The Committee will meet at 8.45 am in the Mary Fairfax Somerville Room (CR2).

1. **Decision on taking business in private**: The Committee will decide whether to take item 4 in private.

2. **Section 22 report - The 2015/16 audit of NHS Tayside**: The Committee will take evidence on the Auditor General for Scotland report entitled "The 2015/16 audit of NHS Tayside: Financial sustainability" from—

   Paul Gray, Director-General Health & Social Care and Chief Executive NHS Scotland, Christine McLaughlin, Director of Health Finance, and Fiona McQueen, Chief Nursing Officer, Scottish Government.

3. **Section 23 report - Changing models of health and social care**: The Committee will take evidence on the Auditor General for Scotland report entitled "Changing models of health and social care" from—

   Paul Gray, Director-General Health & Social Care and Chief Executive NHS Scotland, Shirley Rogers, Director of Health Workforce and Strategic Change, Geoff Huggins, Director for Health and Social Care Integration, Christine McLaughlin, Director of Health Finance, and Fiona McQueen, Chief Nursing Officer, Scottish Government.

4. **Consideration of evidence**: The Committee will consider the evidence received at agenda items 2 and 3 and take further evidence from—

   Caroline Gardner, Auditor General for Scotland;

   Carol Calder, Senior Manager, and Jillian Matthew, Audit Manager, Audit Scotland.
The papers for this meeting are as follows—

**Item 2**

Written submissions PAPLS/S5/17/5/1

PRIVATE PAPER PAPLS/S5/17/5/2 (P)

**Item 3**

Written submissions PAPLS/S5/17/5/3

PRIVATE PAPER PAPLS/S5/17/5/4 (P)
Public Audit and Post-legislative Scrutiny Committee

5th Meeting, 2017 (Session 5), Thursday 9 February 2017

Section 22 report: The 2015/16 audit of NHS Tayside

Clerk’s Note

1. At today’s meeting, the Committee will take evidence from Paul Gray, Chief Executive of NHS Scotland and Director-General Health and Social Care, on the Auditor General report entitled “The 2015/16 audit of NHS Tayside”.

2. The Committee has previously taken evidence from NHS Tayside on this report, and will take further evidence from the health board on Thursday 30 March.

3. The purpose of today’s session is to discuss the implications for the Scottish Government of NHS Tayside’s financial sustainability plans and the agreements reached between NHS Tayside and the Scottish Government.

4. The Committee’s previous work on NHS Tayside can be read here.

5. The following documents are attached for today’s discussion:

   - A written submission from Paul Gray, Chief Executive of NHS Scotland and Director-General Health & Social Care (attached at Annexe A); and
   - Follow-up information from the external auditors of NHS Tayside (attached at Annexe B).

Gary Cocker
Assistant Clerk to the Committee
2016-17 position and underlying operating model

NHS Tayside remains on track to deliver the planned financial outturn in 2016-17, which assumes a deficit of £11.7 million or 1.7% of funding. The Scottish Government has agreed to provide repayable financial support up to the value of £11.7 million, in order to deliver a balanced position, predicated on a realistic plan to return the Board to financial balance.

This support in 2016-17 will be in addition to £20 million which has been provided to NHS Tayside over the last four years, bringing the total financial support to an anticipated value of £31.7 million.

Transformation Programme

NHS Tayside, with the support of the Scottish Government, has developed a Transformation Programme designed to deliver improvements for patients whilst also achieving increased cost effectiveness over the short to medium term. This addresses areas where the Board’s cost base is higher than average, based on NHSScotland Cost Data, and sets out measures to return the Board to sustainable financial balance by 2018-19. External scrutiny and challenge is provided by the Chief Operating Officer of NHSScotland, John Connaghan, who attends Programme Board meetings. As part of a package of tailored support from the Scottish Government, NHS National Services Scotland is also providing programme management and data analytic support to enable the identification of efficiency opportunities and sharing of best practice.

There is some early evidence to suggest that the NHS Tayside’s financial recovery plans are taking effect, with spend reducing in areas such as nurse agency costs. While this improvement is encouraging, the Scottish Government will expect to see replication of these improvements in the other key areas of spend to gain sufficient assurance on the robustness of the overall plan over the next 1-2 years.

The financial position is also supported by NRAC parity funding of £8 million in 2017-18, in addition to the baseline uplift of £10.5 million. NRAC funding is provided to ensure that no Board is further than 1% from parity, based on the calculated shares.

The Board is expected to repay the financial support that has been provided and a repayment profile will be agreed, on the assumption that this will begin in 2018-19 when financial sustainability is achieved.

PAUL GRAY

DIRECTOR-GENERAL HEALTH AND SOCIAL CARE, SCOTTISH GOVERNMENT
Gary Cocker  
Assistant Clerk  
Public Audit and Post-legislative Scrutiny Committee  
Room T3.60  
Scottish Parliament  
Edinburgh  
EH99 1SP

Dear Mr Cocker

Clarification of PwC evidence given at the Public Audit Committee

In response to your email of 12 January 2017, please see below clarification on PwC’s evidence of 2 December 2015, as requested.

On 15 December 2016, Colin Beattie asked (Public Audit and Post-legislative Scrutiny Committee Draft Official Report column 23),

“My first question is for the external auditors. On 2 December 2015, PricewaterhouseCoopers gave evidence that a substantial portion of the deficit was comprised of pension fund deficits and increased national insurance costs. I understand the national insurance costs, but I have seen no reference to pension fund deficits having to be funded by the board that is not referenced in any of the other documents that I have here. It is not referenced by Audit Scotland specifically as a cause of the deficit and it is not in your own management reports. First was the evidence that was given correct? Secondly, how do you account for pension fund deficits?”

(i) First was the evidence that given correct?

I confirm that the evidence provided on 2 December 2015 was correct.

At the Public Audit Committee meeting on 2 December 2015, Colin Beattie raised a question (Public Audit Committee Official Report Column 46), “I see some mention of changes to how the public pension schemes are valued. If I am not incorrect, it appears that the additional costs to the pension are £5.5 million. Kenny Wilson replied, “That is correct”. Colin Beattie asked, “Is that the deficit?” Kenny Wilson replied, “That is in effect the increase in costs that the board will be paying. It is similar to what is happening in all other boards as result of the recent revaluation of the national pension scheme.”

Colin Beattie’s question was referring to paragraph 22 of the Auditor General’s Section 22 report. The 2014/15 audit of NHS Tayside – Financial Management, “Key financial pressures for NHS Tayside relate to the increasing efficiency savings required to meet financial targets, and to ensure that it does not require further brokerage. This is exacerbated by the additional costs that will be incurred due to changes in how public pension schemes are valued, as well as changes in the National Insurance allowances for employees who contract out of the state pension, which accounts for 3.4 per cent of relevant employees’ earnings. The cost of the pension scheme changes to NHS Tayside in 2015/16 is £5.5 million and the National Insurance changes, effective from 2016/17, are estimated to cost approximately £7.8m.”

The wording used by Colin Beattie on 15 December 2016 is slightly different to the initial question. PwC clarified on 2 December 2015 that the additional £5.5m related to the increase in costs that NHS Tayside required to contribute to the pension scheme in 2015/16, which are determined by the scheme.
actuary. This increase in contributions, in addition to the increase national insurance charges, contributed to the financial pressures experienced by NHS Tayside. The evidence given on 2 December 2015 was correct and consistent with the narrative in the Section 22 report.

(ii) How do you account for pension fund deficits?

NHS Tayside participates in the NHS Superannuation Scheme for Scotland providing defined benefits based on final pensionable pay, where contributions are payable by the Board and credited to the Exchequer. The pension cost is assessed every five years by the Government Actuary and determines the rate of contributions required. The most recent actuarial valuation is published by the Scottish Public Pensions Agency and is available on their website.

The NHS Tayside Board are unable to separately identify its share of the underlying notional assets and liabilities of the scheme on a consistent and reasonable basis and therefore accounts for the scheme as if it was a defined contribution scheme, as required by IAS19 'Employee Benefits'. As a result neither a pension asset nor a pension deficit is recorded on the balance sheet of the Board and the amount charged to the Statement of Comprehensive Net Expenditure represents the Board’s employer contributions payable to the scheme in respect of the year. Following the most recent revaluation by the actuary of the pension scheme NHS Tayside’s pension contributions increased in 2015/16 to £55.5m from £49.4m in 2014/15.

We hope this clarifies matters, but you require any further information please do not hesitate to contact me.

Yours Sincerely

Kenneth Wilson
Partner
Clerk’s Note

1. At today’s meeting, the Committee will take evidence from Paul Gray, Chief Executive of NHS Scotland and Director-General Health & Social Care, on the AGS report entitled “Changing models of health and social care”. The Committee’s previous work on this report can be read here.

2. The Committee took evidence from Paul Gray and other Scottish Government officials, and then from East Renfrewshire Health and Social Care Partnership and Clackmannanshire and Stirling Integration Joint Board, on 15 September 2016. The Committee then took evidence from NHS Greater Glasgow and Clyde and NHS Highland on 27 October 2016.

3. On 19 December, Paul Gray provided the Committee with the Scottish Government’s Health and Social Care Delivery Plan, and members agreed to take further oral evidence on this plan. The Cabinet Secretary for Health, Wellbeing and Sport subsequently provided a copy of the local delivery plan guidance.

