



centre for research on
families and relationships

CRFR Policy Scoping Seminar
Health
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Key Points

- The experience of health and illness and the ways in which health (and social care) services are delivered has a significant impact on families and relationships. With the more recent focus on patient experience within health strategy there are clear opportunities to research the impact of many of the initiatives outlined below.
- Health Policy is strongly influenced by the Government under the direction of the Cabinet Secretary for Health and Wellbeing, currently Nicola Sturgeon. Since devolution there has been a continuous stream of health strategy and policy which directs the delivery of services in each of the 15 Health Boards. Whilst there are similar issues affecting health policy in Scotland and England the actual structures, funding mechanisms, culture and strategies are very different. Scotland is recognised as having much more central control and uniformity in terms of policy implementation.
- Patient Focus and Public Involvement (PFPI) is an important element of how health policy is determined and delivered. There are clear opportunities for CRFR to engage in the consultation processes that tend to go alongside most strategic reviews.
- There is a very strong performance management culture with emphasis on achievements of targets relating to health improvement, efficiency, access and treatment. This is also underpinned by regular quality inspection and assessment under the auspices of NHS Quality Improvement Scotland (NHS QIS).
- Tackling health inequalities is a strong driver, particularly focussed on the key health priorities coronary heart disease, cancer and mental health.
- The management of long term conditions has become a key focus in recent years in terms of service redesign, with strong focus on shifting care from acute to community services and fostering patient's skills and support for self-management.

Introduction

NHS Health Policy is a devolved power underpinned by the Scottish Government's five strategic objectives:

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.

The key drivers for all health strategy are a range of demographic features including:

- **Scotland's Population** – 5% increase predicted by 2031 (mainly immigration), then decline.
- **Age Profile** – 31% increase in pensioners by 2031, 81% increase in >75s by 2031
- **Long Term Conditions (LTC)** – 24% adults have a long term condition, health problem or disability. Two thirds >65s have LTC
- **Health Inequalities** – 10.7 year gap between men in least and most deprived areas (Women 6.8 years)

(Scottish Government 2007)

The impact of these trends is not solely on the demand for healthcare but the ability of the NHS to deliver the services required. This concern is based on its own workforce profile (which is also aging and changing in terms of those choosing health as a career), which may be seriously challenged to support increasing health needs. These factors point to a strong need for service redesign, radical changes to models of healthcare delivery and an overarching shift in the balance of care from acute services to primary care.

Working towards a 'Healthier Scotland' has three main components - health improvement, tackling health inequalities and improving the quality of healthcare. There is a very strong driver directed toward empowering individuals to increase their own role in the maintenance and improvement of their health, which focuses strongly on self management for those with existing conditions. This places demands on the health services to change the way it works, to change its culture (from previous paternalism to partnership and shared decision-making) and to provide resources and skills to support patients in this arena.

Physical and mental health and ill-health have the potential to impact on families and relationships at every level and across the life span including pre-conception, antenatal care, childhood illnesses, long term conditions, sensory impairments, accidents and dementia. Core over-riding themes of specific relevance to this context include:

- Tackling health inequalities with particular emphasis on early year's interventions
- Management of long terms conditions with focus on self care
- Recognising and supporting the role of carers

There is increasing recognition that health policy is not limited to the role and function of the NHS but to the inter-relationship between agencies particularly local authorities and the third sector, and there has been a clear shift in policy to promote inter-agency working.

Financial position

There has been significant investment in health services in the last few years, with an average annual uplift of 6%. It is clear that with the economic downturn NHS funding is going to be significantly reduced in the next few years. Current estimates for 2010 are an increase of only 0.7% with a zero percent uplift for 2011. With factors such as agreed pay awards in place, pharmaceutical costs etc it is evident that there will be, in effect, a reduction in health funding on a scale that has not been seen for many years. Whilst the Government is unlikely to cut front-line services, it is clear that there will be challenges ahead in terms of delivery and maintenance of services in their current format. There is, therefore, a very strong emphasis on efficiency measures.

