



SCOTTISH EXECUTIVE

Health Department
Directorate of Performance Management & Finance

NHS
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Dear Colleague

LOCAL HEALTH PLANS: REVISED GUIDANCE

1. I enclose the Revised Guidance for Local Health Plans. This has been produced following an 8 week formal review period and a major seminar on 29 August which attracted a large and diverse number of participants.
2. A wide range of useful and constructive views and comments have been received and these have been very useful in helping to shape the final content of the Revised Guidance. I would like to take this opportunity to thank all those who have contributed during the review period and in particular to the members of the NHS Strategic Planning Network.
3. I have attached as an Annex to this letter a synopsis of the views and comments received and of the Department's responses to them.
4. The production of a Local Health Plan by an NHS Board is an essential element of the proper planning and management of the NHS, of planning for and implementing the NHS National Priorities and of planning and working in partnership with Community Planning Partnerships. I attach great importance to the role and purpose of Local Health Plans and of the need to adhere to the timetables set out.
5. If you need further information, please contact Andy Smith on 0131 244 6918 or Robert Kirkwood on 0131 244 2556.

Yours sincerely

JOHN ALDRIDGE
Director

8 October 2002

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LOCAL HEALTH PLANS: REVIEW OF GUIDANCE SYNOPSIS OF RESPONSES RECEIVED DURING REVIEW PERIOD

The Health Department issued the Review Paper on Local Health Plan (LHP) Guidance on 6 July 2002. The Review Paper sought views on a number of topics and the Review period closed on 30 August. A crucial part of the Review period was the seminar held on 29 August organised by the NHS Strategic Planning Network with support from the Health Department. The seminar was extremely well attended and generated a wide range of valuable views and comments which have been influential in shaping the content of the Revised Guidance (RG) on LHPs.

This Annex sets out a synopsis of the views and comments received during the Review period and from the seminar and the Health Department's response. The Annex is structured around the 3 key headings used in the Review Paper and the specific areas where views were sought.

1. THE PURPOSE OF LHPs

Views were sought on the applicability of the main purposes of LHPs as set out in the Review Paper.

There was a clear consensus around, and welcome for, the main purposes of LHPs as set out in the Review Paper. There were also a number of additional views:

- a. requesting clarification of the relationship between LHPs and Joint Local Health Improvement Plans in particular;
- b. suggesting references needed to be included on the key role of local partners in the LHP process;
- c. highlighting, in some manner, the regional planning dimension;
- d. defining the scope of local in LHPs;
- e. accepting the need for balance between the strategic and local elements of LHPs;
- f. supporting the idea of the LHP acting as a framework with "signposting" to more detailed plans to underpin and implement the framework.

The clear consensus around the main purposes has been fully incorporated into the Revised Guidance (RG). The need for greater clarity relating to the respective roles of LHPs and Joint Health Improvement Plans is acknowledged and this has been expanded upon in the RG. It is accepted that the role of key local partners was, to an extent, underplayed in the Review Paper and the role of local partners has been highlighted in the RG. The future work on and development of the regional dimension in NHS planning is being taken forward in a number of other arenas. The RG will acknowledge this but it is not considered

appropriate or particularly useful at this stage to enter into a great deal of further detail specifically within the RG.

It is agreed that a LHP should strike the balance between the strategic level and a focus on more local issues and that a LHP can successfully combine both elements within the one LHP.

It is also accepted that an important element of the strategic and, to a lesser extent, local levels is the "signposting" to other supporting operational plans and programmes. Provided due weight is given to the National Priorities, this balance is most appropriately struck on a local basis in conjunction with key local partners and reflecting the local Community Plan(s).

2. THE CONTENT OF LHPs

National Priorities

Although no specific views were sought on this particular issue, the topic generated a large number of responses. The overall tenor of the responses encompassed:

- a. There should be a small number of National Priorities and within the LHP process there should be a timetabled opportunity to agree the specific plans to implement the NHS National Priorities prior to a NHS Board's approval of its LHP.
- b. There should be a common format in LHPs for these priorities and not a template in tabular form.
- c. If possible, the Department should issue the priorities earlier than September each year.
- d. The National Priorities should be broadly consistent from one year to the next and, in particular, that new ones should not normally be introduced part-way through the year.

