Agenda

2020 Vision Advisory board

20 January 2014

Location: The Beardmore Hotel, Clydebank

Time: 1500-1700

1.	Welcome and introduction	Chair
2.	Apologies for absence	Chair
3.	Minutes and actions from previous meeting	Chair
4.	Role and Remit	Colin Brown
5a.	2020 Scenario	Colin Brown
5b.	Radical Ideas	Colin Brown
6.	Any other business	All
7.	Date and time of next meeting	Chair

2020 VISION ADVISORY BOARD – 7 OCTOBER 2013

Draft Note of Second Meeting

Present: Cabinet Secretary for Health & Wellbeing
Jeane Freeman
John Connaghan
John A Brown
Sandy Riddle
Ian Welsh
Jason Leitch
Anna Gregor
Angela Wallace
Sheena Macdonald (telephone)
Ian Crichton
Jill Vickerman
Tim Davison
Jamie Newlands
Andrew Morris
Colin Brown

Apologies Charles Hammond
Minister for Public Health

Introduction and note of last meeting

The Cabinet Secretary welcomed members to the second meeting and confirmed with colleagues that the draft note of the first meeting, held on 10 June 2013, was an accurate reflection of issues and actions discussion.

Role and Purpose of Advisory Board

Jill Vickerman introduced a short paper which set out a proposed role and remit for the Advisory Board (including the recommendation that the name was changed to Advisory Board (AB) from the former Steering Group). The proposal for the name change was accepted, and a number of comments were made on the need to extend the description of the role and remit. A revised draft is attached for comment and will be discussed/agreed at the next AB meeting.

2020 Scenario/Narrative

Anna Gregor and Sheena MacDonald introduced this paper which provided a catalyst for a discussion about the need for a detailed 'picture' of how health and care services would be delivered in 2020, followed by a prioritisation of key actions required to achieve this, and a transition plan mapped out which would contain milestones and measures. A key theme of the discussion was the recognition that many of the key actions/changes required were already being tested and implemented somewhere in Scotland, and that the biggest challenge was getting national agreement to focus on implementing these at scale. The terms 'just do it'

and ‘adopt or explain’ were expressed by a number of members. A further reflection was that we were effectively needing to ‘build an aeroplane while flying it’ and this meant one eye on assuring and ensuring business as usual, while looking to the future and implementing innovative changes which would allow us to realise the 2020 Vision.

It was agreed that Anna Gregor would continue to work with Sheena MacDonald, involving other members of the AB, to develop a further version of the scenario paper which reflected the discussion and provided the basis for identifying key actions and a related transition plan. Other members who intimated their willingness to be involved in this work included: Tim Davidson, Jeane Freeman, Andrew Morris, Ian Welsh, Jason Leitch and Jill Vickerman.

It was decided that the discussion on ‘Radical Ideas’ should be postponed, and should be linked to the agreement on the key areas for action identified in the exercise above.

A draft paper is attached for comment, and will form the basis for the substantive discussion at the next AB meeting.

2014/15 Local Delivery Plans

John Connaghan led a discussion about the opportunity presented by the 2020 Vision Route Map to review the current LDP/HEAT target process. He described a proposal to move to a more strategic and longer term new planning process with a holistic delivery narrative which reflected the 12 priority areas in the RouteMap and the 3 dimensions of performance, improvement and co-production. There was a very positive discussion about this direction of travel, and agreement that the time was right to rationalize and reposition the existing 19 HEAT targets and 13 HEAT standards.

JC undertook to feed the comments of the AB into the fast moving review.

AOB and close

There was no further business discussed, the Cabinet Secretary thanked colleagues for attending and participating and an energetic and constructive discussion.

The next meeting will be on Monday 20 January 2014, at 3 pm, Beardmore Hotel Clydebank.

The Quality Unit
November 2013

THE CABINET SECRETARY'S ' 2020 VISION ADVISORY BOARD' - DRAFT ROLE AND REMIT

Role

To provide advice to the Cabinet Secretary on:

- the key challenges and gaps which require to be addressed in the pursuit of the 2020 Vision for Health and Social Care in the context of integration between health and social care services,
- high impact actions and opportunities for driving progress towards the vision which complement and accelerate the range of improvement and performance action established through the workstreams of the 2020 Vision Route Map.
- opportunities for closer working with industry, Third Sector and academia, for mutual benefit.
- existing examples of evidence-based high impact improvements in practice or technologies which require to be implemented at scale and speed.
- the need to secure sustainability by prioritising, improving quality and reducing costs.
- approaches for appropriate engagement with the public.