1. Health Policy

Health Policy is principally directed by the Government's Action Plan **Better Health, Better Care** (2007) which sets out an ambitious 5 year programme of work centred on three core areas:

1. Towards a **Mutual** NHS.
2. Helping people to sustain and **improve their health**, particularly in disadvantaged communities.
3. Ensuring better, local and faster **access to healthcare**.

NHS Policy is translated into local delivery plans in each Health Board (15 in Scotland) and are driven by clear performance management in the form of 29 **HEAT** targets which are set annually by the Government (Appendix 1 details the 2009/2010 targets). Within each category there are a number of targets with specific relevance to families and relationships:

- **Health Improvement** - improving life expectancy and healthy life expectancy – including focus on weight reduction in children, smoking, alcohol and breastfeeding;
- **Efficiency and Governance Improvements** - continually improve the efficiency and effectiveness of the NHS;
- **Access to Services** - recognising patients' need for quicker and easier use of NHS services – including treatment to support drug misusers and access to child and adolescent mental health services;
- **Treatment Appropriate to Individuals** - ensure patients receive high quality services that meet their needs – including reduction in prescribing of anti-depressants (and introduction of associated support structures), increasing the number of older people with complex needs remaining at home and early diagnosis and intervention for people with dementia.

Within the NHS the 'target culture' is very real and has a significant impact on priorities, funding allocation and service redesign.

2. Mutuality

The principle of **mutuality** derives from the public ownership of the NHS and is based on the premise of co-production through significantly increasing public involvement, improving the patient experience, clearer patient rights (and responsibilities) and enhanced local democracy in Health Boards. It also includes offering patients the opportunity to take more control of their health. The translation of this principle into action is evident through:

- **Patient Focus, Public Involvement** – requirements at every level of health organisations to have patient and public representation in decision-making.
- **Patient's Bill of Rights** (final Bill yet to be published following consultation) likely to address:
 - Enshrined right to expect services (including waiting time guarantees)

- Responsibilities
- Involvement and support in decision making about own health and health services
- What can be expected if things goes wrong
- **Better Together Programme** –new improvement programme to gather feedback from patients and staff in order to improve NHS services.

Mutuality also extends to the principles of partnership working with individual patients surrounding clinical decision making about their care and facilitating self care.

3. Health Improvement

3.1 Health Inequalities

Tackling health inequalities was identified by the Cabinet Secretary Nicola Sturgeon as the top priority for the Government's health strategy. This led to the establishment of a Ministerial Taskforce to develop an understanding of deep-seated causes of health inequalities and turn it into practical action through the publication of *Equally Well* (Scottish Government 2008). Some of the headline statistics in this sphere point to a strong relevance of this agenda to families and relationships both in terms of impact of health inequalities, intergenerational influences and the interplay between targeted health interventions, family structures and support mechanisms.

- In Scotland in 2006, healthy life expectancy at birth was 67.9 years for men and 69 years for women. In the most deprived 15% of areas in Scotland in 2005-06, healthy life expectancy at birth was considerably lower at 57.3 years for men and 59 years for women.
- A higher proportion of babies born to mothers living in the most deprived fifth of the population have a low birth weight than those born to mothers living in the most affluent areas (9% compared to 5% in 2004-05).
- In Scotland in 2006, people who had a low household income, or reported finding it difficult to manage on their household income, had poorer mental wellbeing than those with a high household income or who reported finding it easy to manage on their income.
- There are large and increasing relative inequalities in deaths amongst young adults due to drugs, alcohol, assault and suicide.
- In Scotland in 2006, more than two thirds of the total alcohol-related deaths were in the most deprived two fifths of areas.
- Those living in the most deprived 10% of areas of Scotland have a suicide risk double that of the Scottish average.
- Adult smoking rates increase with increasing deprivation. In Scotland in 2005-06, smoking rates ranged from 11% in the least deprived 10% of areas to 44% in the most deprived 10%.
- Compared with the non-South Asian population, the incidence of heart attacks in Scottish South Asians is 45% higher in men and 80% higher in women.
- Lesbian/gay/bisexual and transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use.
- Just under a quarter (24%) of all individuals in households with at least one disabled adult or disabled child are living in relative low income, compared to 16% of those in households with no disabled adults or disabled children.

