

# 18weeks

The Referral to Treatment Standard

“ Better use  
of NHS capacity  
to deliver  
a better deal  
for patients ”

# 18



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## FOREWORD



In December 2007 I published "Better Health, Better Care" in which we set out an important and ambitious action plan to address the continuous need to improve and develop NHSScotland.

I am determined that NHSScotland should deliver swift, high quality, safe and effective patient-centred care for all. One way we aim to achieve this will be by pushing waiting times down as far as possible. Throughout the 60 year history of the NHS the rationing of healthcare by queuing for treatment has dominated the concerns of patients, public and healthcare professionals. The people of Scotland deserve nothing less than a world-class healthcare system, where unnecessary queuing for care becomes a thing of the past. That is why we have set the ambitious goal of ensuring that from December 2011 patients will be treated in less than 18 weeks of seeing their general practitioner.

This National Plan sets out the roadmap to achieving the 18 Weeks Standard over the coming 3 years.

To achieve this we will need to harness the enthusiasm, skill and dedication of the staff providing care in the NHS. I am sure that healthcare professionals, managers and all staff working in the service will engage with the 18 Weeks Programme and ensure we deliver the healthcare system the people of Scotland deserve.

A handwritten signature in black ink that reads "Nicola Sturgeon". The signature is fluid and cursive.

**Nicola Sturgeon**

Deputy First Minister and Cabinet Secretary for Health and Wellbeing  
February 2008

## SECTION 1: INTRODUCTION

### 1.1 18 Weeks: The Referral to Treatment Standard

The Scottish Government has set out the vision for a stronger NHS which will make better use of NHS capacity to deliver a better deal for patients. A major element in achieving this vision will be a new national waiting time guarantee:

**“ a whole journey waiting time target of 18 weeks from general practitioner referral to treatment ... by December 2011 ”**

Cabinet Secretary for Health and Wellbeing,  
*Scottish Parliament – Official Report, 28th June 2007.*

This is an integral element of the five strategic objectives set by the Scottish Government which will structure decision making and give clear focus to delivering for the people of Scotland.

The delivery of the 18 Weeks Referral to Treatment (RTT) Standard will contribute to each of these five strategic objectives.

**A WEALTHIER AND FAIRER SCOTLAND** – faster access to hospital treatment means fewer people unable to work, and better equity of access not dependent on where you live or on the ability to pay for private healthcare.

**A HEALTHIER SCOTLAND** – there is significant evidence that waiting long periods for even “routine” treatment leads to poorer outcomes and higher morbidity. The 18 Weeks Standard will help to sustain a better quality of life for patients.

**A SAFER AND STRONGER SCOTLAND** – stronger local healthcare, helping communities to flourish, reversing the poor health record of Scotland.

**A SMARTER SCOTLAND** – retaining and attracting skilled healthcare professionals to NHSScotland, a healthcare system which will be in the international top-league of healthcare systems.

**A GREENER SCOTLAND** – driving out duplication and waste and making better use of Scotland’s healthcare resources.

NHSScotland has made good progress in reducing waiting times over the last few years. From December 2007, all patients are being seen in a clinic within 18 weeks of being referred by their GP, and if an operation is needed, all inpatients and day cases are being treated within 18 weeks of being placed on a hospital waiting list. These improvements are the result of hard work of all those working in NHSScotland. But waiting times are still too long and much more needs to be done.

From 2011, 18 weeks will become the maximum wait from referral to treatment for non-urgent patients, but most patients will be seen more quickly.

#### 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 other resources that are wasted in the bureaucratic task of managing queues for diagnosis and treatment

The 18 Weeks Standard is different from previous waiting time targets. We will not focus on a single stage of treatment, e.g. the time from referral to first outpatient appointment, or the time from being put on a waiting list until treatment starts; the 18 Weeks Standard will apply to the whole pathway from a GP referral up to the point where each patient is actually treated.

The 18 Weeks Standard requires NHSScotland to measure the total period waited by each patient up to treatment and to manage each patient's journey in a timely and efficient manner.

In setting a whole-journey standard for almost all patient pathways – from GP to hospital – we will create one standard that is well understood by patients and the clinical teams delivering the healthcare. Setting clear and consistent definitions of what this journey includes will be an important early step in this Programme.

Achieving an 18 week pathway from referral to treatment by 2011 is ambitious, requiring a contribution from everyone working in NHSScotland. Where it is needed, extra activity will be commissioned to achieve this, supported with additional resources by the Scottish Government Health Directorates. Radical new approaches will be extended and developed throughout the Scottish healthcare system to make better use of current capacity.

Almost all patient pathways begin (and end) through interaction with primary and community health services. In the past, waiting times reduction strategies have focussed on hospital services. The 18 Weeks Programme will seek to further develop the potential for primary and community care services to work with secondary care in ensuring, where possible, diagnosis and treatment can take place locally and without the need for unnecessary hospital visits.

Such work will assist in the delivery of 18 Weeks RTT through reducing demand on hospital services. Similarly, continuing care of patients following hospital treatment is a vital element in the patient journey. Improved discharge and continuing care will augment the ability of hospitals to provide better care and faster access. This will require coherent planning and joint working between community health partnerships and local acute hospital services.

The emphasis on whole-systems working will also be reflected in the work of the Delivery Teams coordinating national workstreams towards 18 Weeks RTT. The work of the Programme will overlap and complement other improvements in NHS services, such as tackling health inequalities, the Patient Safety Programme (launched January 2008), and the Framework for Adult Rehabilitation.

The Scottish Patient Safety Programme will have four strategic elements that, combined, will deliver the 18 Weeks RTT standard, namely:

#### **Service Redesign and Transformation Strategy**

- ▶ Making the best use of current capacity, improving flow and bringing best practice to improving systems and healthcare delivery.

#### **Planning Strategy**

- ▶ Planning and implementing effective and efficient reduction in access times locally, regionally and nationally.

