting by:

- new and more efficient ways of working, such as using the skills of nurses and allied health professionals to take on more roles and give patients more choice
- better workforce planning to ensure that the right staff with the right skills are available in the right place to treat patients
- more investment in capacity within the NHS, including the Golden Jubilee National Hospital
- increased investment in new diagnostic and other equipment
- new diagnostic and treatment facilities operated by the independent sector for NHS patients
- new mobile diagnostic scanning units provided by the independent sector to improve access
- innovative new community health partnerships to further improve care and treatment outside hospitals
- more strategic and effective use of IT, focussed on developing the single patient record, to improve the patient's experience and make services more efficient

1.20 Combined with changes already happening such as new contracts of employment for NHS staff, these approaches will help the NHS to move towards the point where waiting times will no longer be a source of dissatisfaction for users of NHS services in Scotland.

Services as local as possible, as specialised as necessary

1.21 Shorter waits and greater convenience for patients are an important part of the future of healthcare. But this is not the whole story. People rightly want reassurance that services are being delivered safely and sustainably. Communities want to know that services will be available locally wherever possible. Patients requiring highly skilled interventions need to be reassured that services will be as specialised as they need to be to deliver quality care and the best possible clinical outcomes. Clinical teams that often undertake a complex procedure will get better results than clinicians who see and treat such cases infrequently.

1.22 Scottish Ministers have asked a group led by Professor David Kerr to look closely at these issues, and to involve the public, patients and staff of the NHS in a debate on a National Framework for Service Change. This will report in 2005. Its conclusions will be important in shaping the future pattern of healthcare services in Scotland, but they will not avoid the need for hard decisions in the interests of better healthcare.

1.23 The public and patients also want to know that hospitals in which they are treated will provide a clean and safe environment for healthcare. Scotland is leading the UK, with good progress already made - cleaning services standards are in place and a national cleaning services specification has been issued to all NHS Boards. But there is more to do, and there will be a further announcement in the new year.

1.24 The improvements in services and shorter waits described in this paper will require effective performance management across the NHS, on which we will make further announcements. Lead responsibility for this, and for achieving value for money and better services for patients through increased investment, lies with the Chairs of NHS Boards. The Executive will make sure that Boards have clearly understood targets aimed at better patient care, that there is a clear commitment from each Board to deliver these, and that all necessary actions are being taken to achieve them. Ministers will chair annual accountability review meetings, in public, to review and report on progress. Boards will be in no doubt what is expected of them: that increased resources must be matched by increased results. They will have the support of the Executive in delivering on these expectations for patients.

Conclusion

1.25 These are unprecedented measures for NHSScotland. Shorter waiting times targets, new standards for diagnostic waits, better and more complete definitions of waiting, and the investment and reform that we are taking forward to help ensure delivery add up to a major package of change, the next steps on the way to a twenty-first century health service, fair to all and personal to each.

2. Progress So Far

Reducing Deaths from Cancer and Heart Disease

2.1 Good progress has been made in reducing premature deaths from the 3 "big killers" – cancer, heart disease, and strokes. The overall mortality rate for the under 75s dropped from 486 per 100,000 in 1997 to 432 in 2003: the main reason for this was the reduction in death rates for cancer, heart disease and stroke. The combined rate for these 3 conditions – targeted for action by the Executive because of their impact on life expectancy - fell significantly from 302 per 100,000 in 1997 to 247 in 2003.

2.2 The number of women invited for breast screening has increased from 104,000 in 1997-98 to 110,000 in 2002-03, an increase of 6%. Screening helps to spot signs of cancer early so that quick and effective treatment can start. In 2001-02, we invested £10 million to support implementation of the cancer strategy, increasing to £25 million the following year and sustained at that level thereafter. The number of procedures to help restore blood flow to the heart without open heart surgery – known as coronary angioplasty - has increased from 2,400 in 1998-99 to 4,150 in 2003-04 – up by 75%.

2.3 Patients have benefited from improved cancer, heart disease and stroke services. For example, extra clinical staff have been recruited through the cancer programme: in Highland, an additional breast surgeon has helped reduce waits for first clinic appointments to 10 days. Stroke units have been established in Raigmore Hospital at Inverness and more recently at Ninewells Hospital in Dundee and at Victoria Hospital, Kirkcaldy. Patients benefit from co-ordinated services which result in higher survival rates and more people returning home to regain independence and enjoy a better quality of life.