In order to reduce inequalities in healthy life expectancy and wellbeing generally, the Task Force has identified priorities areas for action:

- Children's very early years, where inequalities may first arise and influence the rest of people's lives.

- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.
- The "big killer" diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

In the light of these priorities, and evidence about what causes inequalities in health, the Task Force has agreed key principles to drive the work. These include:

- Improving the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health.
- Addressing the inter-generational factors that risk perpetuating Scotland's health inequalities from parent to child, particularly by supporting the best possible 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.
- Delivering health and other public services that are universal, but also targeted and tailored to meet the needs of those most at risk of poor health. We need to prevent problems arising in the future, as well as addressing them if they do.

These principles emphasise engagement with families and recognition of the significance of many of the core issues surrounding poverty, access to services for people from disadvantaged groups and support to parents in a child's early years.

Key opportunity for CRFR to inform policy decisions that examine inequality issues and to engage in research that examines impact of some of the initiatives in the context of family structures and the influence these have to bear.

3.2 Management of Long Term Conditions

There are two million people in Scotland with long term conditions. The management of LTCs such as chronic obstructive pulmonary disease (COPD), asthma, epilepsy, diabetes, chronic heart disease and cancer is, therefore, a clear health priority and directs a significant proportion of all health strategy (including several of the HEAT targets) in Scotland. Living with a long term condition at any stage of life has an impact of families and relationships. A **Long Term Conditions Collaborative Programme** (LTCC) has been established which will utilise quality improvement tools and techniques to deliver improvements in patient centred services and change the way care is provided for people with long term conditions through focus on three areas:

1. Self Management
2. Condition Management
3. Complex Care / Case Management

This is a complex area that involves considerable inter-agency working between health, community care, carers and the third sector. The **Long Term Conditions Alliance** which is made up of many voluntary groups and charities that deal with different conditions is a crucial player in the LTC agenda and works both in collaboration with NHS Scotland but also maintaining pressure and focus on patient and carers priorities. **Living Well with Long Term Conditions** (Scottish Government and Long Term Conditions Alliance 2007) sets out the expectations of people with LTCs who call for:

- Better involvement in decision making – with recognition of own expertise
- Recognition and support for the role of carers by NHS staff, including increasing respite services

- Improved communication with all parties about conditions and services (from all sectors)
- Appointment of key worker from the NHS

The NHS response to the LTC agenda is wide ranging and is detailed in a comprehensive document **Long Term Conditions Collaborative: High Impact Changes** (Health Delivery Directorate Improvement and Support Team 2009) in terms of creation new services including case management in primary care, telemedicine, communication via range of media (including text and email direct to patients), education and training, commissioning peer group support, fostering culture change for health professionals from paternalistic to one that empowers and enables and focuses on prevention, anticipatory care and early intervention.

3.3 Self Management

The Scottish Government and Long Term Conditions Alliance jointly published '**Gaun Yersel**': **The Self Management Strategy for Long Term Conditions in Scotland (2008)** which calls for:

- People to have more access to high quality information about their condition and its impact on their life.
- People to have more access to support including peer support.
- Increased provision of emotional and mental health support for people with long term physical conditions.
- A change in culture so that people- those receiving and those delivering services - have the confidence and capacity to work together as partners.
- Better partnerships working by NHS, voluntary sector and local authorities.

One of the first key outcomes from this strategy has been the release of a Self Management Fund for Scotland (£2 million per year, over the next two years) which is available to voluntary organisations and community groups throughout Scotland to support work to encourage people living with long term conditions to learn more about the management of their condition, and to become active partners in their own care. There will be an emphasis on the development of innovative and the LTCAS capture learning gained through the projects and share this widely across Scotland.