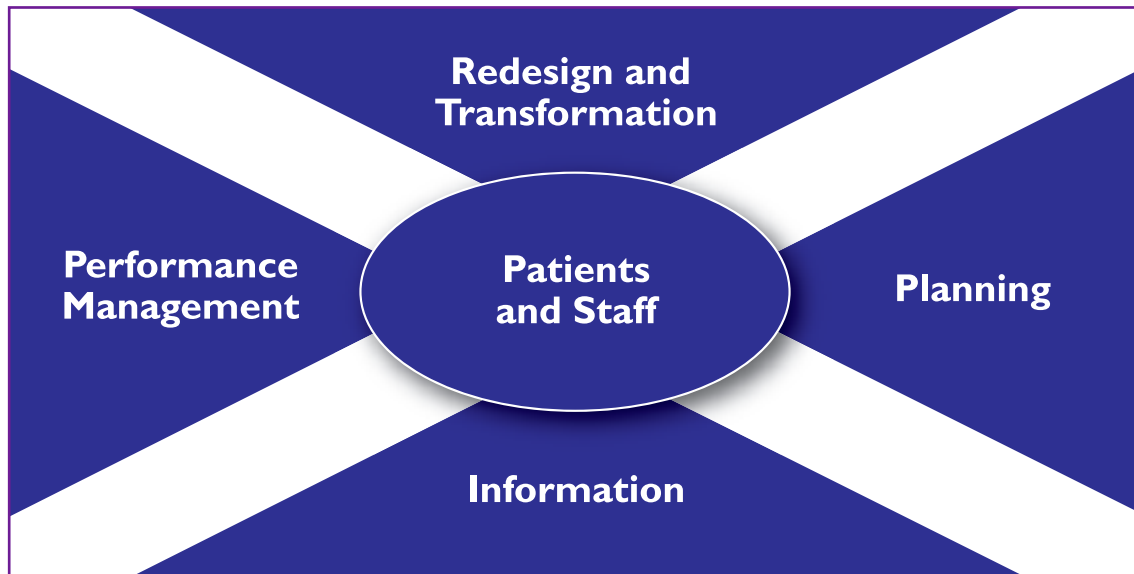
#### **Information Strategy**

- ▶ Developing and using information and eHealth technology to support the Programme.

#### **Performance Management Strategy**

- ▶ Ensuring clear targets are set, and service improvement momentum is maintained, between 2008 and 2011.

Figure 1.1: Strategic Focus for 18 Weeks RTT Standard



This Delivery Strategy describes how the key elements in each of the four strategic areas will be delivered as part of 18 Weeks RTT, and how this work will be coordinated across Scotland.

## 1.2 The 18 Weeks Programme Structure

Some of the elements required to achieve 18 Weeks RTT are either in place or under development. This includes the Waiting Times Management Teams in NHS Boards, National Improvement Programmes, National Delivery Teams, Tailored Support Teams and Information Services Division functions.

These local and national processes have delivered the significant reduction in waiting times seen over the past 5 years. Therefore, it is the intention to **refocus**, rather than **recreate**, the current waiting times structures as much as possible, especially where structures and processes have been proven to succeed.

Support and direction will continue through Scottish Government Health Directorates (SGHD), with lead role under Health Delivery Directorate.

### 18 Weeks RTT Programme Board

The 18 Weeks RTT Programme Board has overarching responsibility to support NHSScotland in delivering the 18 Week Standard by 2011. Where required the Board will provide direction, reporting to the Chief Executive NHSScotland and Scottish Ministers on progress towards this target.

#### Key tasks of the Board

- ▶ To provide maximum support to NHS Boards as they discharge their responsibility to meet 18 Weeks RTT and any legally enforceable waiting time targets
- ▶ To provide direction where required, and ensure NHS Boards' performance is on-track
- ▶ To ensure that the Cabinet Secretary and Scottish Ministers are well informed on all appropriate aspects of the Programme
- ▶ To provide governance over all aspects of the Programme to address inequalities and ensure, in particular, best value in the use of public finances
- ▶ To coordinate the work of the Programme with other complementary workstreams such as Safer Patients Alliance, Efficiency and Productivity Steering Group, eHealth Programme, Prevention, and Self Care and Enablement

The Programme Board is accountable to the Chief Executive of NHSScotland and will report to the Health Directorates Management Board.

Membership of the Board will reflect the necessary input from SGHD, NHSScotland staff and patients in delivering this target .

The Programme Board will set up National Delivery Teams to focus on specific aspects of the overarching 18 Weeks RTT Standard. These teams will approach their tasks in a manner similar to that developed over the past 5 years in reducing outpatient, diagnostic, inpatient and condition-specific waiting times. The duration and composition of these Delivery Teams will vary over the lifetime of the Programme as particular challenges are recognised and addressed.

### Delivery of Service Transformation

Improvement and Support Team will provide support to the redesign and transformation of patient pathways, developing training and education for NHS teams. They will bring learning from the current National Improvement Programmes and evidence from international best practice in clinical systems improvement. The work of this Team will interact with almost all other elements of the Programme to ensure a joined-up approach to reducing the time spent by patients waiting for consultation, diagnosis and treatment. Specific, focussed programmes of work will be aimed at individual specialties and/or elements of the patient pathway (e.g. referral management, daycase surgery). The Service Redesign and Transformation Strategy is described in Section 2.

## Operational Delivery Team

The Operational Team will be instrumental in driving delivery of the 18 Weeks RTT Standard by 2011, along with the interim stage of treatment milestones. Comprising a small number of influential and experienced managers and clinicians from across Scotland, this team will provide an absolute focus on delivery, dealing with the practical drivers and tactical problem solving to facilitate reduced waits and sustained service improvements. The work of this Delivery Team will be fully integrated with the Service Redesign and Transformation strategy.

From the outset, emphasis will be on high volume problem specialties and exemplar specialties. It is likely that a small number of "task-and-finish" sub-groups will be formed to address key packages of work throughout the life of the Programme in order to maintain momentum and aid delivery.

## Diagnostic Delivery Team

Interaction with patients as part of the post-referral diagnostic episode is diverse. Tackling queues will present a significant challenge. This Team will expand the work of the current National Diagnostic Delivery Team to improve waits for tests under 4 main workstreams: imaging, laboratories, endoscopy and physiological measurement.

## Information Delivery Team

The 18 Weeks RTT Standard will require patients to be tracked as they are referred from their GP and onwards through all subsequent diagnostic and treatment episodes. The Team will support the NHS Boards in making this happen, whilst ensuring we do not create administrative costs which add no value to the work of NHSScotland. The Information Strategy is further described in Section 3.

## Capacity and Workforce Planning

NHS Boards need to understand what can be achieved through best use of existing clinical capacity, and where new capacity (either short or long term) would be needed to meet the 18 Weeks RTT Standard. This will have major impact on how we plan changes to the NHSScotland workforce over the next 5 years. The Planning Strategy is expanded further in Section 4.

## Emergency Access Delivery Team

Emergency care is a reliable measure of whole system performance in the acute sector, where it accounts for the majority of in-patient care in both medical and surgical specialties. It is therefore important to achieve a safe and effective balance between elective activity and emergency treatment, and the respective use of available capacity, as a key element of the organisational Balanced Score Card. This Team will take forward the Kerr principles and the work of the current Unscheduled Care Collaborative to embed continuous improvement, linking to work on reducing emergency attendances and realigning patient flows across the whole system. The strategy underpinning this work is described in Section 4.2.

## NHS Board Programme Teams

In addition to these national delivery teams, each NHS Board will be resourced to employ clinical and non-clinical staff who will provide leadership and expertise in achieving the 18 Weeks RTT Standard. The size and scope of work for each NHS Board Programme Team will differ, as influenced by the population served, the current service standards and the needs of the local healthcare system. There will be strong links between these teams and the national delivery teams to ensure a balance between work which is best led locally and areas where a Scotland-wide approach delivers best care for patients.

