East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 23 February 2017

BY: Chief Officer

SUBJECT: Health and Social Care Partnership Performance Report Update

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1 PURPOSE

1.1 To update the East Lothian Integration Joint Board on performance against an agreed suite of indicators which were last reported on in August 2016.

1.2 To inform the IJB of the introduction of new performance measures which will need to be incorporated into local performance monitoring processes.

1.3 Any member wishing additional information should contact the author of the report in advance of the meeting.

2 RECOMMENDATIONS

2.1 The IJB is asked to note the attached second Performance Report (Appendix 1) and to note the progress made against the indicators between August 2016 and February 2017.

2.2 The IJB is asked to discuss the implications of the second Performance Report (Appendix 1) and its consequences for the development of further performance measures and monitoring.

2.3 The IJB is asked to note the additional measures currently being developed by the Scottish Government and COSLA in recent weeks (Appendices 2, 3 and 4) and any that arise in the coming year.

3 BACKGROUND

3.1 During 2015 and 2016 officers of the East Lothian Health and Social Care Partnership (HSCP) worked with colleagues from the Local Intelligence Support Team (LIST) and the Health and Social Care Team within Information Services Division (ISD) to link and integrate NHS and Social Care datasets.

3.2 This work successfully developed a combined dataset providing information on service users' journeys through the health and social care system, the associated costs of such service utilisation and users' demography.

3.3 The intention was to use the intelligence gained to inform the IJB Strategic Plan and other strategies, to monitor performance across a range of measures and to inform the development of Directions for East Lothian Health and Social Partnership.

3.4 The first Performance Report was considered by the IJB in August 2016.

3.5 This second Performance Report presents analysis on 19 of the 20 National Indicators (Table 1). Data is not yet available for indicator 10.

Table 1 **National Performance Indicator**	**Performance**	**Change from Aug 16***
1. Percentage of adults able to look after their health very well or quite well	95.2%	⇔
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	86.3%	⇔
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	83.4%	⇔
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	81.7%	⇔
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	⇔
6. Percentage of people with positive experience of care at their GP practice	84.7%	⇔
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	92.4%	⇔
8. Percentage of carers who feel supported to continue in their caring role	47.7%	⇔
9. Percentage of adults supported at home who agree they felt safe	87.9%	⇔
11. Premature mortality rate (per 100,000 population)	320	⇩
12. Rate of emergency admissions for adults (per 100,000)	9,576	⇧
13. Rate of emergency bed days for adults (per 100,000)	103,788	⇧
14. Readmissions to hospital within 28 days of discharge (per 1,000)	95.1	⇧
15. Proportion of last 6 months of life spent at home or in community setting	85.4	⇧
16. Falls rate per 1,000 population in over 65s	19.1	⇧
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	77%	⇩
18. Percentage of adults with intensive needs receiving care at home. (2014/15)	66%	⇩
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000)	1314.0	⇧
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency	21%	⇩

*** ⇩ = better ⇧ = worse ⇔ = unchanged**

3.6 Indicators 1 to 9 are from the 2015/16 Health and Care Experience Survey (which replaces the GP and Local NHS Services Patient Experience Survey) published by the Scottish Government in July 2016. As the survey only reports every two years, new data will not be available to update the tables until 2018. Data is also awaited for indicator 10 – 'Percentage of staff who say they would recommend their workplace as a good place to work' which has not yet been reported on.

3.7 Indicators 11 to 20 come from the ISD Health and Social Care Team's 'Core Suite of Indicators for Integration' dataset. It should be noted that some data within the report is not directly comparable to the August 2016 Performance Report as updated methodology is used for some indicators.

3.8 The RAG status in table 1 is used to show performance against the Scottish average. Green indicates that the Partnership has a value of at least 2.5% better than the Scottish average; amber indicates that the performance is within 5% of the Scottish average and red is based on the performance being 2.5% worse than the Scottish average. The table also shows if the February 2017 performance is better, worse, or unchanged than in August 2016. These percentage bands were agreed by the Partnership.

In summary East Lothian performs better than the Scottish average on most measures with the exceptions of: positive experience of a GP practice, rate of emergency bed days for adults and number of days spent in hospital for over 75's after they are ready to be discharged.

Since August 2016 performance on the first measure has stayed the same, but performance on the second and third has improved.

Performance on the second and third measures reflects the fact that although East Lothian rate of hospital admission is lower than the Scottish average, once admitted, patients stay longer.

3.9 Further performance measures will need to be incorporated into the existing local performance monitoring processes. Appendices 2, 3 and 4 provide information on current conversations nationally regarding health and Social Care priorities. In addition to these, the National Health and Wellbeing Outcomes for Integration Boards, the Integration Planning and Delivery Principles and East Lothian Health and Social Care Partnership Strategic Objectives, need to be taken into account along with whatever Directions are operational and therefore require monitoring during 2017/18. Appendix 5 summarises the current areas which need to be considered for inclusion into an updated performance monitoring approach.

3.10 The Ministerial Strategic Group for Health and Community Care (MSG) is leading on the development of a suit of reporting integers. The following national indicators are initially suggested for inclusion in a 'data workbook' / interactive dashboard within Source which can be

accessed by MSG and Integrated Authorities (IA). This will be used by MSG and IAs to review progress and in time consider performance against local improvement plans.

1. unplanned admissions

2. occupied bed days for unscheduled care

3. A&E performance

4. delayed discharges

5. end of life care

6. the balance of spend across institutional and community services

Work has started locally involving colleagues at NHS Lothian Analytical Services and ISD.

The various appendixes attached to this report as mentioned in 3.9 above, give the full range of aims and objects the Partnership should be developing. However the table below sets out how and where the supporting data for each of the above 6 indictors will come from.

Indicator		Outputs	Notes
1	Unplanned admissions	• Monthly data o Total number of admissions o A&E conversion rate	• Source: SMR01 • All ages • Crude numbers initially • Local data used to show 'pathway' to admission • Updated monthly with approx 6 week lag and estimates of completeness
2	Unscheduled hospital bed days	• Monthly data o Total number of bed days acute specialities o Total number of bed days mental health specialities	• Source: SMR01 • All ages • Crude numbers initially • Local data used to show 'pathway' to admission • Updated monthly with approx 6 week lag and estimates of completeness • Data relating to unscheduled mental health bed days will be provided separately (quarterly 3 mth lag)
3	A&E performance	• Monthly data o Number of attendances o % seen within 4hrs •	• Source: A&E Datamart • All ages • Crude numbers initially • Local data used to show 'pathway' to admission • Updated monthly with approx 6 week lag and estimates of completeness
4	Delayed discharges	• Monthly data o Total number of bed days occupied o Reason for delay	• Source: ISD • All ages • Crude number initially • Updated monthly with approx 6 week lag and estimates of completeness
5	End of life care	• Annual data o Percentage of last six months of life by setting o Occupied bed days during last six months of life	• Source: Death records, SMR01, SMR04, • Non-accidental deaths only • Breakdown place of residence by community, hospice, hospital (acute/large or community hospital) • Breakdown OBDs by place of residence and (certain) specialties (e.g. rehab) • Updated annually with approx 12 week lag and estimates of completeness
6	Balance of care/spend	• Annual data o Percentage of population in community or institutional settings	• Source: Death records, SMR01, SMR04, Care Home Census, Social Care Census • All ages / Ages 75+ • Breakdown place of residence by Acute hospital, community hospital, , home (supported) and home (unsupported) • Outputs relating to balance of spend will be produced by SG Health Finance

4 POLICY IMPLICATIONS

4.1 There are no new policy implications arising from this paper.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or the economy.