4. The Health and Sport Committee has also undertaken a lot of work on health and social care this session, and is currently in dialogue with the Scottish Government regarding workforce issues. That committee’s work on integrated joint boards (IJ Bs) is also relevant to today’s discussion.

5. The following documents are attached:

   - A written submission from Paul Gray, Chief Executive of NHS Scotland and Director-General Health & Social Care (attached at Annexe A);
   - The Scottish Government’s Health and Social Care Delivery Plan (attached at Annexe B); and

Gary Cocker
Assistant Clerk to the Committee
WRITTEN SUBMISSION FROM PAUL GRAY, DIRECTOR-GENERAL HEALTH AND SOCIAL CARE, SCOTTISH GOVERNMENT

On 20 October, I wrote to the Public Audit and Post-Legislative Scrutiny Committee with a commitment to publish by the end of 2016 a framework setting out how the Scottish Government would deliver the key programmes driving change and improvement across the health and other services. The Health and Social Care Delivery Plan was published on 19 December (it can be found here: http://www.gov.scot/Resource/0051/00511950.pdf).

The Delivery Plan sets out how the key challenges facing health and social care in Scotland will be addressed as part of a coordinated programme of work. It identifies the four priority blocks of activity: the National Clinical Strategy (including changes in primary and secondary care); health and social care integration; public health improvement; and NHS board reform. In addition, there are several key enabling actions which will support these blocks of work – such as the national workforce strategy for health and social care and Sir Harry Burns’ review of health and social care targets.

The Delivery Plan details the steps to ensuring that the 2020 Vision is not only achieved, but embedded and made sustainable through to the end of this Parliament and beyond. Our focus will be in achieving the Triple Aim: better care; better health; and better value. This will require several sets of parallel changes, including:

- building up the capacity of primary and community care to provide effective and proactive support to individuals;
- ensuring that health and social care integration enables greater support for people in their own homes and communities;
- reducing pressure on hospital and primary care that an ageing society will bring by reducing admissions, length of stay and delays in hospital;
- planning the delivery on clinical services by what is most effective and efficient, and taking forward the National Clinical Strategy commitment to consider which services would lead to better outcomes if planned and delivered on a regional, or national basis; and
- developing a comprehensive national approach to public health, with targeted strategies and actions on the key public health issues facing Scotland.

PAUL GRAY
DIRECTOR-GENERAL HEALTH AND SOCIAL CARE, SCOTTISH GOVERNMENT
Health and Social Care Delivery Plan

December 2016
# Health and Social Care Delivery Plan

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Introduction

1. Our aim\(^1\) is a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so.

2. This delivery plan sets out our programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
   - is integrated;
   - focuses on prevention, anticipation and supported self-management;
   - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
   - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
   - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

3. To realise these aims, we will continue to evolve our health and care services to meet new patterns of care, demand, and opportunities from new treatments and technologies. Since 2007 we have ensured that NHS funding has not only been protected but has increased to record high levels, supporting NHS frontline staffing to substantially increase. There have also been significant improvements in treatment times, reductions in mortality rates, and reductions in healthcare associated infections. As a consequence of these improvements, delivered by committed health and care staff across the country, patient satisfaction has also increased to record highs.

4. To meet the changing needs of our nation, investment, while necessary, must be matched with reform to drive further improvements in our services. Our services will increasingly face demands from more people with long-term conditions needing support from health and social care. These challenges were recognised in the Audit Scotland report\(^2\), NHS in Scotland 2016, and underline the importance of bringing together the different programmes of work to improve health and social care services.

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5. This plan is not an exhaustive list of all the actions being taken to improve our health and our health and social care system. While it concentrates on health services, our aspirations will only be delivered through a wider focus on the support provided by a range of services. It acknowledges that change must take place at pace and in collaboration with partners across and outside of the public sector, and that partnership working is essential for the planning that will deliver the actions described here.

**How Will We Deliver Our Plan?**

6. This plan will help our health and social care system evolve, building on the excellence of NHS Scotland, recognising the critical role that services beyond the health sector must play and is ultimately fit for the challenges facing us. What that will look like for individuals is described in more detail in **Appendix 1**. We must prioritise the actions which will have the greatest impact on delivery. We will focus on three areas, often referred to as the ‘triple aim’:

- we will improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all (**better care**);
- we will improve everyone’s health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management (**better health**); and
- we will increase the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention (**better value**).

**Better care**

7. We need to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. That requires a change in our approach to medicine and in how and where the services that support our health are delivered. First, we need to move away from services ‘doing things’ to people to working with them on all aspects of their care and support. People should be regularly involved in, and responsible for, their own health and wellbeing.
8. Ultimately, individuals and where appropriate, their families – should be at the centre of decisions that affect them. They should be given more freedom, choice, dignity and control over their care. Care planning should anticipate individuals’ health and care needs – both by helping those with chronic and other complex conditions to manage their needs more proactively, and by focusing on a prevention and early intervention approach to supporting health throughout people’s lives. This is not always a question of ‘more’ medicine, but making sure that support fits with, and is informed by, individual needs. Success should be measured by better outcomes for individuals, not simply on whether processes and systems have been followed. As set out in the Healthcare Quality Strategy for Scotland\(^3\), it is an approach to health rooted in the principles of care that is person-centred, safe and effective.

9. We need services that have the capacity, focus and workforce to continue to address the increasing pressures of a changing society. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces, not least with respect to an ageing population. For our Community Health Service, that will mean everyone should be able to see a wider range of professionals more quickly, working in teams. For acute and hospital services, it will mean thinking differently about how some health and care services are delivered if we are to ensure people receive high-quality, timely and sustainable support for their needs throughout their lives.

**Better health**

10. To improve the health of Scotland, we need a fundamental move away from a ‘fix and treat’ approach to our health and care to one based on anticipation, prevention and self-management. The key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health.

11. This can only be done by health and other key public sector services (such as social care and education) working together systematically. All services must be sensitive to individual health and care needs, with a clear focus on early intervention. Moreover, it will not just be what services can provide, but what individuals themselves want and what those around them – not least families and carers – can provide with support. Services need to be designed around how best to support individuals, families and their communities and promote and maintain health and healthy living.

Better value

12. Better value means more than just living within our means; it means improving outcomes by delivering value from all our resources. It is not just about increasing the efficiency of what we currently do, but doing the right things in different ways. This will demand an integrated approach to the components of the delivery plan so that the whole approach and its constituent parts are understood and joined up.

13. Critical to this will be shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment.

14. Taking full account of the current pressures on primary and community services, we need to redesign those services around communities and ensure that they have the right capacity, resources and workforce. At the same time, people should look to improved and sustainable services from hospitals.

15. We need to free up capacity in hospitals and acute care, allowing for specialist diagnostic and elective centres to provide better-quality services to people and potentially changes to be made to the location of some services. Services should be organised and delivered at the level where they can provide the best, most effective service for individuals. Regional – and in some case, national – centres of expertise and planning should develop for some acute services to improve patient care. The governance structures of all our NHS Boards should support these changes and maximise 'Once for Scotland' efficiencies for the kind of functions all health services need to deliver. That doesn’t mean structural change to NHS Boards responsible for the delivery of services to our patients but it does mean that they must work more collaboratively and across boundaries.

16. Evolving our services must also be rooted in a widespread culture of improvement. Sustainable improvements in care, health and value will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.

17. Our health and care system has achieved a great deal in the last ten years using improvement methods which are data rich, engaging of leaders and frontline staff, and outcome driven. The Scottish Patient Safety Programme⁴ is a good example of what this approach can deliver. While work in safety, efficiency and person-centred care has been planned and led centrally, the improvement has been local. The NHS Scotland workforce is crucial to this, and teams released to test and measure have already produced globally recognised improvements for Scotland’s patients, families and carers.

18. We will build on the extensive investment in improvement skills and capacity across the health service to continue testing and measuring changes to improve care, supported by the dedicated expertise of Healthcare Improvement Scotland.

19. In meeting the triple aim, our ambition is not about a single strand of work or necessarily about commissioning a new series of projects. Indeed, much of the work is already underway. It is about making sure the different components of change work together to achieve the interlinked aims of better care, better health and better value at pace. Across those different aims, our actions are being driven by four major programmes of activity:

- health and social care integration;
- the National Clinical Strategy;
- public health improvement; and
- NHS Board reform.

20. Taken together, these changes in health and social care will bring long-term sustainability of our services and the continuing improvement of the nation’s health and wellbeing. They are underpinned by a series of cross-cutting, thematic programmes of activity, which are also set out below.

### Health and social care integration

21. Optimising and joining up balanced health and care services, whether provided by NHS Scotland, local government or the third and independent sectors, is critical to realising our ambitions. Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. The people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs.

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22. For better integrated care to become a reality, the new Health and Social Care Partnerships must plan and deliver well-coordinated care that is timely and appropriate to people’s needs. We are integrating health and social care in Scotland to ensure people get the right care, at the right time and in the right place, and are supported to live well and as independently as possible. An important aspect of this will be ensuring that people’s care needs are better anticipated, so that fewer people are inappropriately admitted to hospital or long-term care. Consequently, we are focusing actions around three key areas: reducing inappropriate use of hospital services; shifting resources to primary and community care; and supporting capacity of community care.

### Health and social care integration: actions

#### Reducing inappropriate use of hospital services

In 2017, we will:

- Ensure Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. This will be a key lever in shifting the focus of care across health and social care services.

- Agree with partners how to deliver an ambition of raising the performance of the whole of Scotland on delayed discharges from hospitals to the performance of the top quartile of local areas. This will be done as a step to achieving our wider commitments of eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care.