## Clinical Advisory Group

Each 18 Weeks RTT Delivery Team and NHS Board Programme Team will ensure that the best available clinical and professional advice is used in the planning and delivery of 18 Weeks RTT. The clinicians and healthcare professionals directly involved in the 18 Weeks RTT Programme at a national level will comprise an Advisory Group which will be charged with ensuring a consistent and effective cross-specialty approach to planning and delivery.

Also, the Clinical Advisory Group will commission evidence of best practice to inform the direction of the Programme Board. This will include (but will not be restricted to) consultation and dialogue with patients, the Chief Professional Officers, the Royal Colleges and the Universities.

## Performance Management and Programme Governance

The Access Support Division will take the lead role in ensuring that the tactical and strategic objectives of the Programme Board are translated into satisfactory performance against agreed performance milestones. The nature of this role is described in Section 5.2.

The Programme Board, through the Access Support Division, will be responsible for oversight of significant financial allocations during the period 2008-11. It will be vital that this resource is consistently used to best effect for patients, and achieves the maximum reduction in access times whilst balancing other NHSScotland imperatives. The Programme Board, working with Audit Scotland, will ensure proper transparency and scrutiny of decision making and resource allocations on behalf of the 18 Weeks RTT Programme.

## SECTION 2: THE REDESIGN AND TRANSFORMATION STRATEGY

### 2.1 Service Redesign and Transformation Programme

The Improvement and Support Team (IST) will support NHSScotland to deliver the 18 Weeks Standard with a 3 year Service Redesign and Transformation Programme that engages with every NHS Board.

The Service Redesign and Transformation Programme will build on knowledge and experience of the application of tools and techniques to improve clinical systems and processes. This experience of improving management of demand and capacity, improving patient flow by reducing bottlenecks and using small scale rapid cycles of change to make incremental and sustainable improvement, will provide a solid basis to move forward. The programme will also build in the appropriate approaches to behavioural change management that will be required to deliver service transformation of the scope and scale required.

#### The Programme Design

Delivering 18 Weeks will require a different scale and scope of improvement activity.

It will require a drive from local programme teams to fully engage and embed improvements through operational and clinical management across whole systems. It requires active and sustained Clinical and Executive level leadership.

This is not an isolated target with limited impact on other parts of the healthcare system. It may be expressed as an elective care standard, and whilst there are obvious process improvements to the management of elective pathways, there will be profound implications for the management of long term conditions and the control of variation in unplanned care. These improvements will be supported through the Long Term Conditions Collaborative Programme.

The programme will build on the 5 high impact changes promoted through the Planned Care Improvement Programme:

- ▶ **Improve referral and diagnostic pathways**
- ▶ **Treat day surgery as the norm**
- ▶ **Actively manage admissions to hospital**
- ▶ **Actively manage discharge and length of stay**
- ▶ **Actively manage follow ups**

Moving from waiting list and stage of treatment management to pathway management requires improvement in the efficiency of all patient pathways (from referral to review). If effective scheduling (at the right time and place) for the delivery of 18 Weeks is to be achieved, a far greater emphasis on Primary Care engagement in national improvement programmes is needed. Redesign of patient pathways will require whole systems engagement and need to firmly embed the principles of 'Shifting the Balance of Care'.

At national and local level there will be a strong focus on clinical engagement and clinical leadership to drive improvements that are patient focussed and improve the patient experience as well as the timeliness of access.

The 18 Weeks Service Redesign and Transformation Programme will bring together the learning from the Planned Care Improvement Programme, the Unscheduled Care Collaborative, the Diagnostics Collaborative as well as the learning from the whole journey target from the Eye Care Redesign and Cataract Programme and prospective pathway management from Cancer Performance Support programme. IST will continue the approach of using improvement tools and techniques and managing the spread of high impact changes to provide a systematic and sustainable approach to improvement.

Current programmes work on a 'single' project infrastructure. The scale and scope of this programme means that there will be several 'projects' under the overarching 18 Weeks Service Redesign and Transformation banner, which will need to work in an integrated way. Local support will be provided through a regional management structure. There will be links to regional planning to support the development of regional pathways.

The Service Redesign and Transformation Programme will build on the learning from current service innovations across the UK and internationally as appropriate. This will include:

- ▶ **Better use of information** to identify bottlenecks through a "No Delays Achiever" which will use NHS service data to identify service improvement priorities
- ▶ **'Lean' initiatives** that could be built into 'Lean Hospital' test beds, increasing productivity, efficiency, safety and reliability
- ▶ **Better use of technology** by working with the Scottish Centre for Telehealth and the eHealth Programme to improve the quality and responsiveness of planned care. This could have a national benefit to delivery and sustainability of the 18 Weeks Standard
- ▶ **Workforce development** such as extended and new roles that improve the quality and responsiveness of care, improve flow and provide rewarding careers for NHS staff

The Programme will allocate resources to NHS Boards over three years from 1 April 2008. Smooth transfer from existing IST programmes will be required to maintain the momentum of improvement built up through the current collaborative and improvement programmes and to give NHS Boards the opportunity to build on the capacity and capability for service improvement already in place.

Programme planning guidance will be available following the launch event. The guidance will offer direction for the improvement strategies and key actions NHS Boards should undertake. It will offer greater flexibility in how NHS Boards manage their local infrastructure but will recommend an integrated approach to improvement across all national programmes including the Long Term Conditions Collaborative Programme, the Mental Health Collaborative Programme, the Scottish Patient Safety Programme and Better Together – the patient experience programme.

“ The long term goal is to implement an Electronic Health Record containing whole pathway measurements on a single system.”

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## SECTION 3: THE INFORMATION STRATEGY

### 3.1 Information Challenges

#### The Information Delivery Team

The Information Delivery Team will bring together expert staff currently working in NHS Boards' information processing functions, ISD, and SGHD.

The Delivery Team will:

- ▶ Compile and publish the definitions of what constitutes an 18 Weeks RTT patient pathway,
- ▶ Lead the implementation of a cost-effective and user-friendly means of recording and reporting patients' access times relative to 18 Weeks RTT,
- ▶ Create a reporting framework which will demonstrate progress towards, and adherence to, the 18 Weeks RTT Standard.

#### Current Status

Historically, information systems in the Health Service have had the specific purpose of managing discrete episodes of patient care i.e. inpatient and outpatient activity is managed on separate systems, as are diagnostic tests.

Current patient administration systems (PAS) have not linked outpatient episodes to inpatient episodes and diagnostic tests, and therefore measurement of whole patient pathways from referral to treatment is problematic.

Furthermore, there is a great deal of Health Service activity such as treatment in outpatient and primary care settings that is not recorded on any information systems. Similarly, some AHP and nurse-led services are managed by paper-based systems. Details of the management and activity of these services are not recorded.

However, measurement is just one aspect of the information issues surrounding whole patient pathways. Definition of what constitutes treatment and how to manage tolerances and periods of patient unavailability are other areas that will require clinical engagement and strategic guidance.