6 RESOURCE IMPLICATIONS

6.1 **Finance** - there are no financial resource implications arising from this report.

6.2 **Personnel** - processes need to be developed within the planning and performance function of the Health and Social Care Partnership to monitor and regularly report on the indicators within the performance report and to incorporate new measures as these arise

7 BACKGROUND PAPERS

7.1 Appendix 1 – HSCP Performance Report Update (*NB: Circulated to IJB members only – not for general publication prior to the meeting*).

7.2 Appendix 2 – Health and Social Care Delivery Plan.

7.3 Appendix 3 –Joint Scottish Government and COSLA letter of 15.12.16.

7.4 Appendix 4 – Joint Scottish Government and COSLA letter of 19.01.17.

7.5 Appendix 5 – List of all relevant Performance Indicators.

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DATE	9 February 2017

Appendix 2

Health and Social Care Delivery Plan

Healthier Scotland
Scottish Government

December 2016

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 increase 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.

1 http://www.gov.scot/Topics/Health/Policy/2020-Vision.

2 http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2016.

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.

3 http://www.gov.scot/Resource/Doc/311667/0098354.pdf.

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 Programme[4] 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.

4 http://www.gov.scot/Resource/Doc/311667/0098354.pdf.

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[5];
    - 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.

5 http://www.gov.scot/Resource/0049/00494144.pdf.

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[6] 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**.

6 http://www.gov.scot/Publications/2016/12/2376.

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.

7 http://www.gov.scot/Resource/0048/00487884.pdf.

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[8] 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.

8 http://www.gov.scot/Topics/People/Young-People/child-maternal-health/neonatal-maternity-review.

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.

9 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.

10 http://www.gov.scot/Topics/Health/Support-Social-Care/Health-Literacy.

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[11] 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.

11 http://www.gov.scot/Publications/2014/01/8967.

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**[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.

12 http://www.gov.scot/Resource/0044/00444577.pdf.

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[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[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.

13 http://www.gov.scot/resource/0041/00417331.pdf.

14 http://www.gov.scot/Publications/2009/03/04144703/14.

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.

NHS Board reform

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.

16 http://www.legislation.gov.uk/asp/2014/8/contents/enacted.

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[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-science 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[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[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.

18 https://healthier.scot/.

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?

What will be different for individuals

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- The diet and health of children from the earliest years will improve from coordinated and comprehensive nutritional support for children and families.
- 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.
- 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.
- People will lead more active, and as a result, healthier lifestyles.
- 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.

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.

Context

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.

20 http://www.audit-scotland.gov.uk/report/scotlands-public-sector-workforce.

21 http://www.audit-scotland.gov.uk/report/health-and-social-care-integration.

22 http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_161027_nhs_overview.pdf.

23 http://data.sssc.uk.com/data-publications/22-workforce-data-report/128-scottish-social-service-sector-report-on-2015-workforce-data.

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 Guide[25].

25 http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=25.

27. There is acknowledgement within the social service sector[26] 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).

30. 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.

31. 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.

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Appendix 3

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Mr Jim Forrest – Chief Officer – West Lothian Integration Authority

15 December 2016

Draft Budget 2017/18

Dear Colleagues

We are writing to you regarding the Scottish Government's draft budget for 2017/18, as set out by the Cabinet Secretary for Finance and the Constitution in Parliament today. Letters have also been sent today to Local Authorities and the NHS regarding the budget. This letter lays out how these financial arrangements relate to Integration Authorities. Please take account of all three letters to ensure a full understanding of the financial position and its implications for your responsibilities for the coming year.

This letter also sets out our plans to ensure the Ministerial Strategic Group for Health and Community Care, which is chaired by the Cabinet Secretary for Health and Sport, is well-briefed to fulfil its remit to provide joint political oversight between COSLA and the Scottish Government on progress with implementation of integration.

Priorities

Integration Authorities are responsible for planning and provision of social care, primary and community healthcare, and unscheduled hospital care, for, at least, adults. Integration priorities are to:

1. Reduce occupied hospital bed days associated with avoidable admissions and delayed discharges, focussing investment in care alternatives that can help people to continue living independently in their own homes and communities for as long as possible.

2. Increase provision of good quality, appropriate palliative and end of life care, particularly in people's own homes and communities and also, where appropriate, in hospices, so that people who would benefit from such care access it.

3. Enhance primary care provision, with particular focus on developing and expanding multi-disciplinary teams; sustainability of provision; development of GP clusters; and responsiveness to a new GP contract.

4. Reflect delivery of the new Mental Health Strategy, with particular focus on developing new models of care and support for mental health in primary care settings; improving the physical health of people with mental health problems, and improving mental health outcomes for people with physical health conditions; reducing unwarranted variation in access and assuring timely access; and developing services that focus on the mental health and wellbeing of children, young people and families, including improved access to perinatal mental health services.

5. Where children's services are integrated, continue to invest in prevention and early intervention, particularly in the early years, with the expectation that work will continue to deliver 500 more health visitors by 2018.

6. Support delivery of agreed service levels for Alcohol and Drugs Partnerships' work, in support of which £53.8m is transferring to NHS Board baselines for delegation to Integration Authorities.

7. Ensure provision of the living wage to adult care workers workers and plan for sustainability of social care provision.

8. Continue implementation of Self Directed Support.

9. Prepare for commencement of the Carers (Scotland) Act 2016 on 1 April 2018.

Ministerial Strategic Group for Health and Community Care

As you know, the Ministerial Strategic Group for Health and Community Care provides the forum for joint political oversight of progress with integration by Scottish Ministers and COSLA. The Group has recently considered its requirements in terms of understanding progress on integration. We will take forward work involving Scottish Government officials, COSLA, Chief Officers, and colleagues at NHS NSS leading on the Source and LIST data projects, to establish a suite of appropriate metrics for the Group's routine consideration. This will include agreeing data definitions and an appropriate methodology via which Integraton Authorities can share their objectives for progress in 17/18 and beyond; we will also ensure the work is tied in with Sir Harry Burns' review of health and social care targets and indicators.