Remit

Creation of a more detailed narrative, based on a scenario/scenarios which illustrates where potential changes are needed to achieve the 2020 vision as a basis for planning, delivery and assessing progress.

Agree proposals for additional high impact action, including an assessment of the 'Radical Ideas' invited from other groups (Chairs, CEs etc.) which drive progress to the 2020 Vision/detailed narrative

Contribute to review of LDP/HEAT offering advice on how to use performance management to drive progress towards the 2020 Vision.

Facilitate relationships with academia, industry and Third Sector and agree areas for working, for mutual benefit

Identify 20 quality improving initiatives/actions/innovations already tested which should be rolled to scale – provide advice on how to create a culture of 'adopt or explain'

Governance arrangements

Secretariat will be provided by The Quality Unit in the Scottish Government Health and Social Care Directorates

Meetings will take place on a quarterly basis

The Advisory Board will provide advice to the Cabinet Secretary for Health and Wellbeing, the minister for Public Health, the 'Guiding Coalition' of NHS Board CEs, Chairs and the Scottish Government Health and Social Care Management Board.

The Advisory Board will be set up for 2 years in the first instance, running until 30 June 2015. A review of the on-going need for the Advisory Board will take place at that time.

Membership

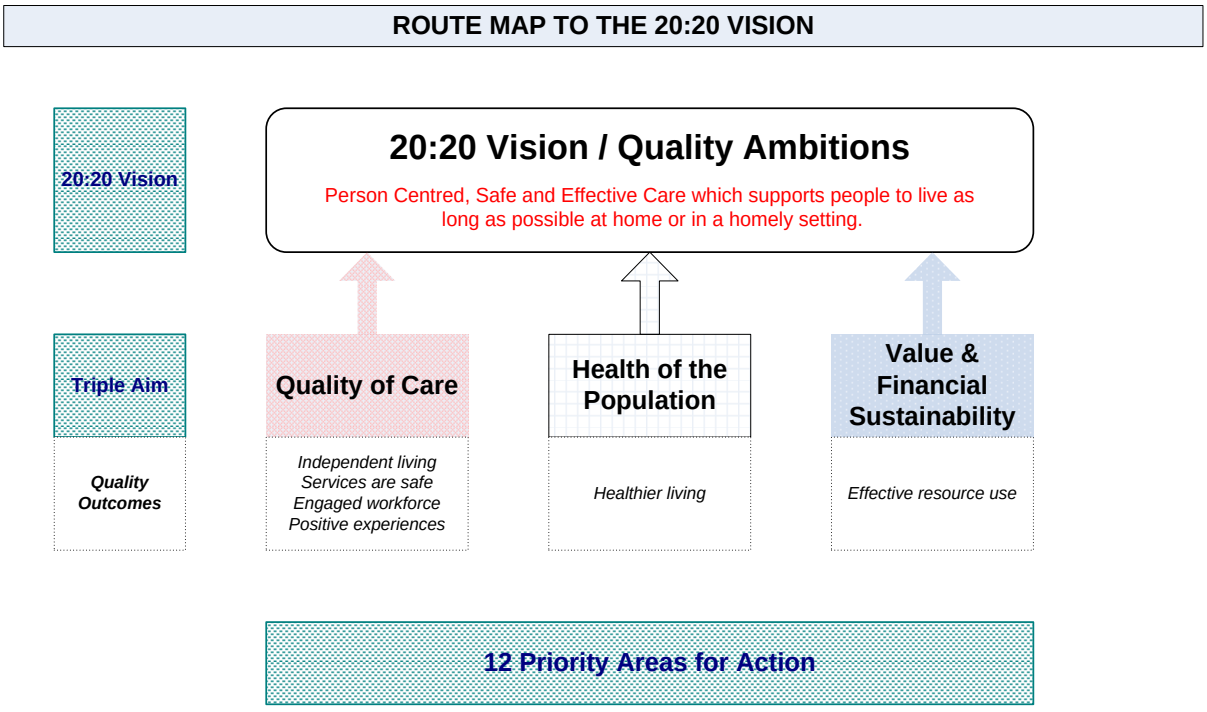
Cabinet Secretary for Health & Wellbeing
Minister for Public Health
Jeane Freeman
John Connaghan
John A Brown
Sandy Riddell
Ian Welsh
Jason Leitch
Anna Gregor
Angela Wallace
Sheena Macdonald
Ian Crichton
Jill Vickerman
Tim Davison
Jamie Newlands
Andrew Morris
Colin Brown
John Brown
Charles Hammond