## Learning from Other Countries

The Welsh Assembly Government (WAG) and England's Department of Health (DH) have commenced working towards RTT standards for their respective healthcare systems. DH and WAG have been developing solutions to the measurement and information issues of whole patient pathways, and much of this work is transferable to NHSScotland.

This approach to measurement has been to build pathway measurement processes around current IT systems with the aim that these processes will be able to evolve into a longer term solution.

However early learning has demonstrated that as well as current information systems being unable to measure whole journey pathways, treatment data is not captured consistently for a large cohort of patients; namely those treated in outpatient clinics and those who are treated medically. Collecting treatment data is crucial for effective performance-monitoring against the standard, but requires changes to current processes and extensive clinical engagement.

Presently within NHSScotland there is also no single system solution to whole patient journey measurements. Local solutions will have to be developed.

This will involve mapping current information flows to understand processes and gaps, and to identify how these gaps can be filled to provide robust information on all stages of the patient journey.

## Key Elements of the Information Strategy

The key information elements necessary to facilitate RTT measurement may include:

- ▶ Key data items including:
  - ▶ Unique, patient-based care episode identifier
  - ▶ Record of outcome of outpatient attendance, including any treatment
  - ▶ RTT status of patient in order to track patients through the pathway
  - ▶ Protocols and minimum dataset for tertiary referrals
- ▶ Where possible, modification of existing PAS systems
- ▶ Extending monthly reporting of waiting times for more than the current 8 diagnostic tests, and quarterly reporting for a range of other diagnostic tests including physiological measurements

- ▶ Regular, formal guidance on reporting and information requirements
- ▶ Web-based data returns
- ▶ Long term eHealth strategy

The future development of IT systems should enable accurate whole pathway measurements, but interim solutions will require to be developed in the short term.

The information work stream of this project therefore requires short, medium and long term tactical approaches.

### Short Term Tactics 2008

- ▶ Develop data definitions for the whole patient pathway measurement including:
  - ▶ The scope of the standard
  - ▶ Clock starts
  - ▶ Clock stops
  - ▶ Events during the pathway period
  - ▶ Tertiary and cross-board referrals
  - ▶ Initial definition of treatments
- ▶ Develop format for unique episode identifier
- ▶ Examine options for recording outcome of outpatient appointments
- ▶ Undertake scoping exercise of PAS systems currently in use in NHSScotland
- ▶ Undertake scoping exercise of current methods of recording non-medical-led service activity
- ▶ Establish pilot sites to explore and develop options for RTT measurement
- ▶ Establish patient and public involvement in the information strategy

The Diagnostics Waiting Times Programme has established tools to measure an important element of the RTT pathway: the period from referral, through outpatient clinic to diagnostic test. NHSScotland will continue to work with ISD during 2008 to expand the use of these tools and improve the reliability of the outcome measures.

## Medium Term Tactics 2008-2009

- ▶ Assess potential of data warehousing to enable whole journey measurements
- ▶ Engage with diagnostic system providers to assess compliance with national developments and reporting requirements
- ▶ Work with clinicians to develop guidance on clinically complex cases and acceptable tolerances
- ▶ Issue further definition on treatments
- ▶ Develop performance measurement and reporting requirements
- ▶ Engage with primary care personnel and system providers
- ▶ Identify areas of risk in personnel and system resources
- ▶ Develop communication strategy for information issues

## Long Term Tactics 2008-2011

- ▶ Develop web-based data returns system
- ▶ Implementation of Electronic Health Record (EHR)

The long term goal is to implement an Electronic Health Record containing whole pathway measurements on a single system.

## eHealth Strategy

EHR is an umbrella term used to describe all the clinical information about a patient which is held electronically and which can be brought together from the data repositories maintained by key software applications.

The NHSScotland eHealth Strategy recognises that for the short to medium term the goal of the EHR will not be achieved by a single all-encompassing software application, but will be achieved through incrementally putting in place and connecting the necessary software and ICT infrastructure components.

There is strong symbiosis between the delivery of the 18 Weeks RTT and the delivery of the eHealth Strategy.

The eHealth strategy states, 'Delivery of the eHealth Strategy will require meticulous and thorough planning, based on targets which are challenging but realistic, with the "patient journey" underpinning all aspects of the approach. In order to deliver the strategy we will build on and develop the skills and experience of existing eHealth staff'.

The delivery of the 18 Weeks RTT will be underpinned by the availability of accurate and timely information provided by eHealth staff in NHS Boards.

The eHealth Strategy is committed to producing a funded staff development strategy in order to achieve the level of in-house skills and competencies required, and provide career development opportunities for eHealth staff in DG-Health, NSS and local NHS Boards.

It is essential that the Information Delivery Team works in parallel with this development in order to ensure skills can be developed that will enhance RTT measurement information.

## Communicating the Strategy

Extensive communication with the service regarding the information requirements of RTT measurement is essential. Early involvement of stakeholders and staff with the appropriate operational and clinical knowledge will be necessary to raise awareness of the tasks and challenges. Clinical champions and executive leadership with visible support will be vital in order to implement the plans that will enable RTT measurement.

## Risks

Measuring whole patient pathways will present significant challenges and risks which will be managed by the Information Delivery Team working with the 18 Weeks RTT Programme as a whole.

### Personnel

The principal risk is the possible scarcity of staff with the skillsets required to enable system changes and data collection.

Additional information staff will be required within the service to develop this work. A lead-time will be necessary in order to train new staff. However, much of this work will be set up and pump-priming during the period 2008-2010. Thereafter, maintenance of the new information systems will form part of the core function of NHS Boards' IM&T resources.

## Information Systems

A further risk is posed by the information systems currently in use in NHSScotland. These systems may not have the functionality in the short/medium term to enable large patient populations to be tracked through their pathways of care.

The experience of the system changes required to implement 'New Ways' and approaches in Wales and England will be assessed. This will assist in obtaining a clearer picture of the ability of current information systems to facilitate RTT measurement and identify potential risks at local level.

## Primary/Secondary Care Interfaces

Whole journey standards will require improved communication between primary and secondary care, and the ability to record treatments provided in the primary care setting that will be defined as 'stopping the clock'.

## 3.2 Lessons Learnt From Existing Referral To Treatment Targets

### Introduction

This is the first time that NHSScotland has been called upon to deliver a maximum wait of 18 Weeks RTT for non-urgent patients. However it is not the first time that the focus has been placed upon the whole patient pathway from referral to treatment. NHSScotland has delivered shorter journey times for a number of condition-specific targets. This promises a package of care that provides the whole patient journey within a given timeframe, rather than splitting care into the traditional stages of treatment (outpatient, diagnostic, inpatient/daycase). A number of lessons have emerged from these total journey targets which may be usefully applied to an 18 Weeks RTT.