Shorter Waiting Times

2.4 Good progress has been made with reducing waits experienced by patients making an appointment to see a member of their primary care team. From April 2004, a target has been put in place to ensure that patients can have access to an appropriate member of the primary care team – GP, nurse or other healthcare professional – within 48 hours. NHS Boards confirm that this commitment is being met. The new GP contract gives extra money for practices that meet the target.

> Mary is a patient at a GP practice in Lanarkshire. Before March 2004, when she needed to arrange an appointment, it was common to wait up to 20 days to see her GP. After the practice participated in the Scottish Primary Care Collaborative change and improvement programme, Mary is now able obtain an appointment with a member of the GP practice team the same or the next day.

2.5 Until 2001, the NHS took regular initiatives to reduce the number of patients on the inpatient and day case waiting list. This is the list of everyone who is waiting for admission to hospital for treatment. Patients are listed for a minor procedure not requiring an overnight stay (a day case) or a bigger procedure where an overnight stay is required (an inpatient).

2.6 Long waits for routine treatment are not desirable from a clinical point of view. And what really matters to patients is how quickly they will be treated, rather than how many others are waiting with them on the list. So since 2001, the Executive has focused priority on reducing the longest waits. Good progress has been made on waiting for inpatient and day case treatment. The NHS in Scotland met its maximum wait guarantee of 9 months by the end of 2003, and is on track to deliver the guarantee of 6 months by the end of 2005.

2.7 But while progress has been made on inpatients, outpatient waiting has risen over the last 3 years. Patients who are referred urgently are of course given priority but some patients with routine referrals are having to wait too long to be seen by a specialist with a view to diagnosis and to find out whether they need further treatment. The NHS is taking action to turn this round. While progress is being made in particular specialties and in some areas, the challenge is to bring all parts of the NHS up to the level of the best.

New Ways of Delivering Services

2.8 The NHS is making progress with new ways of providing care and treatment to patients that are faster and more convenient. Rapid access clinics for patients suffering from chest pain are operating in many parts of Scotland. The clinic in Paisley is staffed by a multi-disciplinary team to ensure prompt diagnosis and treatment. Patients can choose the time of an appointment to suit them, using an on-line system in the GP surgery. The next available appointment is currently within 2 working days.

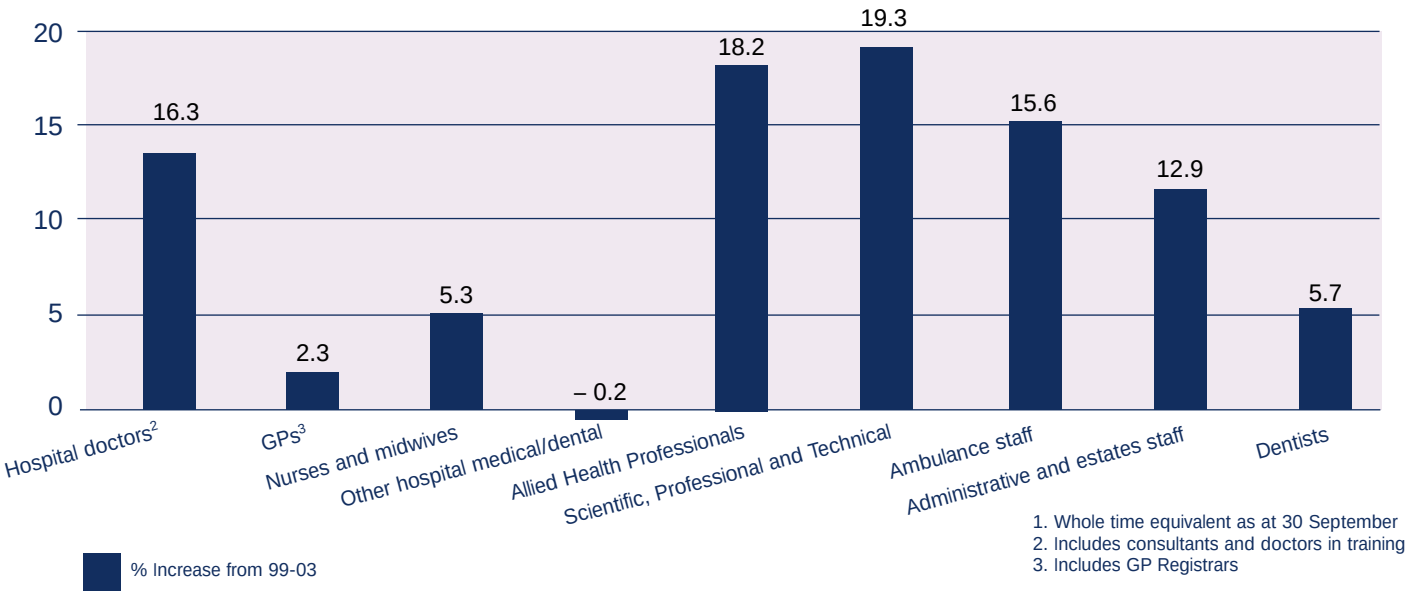
2.9 In Fife, a one stop cataract surgery service has had a dramatic impact on waiting times. By redesigning the service round a fully integrated cataract unit with its own operating theatre, the number of patients who can be seen and treated in a given time has more than doubled and the wait for routine treatment is now down from over a year to 25 weeks. And quality of treatment has improved by ensuring that the patient sees the same nurse all the way through their care and treatment.