A ROUTE MAP TO THE 2020 VISION FOR HEALTH AND SOCIAL CARE

Developing a detailed narrative, a driver diagram and key actions for implementation

Introduction

The 'Route Map' to the 2020 Vision for Health and Social Care in Scotland describes 12 priority areas for action in pursuit of the vision which reflect the 'Triple Aim' of improving quality of care, health of the population and sustainability. It recognises that over the next few years the demands for health and social care and the circumstances in which they will be delivered will be radically different and says that we must collectively recognise and respond innovatively and boldly to the most immediate and significant challenges we face.



The 2020 Vision for Health and Care in Scotland

'*The Scottish National Health Service will be a publicly funded and publicly delivered health care service free to all our citizens. We will have a world-leading healthcare service where everyone is able to live longer and healthier lives at home, or in a homely setting. We will have a focus on reducing health inequalities, on prevention, anticipation and supported self-management. When hospital treatment is required, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission*.'

DEVELOPING A DETAILED NARRATIVE

The 2020 Vision Advisory Board agreed that in order to stimulate a discussion about the key actions required, it would be important to set out in more detail some of the key features of the health and care services we would expect to see in 2020, and how these differ from 2013. It was agreed that such a narrative would provide a basis for assessing the sufficiency of the action already planned under the 12 priority areas in the RouteMap, for considering the range of 'radical ideas' which had been submitted from the NHS Chairs and Chief Executives and for identifying further key areas where action was required.

THE 20:20 VISION – A CLINICAL SCENARIO

Meet the Scott Family

The Scott family – Mr and Mrs Scott, their five children and Mrs Scott's elderly mother, live in a deprived urban area - both parents are unemployed in receipt of benefits, granny lives alone on the far side of town.

The family are known to social services as one of the older children is a known drug user and the mother is a frequent visitor to GP surgery. She is on long term antidepressants, has type 2 diabetes and chronic bronchitis.

The Scottish Healthcare Services response in 2010?

When Mrs Scott phones for an urgent GP appointment for one of the younger children she is on the phone for 25 minutes but unable get an appointment that day. As she is worried, about her child's cough they go to A and E. . She is told on arrival that she should have seen her GP but they are unable to let her go without being seen – A and E is busy and she ends up waiting more than 4 hours but does eventually see someone who is busy and harassed and takes the route of least effort and prescribes and dispenses antibiotics for the child's cough.

Mr Scott signs on regularly for his benefits but never goes near his pharmacy or GP surgery – we do not deliver health interventions at the job centre and we miss an opportunity for healthy lifestyle intervention for his alcohol, obesity and smoking habit. He develops a hoarse voice and he eventually sees his GP who refers him for laryngoscopy. He receives an ENT clinic appointment within 3 weeks as part of cancer waiting times guarantee but when he attends the ENT clinic he is identified as having high BP which needs to be controlled by his GP prior to laryngoscopy. It is up to Mr Scott to phone for another appointment with his GP, and then makes another appointment for the ENT clinic. After all this delay he has laryngoscopy and found to have a polyp – he is sent away with an appointment for pre-op assessment. At pre-op assessment he is found to have a borderline low HB and is sent back to the GP who notes his HB has always been at this level and commences him on iron. He eventually goes in and has his polyp removed. (8 queues to receive definitive treatment).

Grandma Scott was living independently with no assistance - she develops a UTI over Bank Holiday Weekend. She is seen by the OOH nurse who feels she should not be at home alone as she is "off her legs" and admits her to the AMRU. She is moved five times between different wards before care is taken over by medicine for the elderly. She is delayed in hospital further because we did not have 7 day AHP services and now have no carers in her home area to deliver her

home care package. While waiting in the ward she contracts norovirus and her renal function deteriorates. Eventually she goes home with home carers visiting 3 times a day carers. Within 2 weeks from discharge she falls and fractures her hip. She is in hospital for 10 weeks following this and finally moved to a care home in another part of town with poor public transport links – the family are unable to visit any more than monthly.

The eldest daughter is a drug abuser and an irregular attender at the drug and alcohol support team. She becomes pregnant and presents for first appointment at 26 weeks and then is not seen again until she presents in labour – her baby has acute opiate withdrawal syndrome – an urgent case conference is called and the child is taken in to care

The Scottish healthcare response we want to see in 2020?