#### Current NHSScotland "Pathway" Standards

- ▶ 62 days from urgent referral to treatment for cancer
- ▶ 16 weeks from GP referral through a rapid access chest pain clinic or equivalent, to cardiac intervention
- ▶ 18 weeks from referral to completion of treatment for cataract surgery
- ▶ 4 hours from arrival to admission, discharge or transfer for Accident and Emergency treatment

## Measurement

Obtaining waiting time information that measures the entire patient journey has proved the most challenging obstacle in delivering the whole patient journey targets.

As described in Section 2.1, systems are not yet in place across NHSScotland to support measurement of total patient journey times at a national level, although locally some NHS systems do have the potential ability to measure whole patient journey.

Significant effort has been invested to find solutions to capturing the total patient journey times in a meaningful and robust way, building on current national data sets, and anticipating the introduction of New Ways of Defining and Measuring Waiting.

In both coronary heart disease (CHD) and eye care an interim 'tactical' approach to measuring progress against delivery of the waiting time standards has been adopted. The pragmatic solution is to separate the measurement of the constituent parts of the journey, termed as 'chunking'.

For example, for the cardiac journey, the national delivery team has identified the time in weeks that the patient needs to be managed across the pathway from referral, investigation, intervention and surgery. A clinical service is designated as responsible for one 'chunk' of the patient pathway, for example diagnostic angiography. Gaps between the 'chunks' are progressively minimised and eliminated.

If a patient is within the waiting time for each 'chunk' of their pathway, they are within the total pathway waiting time. This allows each service to focus on their responsibilities and eliminates the difficulty of recruiting patient trackers or fast tracking the procurement of IT systems that do not presently exist. This approach does not preclude total patient pathway measurement in the future when IT systems are available.

## Definitions

Defining where the journey begins and ends (i.e. clock start/stop) is critical to its measurement.

A significant amount of work has been carried out to develop meaningful definitions against which the standards can be measured. Much of this has been with clinicians in the specialties of cardiology, ophthalmology and radiology to ensure that the definitions developed are clinically appropriate and have the support of the wider clinical communities. This has been particularly important in cancer and cardiology where significant numbers of patients require specialist treatment across organisational boundaries both within and between NHS Board areas.

## Delivery Team Approach

For all condition-specific targets, the process for ensuring delivery of the standard has been successfully led by a high level National Delivery Team. Each multidisciplinary team, sponsored by the SGHD Delivery Directorate, comprises a small expert group (managerial and clinical) to ensure high level leadership and an absolute focus on delivery.

## Partnership Working

Confidence-building with the NHS and organisational ownership have been key building blocks for target delivery. For example, for Cardiac the delivery strategy for the standard was built 'bottom-up' with NHS Boards and Operating Divisions.

Engagement across the Health Directorates has also been a critical success factor, with continuous engagement between the teams within the Delivery Directorate and with other Divisions within SGHD.

For Cancer, the importance of management grip and clinical engagement with process ownership versus functional silo management should not be underestimated as factors in successfully achieving the 62 day cancer standard.

The A&E target has been heavily predicated upon ongoing and extremely close working relationships between performance management and performance improvement, linked with strategic and policy direction and ongoing interaction with partners across NHSScotland.

## Clinical Engagement

Clinician engagement has been fundamental to acceptance and ownership of the targets. In Cardiac this has been achieved through a leadership role from the CMO's specialty advisor and through the National Advisory Committee for Coronary Heart Disease. Continuing engagement with front-line clinicians: nurses, doctors, AHPs and scientists has also been key.

## Public/Patient Involvement

Public and Patient Involvement has been limited, despite its being integral to building robust health services for the future. In Cardiac, for example, this has so far involved lay members of the National Advisory Committee for Coronary Heart Disease. Public and patient involvement will be extended within the 18 Weeks Programme.

## Common Patient Pathways

Time-based pathways are an essential basis for standardisation and consistency – which are essential to avoid wasteful steps in the pathway. For cancer care, models of same day diagnosis, straight-to-test and pooling of referrals for assessment and diagnosis all cut out additional steps which add delays and increased risks for patients' safety.

## Escalation

Living escalation policies should be embedded in daily practice and used effectively to drive continuous improvement. The Cancer Performance Support Team's role provides an example of detailed engagement with the challenged NHS Boards to ensure delivery of the 62 day target. Similarly, for Unscheduled Care, the use of weekly performance reports for at-risk Boards, supplemented with a detailed and iterative tailored support and intervention, provides a strong methodology for driving performance.

## Inter-Hospital Transfers

The importance of inter-hospital transfer agreements for inter or intra-board referral for cancer assessment, diagnosis and treatment cannot be underestimated. These also need to be embedded and contacts at various sites kept updated. Agreement of these can only be done on the back of the time-based pathways, so that receiving Boards agree when patients should be referred to them for certain treatment e.g. day 31 referred for radiotherapy.

“...provision of sustainable, effective healthcare capacity within local NHS systems is the primary goal...”

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## SECTION 4: PLANNING STRATEGY

### 4.1 Capacity and Workforce Planning

Staff managing, delivering and planning clinical services should understand the factors which impact on the service they provide. There are four key measures which must be understood to properly manage waiting lists, deliver effective services and enable informed decisions when redesigning current services or planning new ones.

The measures are:

- ▶ Demand
- ▶ Activity
- ▶ Capacity
- ▶ Queue

Queues form due to a mismatch between demand and capacity. Imbalance between activity and capacity will lead to inefficiency.

Methods are in place in a number of NHS Boards to capture and utilise this information to achieve sustained waiting times reduction (for example, in achieving the 9 week interim diagnostic waiting time standard). The 18 Weeks Programme will work with NHS Boards and their local project teams to increase our ability to judge where service change is necessary to reduce the whole patient pathway waits to 18 weeks and less.

There is no single solution for estimating the additional work required to achieve a maximum 18 Weeks RTT. This is influenced by the mix and complexity of patients' pathways, sustainability and the shape of the waiting list.

Initial modelling by Health Delivery Directorate estimates that to clear the queue, NHSScotland will need to carry out an additional 85,000 first outpatient attendances and treat an additional 62,500 inpatients/day cases to achieve 18 Weeks RTT.

Further modelling work is required to estimate the additional capacity needed to deliver 18 Weeks RTT on an ongoing basis – accounting for peaks in demand. This model will also need to take account of service redesign, which is expected to deliver improved efficiencies.

In the past, NHSScotland has worked in partnership on a limited and largely short term basis with independent sector healthcare providers in reducing stage-of-treatment waiting times to their current levels. This has never exceeded 0.2% of NHSScotland's overall expenditure.

These arrangements have seen the removal of outstanding queues (or backlogs), but always in the context of parallel investment leading to increased long term NHS capacity and efficiency. Where we have used non-recurring funding with the independent sector, this has eventually been translated to recurring investment within the NHS.