You will see from Christine McLaughlin's letter to Health Boards on the budget that we also intend to give some consideration to the efficacy of current arrangements for delegating appropriate hospital budgets, including set aside budgets, to Integration Authorities. We will report on that to the Ministerial Strategic Group in due course as well.

I trust this letter is helpful to you, and look forward to continuing to work with you as we embed integration across health and social care in Scotland.

Yours faithfully

Geoff Huggins

Paula McLeay.

GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

Appendix 4

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To: Chief Officers – Integration Authorities

19 January 2017

Dear Colleagues

MEASURING PERFORMANCE UNDER INTEGRATION

The Ministerial Strategic Group for Health and Community Care (MSG) discussed how to measure progress under integration at its meetings on 16 November and 21 December.

At the meeting on 21 December MSG agreed that for 2017/18 we will track across Integration Authorities:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

You are each invited to set out your local objectives for each of the indicators for 2017/18 by the end of February. MSG has agreed that it will receive a quarterly overview on progress across the whole system and you are asked to produce your objectives on that basis. We are meeting with the Executive Group of Chief Officers on Friday and will discuss what national support you would want us to offer for this process. Our objective will be to adapt and use existing data collection methodologies where possible and to establish a clear process for the work.

When we met on 16 December we had indicated that as a minimum we would provide data for each partnership covering each of the indicators. The data would show the position for all partnerships to enable individual Integration Authorities to understand the shape and

nature of their service relative to others. We are still working on the structure and format of that data. For now, we attach high level data covering a number of the areas (**Annex A**). Again we would intend to use the conversation on Friday to discuss the structure and format of the data with the intention of writing shortly after to all Chief Officers with the necessary material.

MSG noted that the approach for future years may change as a consequence of the Review into Targets and Indicators being undertaken by Sir Harry Burns and also as data sources for particular areas of service delivery improvement. It also noted that most key service delivery areas under integration have a direct impact on these higher level system indicators. In particular, it is important that we are able to understand both the contribution of social care and primary care services to these higher level system indicators, but also how they support important outcomes in respect of independent living and the protection and maintenance of health.

Local partnerships are already using a wide range of data to support their commissioning and delivery activity and will continue to operate under the duties in the 2014 Act in respect of public reporting. This process is not intended to duplicate or substitute for that process.

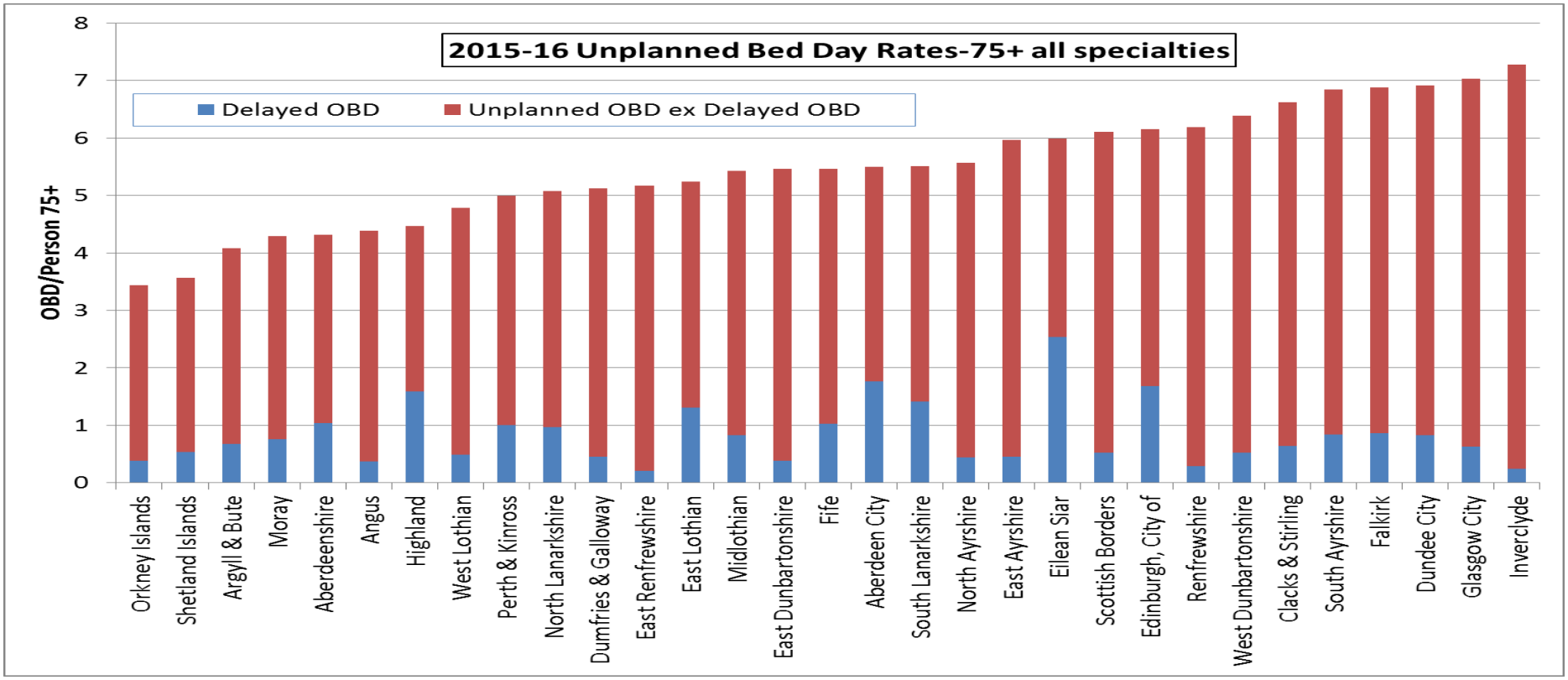
The Local Delivery Plan (LDP) Guidance for 2017/18 has been issued to NHS Chief Executives and sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system you will need to ensure that your objectives and plans are consistent with NHS Board and regional plans for 2017/18.