The NHS and social care provision is an integrated Primary and Social Care system with the services responsive to the Scott family needs and delivering seamless care delivered at home or as close to home as possible. There is now an urgent walk in centre manned 24/7 in the local community hub where no patient will be sent away, or told they are in the wrong place, or have told they have to go somewhere else because our services are now configured to meet patients' needs and not service needs. Individuals or families with needs are identified provided with community contact/ support and offered anticipatory care.

Mr Scott with his alcohol and smoking addiction will receive screening and a brief intervention wherever he contacts the health or social care system e.g. the community pharmacy or job centre. Once a week an advanced nurse practitioner will run a drop in clinic in the local pub and be able to offer both health promoting and illness interventions. The extended primary care team including this nurse will have mobile technology allowing her to access the core patient record and be able to update the record in real time.

Mrs Scott will have access to local support group with talking therapies for her reactive depression and successfully discontinues antidepressants . She becomes member of the local community healthy eating group including a gardening club run by volunteers. By increasing her physical activity and changing the eating habits of her whole family, she and her husband both lose weight and her diabetes is under much better control. She will have been invited for targeted interventions for her specific health needs delivered by the generic motivational change and signposting . If she fails to attend for appointments the local volunteer team that support the health centre make contact with her by text and arrange to go and see her and establish what the barriers and enablers to her participation are; if childcare is the problem then help with child care will allow her to attend. When she phones the surgery her team receptionist establishes with her who the most appropriate member of the team might be and asks how long an appointment she thinks she needs; she receives a reminder text to attend. If direct access to an AHP service is appropriate this is offered at the point of contact. The AHPs make contact by phone wherever possible and provide sign posting and where appropriate health care support worker involvement to support her to attend her self-help, group sessions, personal appointments and work closely with education and sport and leisure providers to provide arrange of interventions. (DN YoC will enable both Mrs Scott and her Health Care Team to her to identify her personal goals/outcomes and connect her with health and community resources to help her to achieve those outcomes. the community.

When she, possibly prompted by her smart phone app is having problems with her diabetes or prompted to attend for screening of risk factors and complications (as in the empowered informed patient) (which has replaced her regular diabetic appointment). This may be supported by contact via her smart TV. She attends regular parenting groups and cookery classes run in the local

school. The lifestyle advisers, from her own community will help her sustain a weight loss using text messages to maintain her engagement.

Information and communication with Mrs Scott recognises and caters for health literacy needs (which in 2010 had been hidden, not recognised and not catered for). She also has access to personal and personalised information about herself and her condition, in range of meaningful formats. All communications are addressed to her, with clarified jargon, with copies to the various involved professionals, and hyperlinks to explanatory videos. As a result she becomes more confident and able to participate in decisions affecting her health, and challenge when she feels concerned Because she has shared in correspondence she has more confidence that her specialist and practice have the same list of medication. She also identifies an error in her prescription. This feedback is used to redesign the service she has been offered to increase safety.

She also has assistance in creating an Avatar through whom she meets others in similar circumstances and receives structured diabetes training (peer and professionally developed and delivered with peer coaching).

When Mr Scott develops his hoarse voice he contacts the GP through his smart TV and has a face time/ Skype call – the GP arranges a one stop visit to ENT the following week – he is sent information through his television regarding what to expect and his laryngoscopy is carried out the day he attends. He then goes immediately for his pre-op assessment in the OP clinic and has his bloods checked using near patient testing. The nurse practitioner accesses his old results and notes his borderline HB and gives an iron prescription which is dispensed by the onsite community pharmacist. He has his polyp removal planned for 6 weeks later and is sent text reminders and pre-op information via his TV, again in a variety of formats.

The community nursing and AHP services will be supporting partners in education to deliver a comprehensive public health promoting programme to the Scott children and healthy eating, exercise, smoking and alcohol advice and support will be instilled and infiltrate the daily lives of the whole Scott family. Early years teams and health promotion teams work with drug and alcohol team to deliver contraception and pre pregnancy advice and when the eldest daughter becomes pregnant she is allocated dedicated midwife and social care support including a community buddy to work with her throughout pregnancy.

For the members of the Scott family in employment, places of work will promote healthy living by all delivering the gold standard of promoting Health in the Workplace - Healthy Working Lives.