- By 2018, we aim to: Reduce unscheduled bed-days in hospital care by up to 10 percent (ie. by as many as 400,000 bed-days) by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. A range of actions will be taken to achieve this, including improving links between secondary, primary and community care under integration, supported by further work to understand better and take action on the extent to which emergency admissions are currently inappropriate and avoidable. As a result, people should only stay in hospital for as long as necessary and get more appropriate care in a more homely setting. It will reduce growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by 2021 (as set out below). The annual reports produced by Health and Social Care Partnerships and regular monitoring data will enable progress to be tracked.
Health and social care integration: actions - continued

- By **2021**, we aim to: Ensure that everyone who needs palliative care will get hospice, palliative or end of life care. All who would benefit from a ‘Key Information Summary’ will receive one – these summaries bring together important information to support those with complex care needs or long-term conditions, such as future care plans and end of life preferences. More people will have the opportunity to develop their own personalised care and support plan. The availability of care options will be improved by doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting.

Shifting resources to the community

- By **2021**, we will: Ensure Health and Social Care Partnerships increase spending on primary care services, so that spending on primary care increases to **11 percent** of the frontline NHS Scotland budget. Again, the annual reports produced by Health and Social Care Partnerships and regular monitoring data will be used to assess progress.

Supporting the capacity of community care

- In **2017**, we will: Continue to take forward a programme of work to deliver change in the adult social care sector, together with COSLA and other partners. This has begun with work to reform the National Care Home Contract, social care workforce issues and new models of care and support in home care. Reform of the National Care Home Contract will maintain the continuity, stability and sustainability of residential care provision while embedding greater local flexibility, maximising efficiency, improving quality, enhancing personalisation and promoting innovation. This national, consensus-based approach to improving social care will reinforce the ability of Health and Social Care Partnerships to match care and health support for individuals more quickly and more appropriately.

National Clinical Strategy

23. The National Clinical Strategy sets out a framework for developing health services across Scotland for the next 10-20 years. It envisages a range of reforms so that health care across the country can become a more coherent, comprehensive and sustainable high-quality service – one that is fit to tackle the challenges we face. At its heart is a fundamental change in the respective work of acute and hospital services and primary and community care, and a change in the way that medicine is approached. As a result, the Strategy aims to:

- strengthen primary and community care;
- improve secondary and acute care; and
- focus on realistic medicine.
Primary and community care

24. Community and hospital-based care needs to be integrated and rebalanced to ensure that local health services are more responsive and supportive to the needs of individuals, not least those with chronic conditions who would be better supported in primary and community care. That requires reforming the latter to deliver a stronger, better resourced and more flexible service for people. We are also working to address the current workload pressures and recruitment challenges facing many GP practices and cannot simply result in a crude redistribution of pressures between different parts of the health service. To do this, we must:

• support individuals, families and carers to understand fully and manage their health and wellbeing, with a sharper focus on prevention, rehabilitation and independence;
• expand the multi-disciplinary community care team with extended roles for a range of professionals and a clearer leadership role for GPs;
• develop and roll out new models of care that are person- and relationship-centred and not focused on conditions alone;
• enable those waiting for routine check-up or test results to be seen closer to home by a team of community health care professionals, in line with the work of the Modern Outpatient Programme in hospitals (as detailed later);
• ensure the problems of multiple longer-term conditions are addressed by social rather than medical responses, where that support is more appropriate; and
• reduce the risk of admission to hospital through evidence-based interventions, particularly for older people and those with longer-term conditions.

We will achieve this by building up capacity in primary and community care and supporting development of new models of care.

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PAPLS/S5/17/5/3
ANNEXE B

### Primary and community care: actions

#### Building up capacity in primary and community care

- **In 2017**, we will: Continue the investment in recruitment and expansion of the primary care workforce which began in 2016, and which will mean that, by **2022**, there will be more GPs, every GP practice will have access to a pharmacist with advanced clinical skills and 1,000 new paramedics will be in post. This will reinforce the workforce and the capacity of primary and community care to support our services for the future and will be done in line with our National Health and Social Care Workforce Plan (as discussed later).

- **By 2018**, we aim to:
  - Have increased health visitor numbers with a continued focus on early intervention for children through addressing needs identified through the Universal Health Visiting Pathway\(^7\), which started in 2016. As a result of this, every family will be offered a minimum of 11 home visits including three child health reviews by **2020**, ensuring that children and their families are given the support they need for a healthier start in life.
  - Have commenced Scotland’s first graduate entry programme for medicine. This will focus on increasing the supply of doctors to rural areas and general practices more generally.
  - **By 2020**, we aim to: Have implemented the recommendations of the Improving Practice Sustainability Short Life Working Group, the GP Premises Short Life Working Group and the GP Cluster Advisory Group. These actions will support more sustainable GP practices over the long term and build stronger links to Health and Social Care Partnerships, ensuring that the changes in primary care are both effective and sustainable.

- **By 2021**, we aim to:
  - Have strengthened the multi-disciplinary workforce across health services. We will agree a refreshed role for district nurses by **2017**, train an additional 500 advanced nurse practitioners by **2021** and create an additional 1,000 training places for nurses and midwives by **2021**. This will build on four successive increases in student nursing and midwifery intakes to meet additional demand, especially in primary and community settings.
  - Have increased the number of undergraduates studying medicine by 250 as a result of the 50 additional places in Scotland’s medical schools introduced in **2016**.
  - Have increased spending on primary care and GP services by £500 million by the end of the current parliament so that it represents 11 percent of the frontline budget. This is a fundamental change in how health resources are directed and will enable the critical shift in balance to primary and community care.

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## Primary and community care: actions - continued

### Supporting new models of care

In **2017**, we will:

- Negotiate a new landmark General Medical Services contract, as a foundation for developing multi-disciplinary teams and a clearer leadership role for GPs.
- Test and evaluate the new models of primary care in every NHS Board, which will be funded by £23 million, and disseminate good practice with support from the Scottish School of Primary Care. These new models of care will include developing new, effective approaches to out-of-hours services and mental health support, and are essential for moving to a more person- and relationship-centred approach to individual care across the whole of Scotland.
- Taken forward the recommendations from the Review of Maternity and Neonatal Services and progress actions across all aspects of maternity and neonatal care.
- Launch Scotland’s Oral Health Plan, following consultation, as part of a comprehensive approach to modernise dentistry and improve the oral health of the population through a prevention and early intervention approach.

By **2018**, we will:

- Have rolled out the Family Nurse Partnership programme nationally to provide targeted support for all eligible first-time teenage mothers. This will give intensive support to mothers and their children and give their health and wellbeing a strong start.

### Secondary and acute care

25. People should only be in hospital when they cannot be treated in the community and should not stay in hospital any longer than necessary for their care. This will mean reducing inappropriate referral, attendance and admission to hospital, better signposting to ensure the right treatment in a timely fashion, and reducing unnecessary delay in individuals leaving hospital. Addressing admission to, and discharge from, hospitals will be the responsibility of Health and Social Care Partnerships; but all partners will need to work together to reduce the levels of delayed discharges, ensure services are in place to facilitate early discharge and avoid preventable admissions in the first place.

26. At the same time, within hospitals, more needs to be done to ensure better outcomes for people, while making a more effective use of resources. There is increasing evidence that better outcomes are achieved for people when complex operations are undertaken by specialist teams and some services are planned and delivered on a population basis. This might mean some services currently delivered at a local level would produce better outcomes for people if delivered on a wider basis. This kind of service change needs to be accompanied by investment in new, dedicated facilities to ensure that the capacity for high-quality, sustainable services can be delivered at the appropriate level.

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27. To achieve this we will take intensive and coordinated action in several key areas of secondary and acute care: reducing unscheduled care; improving scheduled care; and improving outpatients.

### Secondary and acute care: actions

#### Reducing unscheduled care

In 2017, we will:

- Complete the roll out of the Unscheduled Care Six Essential Actions\(^9\) across the whole of acute care. Through improving the time-of-day of discharge, increasing weekend emergency discharges and a more effective use of electronic information in hospitals, we will enhance a patient’s journey at each stage through the hospital system and back into the community without delay.
- Undertake a survey on admission and referral avoidance opportunities. This will give a strong evidence base to target modelling for how to reduce unscheduled care through integrated primary and secondary care services.

#### Improving scheduled care

In 2017, we will:

- Put in place new arrangements for the regional planning of services. The National Clinical Strategy sets out an initial analysis of which clinical services might best be planned and delivered nationally and regionally, based on evidence supporting best outcomes for the populations those services will serve. This is a critical first step towards strengthening population-based planning arrangements for hospital services, working across Scotland. NHS boards will work together through three regional groups. In 2018, the appropriate national and regional groups will set out how services will evolve over the next 15 to 20 years, in line with the National Clinical Strategy.
- Reduce cancellations and private care spend in scheduled care by rolling out the Patient Flow Programme from the current pilots across all NHS Boards. The Programme builds on the success of previous programmes – such as Day Surgery, Enhanced Recovery for Orthopaedics and Fracture Redesign – by increasing national and local capacity to use operations management techniques to improve care for patients. Four pilot boards are implementing improvement projects covering emergency and elective theatre operations, elective surgery planning and emergency medical patient flow. As this is expanded, it will introduce more responsive and efficient secondary care and reduce wastage and the unnecessary use of resources.