Yours sincerely

GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

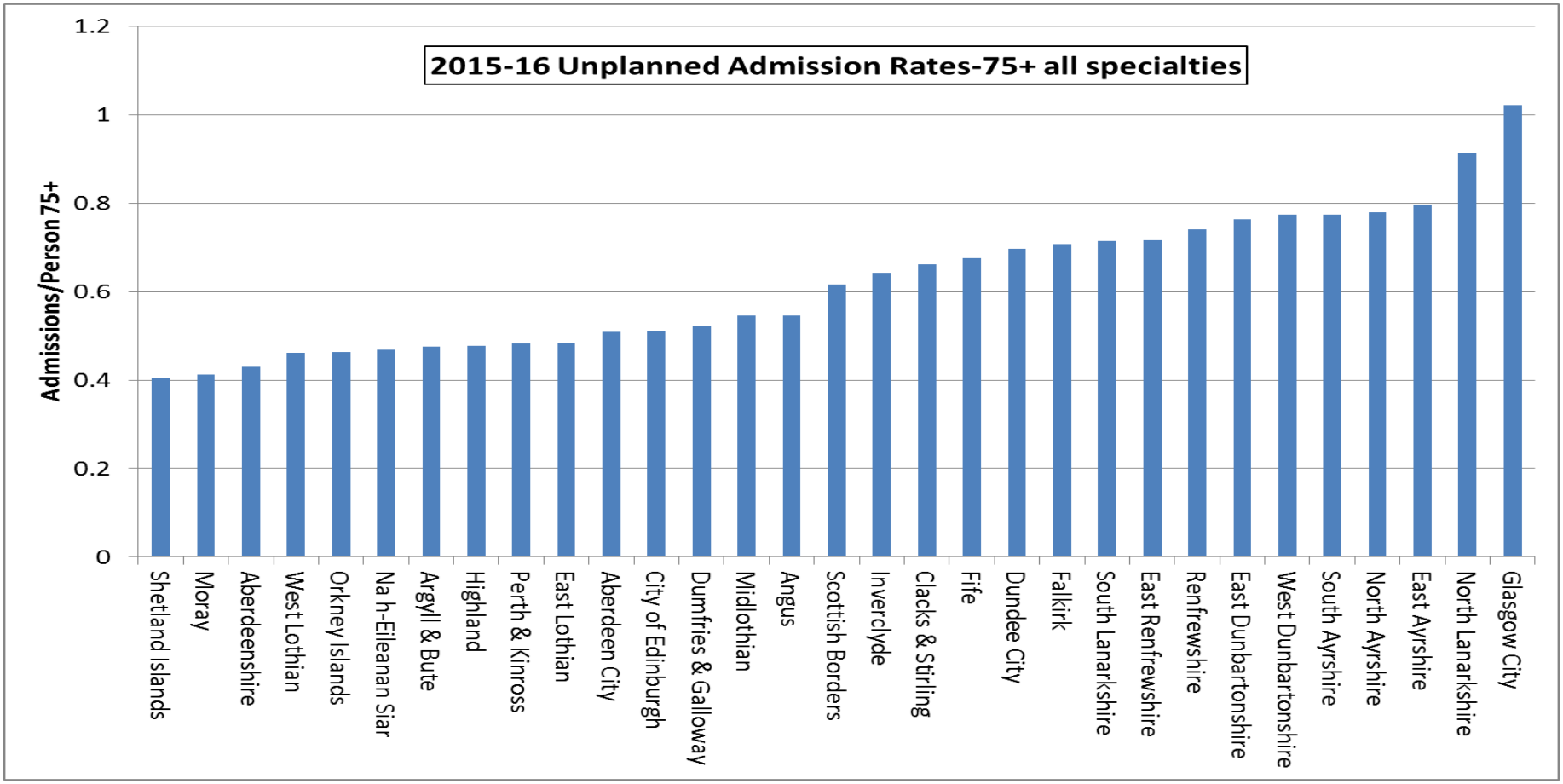
Unplanned Bed Days



Notes: This chart shows the unplanned bed days per capita for people aged 75+ for each partnership (in 2015/16). It is for unplanned bed days in all specialties and differentiates between the bed days used by delayed patients and other non-delayed bed days. A total of 2.5m bed days were used by people age 75+ of which 400k were by delayed patients, an average of 16% of the total bed days for this age group and varying across partnerships from 3.4% to 42%. There is a two-fold variation in the overall bed day rates across partnerships and a 12 fold variation in delayed bed

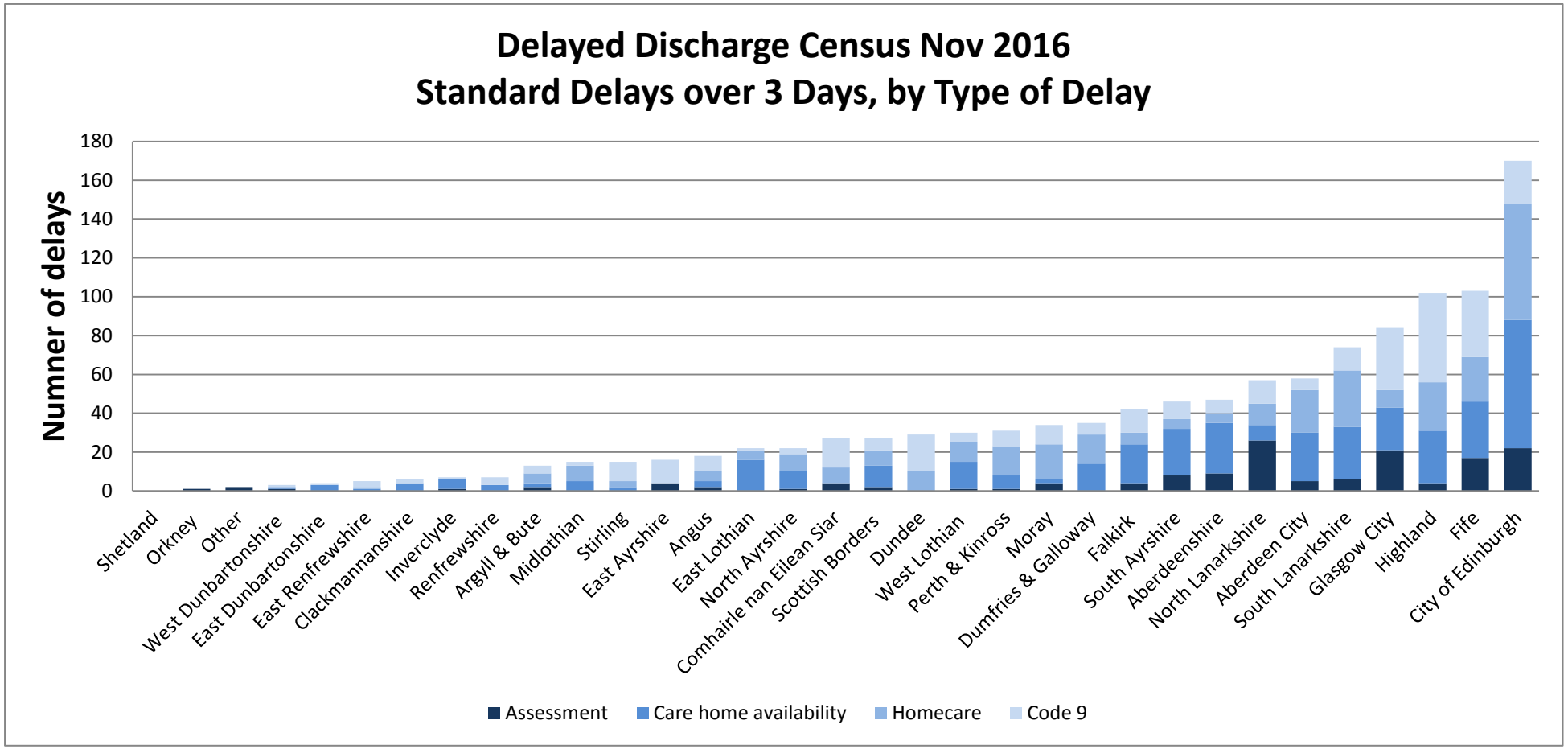
day rates. There is no association between delayed bed day rates and overall bed day rates. We can develop this analysis to include other age groups and to differentiate between specialties and type of delay.