When the youngest child falls over in the playground and bangs their head the school will know how to respond. If the child needs to be seen by a GP there will be an appointment available. If it is out of hours and they attend the local urgent care centre and do not need to attend A and E.

When mum phones the surgery her designated receptionist who knows her and her family will offer her a variety of appointment lengths and allow her to choose what she needs - 10 minutes for the child with a cough but 20 minutes for herself with her depression and worries about her mum.

The GP regularly reviews notes using the SPSP trigger tool and multidisciplinary team review episodes of avoidable harm including admissions, prescribing and polypharmacy and end of life care.

Granny meantime has a package of care developed with her and her family, which is delivered from an integrated health and social care team – she has equipment in her house that allows her to speak directly to her named nurse regarding her heart failure, COPD and diabetes and can transmit remotely her weight, BP, Blood sugar and urine results allowing her medication to be altered. Options for Self Directed support are explored. However when she has an acute exacerbation resulting in poorer mobility and need for assistance with toileting, her Anticipatory care Plan is activated immediately. Instead of an admission, the out of hours "care" team visit through the night and the outreach specialist DME attends the next day. She is then able to attend the practice Ambulatory Care Unit for additional tests and has direct access to the scan that she needs to inform the next step of her care. An enhanced recovery plan is then activated with appropriate nursing and AHP leadership and delivered by a fully skill mixed team. She develops a Deep Vein Thrombosis and is managed completely as an outpatient without a need to go through A and E with the acute and primary care services aligned around her. Her enhanced recovery plan takes account of her additional social care needs that are assessed and met by the local integrated health and social care team. Her cataracts are operated on as a day case and her diabetic appointments are carried out jointly by the GP and the consultant using SKYPE technology.

Unfortunately Granny eventually falls and breaks her hip (in spite of falls prevention risk reduction interventions) – the immediate response promotes enhanced recovery and she is in hospital, operated on and up on the multidisciplinary rehab ward within 24 hours. Her surgeon and multidisciplinary team held a safety briefing and safety pause at the time of her operation. She drops her blood pressure post operatively and the Early Warning system activates electronically. The Critical care outreach team are able to advise and initiate treatment, preventing deterioration and readmission to ITU. 48 hours later she is back in the Promoting Recovery Unit in the local Community Hospital and home with an enhanced care package by day 5.

The hospitals that care for Granny Scott have had no recorded Health Care related Staph Aureus bacteraemia, ventilator acquired pneumonia, pressure ulcers or C diff infections for the last 36 months. Granny Scott did not suffer any avoidable harm during her admission – her falls risk, her nutritional status , continence and skin pressure risk are all actively managed. As her dementia progresses the outreach team support her with additional expertise and care including pressure pads to monitor her movement at night. She becomes increasingly frail and confused and moves in to extra care housing.

Granny Scott manages to cope with activities of daily living through a detailed needs assessment and delivery of services from a range of statutory and non-statutory services including a local "borrow a granny scheme" a community asset approach to maximise the potential of the "well retired" .

Eventually she enters the end stage of her multiple problems and her previously articulated wish to die at home is supported by the REACH hospital at home team consisting of carers, nurses, doctors, 3rd sector and volunteers.

KEY AREAS WHERE CHANGE IS REQUIRED BY 2020?

The key changes required to make the transition from 2010 to 2020 as suggested by the Scott family 'scenario' are set out in the table below, and mapped against the 12 priority areas described in the 2020 Route Map. The table also includes the key 'radical ideas' drawn from a recent exercise where the Cabinet Secretary invited NHS Board CEs and Chairs to identify high impact changes they thought were needed to pursue the 2020 Vision.

Key areas for action/change - Scott family Scenario	**Existing 2020 RouteMap Priority Area**	**Radical Ideas (NHS CEs and Chairs)**		
one-stop care if at all possible	innovation	Virtual Hospital supporting discharge/step down in a safe proactive manner with multidisciplinary teams improving experience and reducing re-admission		
Delays, repetition, waste and queues are eliminated from the process of care	efficiency/ productivity	Developing a federated Primary Care model integrating RCGPs model of care to ensure appropriate learning across all Scotland's practice and driving down unwarranted variation	NES to act as single employer for all doctors in training in Scotland	All education and development of health professionals funded through a single organisation
information is shared and available at the point of need	infrastructure/ eHealth	Consultants to carry out outpatient appointments in the community, linked to the federated primary care model, ensuring learning is disseminated to GPs, particularly those with 'special interests'		
technology is used to enhance information sharing and transfer and Team working	innovation, infrastructure/ eHealth	A 'discharge lounge' combining smart pharmacy and flow to community		
healthcare provision is delivered in the most appropriate setting	innovation			
broader measures of safety will have been developed through the SPSI.	safety, infrastructure/ measurement	'Big Data' – shift from current model of re-active crisis management to strategic and operational planning based on deep understanding of real-time, dynamic and linked data.		