More NHS Staff

2.10 The staff of the NHS are vital to patients' experience of high quality, rapid care and treatment. Many interactions between patients and NHS staff are one to one contacts. Patients want enough of a healthcare professional's time to enable good quality consultation, diagnosis and treatment. So more staff spending more time with patients helps improve patients' experience.

2.11 Between 1999 and 2003, an additional 11,000 NHS staff were employed in Scotland – including 1,150 more hospital doctors, 2,700 more nurses and 1,250 more allied health professionals such as physiotherapists, radiographers and speech and language therapists. The graph below shows by how much each staff grouping grew:

Increase in NHS from 1999 to 2003[1]



1. Whole time equivalent as at 30 September
2. Includes consultants and doctors in training
3. Includes GP Registrars

2.12 Administrative and estates staff as well as clinical and technical staff make a contribution to patient care. For example, additional secretarial support for consultants releases more of the doctors' time for seeing and treating patients. Administrative staff can help patients to have a better experience by speeding the process of making appointments.

Marilyn is a medical records manager with the NHS. Recently Marilyn has led her team to make big improvements in the way patients are booked for outpatient appointments. She has worked closely with clinicians to introduce patient focussed booking across many specialties in the hospital where she works. The team uses text message reminders among other innovative approaches to help ensure that patients are able to attend their appointments.

New Buildings and Equipment

2.13 Since 1999 substantial progress has been made in modernising and upgrading the physical fabric of the NHS in Scotland. For example:

- 8 new hospitals have opened, from a community hospital in East Ayrshire through 2 new general hospitals in Lanarkshire to a major teaching hospital – the new Royal Infirmary of Edinburgh.
- The Golden Jubilee National Hospital was purchased for the benefit of NHS patients in 2002. From that date, since it began working as an NHS hospital, activity has gone up from 2,500 procedures a year to over 13,000 procedures in 2003-04, with a further increase to 18,000 procedures planned for this year.
- £33 million has been committed to radiotherapy equipment modernisation. All 5 Scottish centres now have state of the art linear accelerators able to achieve better results for more patients. By the end of 2005-06 there will be 24 modern linear accelerators in Scotland.

Better Quality Healthcare

2.14 Consistently high quality healthcare in all parts of the NHS is what people expect. The Clinical Standards Board for Scotland was established in 1999. Its aim is to help deliver consistently high standards of quality in health care. Since a new, merged body – NHS Quality Improvement Scotland – was set up in 2003, a more focused and integrated approach is being taken to quality in the NHS in Scotland. Clinical standards have been set for breast, lung, colorectal and ovarian cancer; coronary heart disease; schizophrenia; diabetes; stroke and renal services, among others. NHS Boards' performance against these standards is reviewed regularly and full reports are published. There is evidence that clinical standards are being driven up as a result.