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\(^9\) [http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care](http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care).
Secondary and acute care: actions - continued

By 2021, we will:

- Complete investment of £200 million in new elective treatment capacity and expanding the Golden Jubilee National Hospital. Overall, this investment will ensure that there is high-quality and adequate provision of elective care services to meet the needs of an ageing population.

- Complete investment of £100 million in cancer care to ensure: earlier detection with more rapid diagnosis and treatment; more and better care during and after treatment, taking account of what matters most to people with cancer; increased entry to clinical trials/research; and an evidence driven cancer intelligence system for clinicians and patients with access to near-to-real time information through care pathways. Addressing cancer in such a comprehensive way will target one of the critical health issues facing the population.

Improving outpatients

- By 2020, we aim to: Have reduced unnecessary attendances and referrals to outpatient services through the recently-published Modern Outpatient Programme. The aim is to reduce the number of hospital-delivered outpatient appointments by 400,000, reversing the year-on-year increase of new appointments. It will draw on the existing Delivering Outpatient Integration Together (DOIT) Programme and other activities such as the Technology Enabled Care Programme to:
  - give GPs greater access to specialist advice to reduce the time people wait to get appropriate treatment;
  - use clinical decision support tools to reduce the amount of time people wait to get the right treatment;
  - reduce the number of attendances for people with multiple issues through a holistic approach to their support and care;
  - enable GPs to have more access to hospital-based tests so that people can be referred to the right clinician first time; and
  - facilitate more return or follow-up appointments in non-hospital settings through virtual consultation from their own home.
Realistic medicine

28. We need to change our long-term approach to the role of medicine and medical interventions in our health and wellbeing. A new clinical paradigm, based on a ‘realistic medicine’ approach and backed by clinical leadership, will support people through informed, shared decision-making that better reflects their preferences and what matters most to them. There needs to a greater focus on the discussions that medical practitioners have with people about their care, and what different types of medical intervention can entail. Relationships between individuals and practitioners should be based on helping people understand options about their care and choose treatment according to their preferences.

29. At the same time, we must get better value out of medicine and medical interventions and find ways to reduce any unnecessary cost. Waste and variation in clinical practice need to be addressed, and we should also support the reliable implementation of effective interventions that are not currently being made available to people.

30. Consequently, we need to take forward actions that will strengthen relationships between professionals and individuals as well as reduce the unnecessary cost of medical action.

### Realistic medicine: actions

**Strengthening relationships between professionals and individuals**

In **2017**, we will:

- Refresh our Health Literacy Plan, Making It Easy\(^{10}\), to support everyone in Scotland to have the confidence, knowledge, understanding and skills we need to live well with any health condition we have.

- Review the consent process for patients in Scotland with the General Medical Council and Academy of Medical Royal Colleges and make recommendations for implementation from **2018** onwards. This is a key element in transforming the relationship between individuals and medical professionals.

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Realistic medicine: actions – continued

By 2019, we aim to:
- Commission a collaborative training programme for clinicians to help them to reduce unwarranted variation. This will support a workforce that can find more effective and valued ways of delivering medicine.
- Refresh the Professionalism and Excellence in Medicine Action Plan and align high-impact actions to realistic medicine.

Reducing the unnecessary cost of medical action

By 2018, we aim to:
- Incorporate the principles of realistic medicine as a core component of lifelong learning in medical education and mainstream the principles of realistic medicine into medical professionals’ working lives at an early stage.

By 2019, we aim to:
- Develop a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost and reduce the overall cost of medicine.

Public health improvement

31. Scotland’s ability to respond to infectious diseases and other risks to health matches and, in some cases, exceeds that of much of the developed world. But in common with many developed societies, we face greater challenges to public health arising from lifestyle behaviours, wider social-cultural factors that prevent positive health choices being made and a modern environment that impacts on the health and wellbeing of individuals, families and communities. There are many social determinants which impact on health and wellbeing, including those that can affect us from our earliest years throughout our lives, such as Adverse Childhood Experiences. We need to increase public and service knowledge and awareness of where avoidable harm can be reduced, including a wider understanding of both physical and mental health and the right actions to promote and strengthen healthy lifestyles.

32. This requires a concerted, sustained and comprehensive approach to improving population health through targeting particular health behaviours, acting to reduce avoidable harm and illnesses and taking a population- and lifetime-wide approach to prevention and early intervention treatment. We will:

- create a clear set of **national public health priorities** for Scotland as a whole and streamline the currently cluttered **public health landscape**;
- develop and build on our sustained approach to addressing the **key public health issues** of alcohol and tobacco misuse and diet and obesity;
- drive forward a new approach to **mental health** that ensures support and treatment are mainstreamed across all parts of the health service – and beyond – and is not simply the responsibility of specialist services, working within the framework of a new 10-year mental health strategy to be published in early 2017; and
- support a **More Active Scotland**\(^\text{12}\).

### Public health improvement: actions

**Supporting national priorities**

- **In 2017**, we aim to: Set national public health priorities with SOLACE and COSLA, that will direct public health improvement across the whole of Scotland. This will establish the national consensus around public health direction that will inform local, regional and national action.
- **By 2019**, we aim to: Support a new, single, national body to strengthen national leadership, visibility and critical mass to public health in Scotland. Such a body will have a powerful role in driving these national priorities and providing the evidence base to underpin immediate and future action.
- **By 2020**, we aim to: Have set up local joint public health partnerships between local authorities, NHS Scotland and others to drive national public health priorities and adopt them to local contexts across the whole of Scotland. This will mainstream a joined-up approach to public health at a local level.

Public health improvement: actions – continued

Supporting key public health issues

In 2017, we will:

• Continue delivery of the ambitious targets set out in our 2013 Strategy, Creating a Tobacco Free Generation\(^\text{13}\), including reducing smoking rates to less than 5 percent by 2034. We will implement legislation to protect more children from secondhand smoke and reduce smoking in hospital grounds.

• Refresh the Alcohol Framework\(^\text{14}\), building on the progress made so far across the key areas of: reducing the harms of consumption; supporting families and communities; encouraging positive attitudes and choices; and supporting effective treatment. A key part of the Framework is the introduction of a minimum unit price for alcohol and we will work towards its implementation at the earliest opportunity, subject to the current legal proceedings. This will combine into a highly ambitious approach to reducing alcohol harm in Scotland.

• Consult on a new strategy on diet and obesity. There are huge preventable costs to NHS Scotland and society associated with poor diet, as one of the critical health issues we are facing, and it requires a different approach to diet and obesity.

• Introduce the Active and Independent Living Improvement Programme which will support people of all ages and abilities to live well, be physically active, manage their own health conditions, remain in or return to employment, and live independently at home or in a homely setting.

• By 2021, we will: Deliver the Maternal and Infant Nutrition Framework with a focus on improving early diet choices and driving improvements in the health of children from the earliest years. This will include: by 2017, rolling out universal vitamins to all pregnant women; by 2019, consolidating best practice and evidence on nutritional guidance for pregnancy up to when children are aged 3, and developing a competency framework to promote and support breastfeeding; and by 2020, have integrated material into training packages for core education and continuing professional development.


Public health improvement: actions - continued

Supporting mental health

- **By 2018**, we will: Improve access to mental health support by rolling out computerised cognitive behavioural therapy services nationally.

By **2019**, we will:
- Have evaluated the most effective and sustainable models of supporting mental health in primary care, and roll these out nationally by **2020**.
- Have rolled out nationally targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder.

By **2020**, we will:
- Have improved access to mental health services across Scotland, increased capacity and reduced waiting times by improving support for greater efficiency and effectiveness of services, including Child and Adolescent Mental Health Services and psychological therapies. This will be accompanied by a workforce development programme and direct investment to increase capacity of local services.
- Have delivered new programmes promoting better mental health among children and young people across the whole of Scotland.
- **By 2021**, we will: Have invested £150 million to improve services supporting mental health through the actions set out in the 10-year strategy.

Supporting a More Active Scotland

- **In 2017**, we will: Publish a new delivery plan to support the Active Scotland Outcomes Framework and the Vision for a More Active Scotland, with greater action to address inequalities in physical activity across Scotland and a refocusing of resources.
- **By 2019**, we will: Have embedded the National Physical Activity Pathway in all appropriate clinical settings across the health care system, ensuring that:
  - hospitals routinely support patients and staff to be more physically active;
  - we build on our success in schools, creating a culture of being active within children and young people. This will include rolling out the Daily Mile, extending the number of school sports awards, strengthening the Active Schools network creating more quality opportunities and supporting more active travel to and from school;
  - all partners stay on track for delivering 200 Community Sports Hubs, providing local places for communities to be active designed by themselves around their own needs; and
  - we continue to build on the legacy of the 2014 Commonwealth Games using the European Championships in Glasgow in 2018 to encourage more Scots to be active.
33. As the NHS moves into this new and changing delivery environment, we need our health bodies and governance models to reflect those changes and support the delivery for the people of Scotland. Our reform focus will continue to be on providing quality care for people, a shift towards prevention and early intervention, and making best use of our resources, rather than on structures and bureaucracy. Governance arrangements will only adjust to support this shift if required – i.e. the ‘form’ of governance would follow the ‘function’ of service planning and delivery. Any such changes would have to meet two tests. Firstly, that the changes were better able to respond to the needs of local communities. Secondly, that the changes would have to ensure better collaboration between NHS boards and, additionally, improve how our NHS works with providers of other public services to secure better outcomes for people.