other	workforce	Encourage more school leavers into a caring career		
Service users will know their contact and know how to access	person-centred			
Care is delivered by most appropriate and trained members of the multidisciplinary team	workforce	Integrating out of hours services through effective coordination of the interdisciplinary team	Effective 7*24*365 models of working	Develop education and training programmes for remote and rural healthcare
staff are supported and allowed to fully use their skills	workforce	Smart consultant capacity ensuring capacity available to respond to annual patterns of demand		
Care will be proactive and anticipatory	workforce			
Community will be empowered to deliver healthy living	public health, person-centred care			
trained and supported volunteers will be actively involved in the community	person-centred care			
People and their health care professionals are enabled to collaborate in '*living as well as possible at home or in a homely setting'*	innovation, person-centred, primary care			
Care planning, shaped and informed by Talking points, CBAS, Care Plus etc. systematically implemented.	workforce, multimorbidities, person-centred			
hospitals and communities and carers/families collaborate to deliver integrated and seamless care	person-centred, integration			

Key points made by member of the Advisory Board during discussions have not been included in the table;

- There is a need to be clear what the existing evidence-based high impact practices, pathways, technologies etc. are, and agree that these should be done ('just do it') nationally with an 'adopt or explain' culture.
- There needs to be work done to understand the costs of taking/not taking action
- We need to take action to reduce/redirect demand for care / demand management
- We are effectively 'building an aeroplane while flying' – this needs to be acknowledged and managed
- Stronger partnerships are required with academia and industry/commerce
- The 'gravitational pull' needs to be shifted from the hospital to the patient
- Healthy working needs to be promoted
- We need to explore the role/power of schools in teaching children how to manage their healthcare needs as well as their lifestyles
- Potential to explore different models with other services providers where triggers are pulled e.g. 'first in the door'
- We need to send strong messages to the public, empowering them to change their actions and expectation – possibly through use of scenarios
- Need to de-politicize bureaucracy, developing a sense of shared community resource
- We need brave leaders who are supported to take risks with change and 'just do it'
- Take 20 examples of what we want to happen at scale, and pursue vigorously (informed by above table?)

Developing a 2020 Vision Driver Diagram and an Action Plan

It is proposed that the Advisory Board consider the above scenario, the mapping to the 1 priority areas, the radical ideas, and the issues raised in discussion to develop a 'driver diagram' for the 2020 Vision which will form the basis of an Action Plan. It is proposed that this driver diagram should include all of the key actions required to deliver the 2020 Vision, and should indicate where these are already being pursue/delivered through the existing workstreams underpinning the 12 priority areas. This will result in agreement on key areas for action which the Advisory Board can identify/agree for separate and focussed action, with related timescales, milestones, costs and delivery mechanisms. See outline Driver Diagram below.

2020 VISION DRIVER DIAGRAM

2020 Vision	Aim	Objective	Key Areas for Action	Further key actions required?
Person-Centred, Safe and Effective Care which supports people to live as long as possible at home or in a community setting	Improve the Quality of Care	Increase the role of Primary Care	There is now a strong consensus on the urgent need for an expanded role for primary care in general and general practice in particular. This is at the heart of our 2020 Vision, revolving around keeping people healthy in the community for as long as possible. We know it is a prerequisite to tackling health inequalities and the challenges facing unscheduled care. Happily, it is also entirely consistent with what we know of people's own preferences. The recent agreement in Scotland on next year's GP contract in the context of a bitter impasse in England gives us an unprecedented opportunity to make serious progress. There are many strands to this. Inevitably it will mean some shifts in resources from institutional care, whether financial or capacity in its various forms. We have talked about this for too long without serious impact. We need to be creative, building on our Change Fund model, in incentivising more directly those changes in primary care - of which there are many excellent examples all-round the country which in reality reduce the pressure on our hospitals.	
		Integrate Health and Social Care	Integration of adult health and social care is a key part of the Scottish Government's commitment to public service reform in Scotland. We will continue to drive forward the widely endorsed commitment to integrating health and social care services in Scotland, sharing and building on successful models, recognising the importance of some local flexibility and the need to identify training and development requirements for staff which will feed in to the Workforce 2020 vision action plan.	
		Accelerate Safety Programmes	Building on the world-leading and recognised success of the Scottish Patient Safety Programme, we will continue the ground-breaking extension of this programme into primary care, paediatrics and mental health, and will embark on the development of a new Scottish Patient Safety Index to accelerate our progress in driving down harm in acute care settings.	
		Make Care more Person-Centred	Driving a focus on person-centred care through a programme of work focussing on the care experience of patients, through work on staff experience/engagement (through the 'Everyone Matters' - a 2020 Workforce Vision) and through a programme of work, led by the Alliance and JIT on increasing people-powered health through	