Within cancer services the language is of supported self management and focuses on what can be *added* to the existing services, not *instead* of existing services and about working together in a supportive way throughout the whole patient journey of care. The model is person centred and includes the following components at different stages across a pathway of care:

- Prompts and questions to ask
- Who to contact
- Information and resources
- What can I do for myself?

Key opportunity for CRFR to engage in evaluation of the use of Self Management Funds and how they impact on families where the focus of management of a long term condition has involved increased elements of self management.

3.4 Carers Strategy

It is estimated that there are 600,000 carers in Scotland. The Scottish Executive introduced a Strategy for Carers in 1999 which focussed on the following priorities:

- The promotion of new and more flexible services for carers, including respite care, at a local level.
- The introduction of national standards for such services.
- The need for monitoring by the performance of health and social services in supporting carers.

- The introduction of carers' legislation to allow carers' needs to be met more directly.
- The provision of better and more targeted and information for carers at a national level.
- Attention to the specific needs of young carers.

In 2006 there was a specific directive to all Scottish Health Boards to formulate their own **Carer Information Strategy** which aims to ensure that carers are well informed and supported in their caring role. This includes access to information, consideration of their own health and well-being, time off / respite, emotional support, training and support to care and a voice.

Key opportunity to become engaged in evaluation of impact of the Carer Strategy and how this is being perceived by family carers.

3.5 Children and Young People's Health

Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland (Scottish Government 2007) identified key concerns about the health and wellbeing of children and young people including:

- **Increase in prevalence** of some conditions:
 - diabetes – Scotland has one of highest rates in world for this condition
 - cancer - although survival rates have also improved substantially during the same period the number of children in Scotland developing cancer each year has increased by over 20% between 1975-79 and 1995-99.2
- **Vulnerability** - placing their well-being at risk to the wider societal changes, challenges and inequalities that affect their parents and carers:
 - 40-60,000 children in Scotland have a drug abusing parent and up to 100,000 live in households where one or more parents has an alcohol problem.
 - Over 12,000 children and young people are looked after by Local Authorities. Within this group over 40% have emotional or mental health problems.
- **Mental health** - As many as 10% of children aged 5-15 years have clinically diagnosed disorders of mental health. Young carers, of whom there are over 16,000 in Scotland, are twice as likely as their peers to have mental health issues.
- **Medical advances** - children who would previously have succumbed to extreme prematurity or serious chronic illness are enabled to survive through childhood and beyond. Around one-third of very low birth weight babies (<1000gm) will be disabled, about half of them severely. A specific strategy will be developed for children and young people with **complex needs** (see 4.6)
- **Deprivation and social exclusion** - the gap between the most and least affluent is widening and in some areas life expectancy is actually falling. Death in childhood is rare but mortality rates for children are nearly twice as high in the most deprived sectors of the community compared to more affluent areas. Teenage girls who live in areas of deprivation are three times more likely to become pregnant.
- **Changing social pressures and cultural attitudes** - result in changing patterns of behaviour-dependent health issues
 - By age 13, 6% of children describe themselves as regular smokers rising to 19% by age 15.
 - By Primary 7, 11% of schoolchildren are classified as "severely obese", a further 8% are clinically obese and in total 34% are overweight or obese.
 - 35% of 15 year olds report at least occasional drug use with 4% using drugs most days.

- None of the top ten leisure activities Scottish 11-16 year olds describe as “things they are most likely to do in a typical week” involves sport or physical activity.
- **Workforce challenges** - Many child health teams have less than the recommended medical consultant numbers required to provide 24 hour/7 days a week cover with some specialist services having only one or two providing a service for Scotland or their local area. This particularly affects child and adolescent mental health teams (CAMHS). Rural areas of Scotland often have few, if any, clinical staff specialising in the care of children.

4. Improving the Quality of Care

There are a range of strategic documents focussed on specific diseases, services and elements of care. Most will have relevance for families. A few recent documents have been selected for information.