Better Patient Experience

2.15 People quite rightly expect their hospitals to be clean and safe, that NHS staff will treat cleanliness as a priority, and that they will receive acceptable food while in hospital. In the White Paper "Our National Health", published at the end of 2000, we set the objective of introducing standards for infection control, cleaning standards, and hospital food. All standards are now in place. Inspection reports have been produced or are in process. The Healthcare Associated Infection Task Force is leading a major effort to reduce the risk of infection in our hospitals. By publishing a comprehensive National Cleaning Services Specification, Scotland has taken a lead across the UK. The number of infection control nurses has risen by 66% between the beginning of 2003 and November 2004 and now stands at 138. And over 200 NHS staff have completed training in a new programme for cleanliness champions established in 2003.

Listening to Patients Better

2.16 In 1999 the Executive realised that more needed to be done by the NHS to inform patients and involve them in their treatment. And the public and communities had to be given a bigger say in deciding how and where healthcare services are delivered. A major programme of patient focus/public involvement activity has been underway since 2001. To help deliver our commitment to ensure that people with mental health problems, and other vulnerable people, have access to advocacy services we are supporting the Advocacy Safeguards Agency. The Executive has invited 100 members of the public to help provide an equality and diversity perspective to the NHS on access to service issues. These and other initiatives are helping to ensure that patient experience is given proper weight by Boards in developing services.

2.17 This approach is underpinned by a new statutory duty of public involvement laid on Boards in the NHS Reform (Scotland) Act 2004.

2.18 The new Scottish Health Council – which will be open for business in April 2005 – will monitor progress in improving patient focus and public involvement. The Council will work with the Service to develop and spread good practice. And we have very recently set the NHS a challenging new target: all NHS Boards will achieve year on year improvements in involving the public in planning and delivering NHS services and in involving patients in decisions about their own health care and the development of services. Progress will be assessed by the Scottish Health Council and their reports will be published.

3. Quicker, Better Care

3.1 We have laid the foundations and have made a start towards shorter waits. Now we need to do more to reduce waiting and to reinforce quality across all stages in the patient's experience of care and treatment. These stages begin with initial contact with a practice team at the local GP surgery or the community pharmacy, through diagnostic tests, seeing a specialist as an outpatient, and on to treatment as an inpatient or day case patient where necessary.

Primary Care

3.2 Recent figures illustrate the very large number of contacts already taking place: 26 million in the year ended March 2004, of which over 15 million were with GPs and over 9 million with practice nurses and district nurses. This represents over 90% of patient contacts with the NHS. We will **continue to ensure that the 48-hour maximum wait target is delivered** for the benefit of patients all over Scotland. This pledge will remain in place as numbers of consultations and patient contacts in primary care increase.

3.3 With service redesign and the expansion of staff roles, primary care staff will undertake more procedures. These range from drawing blood for diagnostic testing to undertaking minor surgery. And more people will have access to a wider range of services in their local surgery – provided for example by specialist nurses – that might previously have required a hospital visit.

3.4 Local diagnostic and treatment centres – such as Leith Community Treatment Centre in Edinburgh and Stracathro Hospital in Angus – are already able to offer local access to diagnostic services such as X-ray and endoscopy. This for many patients is a more convenient alternative to a hospital visit. We expect to see more local diagnostic and treatment centres develop as Boards work to ensure that waiting times targets are met.

Shorter Waits for Diagnostic Tests

3.5 Shorter waits for diagnostic tests and procedures will make a vital contribution to shorter waits overall. Up to now, the NHS has had no standards for waiting for routine diagnostic tests. So a patient might move rapidly to see a specialist as an outpatient but then wait months for diagnostic tests. Waiting can vary widely between different tests (eg MRI scans, barium meals, endoscopies - internal examinations using a micro-camera) and between different NHS Board areas. This is a frequent source of frustration to patients, who must put up with stress and uncertainty until a diagnosis is confirmed.

3.6 We aim to consign that to the past. We **have decided to set new waiting time standards for key diagnostic tests**. We are working with the NHS and others to decide what these should be and from when they will apply – but they will have the effect of reducing longest waits substantially. We will set and announce the new standards by Spring 2005. We aim to set these waiting times standards ahead of any other part of the UK, and will begin to measure and report performance as soon as possible.