34. We will also build on the work that has already taken place through a ‘Once for Scotland’ approach to provide efficient and consistent delivery of functions and prioritise those non-patient facing services which make sense to be delivered on a national basis. The approach will consider the differing needs across Scotland, and will be, for example, 'island-proofed' as part of the Scottish Government’s wider commitment on recognising the distinct nature of island communities. Our territorial and patient facing national boards such as the Ambulance Service and NHS 24 must be allowed to focus on delivery of the “triple aim” of better care, better health and better value.

### NHS Board reform: actions

In 2017, we will:

- Review the functions of existing national NHS Boards to explore the scope for more effective and consistent delivery of national services and the support provided to local health and social care system for service delivery at regional level. As part of this, clear guidance will be put in place to NHS Boards that their Local Delivery Plans for 2017/18 must show their contributions to driving the work of this delivery plan, not least their contributions in support of the regional planning of clinical services.

- Ensure that NHS Boards expand the 'Once for Scotland' approach to support functions – potentially including human resources, financial administration, procurement, transport and others. A review will be completed in 2017, and new national arrangements put in place from 2019.

- Start a comprehensive programme to look at leadership and talent management development within NHS Scotland. This will ensure that current leaders are equipped to drive the changes required in health and social care, but it will also ensure sustainability of approach by identifying the next cohort of future leaders of NHS Scotland.
Cross-cutting actions

35. Improvements will be driven by the key components set out above, but they will need to be supported by a series of cross-cutting sets of actions. These are the key programmes of work which will inform all the change set out here:

- our approach to improving the services for children and young people through Getting It Right For Every Child;
- the National Health and Social Care Workforce Plan;
- the review of health and social care targets.
- a focus on research and development, innovation and digital health; and
- a robust approach to engagement.

Getting It Right For Every Child

36. The principles of our Getting It Right For Every Child\(^{15}\) approach to improving services for children and young people are simple: more effective and widespread prevention and early intervention; better cooperation amongst professionals and between them, the child or young person, and their family; and a holistic approach to addressing a child’s wellbeing. In addition to actions included in the main components of work above, we will drive this agenda through: continued implementation of Children and Young People (Scotland) Act 2014\(^{16}\), in particular, the Named Person and the Child’s Plan; and developing a new Child and Adolescent Health and Wellbeing Strategy in 2017. This will form the cornerstone for a comprehensive approach to ensuring that all the factors affecting a child’s or young person’s health are regularly identified and supported with the individual, their family and, where appropriate, services.

\(^{15}\) http://www.gov.scot/Topics/People/Young-People/gettingitright/what-is-girfec/foundations.

National Health and Social Care Workforce Plan

37. Reform that delivers improved outcomes for patients can only happen with a committed, supported workforce that has the right skills, flexibility and support. Everyone Matters: 2020 Workforce Vision\(^\text{17}\) sets out the health and social care workforce policy for Scotland, and a vision and values. The National Health and Social Care Workforce Plan will take forward the commitment to a sustainable workforce by establishing the priorities for action, assess current resources, and detail the actions to close the gap between what we have and what we will need to deliver high-quality, integrated and transformed services to those who need them. To be published in Spring 2017, the Plan will:

- align workforce planning more effectively with the different components of the delivery plan so that capacity challenges are identified at an early stage; and
- improve workforce planning practice to make clearer what should be planned at national, regional and local levels.

A short discussion paper outlining these arrangements, produced in consultation with key stakeholders, is attached at Appendix 2.

Review of health and social care targets

38. Targets can be instrumental in driving improvements in performance, but we need to ensure that performance is focused on improving outcomes for individuals and communities. Chaired by Sir Harry Burns, a national review is being conducted into the present suite of targets and indicators for health and social care. The review will work with service users, staff, professional bodies, and providers to ensure targets and performance indicators lead to the best outcomes for people being cared for, whether in hospital, primary care, community care or social care services. The interim report is expected in the Spring and the final report later in 2017.

Research and development, innovation and digital health

39. Research is central to all high-performing health systems, leading to better targeted and more personalised treatment and improved patient outcomes. Scotland has a solid track record as a health research nation and in winning competitively awarded research funds. Research and development (R&D) and innovation are core activities for our health and social care services in Scotland and development in health and social care will depend on the science and discovery that underpins it. Through NHS Research Scotland (NRS), there is already a firm foundation of collaborative R&D partnership working successfully across NHS Scotland, academia and life-sciences industries. We will continue to invest in NRS to support health-related R&D, building on its model to drive a renewed effort in health innovation, as well as in Scottish Health Innovations Ltd to encourage, develop and appropriately commercialise innovative ideas and new technologies arising from within the health services. By 2018, we will also:

\(^{17}\) http://www.workforcevision.scot.nhs.uk.
• create governance structures to support a new, coherent and concerted effort on the promotion and exploitation of health-related innovation and new technologies for the benefit of the whole health service;
• develop regional innovation clusters to translate cutting-edge research and innovation into excellent individual health care; and
• support innovation and technology capacity-building at national, regional and local levels by facilitating, encouraging and empowering those who work in health and care to identify innovation challenges and develop partnerships to deliver solutions.

40. Digital technology is key to transforming health and social care services so that care can become more person-centred. Empowering people to more actively manage their own health means changing and investing in new technologies and services, by, for example enabling everyone in Scotland to have online access to a summary of their Electronic Patient Record. The time is right to develop a fresh, broad vision of how health and social care service processes in Scotland should be further transformed making better use of digital technology and data. There is an opportunity to bring together all IT, digital services, tele-health and tele-care, business and clinical intelligence, predictive analytics, digital innovation and data use interests in health and social care. This will be taken forward through:

• a review led by international experts of our approach to digital health, use of data and intelligence, to be completed in 2017, which will support the development of world-leading, digitally-enabled health and social care services; and
• a new Digital Health and Social Care Strategy for Scotland, to be published in 2017, that will support a digitally-active population, a digitally-enabled workforce, health and social care integration, whole-system intelligence and sustainable care delivery.

Engagement

41. Engagement with patients, service users, staff and their representatives, key stakeholders and volunteers is vital in delivering our plans. The public and all stakeholders must not only be aware of the broader context within which decisions about any service changes are taken over the coming years, but inform how those decisions are taken from a position of understanding both the challenges and opportunities facing us.
42. There has already been huge engagement in developing health and social care integration, realistic medicine and through the National Conversation on Creating a Healthier Scotland\textsuperscript{18}. The latter alone reached over 9,000 people through 240 events and engagements and with over 360,000 inputs through digital and social channels. Building on this work, the Our Voice framework\textsuperscript{19} has been developed in partnership with NHS Scotland, COSLA, the ALLIANCE and other third sector partners to support people to engage, with purpose, in improving health and social care. The framework builds on much of the good work already underway at individual and local level to hear the voices of patients, their families, carers and unpaid carers, and involve them in improvement. We will explore ways in which Our Voice can support engagement on the work of this delivery plan through use of methods such as the national citizens' panel and citizens' juries.

43. Key to this will also be building on existing engagement mechanisms to ensure that all those who will be critical in delivering this change are fully involved in planning how it will take place. Work will continue with delivery partners across the public sector on how to take forward the different existing components of the delivery plan’s activity, and this will be accelerated in the context of ensuring that the links between different activities are identified and opportunities for joint working maximised.

44. At the same time, it will be essential that engagement with the NHS Scotland workforce around this agenda is robust and makes full use of the potential of the workforce to drive this change. Through developing the National Health and Social Care Workforce Plan and as part of wider professional engagement, we will work with relevant organisations and bodies to ensure that the workforce needs of the future are identified early and fully and the contributions of the workforce to these workstreams are properly supported. In recognition of the established partnership working model in NHS Scotland, we will develop this work further in collaboration with trade union and professional organisations.

\textsuperscript{18} https://healthier.scot/.
\textsuperscript{19} http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice_framework.aspx#.WEk5e7lDTEo.
How Will Delivery Of Our Plan Be Funded?

45. Achieving long-term financial sustainability of our health and care system and making the best use of our total resources is critical to this delivery plan. We will need to deliver transformational change while managing increasing demand for services, inflationary pressures and the growing needs of an ageing population. This will require a short-, medium- and long-term focus on sustainability and value of services alongside reform.

46. Over the next five years, we will invest £70 billion of resources in our health and social care system. At the same time the impact of our demographics and inflation in pay and in prices means that we must increase our overall productivity. Health funding is expected to grow in resource terms by the end of this Parliament, with significant planned investment in areas such as primary care, mental health, social care, cancer and new elective capacity. Spending on primary care services is set to increase by £500 million so that it accounts for 11 percent of the frontline NHS Scotland budget by May 2021.

47. A financial plan will support this delivery plan, creating the environment and incentives for change, and supporting transition. This will ensure stability to maintain the quality of care, health of the population and best value from resources through:

- providing dedicated funding to invest in the levers of change;
- putting in place arrangements to support sustainable financial balance across the whole of NHS Scotland;
- creating short-term financial capacity to allow time to deliver change through efficiencies in current ways of working;
- supporting clinicians to make best use of resources through investment in costing and value tools to support shared decision making on clinical and financial evidence;
- driving an early intervention and prevention approach across services; and
- developing an approach to infrastructure and digital that supports the shift from hospital to community and primary care and works across the public sector estate.

48. The components within the delivery plan will be financially and economically assessed at key stages in their development, from initial scoping through to implementation, to create a comprehensive assessment of affordability and sustainability.
How Will Delivery Be Tracked?