4.1 Living and Dying Well

Living and Dying Well (Scottish Government 2008) uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland. Palliative and end of life care are described as being integral aspects of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable condition. The strategy emphasizes that palliative care is not just about care in the last months, days and hours of a person’s life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards. It advocates that a palliative care approach should be used as appropriate alongside active disease management from an early stage in the disease process. The emphasis throughout is that palliative care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement. The strategy focuses on four key areas:

- Assessment and review of palliative and end of life care needs
- Planning and delivery of care for patients with palliative and end of life needs
- Communication and co-ordination
- Education, training and workforce development

4.2 Better Cancer Care: an Action Plan

It is projected that the number of people diagnosed with cancer is likely to rise to nearly 35,000 per annum between 2016 and 2020 from the current levels of around 30,000 patients per year. This reflects the impact of Scotland’s ageing population as well as improvements in diagnosis. More people will also be living longer after their cancer diagnosis. **Better Cancer Care** (Scottish Government 2008) presents a detailed action plan that focuses on

- Prevention
- Early detection
- Genetic and molecular testing
- Referral and diagnosis
- Treatment
- Living with Cancer
- Improving the quality of patient care.

As with most strategies there is a focus on the need for targeted to tackle persistent levels of inequality since people living in deprived areas are more likely to be diagnosed with cancer and have a higher death rate than those who live in more affluent areas.

4.3 Co-ordinated, Integrated and Fit for Purpose, A Delivery Framework for Adult Rehabilitation in Scotland

The need for a successful, comprehensive rehabilitation service is described in **A Delivery Framework for Adult Rehabilitation in Scotland** (Scottish Government 2007) which focuses on three key groups - older people, people with long-term conditions and people returning from work absence and/or aiming to stay in employment (vocational rehabilitation). The report describes the development of models which identify opportunities for early intervention, with emphasis on self management and health promotion, utilising community culture, leisure centres, lifelong learning opportunities and voluntary agency services. It recommends development of a systematic approach to delivering rehabilitation to individuals by providing effective integrated services. The strategy includes:

- the establishment of local rehabilitation co-ordinators in each NHS Board
- a national rehabilitation group to oversee the implementation of the framework
- a managed knowledge network to ensure health and social care practitioners and service users can access up-to-date evidence on rehabilitation

The Government has pledged a £2 million support package to roll out the recommendations.

4.4 Towards a Mentally Flourishing Scotland

Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 (Scottish Government 2009) was published May 2009. It lays out the Government's plans to support: the promotion of good mental wellbeing; reducing the prevalence of common mental health problems, suicide and self harm; and improving the quality of life of those experiencing mental health problems or mental illness. The policy document deals with mental wellbeing as well as mental illness and mental health problems. Mental wellbeing includes both *how people feel* – their emotions and life satisfaction – and *how people function* – their self acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy. It argues that some people who experience mental illness *may* have a good quality of life and experience good mental wellbeing. Others who do not experience mental illness *may* nevertheless have poor mental wellbeing and a poor quality of life. Mental health **improvement** refers to activity to promote good mental wellbeing in the general population; to reduce the prevalence of common mental health problems; and to improve the quality of life for those experiencing mental health problems or mental illness. The approach is based on a social model of health which recognises that mental state is shaped by social, economic, physical, and cultural environment, including people's personal strengths and vulnerabilities, their lifestyles and health-related behaviours, and economic, social and environmental factors.

4.5 Keep Well

A key priority for the Scottish Government is to strengthen and enhance primary care services in deprived areas to reduce health inequalities. To support this, the Keep Well programme is piloting an anticipatory care model within geographic communities of greatest need. The Keep Well programme has provided extra resources for primary care services in deprived areas, primarily for additional staff to identify, contact and offer health checks and risk assessment to those who may be at risk. Keep Well is now entering its second phase and Well North has been established to extend and adapt the model to remote and rural Scotland. As part of wave two of Keep Well work will be targeted to specific populations including: homeless people; travelling communities; and prison populations.