Unplanned admissions



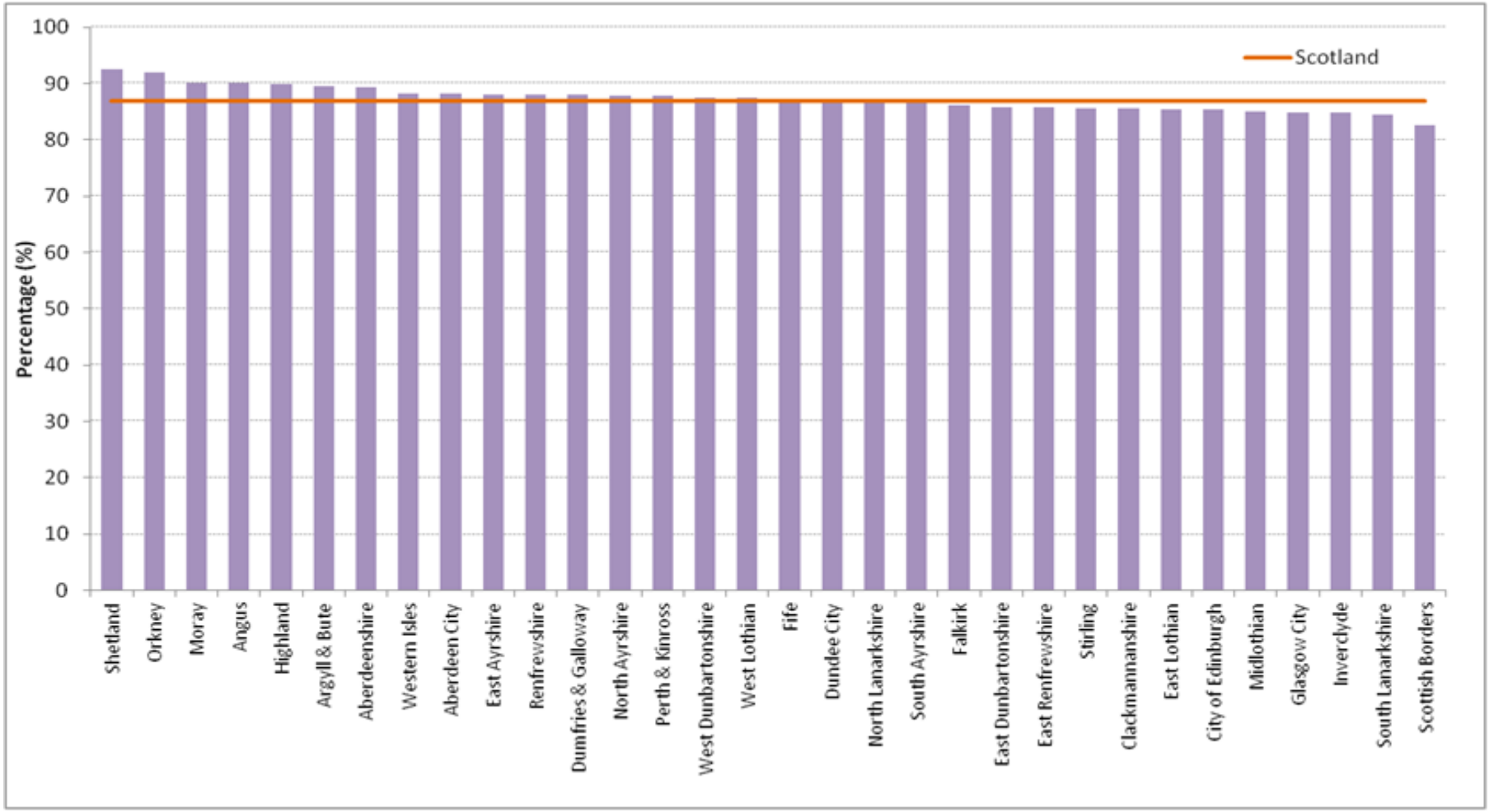
Notes: This chart shows the unplanned admissions per person aged 75+ in all specialties in 2015/16. We can see that the two fold variation seen in the bed days chart is evident here, although there is some slight re-ordering which is to be expected as bed day rates are a function of admission rates and length of stay. We can develop this analysis to consider different age groups and specialties.