It is accepted that there should be, clearly set out, NHS National Priorities and these are now included in the RG. It is agreed that there should be a common format for the National Priorities and this is included in the RG. This will facilitate a clear focus on the progress towards meeting the National Priorities and clarify, on a consistent basis, the planning, implementation, financial and monitoring arrangements which are in place in each NHS Board area. This will not only inform the Health Department on progress but will also allow the public/local community to ascertain progress on the National Priorities in their own local area.

Given the acknowledged and agreed importance of the NHS National Priorities it is considered that there should be, within the LHP process, a formal agreement on the NHS National Priorities Implementation Plans between the Department and each NHS Board. To facilitate this agreement it is considered that it would be helpful to introduce a degree of timetabled prior discussion between the Department and each NHS Board before the final approval of LHPs by NHS Boards.

The timetable for issuing the National Priorities was originally set to allow for a full assessment of progress from previous years and the completion of the Accountability Review process. It is considered that, at least for this next year, the Department should continue with the September timetable for issuing the Priorities. This will be reviewed in future years in the light of experience. The Department acknowledges the expressed desire for consistency/stability from one year to the next in relation to the National Priorities and the desire not to introduce new priorities throughout the year.

Financial Planning

Views were sought on financial planning and the integration of financial and LHP planning into one timescale and document.

There was a very clear and consistent consensus on, and support for, the idea that financial and LHP planning should be integrated into one timescale and one document or, if not one document, at the very least 2 or more documents which are closely related and mutually "signposted".

It is accepted that this integration would be very useful and this is reflected in the RG.

Structure of LHPs

Views were sought as to whether or not there should be a common structure for all LHPs.

Although there were a number of slightly different views, the overall consensus was that there was no overriding need for a common structure. The view was clearly expressed that this was a matter for local flexibility in the light of local circumstances. The inter-related consensus view was that the Department should only be prescriptive where it needed to be ie, on National Priorities and financial planning and significantly less so on most other issues. This, it was felt, would increase local flexibility and facilitate integration with locally focused plans eg, Community Plans and Joint Health Improvement Plans.

It is accepted that the RG should reflect the consensus on this issue and therefore there is no explicit guidance (with the exception of National Priorities and finance) on the structure of LHPs. The structure of LHPs will be a matter for local decision and flexibility.

Timescales for LHPs

Views were sought on a 3 or 5 year timescale and the annual production of LHPs.

In relation to the 3 or 5 year timescale there was a very clear consensus for the 3 year time frame. This was recognised as complementing other key public sector planning and financial planning frameworks. In terms of the annual production of LHPs the consensus was that this would be acceptable for the detailed operational plans underpinning the strategic direction and National Priorities but it would be neither appropriate nor necessary to fully revisit the strategy of the LHP on an annual basis.

The consensus is accepted that the strategic time frame for LHPs should be for 3years. With regard to the annual production of LHPs, it is accepted that they should be produced on

an annual basis but with a focus on specific implementation plans, in particular those plans supporting the National Priorities.

The Role of the Health Department

Views were sought on a revised role for the Department in the LHP process.

The clear consensus was that the LHP process should be closely integrated with the annual NHS Accountability Review process and that the Department should not need, with the exception of plans for the NHS National Priorities, to have submitted to it or formally comment on the whole of draft LHPs. There were some concerns expressed about the various timetables for other plans produced at the local level eg, Community Plans and Joint Health Improvement Plans and how these would be integrated with that for the LHP.

The consensus on the integration with the Accountability Review process and on draft LHPs is reflected in the RG. In relation to the integration of timetables at the local level, it is accepted that there are issues at the local level which can arise from multiple planning timescales. However, it is considered that this is an issue which is best resolved and managed at the local level.

Other Issues

Views were sought on a number of supporting issues.

There were comparatively few views received on these issues, with the exception of public/community involvement. The question of the strategic nature of the LHP (raised as one of the supporting issues) was generally encompassed within views on the purpose of LHPs. The issue of public/community involvement generated a considerable response. There was an overall consensus that the RG should contain more specific guidance on LHPs and that this should emphasise the "process of public engagement/involvement in LHPs" rather than the "one-off" nature of specific consultations. Although it was also accepted by respondents that consultation was an important integral part of the process of producing a LHP.

The consensus view on public/community involvement has been reflected in the RG. It is accepted that the process by which the public/local community/local partners are engaged/involved is important and plays a crucial part in obtaining local "ownership" of the LHP.