			co-production and building on assets.	
		Improve unscheduled and emergency medicine	A new Expert Group has been established to identify and agree high impact actions to transform the way that unscheduled care is delivered with a focus on reducing the number of people who present at A&E departments through action in the community, in primary care and to improve the flow of patients out of A&E. Specific work will be done to improve services at weekends and out of hours in both urban and remote and rural areas.	
		Improve support for multimorbidity	Through detailed analysis of available data high impact changes will be agreed which will deliver improved outcomes for people living with multiple morbidities, including mental health conditions. We will consider the whole pathway of care and focus is on people aged <65 years in areas of deprivation high levels of health inequalities. This work will link closely with the work to expand the role of primary care, to improve unscheduled care and to integrate health and care services. Whilst further work is needed to clarify the extent of health needs that can be met through self-directed support and integrated services, there is already strong evidence of individuals improving their health and wellbeing when they are able to tailor their support. Self-directed support can contribute to tackling health inequalities, with citizens having access to meaningful information and advice that enables them to design truly person centred care. This work will link closely with the work to expand the role of primary care, to improve unscheduled care and to integrate health and care services.	
	Improve Public Health	Improve support in early years	This Government has made a commitment to recognise that the most important stage in life to tackle action to reduce inequality and improve health and life chances is in the early years. We will drive forward the early years collaborative, breaking new ground in improvement methodology across the full range of public partners involved in a child's early years.	
		Reduce health inequalities	We need to refocus our efforts on health inequalities particularly in the context of benefits cuts which will impact most on those most at risk of ill-health. We will do this by targeting improvement resources into primary care in the most deprived areas of Scotland including staff and equipment such as tele-health facilities.	

		Take preventative measures	Despite significant improvement in health outcomes in recent years, Scotland continues to have a poor record of healthy life expectancy. Alongside the commitment to refocus energy on targeting health inequalities, we will continue to pursue a preventative agenda in partnership across the public sector, concentrating on tackling Scotland's relationship with alcohol, smoking and increasing levels of physical activity. We will also continue to invest in the hugely important programme of work to increase the early detection of cancer.	
	Increase Value and Sustainability	Establish a workforce 2020 vision and action plan in partnership	Major programme to work in partnership with staff, professional bodies, union to establish and agree a vision for the health and care workforce required to realise the 2020 vision, supported by a detailed action plan with key high impact milestones for delivery in 2013/14 and each year thereafter.	
		Increase efficiency and productivity	Take forward an ambitious programme to identify and implement a shared services approach across all relevant areas recognising the opportunities of securing a more unified approach in some areas versus the benefits of delegation of responsibilities for decision making, design and delivery to local levels in other areas. Fully implement the Efficiency and Productivity Portfolio of action at scale, including a specific focus on reducing drug costs through a single programme management focus on prescribing savings, which better co-ordinates both the national and local work in this area and optimise the use of management information to highlight areas for improvement.	
		Invest in innovations which increase quality, reduce costs and grow Scottish economy	The new Innovation Partnership Board which has been established to take forward the joint Statement of Intent between Government, NHS and Industry will additionally be asked to oversee a new Innovation Fund which will be tested through 2 initial pilots before role out to scale. The approach is an ambitious one and aims to target high value fundraising through philanthropy, European funding, assessing the Oxford University funding model	

2020 VISION ADVISORY BOARD
SUMMARY OF RESPONSES TO THE
2010/2020 SCENARIOS PAPER

Introduction

1. At the 2020 Vision Advisory Board's (VAB) meeting on 7 October 2013 Anna Gregor and Sheena MacDonald proposed the development of illustrative examples of scenarios of user involvement, service design and possible responses in 2010 and 2020 respectively.