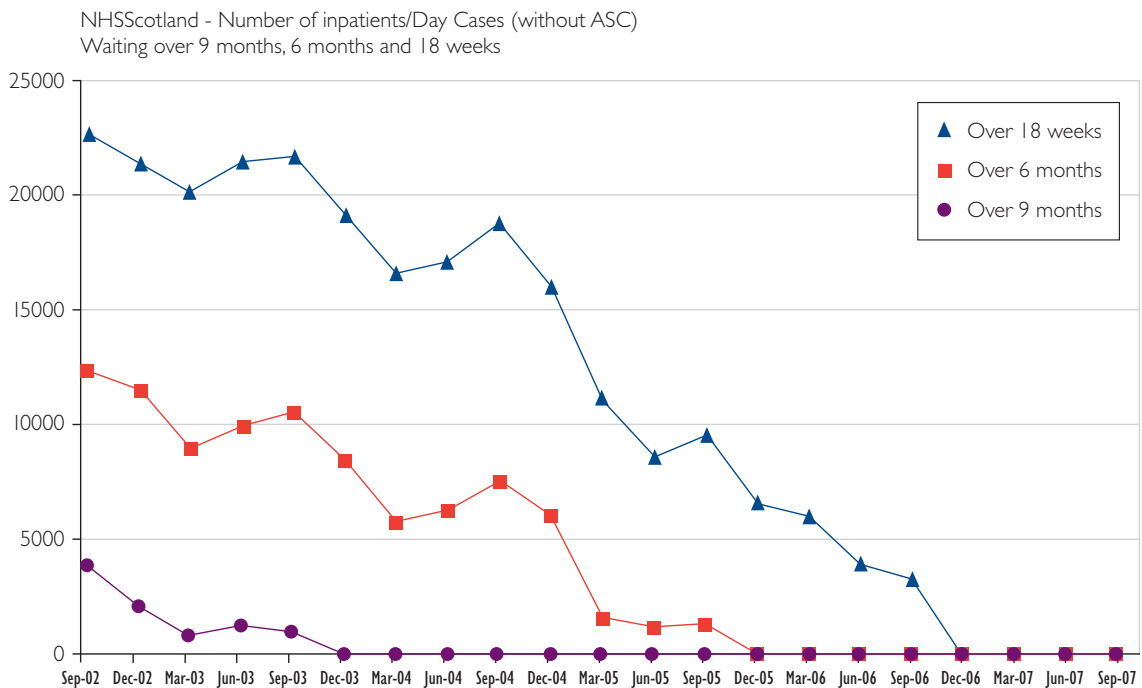
Clearly, provision of sustainable, effective healthcare capacity within local NHS systems is the primary goal in delivering the 18 Weeks RTT. In some instances, however, it may be necessary for NHS Boards to use the capacity provided through independent sector providers to achieve shorter waiting times.

NHS Boards will be charged with ensuring that all such agreements represent efficient use of public finance and deliver safe and effective healthcare to patients. All such partnerships will be of limited duration, with the expectation that local NHS capacity will be developed as required during the period of the agreement.

The Programme Board will monitor all such agreements in relation to these criteria, and will provide advice to NHS Boards as required to ensure efficient use of healthcare resources.

Whilst NHSScotland has been highly effective in reducing access times to outpatient clinics and inpatient/daycase treatment – as demonstrated in Figure 4.1 below – the diverse range of patient pathways and episodes of care which are covered by 18 Weeks RTT will require a more sophisticated degree of capacity planning than that done to date.

Figure 4.1 Inpatients / Day cases waiting times



## Matching Workforce and Capacity

The introduction of the 18 Weeks RTT by 2011 will be challenging for Boards: getting the workforce right will be pivotal to achieving this step change in service delivery and improvement in healthcare in NHSScotland.

The National Workforce Planning Framework, published in 2005, and now being implemented, provides the strategic direction and structure to take workforce planning forward. A key element of the framework is to connect workforce planning with service and financial planning, education and training support and regulatory requirements.

Workforce planning, like capacity planning, is an iterative process and Boards will need to consider within that process what the workforce requirements will be to deliver the 18 Weeks Standard. For the most part, this is likely to involve existing staff working differently in redesigned services. The lead-in time for training more pre-registered healthcare professionals is beyond the delivery time for this standard. 'More of the same' will not be the solution. Service and workforce planners will need to work together to plan and deliver the changes required, both for the short term to achieve the standard, and for the longer term to maintain it.

Using a competency-based approach to planning the capacity required will help to expand roles and ensure staff in all healthcare professions work at the top of their competency level. It will avoid the risk of traditional roles and existing ways of working restricting our thinking. This will mirror the innovative and lean approaches taken in service planning. We must make the best use of the skills and knowledge existing in all parts of the workforce. Planning the capacity will include consideration of the need for staff to plan, manage and monitor the standard as well as staff capacity to deliver the standard to patients. The former should be kept to a minimum and will reduce over time as the changes required to deliver the new standard are embedded and become the 'norm'.

The outcome of this work to plan the workforce will not be exclusively about the numbers required. Clear plans for changes to roles and training and development will also result, driven by the redesign and transformation programme.

## 4.2 Balancing Elective and Emergency Care

### Introduction

In the interests of patient safety and optimising patient outcomes, it is important to achieve a balance between elective work and emergency care. By addressing the demands of both these elements of the acute care system, scope for delivery of the 18 Weeks RTT will be safeguarded, whilst also providing timely and fit-for-purpose unscheduled care.

It is critical that, with the focus on delivering elective targets, the needs of our unscheduled patients and our emergency admissions receive an equal emphasis – and that one set of performance achievements are not delivered at the expense of the other. Only by managing the interface between the two aspects of care, and addressing the often competing requirements, will use of current capacity be optimised and positive outcomes – both for patients and performance – be achieved.

To ensure a safe and balanced health care service, elective access targets must not unbalance the system, and equal emphasis should be placed upon access to unscheduled care. This approach will support delivery of an 18 week total journey guarantee by proactively addressing tensions in service provision across the whole system.

The key elements to be addressed in achieving this balance relate to capacity and demand management and optimising patient flows, including diagnostic services, to the benefit of both elective and emergency services (as highlighted in figure 4.2). In particular this encompasses the various elements of proactive bed management and robust discharge planning. This 'pull system' should start at the back door of the hospital and manage patient flows through all parts of the care pathway. Demand, and therefore capacity, required on particular days of the week, time of day, and even time of year, is largely predictable. This knowledge can be used to manage variation and even to transfer some of the unscheduled care workload to planned care through careful scheduling.

Figure 4.2: Hospital Care



In addition, realigning patient flows into the acute sector along with the management of long term conditions in the community (using a 3-tier model of care: self management, specialist care and case management) will shift the balance of care further, balancing the utilisation of the available resource and improved patient outcomes.