3.7 Better IT, wider roles for nurses - in for example endoscopy services, more diagnostic capacity, and clear standards backed by performance management actions will all help ensure shorter waits.

Janice is a nurse endoscopist. To help tackle long waits for endoscopy, which has in the past been carried out by consultants, she trained last year to provide this service for patients. So far she has seen over 800 patients. They would otherwise have had to wait to see a consultant. With the success of the service Janice is now training to provide 2 additional types of endoscopy. Four other nurses in the NHS Board area are now training so they can expand this service further.

Shorter Waits for Outpatients and Inpatients

3.8 Waiting to be seen by a specialist or for treatment is not only frustrating, it can make a clinical condition worse, and mean that someone has to bear pain or disability for longer than they need to. So we have decided to set new, shorter outpatient and inpatient waiting times targets. Meeting these will take

the NHS further in the direction of providing responsive, patient-centred services. The new targets are for **a reduction to an 18 week maximum wait for both outpatients and hospital treatment by end-2007**. These new targets are tough but achievable because of reform and the new resources we are putting in. We estimate that achieving a maximum 18 week wait for hospital treatment and for outpatients **will benefit around 270,000 patients in Scotland each year.**

3.9 Meeting the new targets will require new ways of working to increase NHS productivity while maintaining quality standards. There are already examples of sharp reductions in waiting times through service redesign. The challenge is for all parts of the NHS to come up to the level of the best.

John has suffered from psoriasis, a skin condition, for 12 years. It flares up from time to time and he has had routine appointments over many years with the consultant dermatologist in Dumfries. The problem is that flare ups rarely happen at the time of his 6 monthly check-ups and travel to the hospital is 20 miles return. Following a review of how the outpatient service was organised, John now receives a phone call periodically from the consultant to check on his condition. He no longer travels at 6 monthly intervals to the hospital. If a flare up happens he gets an urgent appointment quickly instead of a routine appointment when there may be little need.

3.10 Illnesses that require urgent intervention like cancer and heart disease will continue to have their own shorter waiting times targets, so that patients will be seen and treated more quickly.

3.11 Expanded roles for healthcare staff are already making a vital contribution to shorter waits. We are also encouraging active benchmarking and other performance improvement actions among NHS Boards so that systematic progress can be made. If the reasons for variations in performance are understood properly, it is easier to improve performance in areas that are behind the best. We expect NHS Boards to take a close interest in performance improvement through benchmarking.

3.12 Strategic investment in IT will also help reduce waiting by improving efficiency, automating manual processes, and ensuring that the right information arrives where it is needed on time.

Targets for Specific Conditions

3.13 In addition to the new maximum overall wait targets, we will introduce new targets for condition-specific maximum waits. We are setting a **new stretching but achievable target for cataract surgery**. The maximum wait from referral by a GP or optometrist to surgery will be 18 weeks. This will be implemented across the NHS in Scotland by the end of 2007, bringing significant quality of life benefits to the 20,000 or so patients who need cataract surgery each year.

3.14 We are also introducing **a new waiting times target for patients seen in Accident and Emergency Units:** from the end of 2007, patients will wait no longer than 4 hours between arriving at a Unit and admission, discharge or transfer, unless there are stated clinical reasons for keeping the patient in the Unit. This maximum wait will also apply to all other emergency care in minor injuries units or areas of assessment units where trolleys are used.

3.15 When someone fractures their hip, risks are reduced and recovery is helped by undergoing surgery as quickly as possible. NHS Quality Improvement Scotland has already set a clinical standard that a patient entering a specialist orthopaedic unit for surgery following hip fracture should be operated on within 24 hours of admission. From the end of 2007, all orthopaedic departments handling trauma cases will comply with the **24-hour surgery target for hip fracture cases**, unless there are documented clinical reasons relating to the patient's condition that make this undesirable.

3.16 As we made clear in the early autumn, we have made a commitment that **from the end of 2007, no patient will wait more than 16 weeks for cardiac**

intervention. This target covers the period from GP referral through rapid access chest pain clinic or equivalent, to cardiac intervention thereafter. **For the first time, our new target includes the period following the GP referral and will cover more heart treatments, including heart valve surgery**. It is a reduction by 10 weeks on the current target and is significantly shorter than is available anywhere else in the UK. But more importantly, it will bring direct benefit to hundreds of patients and it will be achieved for them by the end of 2007.