2. This led to a wide ranging discussion with regard to the key issues which needed to be addressed in order to achieve the '2020 Vision for Health and Social Care'.

3. Building on the discussions at the meeting, a paper was circulated to members on 21 November 2013[1] with a request for comments by 20 December 2013.

Purpose

4. The purpose of this note is to provide a summary of the key issues which emerged from a review of the responses received[2] (see paragraph 5) and to propose next steps (see paragraphs 6-8).

Summary of Key Issues

5. The following points are derived from the responses received and are presented here as a summary of key themes:

<u>Living Well in Scotland</u>

- It is necessary to facilitate and foster approaches which radically rethink what it requires for people to 'live well' in Scotland This will mean genuinely working to our vision and living our values to create the conditions for success; and, considering health and social care as being supported by a mixed landscape of local and national support.

<u>Leadership</u>

- Strong, visible, empowered leadership is necessary to continually challenge perceived and actual barriers to changes which will foster safe, effective and person-centred care. This will also require the provision of time and space to enable relationship building across sectors.

[1] Email and attachment from Dot Hartley 21/11/13, 14:30
[2] NHS Tayside, The ALLIANCE, Dr Sheena MacDonald, Scottish Lifesciences Association (as at 03/01/14)

Active Citizenship and Resilient Communities

- Promoting active citizenship (and developing the capacity of individuals) is considered to be of crucial importance as is investing in approaches which place a value in reciprocity and strong community connections between all formal and informal sources of support (with particular emphasis on communities in areas of high deprivation). Further, greater knowledge of, and confidence in, the Third Sector and community based support is considered to be a key underpinning factor. Therefore, embedding a co-production approach is fundamental – people who use and support services and carers (noting, in particular, that unpaid carers require effective support) must be involved from the outset in the design of solutions; and the organisations involved in supporting them need to be able to function on a sustainable basis.

Engaged Local Communities

- It will be important to engage with communities to consider alternatives to hospital based care (recognising the level of attachment which many communities have to their local hospitals). Such an approach should demonstrate evidence of better health outcomes rather than arguments based on affordability alone. This will require the promotion of health equity; and, co-production and assets-based approaches which have the aim of enhancing community resilience and social capital as well as achieving the appropriate balance of care in response to, for example, demographic change and new technologies.

Services Designed By and Around Individuals and Families

- Individuals and families require a clear and specific description of how services are organised to support them personally with a focus on their needs (rather than those of the service(s) concerned). This means that healthcare and other services should be provided in the most appropriate and accessible settings (including 'virtual' ones via digital technologies) for people at times which suit them.

- Professionally driven single-disease based models need to evolve into more holistically based, person-centred approaches. This will mean moving away from linear pathways of care and support to approaches which adapt to people in accordance with their needs at particular times – this should be predicated on an assets based approach rather than a deficits based one which attempts to 'fix' rather than 'enable'.

Catalysing Innovation

- It will be necessary to continue to build capacity and capability for quality improvement which catalyses innovation. Local, national and international networks should be developed and utilised to learn from and promulgate good practice where innovation is leading to sustainable systems and services.

- The life sciences industry (and the business community more generally) needs to see a clear strategic direction and a level of assurance about what will actually happen in order that there is sufficient confidence for investment in new models of service design and delivery rather than the current approach which tends to focus on hospital based services.

Next Steps for the 2020 Vision Advisory Board

6. At its meeting on 20 January 2014, the 2020 Vision Advisory Board should review the final version of the scenarios paper circulated in conjunction with the summary points set out above.

7. All members should be asked to come prepared to participate in the discussion and to contribute (or re-state) their perspectives on the question posed previously with regard to actions, behaviours and principles that will most likely facilitate the achievement of the 2020 Vision.

8. The outcome of the discussion should then provide the framework which the 2020 Vision Advisory Board will use to organise its work, set its priorities and plan key outputs and outcomes in accordance with the revised remit (circulated previously). This will also require engagement with the other constituent groups within the wider 2020 'architecture'.

Conclusion

9. From the responses received the following have emerged as possible themes around which the VAB may wish to focus its work:

- living well in Scotland
- leadership
- active citizenship and resilient communities
- engaged local communities
- services designed by and around individuals and families
- catalysing innovation

HEALTH AND SOCIAL CARE DIRECTORATES
SCOTTISH GOVERNMENT

10 JANUARY 2014