### Balancing Elective and Emergency Admissions to Hospital

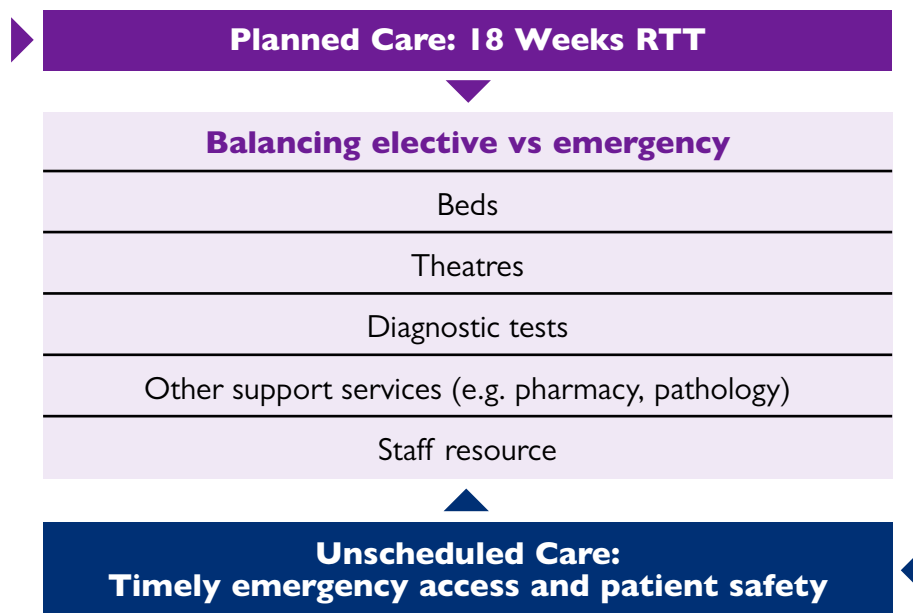
At the end of 2007, NHSScotland delivered 8 key access standards which relate both to elective and emergency access (outpatients, inpatient/daycases, accident and emergency, cancers, cardiac, cataracts, hip fracture and diagnostic tests).

A fundamental part of delivery is embedding service improvement into operational management to bring about sustainable change. In this way, targets will be achieved by genuinely improving systems and processes for long term benefit, not by short term initiatives to temporarily reduce the stock of patients waiting.

This is best delivered on a whole systems basis within acute care, taking cognisance of the inter-relationship between planned care and unscheduled care and their reliance upon the same set of services within the acute hospital setting, as illustrated in figure 4.3. Within the acute setting there is potential to embed new systems and processes for aligning different calls on capacity and streamlining the dynamics between elective and emergency flows.

NHSScotland must provide patient care within the finances set by Parliament. For this reason a programme of work is needed to facilitate clear actions based on a firm understanding of demand and capacity, prediction and management of variation. This ties in with the concepts of efficiency and productivity and maximisation of output from the available resource base.

Figure 4.3: Achieving a Balance between Planned Care, Unscheduled Care and 'in-hospital' services



Emergency demand is predictable, and can be mapped out and used as a basis for resource utilisation and managing patient flows through the care pathway. The criteria behind this involve predicting peaks and troughs in activity and matching these to maximise use of the available resource, both by day of the week and by time of the year.

Diagnostic services, too, are a fundamental element of both elective and emergency care. Delays in accessing the relevant services can influence emergency access waits, as well as outpatient, inpatient or daycase services. If these are treated as separate queues, bottlenecks will result. It is therefore important that predicted emergency demand for diagnostic tests is scheduled in, especially at peak times, allowing peaks and troughs in capacity to be minimised.

This work is designed to maximise the use of capacity and to match this with the combined elective and emergency cases presenting. Just as elective surgery can be managed according to waiting list size and shape, so too can emergency provision be managed according to prediction and planning. Thus, the volume of unscheduled cases, and even day of the week and time of day, may to a large extent be pre-planned based on long term trends and recent performance. System Watch provides a useful management tool for predicting and managing demand, which could usefully be mainstreamed into daily operational management approaches.

Capacity planning and prediction is an important tool for achieving a balance across operational delivery and optimising the use of physical and human resources available. Getting this right will benefit the delivery of both elective and emergency care, creating a win-win situation.

In ensuring a balance between emergency and elective provision within the acute sector, there is also a need to pursue access points to the service, shown in figure 4.4 below. This encompasses the management of emergency demand and enhancing out-of-hospital care streams, bringing a higher profile to admission alternatives (e.g. community-based self care for long term conditions) and admission avoidance. This also involves enhanced whole systems partnership working, involving primary care (CHPs, GP in-hours services, GP OOHs), secondary care, local authority and social work, voluntary sector; NHS 24 and Scottish Ambulance Service. It will be important that improvement programmes for long term conditions and the 18 week total patient journey are developed in tandem to ensure their interrelationship and to facilitate ongoing partnership working.

Figure 4.4: Access Points to Unscheduled Care



## Conclusion

Implementing the 18 Weeks RTT pathway will bring many benefits to patients. It is important that the acute sector does not unbalance its service provision to patients by reducing RTT waits at the expense of unscheduled emergency admissions and treatments.

This programme of work would ensure that, through whole systems capacity planning and delivery, access to emergency consultation and treatment receives an equally high priority to elective activity, and that bed management and predictive planning tools can be successfully used to synchronise both aspects of the care package.

“...the 18 Weeks Standard will require a wide-ranging, systematic approach to designing and managing each patient’s journey...”

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## SECTION 5: PERFORMANCE MANAGEMENT STRATEGY

### 5.1 Performance Indicators

Pending the implementation of RTT measurement (remitted to the Information Delivery Team), performance management of delivery towards 18 Weeks RTT will be focused on stage of treatment waiting times. Whilst full analysis of resource implications for each step is ongoing, the potential milestones are described below.

Figure 5.1: Performance Milestones to 2011

|   |                             | Dec '07<br><i>Delivered</i> | Mar '09<br><i>HEAT</i>      | Mar '10<br><i>Potential</i>                        | Mar '11<br><i>Potential</i>                        | Dec '11               |
|---|-----------------------------|-----------------------------|-----------------------------|--|--|-----------------------|
| Stage-of-Treatment Performance            | New Outpatient Clinic       | 18 weeks                    | 15 weeks                    | 12 weeks   | 9 weeks  | 18 Weeks RTT Standard |
|   | Diagnostics (8 key tests)   | 9 weeks                     | 6 weeks                     | 4 weeks  | 4 weeks  |                       |
|   | Other diagnostics           | No standard                 | Improved reporting          | 12 weeks?  | 9 weeks?   |                       |
|   | Inpatient/daycase treatment | 18 weeks                    | 15 weeks                    | 12 weeks   | 9 weeks  |                       |
| Performance Against 18 Weeks RTT Standard |                             | Data Development Milestones | Data Development Milestones | 75% non-admitted patients<br>60% admitted patients | 85% non-admitted patients<br>75% admitted patients |                       |

The precise interim stage of treatment and RTT milestones will be included in the annual Local Delivery Plan guidance issued by SGHD to NHS Boards.