49. It is crucial that the delivery plan does not remain a simple statement of intent, but a continuing process of monitoring, challenge and review. Every component of the delivery plan will continue to be tested for its fit with our strategic aims and how it supports shifting the balance of care towards community settings, managing demand, reducing waste, harm and variation, and delivering value from our total resources. We will challenge the expected levels of investment and levels of efficiencies in local, regional and national plans to ensure delivery of the aims of the delivery plan.

50. As part of this, a robust, integrated performance framework for the different components of the delivery plan will be developed for early 2017. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated outcomes can be fully realised, but that the delivery plan is updated with new measures as appropriate. It cannot remain a static document, but a way of continually assessing whether the measures and approach being taken are appropriate and sufficient to secure our Vision.
### Appendix 1: What Will Be Different in a Transformed Health and Social Care System in Scotland?

<table>
<thead>
<tr>
<th>What will be different for individuals</th>
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</thead>
<tbody>
<tr>
<td>• People will be equal partners with their clinicians, working with them to arrive at decisions about their care that are right for them. They will be supported to reflect on and express their preferences, based on their own unique circumstances, expectations and values. This might mean less medical intervention, if simpler options would deliver the results that matter to them.</td>
</tr>
<tr>
<td>• People will be supported to have the confidence, knowledge, understanding and skills to live well, on their own terms, with whatever conditions they have. They will have access to greater support from a range of services beyond health, with a view to increasing their resilience and reinforcing their whole wellbeing.</td>
</tr>
<tr>
<td>• Health and social care professionals will work together to help older people and those with more complex needs receive the right support at the right time, and where possible, live well and independently by managing their conditions themselves.</td>
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<tr>
<td>• Hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter. Individuals will benefit from more care being delivered in the community, and where possible, at home.</td>
</tr>
<tr>
<td>• Everyone will have online access to a summary of their Electronic Patient Record and digital technology will underpin and transform the delivery of services across the health and social care system.</td>
</tr>
<tr>
<td>• Children, young people and their families will benefit from services across the public sector – including health, education, social care and other services – working together to support prevention and early intervention of any emerging health issues.</td>
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<tr>
<td>• The diet and health of children from the earliest years will improve from coordinated and comprehensive nutritional support for children and families.</td>
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<tr>
<td>• There will be a significant reduction in the harmful impact on health of alcohol, tobacco and obesity, and our approach to oral health will be founded on prevention.</td>
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<tr>
<td>• People will have access to more and more effective services across the health system to support mental health, including the specialist services for children and young people. Mental health will be considered as important as physical health.</td>
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<tr>
<td>• People will lead more active, and as a result, healthier lifestyles.</td>
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<tr>
<td>• People will receive more sensitive, end of life support that will aim to support them in the setting that they wish. All those who need hospice, palliative or end of life care will receive it and benefit from individual care and support plans. Fewer people will die in hospitals.</td>
</tr>
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What will be different for communities

• Most care will be provided locally through an expanded Community Health Service, avoiding the need to go into hospital.

• People will benefit from local practices and other community care with a wider range of available support. Practices will typically consist of complementary teams of professionals, bringing together clusters of health support and expertise. Communities will have access to quicker and joined-up treatment – this might be the GP, but supported by a team including highly-trained nurses, physiotherapists, pharmacists, mental health workers and social workers. GPs will take on a greater leadership role.

• Local practices will be able to provide more information and secure better advice for people locally without the need to attend hospitals to get specialist consultancy advice. That advice will be increasingly delivered locally.

• Families will receive more integrated and extended primary and community care for their children. There will be more home visits from health care professionals, including three child health reviews, and teenage mothers will receive more intensive and dedicated maternal support.

What will be different regionally

• Some clinical services will be planned and delivered on a regional basis so that specialist expertise can deliver better outcomes for individuals, services can be provided quicker and stays will be shorter. This will ensure that the services provided to people are high quality and the expertise remains as effective as possible.

• More centres will be provided to help NHS Scotland handle the growing demand for planned surgery, particularly from an ageing population. Such centres will allow medical professionals to become extremely skilled and have facilities to the highest standards. This will take pressure off other hospitals so there are fewer delays when urgent or emergency care is needed.

What will be different nationally

• There will be a national set of health priorities giving clear, consistent direction for how to improve public health across the whole of Scotland and a single national body to drive the priorities.

• Services and functions of the health service which can be delivered more efficiently at national level will be done on a ‘Once for Scotland’ basis.
Appendix 2: National Health and Social Care Workforce Plan: Outline Discussion Paper

Introduction

1. This document sets out the initial arrangements for the production, in early 2017, of a National Discussion Document on workforce planning in health and social care. A consultation exercise undertaken at this stage will report back and a final version of a National Health and Social Care Workforce Plan will be published in Spring 2017. There are three distinct stages:
   - **Outline Discussion Paper**: setting out initial arrangements prior to -
   - the **National Discussion Document**: to be published in early 2017, leading to -
   - the **National Health and Social Care Workforce Plan**, to be published by Spring 2017.

2. This is a complex area which will need time for all relevant stakeholders to have an opportunity for real engagement in order fully scope the landscape, issues and levers in order to ‘get it right’. The production of the Workforce Plan by Spring 2017 should be seen as an intermediate step and part of a developing and iterative approach, not an end in itself. The Workforce Plan will be the first in an annual series aimed at improving workforce planning practice, as well as developing more effective and informed intelligence.

3. The Workforce Plan will present an opportunity to: a) refresh guidance for production of NHS Scotland workforce plans; and b) introduce workforce planning to which provides an overall picture for health and social care staff. The current position is different for NHS Scotland and Health and Social Care Partnerships, but the two will become increasingly interdependent in delivering care across Scotland, linking back to the recent Audit Scotland report recommendations. This outline discussion paper, the forthcoming National Discussion Document and the Workforce Plan, therefore, seek to achieve a balance in referring to working planning as it applies across NHS Scotland, and social work and social care interests.

4. Health and Social Care Partnerships are expected to develop integrated workforce plans to ensure people get the right support at the right time from staff who not only have the skills but are working in the most appropriate setting. The Workforce Plan should, therefore, look to support this agenda.
5. The need for the Workforce Plan derives from the national and international context within which workforce planning in health and social care needs to take place. The incremental approach reflects the timelines required to deliver a changed workforce and the effects of changing demand, demography and generational perspectives on work/life balance and careers. While the Workforce Plan and subsequent annual Plans will be practically focused and useable, they must also read across to and be able to adjust to strategic areas of health and social care reform.

6. This paper describes outline arrangements, processes around engagement, and some of the context for this work.

Aim of the Outline Discussion Paper

7. The aim of this paper is to set out the intended actions reflecting the Scottish Government’s Programme for Government commitment on workforce planning and to assure organisations within health and social care – including NHS Boards and the full range of employers in the social service sector – of their full involvement in the work being undertaken to realise this commitment.

Objectives

8. We are working to develop national and regional workforce planning through a Workforce Plan which helps deliver the direction set out in a range of strategic developments – among them this delivery plan as well as the National Clinical Strategy – while also reflecting progress in key areas of health and social care such as integration and self-directed support. To do this, we must ensure that all key stakeholders are able to contribute to and help to shape the Workforce Plan, so that it addresses their interests and issues.

9. As we work towards a Workforce Plan in 2017, we want to ensure a clear view for those responsible for workforce planning within health and social care services, on:
   - roles and responsibilities with regards to workforce planning, and in the production of the Workforce Plan itself, as well as current arrangements already in place;
   - Ministers’ intentions to ensure better coordination of national, regional and local workforce planning against a complex and shifting health and social care background; and
   - how more consistent and coordinated workforce planning can help deliver better services and outcomes for Scotland's people.

The Workforce Plan will also provide an opportunity to consider integrated workforce planning arrangements, recognising differences in workforce planning practice between NHS Scotland, local authorities and other social service employers.
10. The need for a Workforce Plan stems from the Programme for Scotland commitments in relation to health and social care, as well as from Audit Scotland recommendations on workforce planning in relation to its recent findings on the public sector workforce\(^{20}\), health and social care integration\(^{21}\) and on the NHS in 2016\(^{22}\).

11. It is important that the Workforce Plan should apply in an integrated context, covering the social care services sector, comprising a wide range of support and services and employing 130,000 NHS Scotland staff and over 200,000 staff across the third, independent and public sectors\(^{23}\). There is a statutory duty on NHS Boards to undertake workforce planning and this will continue to apply. We, therefore, expect the Workforce Plan to be:

- **a strategic document**, setting out the workforce vision for health and social care services, the priorities to be taken forward, the assessment of current resources to deliver the vision, and actions to close the gap between what we have and what we will need;
- **apply at a national level**, linking, as appropriate, to regional and local levels; and
- **active and useable**, making coherent workforce planning links between national and regional activity and offering frameworks for practical workforce planning in both the NHS Scotland and social services sectors.

12. The Workforce Plan will consider how workforce planning is influenced by the following developments in health and social care:

- public service reform and integration of health and social care, allowing space for NHS Boards, local authorities and Health and Social Care Partnerships to plan for the workforce for the health and social care system that Scotland needs, now and in future;
- Progr.5ng plans for elective centres;
- recommendations on workforce planning from Audit Scotland\(^{24}\);
- the NHS Scotland Workforce 2020 Vision, Everyone Matters; and
- approaches and methodologies in use which support development of services delivered by multi-disciplinary teams – for example, the Workforce Planning Guide by the Scottish Social Services Council, the NHS Scotland 6 Step Model, and local authority tools and guidance.