4.6 Children and Young People's Health

Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland (Scottish Government 2007) sets out a structured programme of actions, drawn primarily from existing policy initiatives and commitments in response to the factors identified in 3.5. There is a strong emphasis on interagency working, including education.

The delivery of the *Action Framework* presents a major challenge. To support that delivery process the *Action Framework* includes progress measures for each element of the programme which will act as markers of change and improvement and will allow progress to be monitored and managed over time. The ultimate outcome must be a pattern of support, intervention and service delivery that meets the needs of current and future generations of children and young people in ways that are:

- targeted to the health challenges of the 21st century
- based on the best available evidence
- designed to protect and promote health as well as treating disease
- capable of addressing the needs of children who may be vulnerable or at risk
- centred on children, young people and their families
- delivered consistently and equitably throughout the country and are fully integrated with the more wide-ranging cross

4.7 Children and Young People with Complex Needs

Service Provision for Children and Young People (CYP) with Complex Needs in a Community Setting from the Perspectives of Nursing and Allied Health Professionals

(Scottish Government 2009) was published in June 2009 as one of the recommendations from the Action Framework. This research report set out to:

- Review the UK and international literature on the models of care for CYP with complex needs in the community.
- Present a picture of where CYP currently receive care (multi-agency); knowledge and skills involved in providing that care; and the issues facing the service.

The term complex needs encompass children with a range of conditions and medical needs. The agreed definition is *“A child with multiple and complex disabilities has at least two different types of severe or profound impairment such that no one professional, agency or discipline has a monopoly in the assessment and management.”*

Delivering a Healthy Future (Scottish Executive 2007) states that there are approximately 7000 CYP with a range of complex needs at any one time in Scotland, but this figure needs to be kept under review as criteria change and services develop. For example, it will decrease if only the most stringent criteria are applied but is likely to increase with increasing survival rates of pre-term infants; those born with congenital impairments and cancer; and the improved prognosis. Some key elements of the findings include:

- **Integration and delivery of services** - CYP with complex needs are increasingly managed in the community and this has implications for the transfer of resources from acute to community settings to ensure that quality services are delivered to the right person and at the right time. There was evidence that practitioners were using, or were moving towards, a person centred model of care, with the child and the family at the centre. This increases the need to integrate services, and strengthen partnerships and collaborative working.
- **Service capacity and capability** - A lack of suitably qualified staff was a recurring theme in the research. It was felt that there was not enough staff with the appropriate level of expertise to deliver the necessary services. Lack of available qualified staff with appropriate expertise and experience was also felt to inhibit the scope for developing capacity within the workforce.
- **Equity and gaps in service provision** - While there was a broad acceptance of the need to move towards a model of family centred or child-centred service delivery, practitioners were not confident that the needs of CYP with complex needs in the community were being met, or that the views of this client group were being taken into account, particularly in relation to service planning and implementation. This was particularly true for families in rural and remote areas and those less able to fight for the needs of their child. In general, issues relating to age-appropriate services were highlighted at particular transition points. The “in-betweeners” i.e. adolescents and young people, were felt to be particularly disadvantaged.

Transition arrangements across sectors and between different services were often felt to be at best inconsistent, and at worst, non-existent. Constraints within children's services, and the inappropriateness of adult services, were perceived

- **Communication and information** -The number of practitioners involved with CYP can lead to duplication of record keeping, frustration on the part of families and young people and considerable potential risk in terms of safe case management. Participants suggested that one way of addressing this issue was the use of joint record keeping within and across services however, there was little evidence of shared assessments in use.

5. Future Policy

Scotland's first Dementia Strategy is due for publication in late 2009. The care and treatment of people with dementia and support for their carers has become a key priority not only for the NHS but social care.

Conclusions

The health policy arena is a dynamic field, heavily influenced by the Government of the day. Scotland has many challenges in terms of its health and population demographics and the delivery of health care can be strongly influenced by geography, particularly for communities in remote and rural areas. The emphasis on reducing health inequalities and recognition of the need to shift the balance of care to the community with focus on self management and support for carers carries strong relevance for CRFR.