Delayed Discharge Census: Standard Delays > 3 days by type of delay



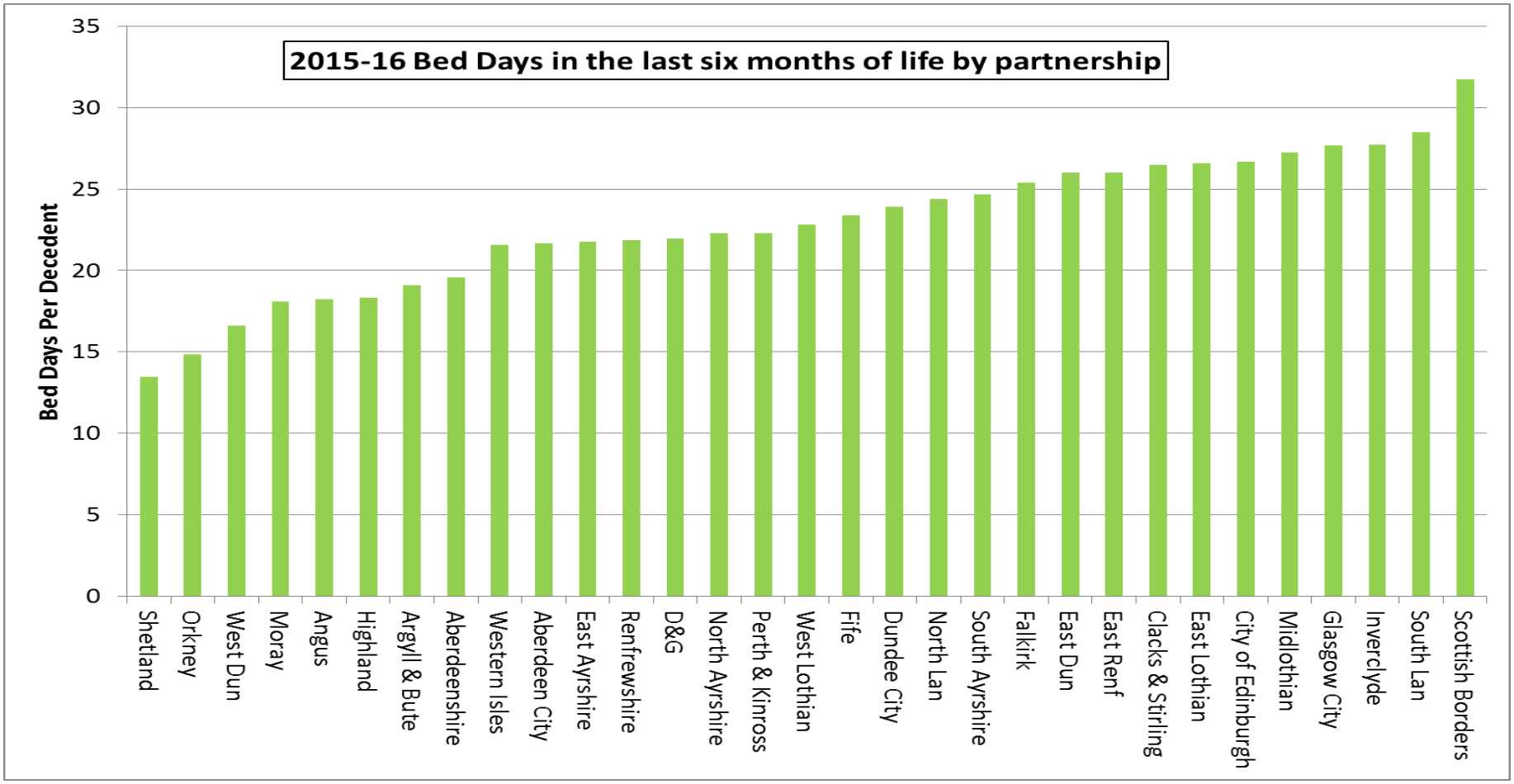
Notes: this chart shows the number of delays by type of across all partnerships. These figures exclude family reasons. There is considerable variation across partnerships. There are also differences in the main reason for delays. For example while care home and home care are key reasons for some partnerships, Code 9 categories appear to be the main reason for others

End of Life (a)



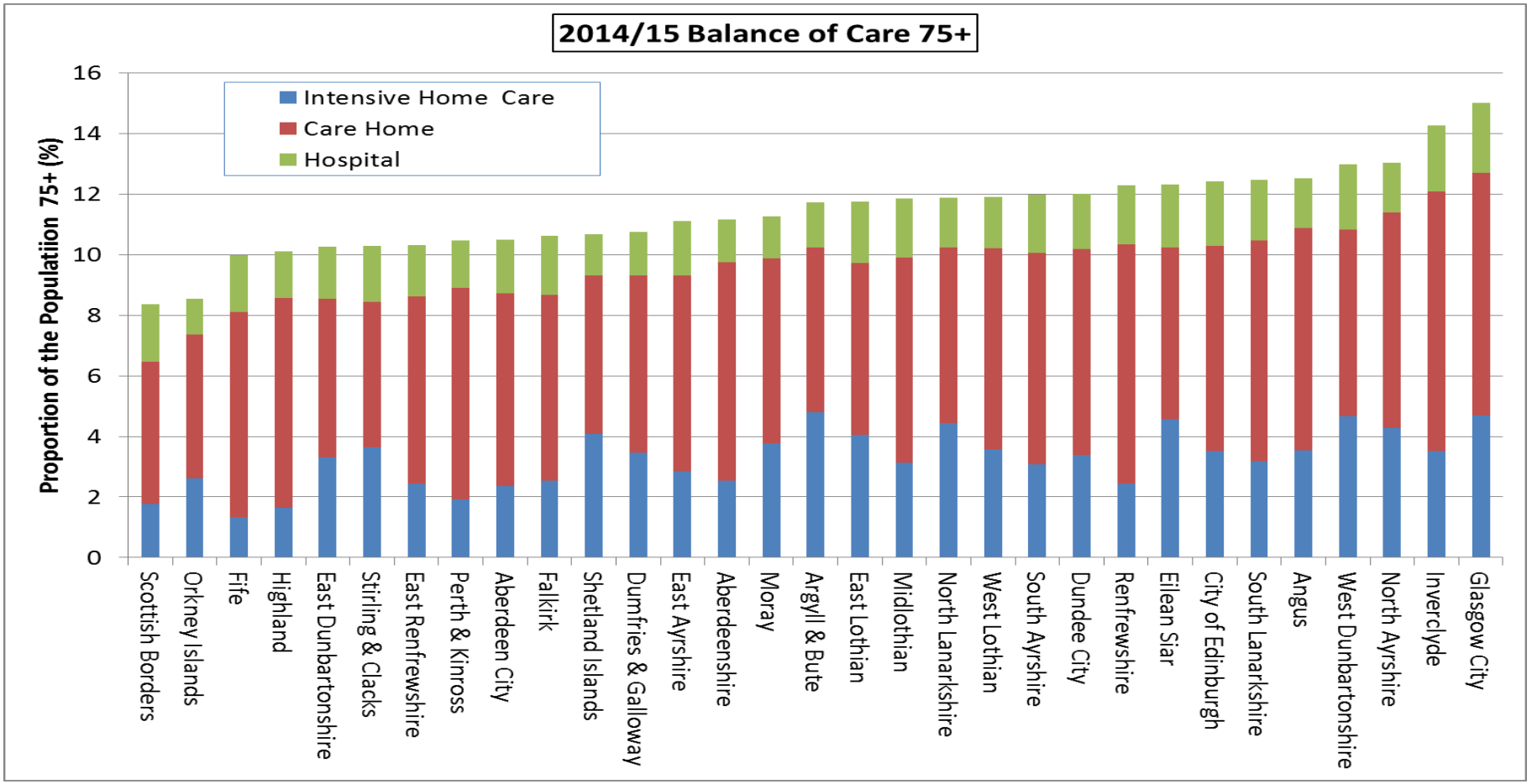
Notes: This chart shows the proportion of the last six months of life spent at home or in a community setting for people who died in 2015/16. There is a difference of 10% across partnerships. We can develop this analysis by considering different age groups and by differentiating between settings.