\(^{24}\) “The Scottish Government, in partnership with NHS Boards and integration authorities, should share good practice about health and social care integration, including effective governance arrangements, budget-setting and strategic and workforce planning”. [Audit Scotland – NHS in Scotland 2016-17].
13. In relation to meeting the challenging health and social care needs required, the Workforce Plan will:

- set out a useable framework to improve current workforce planning practice;
- clarify how workforce planning should take place nationally, regionally and locally across health and social care;
- map and coordinate similarities and differences in workforce planning practice; and
- harmonise, reconcile and share approaches where appropriate, while preserving what works well.

Intended outcomes

14. The Workforce Plan will help to bring about:

- clearer understanding about respective roles and responsibilities on workforce planning;
- clearer understanding about the changes and improvements which need to be made and why;
- improved consistency, allowing for sharing of best workforce planning practice across Scotland;
- clearer evidence that robust workforce planning helps to deliver effective, efficient delivery of services and better patient/service user/client outcomes; and
- a longer-term view of the challenges in regard to capacity and capability of this workforce and the solutions we need to design now in response to these.
Process for developing the Workforce Plan

15. An important first step will be to define and articulate the scale of the challenge and the scope of the Workforce Plan. Though NHS Boards are required to follow a single methodology, workforce planning practice can vary significantly. There is also considerable diversity in workforce planning practice between NHS Boards and employers in the social services sector. However, there are indications that workforce challenges are common to both, including: an ageing workforce and the need to provide care for a larger proportion of the population; increasing activity and demand on services; difficulties in recruitment for some hard-to-fill posts; the need to design multi-professional approaches to service challenges; and the availability and suitability of training and career pathways. Starting to be clearer about what can/should be dealt with nationally, regionally and locally will help.

16. Some workforce planning issues will require more pressing action. For the short to medium term, the Workforce Plan will need to:
   • for NHS Scotland, align workforce planning objectives with strategic policies, enabling capacity challenges to be identified before they become an issue;
   • improve workforce planning practice and issue more useable guidance to assist employers. This will apply across health and social care and, for NHS Scotland, will be specific about how this can be done at national, regional and local levels, recognising the key interest of Health and Social Care Partnerships in this development; and
   • examine how collecting, reporting and triangulating workforce planning information might be undertaken more efficiently, so we ensure it embeds with strategic and financial planning issues and translates into planned rather than reactive action. This might also be explored in an integrated context, given the range of different tools and resources available.

17. For the longer term, the Workforce Plan will need to develop a series of actions, perhaps set within a framework of tools accessible by different employers, allowing them to use these to build sufficient numbers of appropriately trained and qualified staff. This will involve exploring how to develop better intelligence through workforce analysis – being clear how a range of demand factors impact on supply. We will want to describe this in more detail as we move to publish the National Discussion Document in early 2017.
Timescale

18. Designing a framework for workforce planning which can apply successfully to different sectors will take time. The arrangements for publishing the National Discussion Document and the Workforce Plan are:

- in **December 2016**, issue this Outline Discussion Paper, seeking input in parallel from key stakeholders and consulting with COSLA and other key local government partners, NHS Management Steering Group, the Scottish Partnership Forum, the Human Resources Working Group on Integration and employer representative bodies such as Scottish Care and the Coalition of Care and Support Providers in Scotland. There will also be discussions with NHS Scotland and Health and Social Care Partnerships, professional bodies, representatives from the primary care sector and other professional stakeholders;
- in **early 2017**, publish the National Discussion Document, aligning with other relevant publications/releases at that time; and
- in **Spring 2017**, publish the National Health and Social Care Workforce Plan, which NHS Boards and employers in the social care sector can use to support development of their local plans, working with Health and Social Care Partnerships as appropriate.

Approach

19. The proposed new approach in the Workforce Plan will require roles and responsibilities in respect of workforce planning activity to be clarified and will involve:

i. forging closer links between and among:

- senior managers in NHS Boards, local government and the social services sector responsible for strategic planning;
- planners in NHS Boards, local government and the social services sector involved with implementing robust, progressive workforce plans, and aligning them with those for financial and service planning;
- service managers, in a unique position to know the strengths and weaknesses of services to patients, service users and clients provided locally;
- groups of health and social care professionals, whose views on achieving an optimum workforce balance will help build a workforce which will meet the future needs of health and social care;
- trade unions across health and social care, whose input is key to creating the right working conditions for those professionals; and

ii. equipping NHS Boards, local government and the social care sector with the means to plan ahead effectively to ensure they have the right staff in the right place at the right time to provide safe, high-quality health and social care services for Scotland’s people.
Next steps

20. We want as far as possible to use the existing infrastructure to work towards a Workforce Plan by:

- using this Discussion Paper and the National Discussion Document to invite constructive input, views and comment; and
- visiting NHS Boards, Health and Social Care Partnerships, COSLA, local authorities and other social services employers to seek views, intelligence and support; and consulting the full range of stakeholders across the health, social care sectors, independent sector, trade unions and professional/regulatory organisations, educational institutions and other interested parties.

21. Arrangements covering governance, data and risks are currently being put in place to underpin the development of the Workforce Plan. These will ensure priority issues faced by the health and social care sector are addressed in a fully inclusive way. Once agreed, these arrangements will be shared with relevant parties.

Challenges

22. Some of the workforce planning challenges specific to NHS Boards and social services sector are outlined below.

NHS Boards

23. Building a more effective workforce planning network with NHS managers, including HR Directors and workforce planners in NHS Boards, is urgently required.

- **Nationally:** we will hold early discussions with HR Directors about the establishment of a national workforce planning group, to be taken forward in partnership between Scottish Government and the service, to ensure there is clarity of responsibility, governance and expectation. Dialogue to facilitate and establish this will involve membership from the wider medical and non-medical professions. This group will also need to consider how best to involve Health and Social Care Partnerships and social care representatives on practical workforce planning issues. The group will require a work programme that is solution-driven, and will need an active and dynamic agenda that prioritises workforce planning challenges, linked clearly to national priorities.

- **Regionally:** regional workforce planning already takes place in the North, West and South East/Tayside – but it is variable in scope. A more inclusive approach is needed to allow solutions to be designed across individual NHS Board boundaries. The discussions above could also consider how work should be grouped at regional level, to evolve regional approaches to particular capacity challenges.
• **Locally:** we need to maintain links with individual NHS Boards, local authorities and Health and Social Care Partnerships to ensure they are aware of and able to respond to the challenges in the Workforce Plan.

**Social care employers**

24. The Workforce Plan will need to recognise and address the challenges faced by the social services sector in recruiting and retaining the staff needed to deliver social care services. It will need to be relevant in different contexts, and achieve a 'fit' between existing workforce plans within health and social care (including NHS Boards, Health and Social Care Partnerships and local authorities).

25. Opportunities for joint working on this topic should be explored to minimise duplication of effort. It may be possible in future, for example, to consider the scope of Health and Social Care Partnership and NHS Board workforce plans so that they apply in more focused ways to different parts of the workforce – for example, the workforce delivering community health and social care services, and the workforce which delivers acute sector services. There will be opportunities to look at these issues in the National Discussion Document in early 2017.

26. It may be appropriate for the social care services sector to consider: whether it might build national and regional approaches into its workforce planning; and how local flexibility can best operate (particularly in the context of local government). Discussion on this will require further engagement within the social care sector, specifically involving local government and its representative organisations. In the social services sector it is understood that most, if not all, organisations take decisions about workforce planning at senior level and collect data on current:

• staff numbers and costs;
• vacancies; and
• training activity.

Most organisations use this data for budget setting, day to day management and planning for short term needs. However relatively few use workforce planning tools – the most widely used being the Scottish Social Services Council Workforce Planning Guide²⁵.

27. There is acknowledgement within the social service sector about the urgency of workforce planning issues in light of demographic effects (such as ageing workforce) which influence the ability to plan ahead, the reliance of forecasting on available budgets and the daily effects of service changes (with consequences in planning for workforce). There are strong interconnections between workforce planning and pay, recruitment and retention and a range of other factors. It is clear that this will require an integrated approach not only to planning for services but also to workforce planning. This will require a systematic approach informed by accurate, coordinated and relevant data, allowing available capacity to be deployed flexibly.

Health and Social Care Partnerships

28. Although Health and Social Care Partnerships are required to complete integrated workforce development plans, not all have yet been completed and there is some variance in their contents. The position of Health and Social Care Partnerships is relevant here too. Although Health and Social Care Partnerships are not employers themselves, they are tasked with managing joint budgets to provide integrated health and community care services in the most effective way possible. They will play a key role in shaping workforce demand and in supporting ‘intelligent forecasting’, which should be reflected in both NHS Scotland and social care services workforce planning.

Discussion

29. We plan to contact all NHS Boards, COSLA and Health and Social Care Partnerships as we engage on developing the National Discussion Document. While aims and expectations depend on effective communication, we are realistic about the audience we can achieve in the limited time available. All are important and will need good reason to invest in facilitated time.