3.17 But heart problems can show themselves in other ways than chest pain. To ensure that the full range of cardiac interventions is available to patients as quickly as possible, we are putting in place a further target. **From the end of 2007, no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment.**

Sylvia attended a surgical outpatient clinic in Glasgow in October 2002, where she met a surgeon to discuss her case. She had bypass surgery 15 weeks later in January 2003 – well within the previous target time of 24 weeks. This was a step change from the situation prior to 2002, when there were no formal waiting time targets at all. Henry, for example, had angiography in January 1999 and then had to wait over a year until February 2000 for bypass surgery. Since June 2004, we have brought waiting times for all patients to the kind of level that Sylvia experienced – no patient will wait more than 18 weeks for bypass surgery or angioplasty.

Clearer and More Consistent Definitions

3.18 By the end of 2007, the NHS in Scotland will calculate patients' waiting times on a different basis that will be **fairer, more open to scrutiny, more understandable, and which will help put patients at the centre of their care**. Waiting times will be calculated from the date a patient is placed on the waiting list to the date of an outpatient appointment or hospital admission for treatment. Availability status codes – which at present mean that some patients waiting for highly specialised or low priority treatment wait longer than the maximum waiting times - will be abolished. Patients who are waiting for such treatments will be admitted within the same maximum waiting times period as all other patients. Patients will have any periods of unavailability for medical, social or personal reasons subtracted from the calculated waiting time. Periods of unavailability will be reviewed regularly, so that no-one will remain unavailable for treatment for more than 3 months without a check on their status.

3.19 The new arrangements also mean that patients have to take responsibility for accepting and keeping a reasonable offer of an outpatient consultation or hospital admission for treatment. Patients who fail to turn up for an appointment or admission without prior warning will return to the start of the waiting queue, unless there are clinical or other compelling reasons for treating them more quickly. Effectively they will have their waiting times “clock” returned to zero. New patient-focussed booking systems, now being introduced across the NHS in Scotland, will help to ensure that patients have the opportunity to choose an outpatient appointment that is convenient.

3.20 These are huge changes and will bring substantial benefits to patients. Ending availability status codes means that no patient will be placed outside our waiting times commitments and very long waits will be eliminated. The arrangements will be open and transparent and will ensure fairness and consistency across Scotland. Patients will receive better information about what they can expect from the NHS in terms of maximum waits, about any change in their status, and what will happen next and when.

4. Delivering the Changes

4.1 Achieving the ambitious objectives we are setting means keeping up the momentum of progress and change across the NHS. NHS teams are already working hard to respond to the needs of patients. They demonstrate dedication, professionalism and skill. Investment and reform together will support the NHS to achieve the new targets for the benefit of all patients.

More Care and Treatment in the Community

4.2 The NHS is already making good progress in treating people at home and in the community. The Executive believes strongly that care should be delivered as close to home as possible, consistent with clinical safety and quality. People should be cared for in hospital only when absolutely necessary. Care and treatment capacity in primary and community care – already accounting for over 90% of patient contact with the NHS - needs to be taken further forward.

4.3 In future there will be better planning of unscheduled care and more people will be treated effectively in the community rather than bringing them into hospital. Resources will be targeted to help the NHS respond to the needs of patients most likely to find themselves receiving unscheduled care – the elderly, people with complex combinations of illnesses, and people who suffer from chronic conditions such as diabetes and asthma.

4.4 NHS Boards are being set a new target out of the Spending Review to give priority within primary care to identify and treat patients at heightened risk of emergency admission to hospital. Every Board must reduce the number of emergency admissions for people over 65. The target for individual Community Health Partnerships (CHPs) takes account of local circumstances and factors such as deprivation, the age of the population and the amount of chronic illness. This places responsibility squarely on CHPs to improve chronic disease management in the community through supporting particular patients. CHPs will achieve the target by targeting those most at risk in the community, particularly patients with multiple long term conditions, with monitoring, support and prevention, through approaches such as intensive case management and disease management.