End of Life (b)



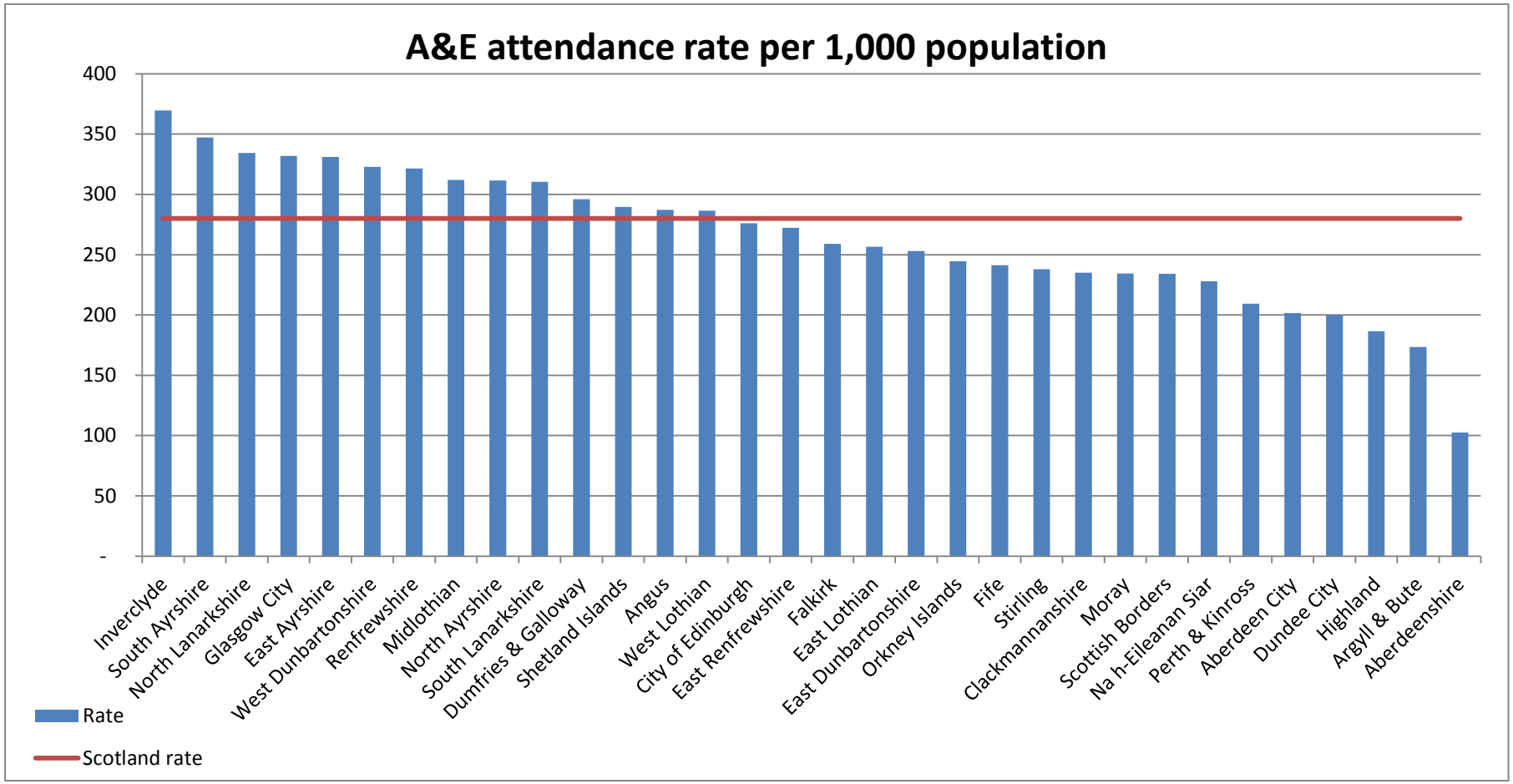
Notes: This chart shows the average unplanned bed days in the last six months of life for people who died in 2015/16. There is a two- fold variation across partnerships. If all Scottish partnerships could attain the same bed days per decedent as Shetland, half a million bed days could be saved-equivalent to the 10% commitment in the Delivery Plan.

Balance of Care



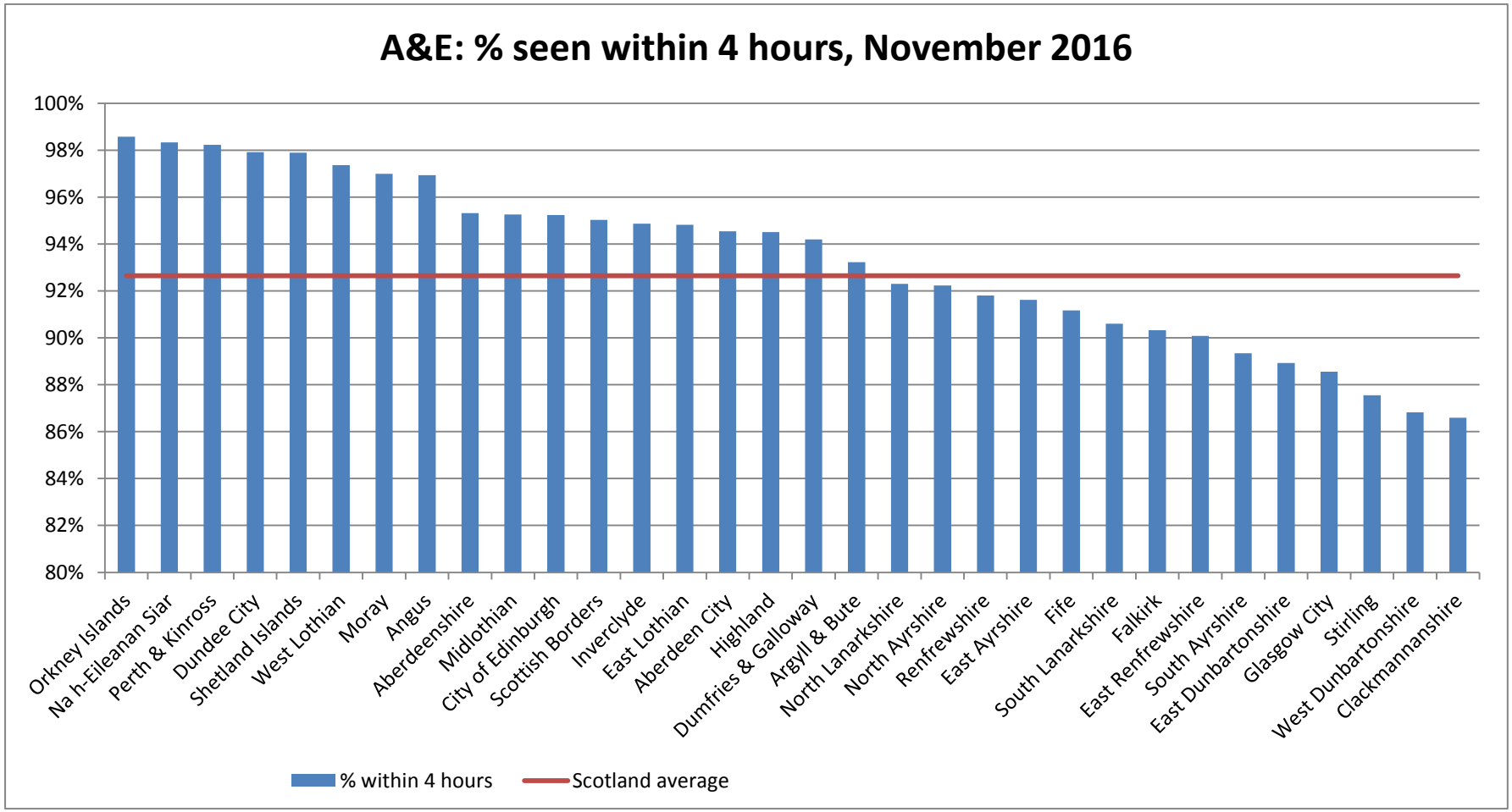
Notes: This chart looks at balance of care for people aged 75+ and shows the proportion of partnership populations aged 75+ who were either in hospital, in a care home or in receipt of 10+ hours home care in 2014/15. There is an almost two-fold variation (8% c/w 15%). Across Scotland, 8.5% of people aged 75+ were either a care home or hospital varying from 5.9% to 10.7% across partnerships. We can develop this analysis to include other age groups and to reflect the balance of care as a spectrum of settings; we can also look at spend across the spectrum.