26 "Recruitment and Retention in the Social Service Workforce in Scotland" – Shona Mulholland, Jo Fawcett and Sue Granville (Why Research).
We will aim to involve the following professional staff groupings, principally through their existing representative bodies but also, where possible, individually:

- staff side representatives – including Scottish Partnership Forum, the Society for Personnel and Development Scotland, Unison, Unite, GMB, the Royal College of Nursing, the Royal College of Midwives, and the British Medical Association;
- the HR Working Group on Integration;
- COSLA;
- NHS Boards and local government (through SOLACE);
- Health and Social Care Partnerships;
- HR and SP Directors;
- Medical Directors;
- Nursing Directors;
- Chief Social Work Officers;
- Finance Directors;
- service managers;
- workforce Planners in NHS Boards – regional and local – and in local authorities;
- recruitment managers;
- service planners, including for acute and elective services, as well as representatives from local cancer planning groups and other condition-specific groups (such as the National Advisory Committee on Stroke);
- clinicians and health and social care professionals;
- NHS Education in Scotland, Scottish Social Services Council and other regulatory and educational interests;
- the Royal Colleges; and
- social care employer representatives bodies – the Coalition of Care Providers in Scotland, Scottish Care and others.

We will communicate with the groups outlined above in various ways, including:

- tapping into planned meetings of existing committees, boards and other gatherings as appropriate, rather than setting up new structures;
- assessing whether ‘roadshow’-type events – with regional/board variations taking account of local issues – may be useful;
- holding specific small events or workshops – informal and flexible, with few attendees but lively discussion;
- organising more formal meetings, with presentations followed by discussion; and
- facilitated discussion, at events such as Strengthening the Links.
Cabinet Secretary for Health, Wellbeing and Sport
Shona Robison MSP

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E: scottish.ministers@gov.scot

1. Ms Jenny Marra – Convener Public Audit and Post-legislative Scrutiny Committee
   papls.committee@parliament.scot

2. Mr Neil Findlay – Convener Health & Sport Committee
   HealthandSport@parliament.scot

25 January 2017

Dear Convener,

Please see a copy of the letter that was sent to NHS Board Chairs and CoSLA on 25 January 2017 regarding Local Delivery Plans for 2017-18 and the engagement of Health & Social Care Partnerships in the planning process.

Yours sincerely,

SHONA ROBISON

St Andrew’s House, Regent Road, Edinburgh EH1 3DG
www.gov.scot
25 January 2017

Dear Colleagues,

The Scottish Government published the Local Delivery Plan (LDP) Guidance for 2017-18 on Monday 16 January. This guidance complements and supports the Scottish Governments Health and Social Care Delivery Plan which sets out the actions required to reform and further advance health and social care services.

NHS Boards are expected to engage with Health and Social Care Partnerships in the preparation of LDPs with a relationship based on collaboration. LDPs for 2017-18 will set out the local actions that Board’s and their partnerships are taking to help progress the priorities and actions set out in the Health & Social Care Delivery Plan.

LDPs will also set out the steps that Boards are taking to prepare for the regional planning and delivery of services during 2017/18 and demonstrate how they plan to develop this approach throughout the year.

The existing LDP Standards have not changed this year pending the outcome of the national review of health and social care targets and indicators being led by Sir Harry Burns. Initial recommendations are due in Spring 2017.

I look forward to further engagement with you around these matters over the course of the year.

Best wishes,

SHONA ROBISON
Dear Colleague

Local Delivery Plan (LDP) Guidance 2017/18

Summary
The LDP Guidance 2017/18 sets out the Scottish Government planning priorities for NHS Boards.

Background
The Health and Social Care Delivery Plan sets out the actions required to reform and further enhance health and social care services. The draft Scottish Budget has been published and letters of indicative allocations issued to NHS Boards. At the same time letters on draft budgets were issued to Health & Social Care Partnership Chief Officers and Local Government Chief Executives. Sir Harry Burns is leading the national review of targets and indicators for health and social care - initial recommendations are due in Spring 2017.

Action
NHS Boards must engage with Health & Social Care Partnerships in the preparation of LDPs with a relationship based on collaboration. The LDP Process will evolve as new arrangements for regional planning and delivery of services are put in place. We will also need to take account of the national review of targets and indicators. NHS Boards should submit their draft LDP to NHSLocalDeliveryPlans@gov.scot by 31 March 2017. Feedback will be provided to NHS Boards in April. Final LDPs should be submitted by 30 September 2017.

Yours sincerely

JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer

16 January 2017

Addresses
For action
1. Chief Executives

For information
1. COSLA
2. HSCP Chief Officers
3. Local Authority Chief Executives
4. NHS Board Chairs
5. NHS Directors of Finance
6. NHS Directors of Planning

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1. Local Delivery Plan Guidance 2017/18

1.1 Increasing healthy life expectancy purpose target

The Scottish Government has a key purpose target to increase healthy life expectancy (available at http://www.gov.scot/About/Performance/scotPerforms). Increasing healthy life expectancy will mean that people live longer in good health, increasing their capacity for productive activity and reducing the burden of ill health and long term conditions on people, their families and communities, public services and the economy generally. We expect that the actions that NHS Boards set out in their LDPs will help to increase healthy life expectancy.

1.2 Health and Social Care Delivery Plan

The Scottish Government's 2020 Vision for health and social care is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- Where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

Prevention, particularly in the early years, is critical to improving the long term health of the people of Scotland.

The Health and Social Care Delivery Plan (available at http://www.gov.scot/Publications/2016/12/4275) sets out our programme to enhance health and social care services. The Health and Social Care Delivery Plan recognises that we must prioritise the actions which have the greatest impact on delivery. It focuses on three areas often referred to as the Triple Aim: better care; better health; better value. Within their LDP, NHS Boards will set out by March their initial plans on the agreed local actions being taken forward in 2017/18 to deliver the actions and milestones set out in the Health and Social Care Delivery Plan. The LDP will set out the impact these local actions will have on outcomes and the way in which progress will be monitored.

The increase in Health Visitor numbers, implementation of the Universal Health Visitor Pathway and expansion of the Family Nurse Partnership Programme are pivotal elements of our focus on prevention. We would expect prevention to feature strongly in LDPs with specific links to HV and Family Nurse Partnership expansion in the context of 'Getting it Right for Every Child'.

Establishing strong and effective population based regional planning and delivery is a fundamental aspect of the Health and Social Care Delivery Plan. Within their LDP, NHS Boards will set out the practical early steps they are taking to ensure they are prepared to co-operate fully in regional planning and delivery of services during 2017/18. In the final LDPs to be submitted by September we would look for the regional planning and delivery
aspects to be more fully developed. We will continue to work closely with NHS Boards to develop our approach to regional planning and delivery.

1.3 National review of targets and indicators for health and social care

Sir Harry Burns is leading the national review of targets and indicators for health and social care. This work includes consideration of the LDP Standards. Scottish Ministers will consider review recommendations which are due in Spring 2017. In the meantime, LDP Standards currently remain in place these are accessible at http://www.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance. In their planning for 2017/18, NHS Boards must continue to ensure that clinical priority is given to patients – including unscheduled care, cancer and other patients referred with urgent status. NHS Boards will continue to maintain local improvement trajectories for current standards and these will be discussed at mid-year reviews against a background of appropriate risk assessment. Further detail will be provided on the format of information required to support discussion on standards at mid-year reviews.

Boards are reminded that a key aspect of our 2020 Vision relates to safety and person-centeredness. Boards are expected to continue to set improvement aims for these dimensions.

1.4 Financial Planning

Draft Budget 2017/18 indicative allocations letters were issued to NHS Boards in December 2016 to support delivery of budget priorities. Within their Local Delivery Plan, NHS Boards will set out Financial Plans for a minimum period 2017-18 to 2019-20. The supporting narrative should provide clear financial details on:

- NHS Board Revenue outturn
- NHS Board Capital outturn
- The contribution to each Integration Authority, showing comparative data for 2016-17
- Planned expenditure on primary care and mental health, showing comparative data for 2016-17
- Actions being taken to shift the balance of care from acute to community settings, as part of the commitment to deliver more than half of the NHS frontline spending in community health services by 2021-22.
- Investment plans in prevention and early prevention, particularly in early years
- Approach to ensuring Alcohol and Drugs Partnerships deliver agreed service levels
- Planned actions in relation to the Sustainability and Value programme, including:
  - Implementation of the Effective Prescribing programme;
  - Delivering a quality and cost assessed improvement plan to respond to Productive Opportunities identified from benchmarked performance;
  - Reducing medical and nursing agency and locum expenditure, as part of a national drive to reduce this spend by at least 25% in-year; and
  - Implementation of opportunities identified by the national Shared Services Programme.
1.5 Workforce Planning

Everyone Matters: 2020 Workforce Vision remains the workforce policy for Scotland. Boards are therefore asked to provide, within their LDP, a short outline of their local Everyone Matters: 2020 Workforce Vision Implementation Plans for 2017-18 to deliver the 5 priorities; Healthy Organisational Culture; Sustainable Workforce; Capable Workforce; Workforce to Deliver Integrated Services; and Effective Leadership and Management.

A National Health and Social Care Workforce Plan is planned for publication in Spring 2017. The Plan will present an opportunity to refresh guidance for the production of NHS workforce plans; and introduce workforce planning which provides an overall picture for health and social care staff. The Scottish Government intend to circulate a National Discussion Document in early 2017 which will look at the practical issues involved, seeking input from NHS Boards and others. NHS Boards will also be required to publish their wider workforce plan during 2017 and are reminded that the application of the Nursing and Midwifery Workload and Workforce Planning Tools are mandatory and should be used and documented in the development of Workforce Plans and workforce projections.