4.5 Patients with diabetes are being helped to manage their condition better, by assisting GP practices to take a systematic approach to care and treatment. By sustaining the improvements already achieved through the diabetes collaborative project over the next 10 years, it is calculated that over 2,600 Scots will experience fewer complications, 1,750 fewer people will suffer stroke or heart failure and there will be 780 fewer deaths from diabetes. These improvements can be achieved as the collaborative project extends its reach.

4.6 As well as offering better care closer to home, reducing emergency admissions releases hospital resources to provide more planned treatment and therefore less waiting. It also reduces the number of patients whose discharge from hospital is delayed following an emergency admission. The experience of these patients is likely to be unsatisfactory. Delayed discharges mean less capacity to treat other patients waiting for surgery.

New Roles for Staff

4.7 The future of health services means developing clinical teams and clinical leadership from a wide range of health care professions. This approach will require a major shift from conventional service delivery to provision that is focused on the needs of patients and service users and communities. Nursing and the Allied Health Professions are at the forefront of developing role flexibility and integrated team working. We are currently consulting with the NHS on a new approach to role development that will help reduce waiting times and improve clinical outcomes in key priority areas.

Helen is a nurse in Glasgow. Previously to progress her career would have meant moving into management and away from hands-on care. But new ways of working now mean that Helen is leading a multidisciplinary team to provide better services to orthopaedic outpatients. She can now develop professionally without having to move away from improving patient care. And she is now able to make changes to services that dramatically improve the patient experience. One example of this is a new nurse-led arthroplasty (joint replacement) service. Helen is able to discharge her patients rather than wait on a doctor to do this. Patients are given contact details on discharge should any problems arise and direct access can be arranged.

Redesigning Services Round Patients

4.8 Service redesign works and can streamline patient contact. Listening carefully to patients, using technology and information effectively, and removing duplication and unnecessary work all help to increase NHS effectiveness and thus reduce waiting and improve the patient experience. Waiting times improvements of up to 80% have been achieved through successful use of service redesign methods in NHS Boards in Scotland.

4.9 NHSScotland continues to redesign key services. Over the next 3 years, it will develop and implement more programmes focused on helping to deliver the 18 week maximum wait targets for both outpatients and inpatients, building on its existing programmes within primary care, outpatients and cancer which are already improving patient access. These programmes target all aspects of the patient experience including booking, primary care, outpatients, diagnostic services, theatres, inpatient and day case services.

4.10 For example, as a result of service redesign work, in one Scottish hospital the level of patient cancellations for new Ear, Nose and Throat consultations fell from 18% to 6% while in another, checking that the patient still needed their appointment reduced waiting times in Oral Surgery from 61 weeks to 17 weeks.

4.11 Major improvements can be made through designing processes round patients.

Conor is a patient at Yorkhill Sick Children's hospital. He has attended clinics there with his mother for some time. In the past, the hospital wrote to Conor's mother and told them when their appointment would be, whether or not it suited them. Conor's mother is a single mum and works full time. Now Yorkhill have introduced Patient Focussed Booking, Conor and his mother receive a letter 6 weeks before the likely appointment. The letter asks them to call Yorkhill and agree a day and time that suits them. This is much more convenient and can be fitted around major work or school commitments.

More Capacity

4.12 Alongside service redesign and reform, additional capacity will be provided within the NHS and from the independent sector, targeted at reducing waiting. The Executive will increase capital investment in the Golden Jubilee National Hospital at Clydebank over the years to 2007-08 to **bring all of the available floor space into intensive clinical use**, and we will provide extra revenue funding to pay for the staff who will care for patients in these new wards. As a result, we expect the Golden Jubilee to be able to carry out 10,000 extra procedures annually by 2007-08 when all of the additional capacity and staff are in place – taking the total number of procedures to 28,000 each year. Further expanding capacity at the hospital is a good way of ensuring that new money goes directly into reducing waiting times.

4.13 To help the NHS meet the challenging new heart treatment guarantee, **new investment of up to £12 million over 3 years** will go into improving facilities and increasing capacity in treating coronary heart disease. This will enable more patients to be treated quickly. In 1999, the national maximum waiting time guarantee for adult cardiac surgery was 12 months. Currently, patients wait no more than 18 weeks for heart bypass surgery or angioplasty. The new investment will help push waiting times for all cardiac interventions down to the 16 weeks guarantee.