A&E (a) : **A&E attendance rate per 1,000 population by Partnership 2015/16**



Notes: this shows the attendance rate at A&E per 1000 population by Partnership. There is considerable variation between Partnerships –370 per 1000 population in Inverclyde while 102 attendees per 1000 population in Aberdeenshire (Scotland – 280 per 1000). The difference is likely to reflect a range of issues including demographic factors, proximity of population to A&E facility as well as other healthcare provision .

A&E % seen within 4 hours



Notes: This chart shows performance on the 4 hour wait target by partnership. There is a difference of 11% between the highest performing area and the lowest performing area. The Scotland average is 93%. We can also provide A&E data on conversion rate- eg the proportion of A&E attendances which result in admission to hospital

Appendix 5

Summary of Performance Indicators

National Health and Wellbeing Outcomes for Integration Joint Boards

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 5. Health and social care services contribute to reducing health inequalities

Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Outcome 7. People using health and social care services are safe from harm

Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services

Integration Planning and Delivery Principles

The main purpose of the principles is to improve the wellbeing of service-users and to ensure services are provided in a way which:

1. Are integrated from the point of view of service-users
2. Take account of the particular needs of different service-users
3. Take account of the particular needs of service-users in different parts of the area in which the service is being provided
4. Take account of the particular characteristics and circumstances of different service-users
5. Respects the rights of service-users
6. Take account of the dignity of service-users
7. Take account of the participation by service-users in the community in which service-users live
8. Protects and improves the safety of service-users
9. Improves the quality of the service
10. Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
11. Best anticipates needs and prevents them arising
12. Makes the best use of the available facilities, people and other resources.

East Lothian Health and Social Care Partnership Strategic Objectives

A. To make universal services more accessible and proportionate to need and to develop our communities.

We want to improve access to our services, but equally to help people and communities to help and support themselves too.

B. To improve prevention and early intervention.

We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises.

C. To reduce unscheduled care.

We want to reduce unnecessary demand for services including hospital care.

D. To provide care closer to home.

We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can.

E. To deliver services within an integrated care model.

We recognise the need to make people's journey through all our services smoother and more efficient.

F. To enable people to have more choice and control.

We recognise the importance of person centred and outcomes focused care planning.

G. To further optimise efficiency and effectiveness.

We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face.

H. To reduce health inequalities.

We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.

I. To build and support partnership working.

We recognise the importance of developing effective and wide ranging strategic partnerships in delivering our ambition, vision and values.

Health and Social Care Delivery Plan Actions

Health and Social Care Integration

1. Reducing inappropriate use of hospital services.
2. Shifting resources to primary and community care.
3. Supporting the capacity of community care.

Primary and Community Care

4 Building up capacity in primary and community care.

5. Supporting development of new models of care.

Secondary and Acute Care

6. Reducing unscheduled care.
7. Improving scheduled care.
8. Improving outpatients.

Realistic Medicine

9. Strengthen relationships between professionals and individuals
10. Reduce the unnecessary cost of medical action.

Public Health Improvement

11. Supporting national priorities
12. Supporting key public health issues
13. Supporting mental health
14. Supporting a more active Scotland

Integration Priorities -Scottish Government and COSLA Joint Letter 15.15.206

1. Reduce occupied hospital bed days associated with avoidable admissions and delayed discharges, focussing investment in care alternatives that can help people to continue living independently in their own homes and communities for as long as possible.
2. Increase provision of good quality, appropriate palliative and end of life care, particularly in people's own homes and communities and also, where appropriate, in hospices, so that people who would benefit from such care access it.
3. Enhance Primary care provision, with particular focus on developing and expanding multi-disciplinary teams; sustainability of provision; development of GP clusters; and responsiveness to a new GP contract.
4 Reflect delivery of the new Mental Health Strategy, with particular focus on developing new models of care and support for mental health in primary care settings; improving the physical health of people with mental health problems, and improving mental health outcomes for people with physical health conditions; reducing unwarranted variation in access and assuring timely access; and developing services that focus on the mental health and wellbeing of children, young people and families, including improved access to perinatal mental health services.
5. Where children's services are integrated, continue to invest in prevention and early intervention, particularly in the early years, with the expectation that work will continue to deliver 500 more health visitors by 2018.
6. Support delivery of agreed service levels for Alcohol and Drugs Partnerships' work, in support of which £53.8m is transferring to NHS Board baselines for delegation to Integration Authorities.
7. Ensure provision of the living wage to adult care workers and plan for sustainability of social care provision.
8. Continue implementation of Self Directed Support.
9. Prepare for commencement of the Carers (Scotland Act) 2016 on 1 April 2018.

Measuring Performance under Integration—Joint Scottish Government and COSLA Letter 19.01.17

1. Unplanned admissions.
2. Occupied bed days for unscheduled care.
3. A&E performance.
4 Delayed discharges.
5. End of life care.
6. The balance of spend across institutional and community services.