References

- Health Delivery Directorate Improvement and Support Team (2009) Long term Conditions Collaborative; High Impact Changes. Available online
<http://www.scotland.gov.uk/Publications/2009/03/06084301/0>
- Scottish Government (2007) *Better Health, Better Care: Action Plan* Scottish Government
- Scottish Government (2007) *Co-ordinated, Integrated and Fit for Purpose, a Delivery Framework for Adult Rehabilitation in Scotland*
<http://www.scotland.gov.uk/Resource/Doc/166617/0045435.pdf>
- Scottish Government (2007) *Delivering a Healthy Future an Action Framework for Children and Young People's Health in Scotland*
<http://www.scotland.gov.uk/Resource/Doc/165782/0045104.pdf>
- Scottish Government and Long Term Conditions Alliance (2007) *Living Well with Long Term Conditions*.
- Scottish Government (2008) *Better Cancer Care: an action plan*
<http://www.scotland.gov.uk/Resource/Doc/242498/0067458.pdf>
- Scottish Government (2008) *Living and Dying Well a national action plan for palliative and end of life care in Scotland*
<http://www.scotland.gov.uk/Resource/Doc/239823/0066155.pdf>
- Scottish Government and Long Term Conditions Alliance (2008) *'Gaun Yersel': The Self Management Strategy for Long Term Conditions in Scotland*
http://www.ltcas.org.uk/fileadmin/ltcas/PDFs/LTCAS_gaun_yersel_.pdf
- Scottish Government (2008) *Equally Well: Report of the Ministerial Taskforce on health inequalities*
<http://www.scotland.gov.uk/Publications/2008/06/25104032/0>
- Scottish Government (2009) *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*
http://www.scotland.gov.uk/Resource/Doc/271822/0081031_.pdf
- Scottish Government (2009) *Service Provision for Children and Young People with Complex Needs in a Community Setting from the Perspectives of Nursing and Allied Health Professionals*
<http://www.scotland.gov.uk/Resource/Doc/274582/0082183.pdf>

Websites

Better Together

http://www.bettertogetherscotland.com/bettertogetherscotland/CCC_FirstPage.jsp

Carers Scotland

<http://www.carerscotland.org/Home>

Long Term Conditions Alliance

<http://www.ltcas.org.uk>

Keep Well Scotland

<http://www.keepwellscotland.com/>

Appendix 1 HEAT Targets 2009/10

Those seen to be of specific relevance to families and relationships have been highlighted.

Health Improvement

1. 80% of all three to five year old children to be registered with an NHS dentist by 2010/11.
2. Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.
3. **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.**
4. 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.
5. Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 - 2010/11.
6. **Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.**
7. Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2009-10.

Efficiency

1. NHS Boards to deliver agreed improved efficiencies for 1st outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011.
2. NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.
3. NHS boards to meet their cash efficiency target.
4. To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010.
5. NHS Scotland to reduce emissions over the period to 2011
6. Achieve universal utilisation of CHI (radiology requests)
7. NHS Boards to ensure at least 80 per cent of staff covered by Agenda for Change to have their annual Knowledge Skills Framework development reviews completed and recorded on e-KSF by March 2011.

Access Targets

1. Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11.
2. The maximum wait from urgent referral with a suspicion of cancer to treatment is 62 days; and the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer will be 31 days from December 2011.
3. Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 12 weeks from being placed on a waiting list to admission for an inpatient or day case treatment from 31 March 2010.
4. **To offer drug misusers faster access to appropriate treatment to support their recovery.**
5. **NHS Boards to deliver faster access to Child and Adolescent Mental Health Services.**

Treatment Targets

1. QIS clinical governance and risk management standards improving.
2. **Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.**
3. Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009).
4. 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.
5. Improvement in the quality of healthcare experience.
6. **Increase the level of older people with complex care needs receiving care at home.**
7. **Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.**
8. To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.
9. To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010; to introduce and comply with local antimicrobial policies by 2010; and to reduce the rate of C.diff infection in hospitals by at least 30% by 2011.
10. By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.