4.14 Tackling waiting for diagnostics is a key aim. As well as being committed to maximising utilisation of all existing diagnostic equipment, we will, as part of our capital investment plan, put an additional £125 million into new medical equipment over the next 3 years. This will include provision for both replacement and additional diagnostic equipment. We will back this up with increased revenue resources that will help to pay for training, staff and related costs, and redesign programmes to ensure that the new equipment delivers reduced waiting times. In addition we will support initiatives to build radiology capacity that explore new roles for radiography staff such as radiography consultant posts as well as specialist and assistant practitioners. We will commit this additional investment on the basis that NHS Boards accept responsibility for delivering the additional activity and shorter waits that patients expect and that the investment makes possible.

In Lanarkshire, Marie helped to start a new nurse-led biopsy service – taking tissue samples for analysis - to reduce waiting times for this important diagnostic test. This new service means that when patients see a consultant and a decision is made to take a biopsy, this can be done right away without a second wait to see a doctor. Feedback from patients shows that they are very happy with the new nurse-led service.

4.15 Plans for increasing NHS capacity through investing in new walk-in, walk-out hospitals (also known as ambulatory care and diagnostic centres or ACADs) are well advanced in Glasgow, and treatment centres are already in operation for example at Stracathro in Angus and in Leith.

Using the Independent Sector

4.16 We will fund arrangements with the independent healthcare sector for **new diagnostic and treatment facilities, catering for NHS patients and offering rapid diagnosis and care**. We will require the independent sector to work to strict rules designed to avoid recruitment of NHS staff in Scotland, which would simply cause shortages in NHS hospitals.

4.17 The Executive will also work with the NHS to negotiate cost-effective contracts with independent healthcare providers to purchase additional imaging capacity. This is likely to take the form of **new flexible, fully-staffed mobile scanning units** to provide more and quicker diagnostic testing for NHS patients. Such units are already in use under contract to the NHS in Scotland. The NHS must be satisfied that such contracts demonstrate value for money and better services for patients. As with our plans for new diagnostic and treatment facilities, we will insist on contract terms to prevent staff being "poached" away from the NHS.

4.18 In addition, we will negotiate contracts with the independent healthcare sector worth up to £45 million over 3 years to **enable NHS patients to receive their operations more quickly** where clinical quality and value for money can be guaranteed. **This will help the NHS secure treatment for patients currently waiting longer than 18 weeks for surgery**. We will target orthopaedic surgery, where there is rising demand from the ageing population.

Better IT

4.19 Investment in modern IT will help achieve a more efficient and integrated service, cutting out wasted effort in looking for paper notes, test results and letters. The eHealth Strategy will ensure that all the necessary information is available where and when it is needed.

4.20 We will target investment in our IT systems on efficient management and monitoring of each stage of care and treatment. At the heart of this will be powerful systems to help manage waiting lists and report on performance.

4.21 The IT Strategy for NHSScotland has 2 key objectives. First, sharing of patient record information among all members of the clinical team to support better care for the patient. And second, to fill gaps where modern IT systems are still not in place. For example, a national project is providing Picture Archiving Computer Systems (PACS) to store medical images such as X-rays in digital form allowing them to be transmitted electronically to where they are needed.

4.22 The aim is a single electronic clinical record for each patient in Scotland, with strict controls over access. This will help improve care for, for example, patients who move around Scotland and for patients with chronic disease.

4.23 These developments are vital to improving the patient's experience and to increasing the efficiency and effectiveness of the NHS. They will also enable the NHS to communicate better with patients. As in other large organisations, IT lies underneath the surface but is absolutely vital to ensuring that people, information and equipment are in the right place at the right time to serve patients well. Any service that aims to be fit for the 21st century and which deals with large numbers of users, working to increasingly short timescales, must use modern, well designed IT systems if it is going to succeed.

4.24 Our ultimate goal is to make it easier for patients to become directly involved in their healthcare through electronic access. Already trials are underway. For example in Irvine, patients with the Townhead GP practice are able to securely log on to a Patient Online System to book appointments, renew prescriptions, and get test results with their GP's comments. We will learn from this and similar work to develop more large scale plans.

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