The RTT performance indicators will distinguish between two types of patient pathway: “non-admitted” patients who are returned to GP/GDP care following consultation and diagnosis; and “admitted” patients whose journeys include admission to hospital for treatment. The latter pathway is normally longer, and so it is anticipated that this will take more time to achieve across Scotland – though, the patient wait from referral to treatment is much simpler to measure, so baseline data against the RTT standard will be available earlier than for non-admitted pathways.

From mid 2009, increased emphasis will be placed on performance-managing whole journey waits, whilst using stage-of-treatment targets as a back-stop to prevent the longest waits creeping upwards.

## 5.2 Delivery Management

### Performance Management

The task of ensuring progress towards the interim performance indicators for each stage-of-treatment target will lie with the Health Delivery Directorate.

The Access Support Division will ensure that the tactical and strategic objectives of the Board are translated into satisfactory performance against the above milestones.

Access Support, and the Divisions within Health Delivery Directorate, will:

- ▶ Agree with NHS Board Chief Executives monthly improvement trajectories towards each stage-of-treatment target
- ▶ With NHS Boards and colleagues in the Health Delivery Directorate, ensure that these improvement trajectories are ‘delivery proofed’
- ▶ Hold regular review meetings with NHS Boards’ executive teams on progress against stage-of-treatment targets
- ▶ With NHS Boards and colleagues in the Health Delivery Directorate, risk-assess progress against improvement trajectories
- ▶ Where progress is not satisfactory, agree binding recovery plans with NHS Boards;
- ▶ Introduce weekly performance management regime where required
- ▶ Allocate agreed funding against NHS Board’s improvement plans (see Delivering Best Value, below)

- ▶ Where required, coordinate requirements for additional activity between NHS Boards and with the Golden Jubilee National Hospital, Stracathro Treatment Centre and, if required, the independent sector
- ▶ As required establish specialty, condition or site-specific delivery-focused teams to ensure stage-of-treatment targets are achieved
- ▶ Liaise with professional bodies, specialty advisors and partnership organisations to facilitate effective delivery of stage-of-treatment targets
- ▶ Where required, review NHS Board capacity plans for delivery of stage-of-treatment targets and if necessary recommend amendments
- ▶ Work with Delivery Analysis Team and ISD to ensure that adequate information resources are available to manage and measure progress towards stage-of-treatment targets
- ▶ Provide briefing and expert advice to Ministers, DG-Health, the Programme Board and NHS Boards on progress and risk against stage-of-treatment targets
- ▶ If required, initiate and escalate action under step-in rights; including, as appropriate, commissioning tailored support; peer mentoring, and ultimately recommending that specific management functions are transferred to a recovery team
- ▶ Strategically and tactically manage and decide allocation of funding to ensure best value

## Delivering Best Value

Clear emphasis will be placed on achieving best value for the resources allocated to NHSScotland by Parliament. This will mean that NHS Boards will be required to demonstrate the achievement of the step-improvement in waiting times as an explicit condition to the release of any investment for achieving 18 Weeks RTT.

This link between resources and delivery will be a factor in the published performance information for all NHS Boards, and a significant element of the Annual Reviews led by the Cabinet Secretary for Health and Wellbeing.

## Balancing Priorities for NHSScotland

Clearly, the progression of NHSScotland towards 18 Weeks RTT must be balanced against other NHS priorities such as combating healthcare infection, providing access to better primary and community care and any other elements of *“Better Health, Better Care”*.

Access Support will work closely with the Performance Management Division to ensure a coordinated approach is adopted when connecting with NHS Boards across the range of performance management issues.

## 5.3 Risks to Delivery

Achieving the 18 Weeks Standard will require a wide-ranging, systematic approach to designing and managing each patient's journey through the primary and secondary healthcare systems from initial contact with a GP (or member of the primary care team), through tests and diagnosis, to treatment where required.

Managing the connections between the diverse parts of the overall healthcare system will require excellent administrative systems supporting the work of the clinical teams, with a strong emphasis on the patient's whole episode of care. There are significant clinical, administrative and management challenges to be addressed: some of this work is underway, but there is still a good deal to do.

These challenges include:

- ▶ Planning for, and recruiting, enough skilled clinical staff to undertake any additional activity required
- ▶ Putting in place the other resources – such as beds, theatres, and diagnostic equipment – to sustain the necessary increase in activity, both backlog and recurrent
- ▶ Implementing systems to accurately measure each patient's journey through the healthcare system to gather and report sufficient information to identify delays and allow remedial action where necessary
- ▶ Implementing eHealth systems to support joined-up healthcare between the diverse healthcare inputs into each patient pathway
- ▶ Ensuring sufficient financial resources to meeting the 18 Weeks Standard whilst leaving sufficient developmental resource for other healthcare priorities e.g. mental health, preventative/anticipatory care and public health
- ▶ Making sure that the 18 Weeks Standard does not distort clinical prioritisation: seeing urgent patients – such as cancer and cardiac cases – as quickly as possible and 'routine' patients in date order
- ▶ Achieving sound clinical leadership and engagement in both primary and secondary care
- ▶ Ensuring sustainable NHS Board Executive ownership and direction across the lifetime of the programme

The 18 Weeks RTT Programme Board will evaluate all risks to delivery as part of the oversight of work towards meeting the 18 Weeks RTT Standard. Each area of risk identified will lead to an Action Plan being implemented. Where necessary, the Programme Board will commission pieces of work nationally to support NHS Boards in meeting these challenges.

## 5.4 Timetable of the Key Deliverables To 2011

The table below summarises the succession of milestones, performance indicators and data collection landmarks which will be led by the 18 Weeks RTT Programme Board from its inception in October 2007, to achieving the 18 Weeks RTT Standard from December 2011.

|      |  |
|------|--|
| 2008 | <ul style="list-style-type: none"> <li>▶ National Delivery Teams in place</li> <li>▶ Equality Impact Assessment</li> <li>▶ Key start/stop definitions published</li> <li>▶ Completion of Service Redesign Strategy</li> <li>▶ 1st Baseline data for admitted patient pathways</li> </ul> |
| 2009 | <ul style="list-style-type: none"> <li>▶ 15 week and 6 week stage-of-treatment maximum waits in place</li> <li>▶ 1st Baseline data for non-admitted patient pathways</li> <li>▶ Next stage-of-treatment maximum waits set out</li> </ul>   |
| 2010 | <ul style="list-style-type: none"> <li>▶ First RTT performance targets achieved</li> <li>▶ Web-based data returns system in place</li> <li>▶ Final stage-of-treatment maximum waits in place</li> </ul>  |
| 2011 | <ul style="list-style-type: none"> <li>▶ Second RTT performance targets achieved</li> <li>▶ 18 Weeks RTT becomes operational standard for NHSScotland</li> </ul>   |

[www.18weeks.scot.nhs.uk](http://www.18weeks.scot.nhs.uk)



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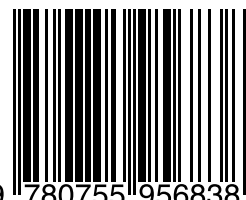
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