3. THE PROCESS OF PRODUCING LHPs

Views were sought on the timetable for producing LHPs.

The clear consensus was that the timetable set out in the Review Paper was broadly acceptable with a welcome for the 6 month "planning window" from September to February.

The consensus on the timetable is reflected in the RG.

LOCAL HEALTH PLANS

REVISED GUIDANCE

Introduction

1. The Local Health Plan (LHP) Guidance was issued by the Health Department in November 2001. At that time a commitment was given to review the Guidance in summer 2002. This review has been completed and the Revised Guidance is now set out in this document. The Revised Guidance takes fully into account the views and comments received during the review period and the key outcomes from the LHP seminar held on 29 August.

2. The Revised Guidance is structured around the 3 key headings as set out in the Review Paper:

- a. the purposes of LHPs;
- b. the content of LHPs; and
- c. the process/timetable for LHPs.

The Purposes of LHPs

3. The key purposes of LHPs are:

- a. NHS Boards and Staff A Local Health Plan:
 - i. enables a Board to be clear about its overall **strategic** direction and financial planning/position;
 - ii. enables a Board to fulfil its corporate governance role within the NHS;
 - iii. allows a Board to be specific and detailed about its implementation plans for NHS National Priorities and local priorities for the next year;
 - iv. allows a Board to set out how the NHS will implement its plans for its own services and services provided in partnership with other bodies/agencies;
 - v. allows a Board to communicate with its staff about its overall **strategic** direction;
 - vi. ensures a Board has an integrated and comprehensive planning process.
- b. Local Community A Local Health Plan:
 - i. enables the local community to be clearly informed about and engaged with local health improvement and NHS service issues;

- ii. allows 2-way communication between a Board and the local community;
 - iii. allows Community Planning partnerships plans, including Joint Health Improvement Plans, to feed into the LHP.
- c. Scottish Executive A Local Health Plan:
- i. enables assessment of progress towards meeting the agreed plans for the implementation of NHS National Priorities;
 - ii. provides a basis for accountability to Ministers and Parliament.

4. The **Local** Health Plan's primary focus should be on the local aspects of health improvement and improving local health services. This does not detract from the need to balance this local focus with proper attention to the implementation of NHS National Priorities but a LHP is intended to be focused at the local ie, NHS Board, level.

5. The LHP will need to assess and take into account those elements of the NHS's services which are planned and provided for on a regional basis (ie, across more than one NHS Board area). The LHP will also need to be clear about the current and potential future local implications resulting from the provision of services on a regional basis.

The Content of LHPs

NHS National Priorities

6. The LHP will contain specific and detailed implementation plans, in common format (paragraph 8), for the NHS National Priorities. The National Priorities for 2003/04 are:

- **Health Improvement: Step Change in Scotland's Health Status**
- **Delayed Discharges**
- **48-Hour Access**
- **Cancer**
- **CHD/Stroke**
- **Mental Health**
- **Health Care Acquired Infection**
- **Waiting Times**
- **Public Involvement**
- **Workforce Development/Staff Governance**
- **Financial Break-Even**
- **Service Re-Design**

7. The common format will be as set out below in paragraph 8, but will not be applicable to the National Priority on Financial Break-Even. This is specifically taken into account in the context of financial planning as set out in paragraph 10 of this Revised Guidance.

8. a. NHS National Priority and Targets.

- b. Local Position in relation to Target ie, progress over the last year.
- c. Services:
 - i. current services;
 - ii. proposed new/improved services and levels of investment;
- d. Outcomes:
 - i. actual outcomes from current services;
 - ii. anticipated/planned outcomes from proposed new improved services.

9. The plans, in common format for the NHS National Priorities, are a key component of the planning and implementation framework for the NHS in Scotland. In view of the crucial and acknowledged importance of the National Priorities, the plans for these Priorities will form the basis of an NHS National Priorities Implementation Agreement between the Department and an NHS Board. This agreement will be arrived at between the Department and an NHS Board before the final LHPs are submitted to the Department by the end of March 2003. To achieve this the Department will need completed drafts of the common formats for the NHS National Priorities by the end of January 2003 (paragraph 16).

Financial Planning

10. This section of the LHP should show how the resources of the NHS Board and its constituent Trusts will be used to support and develop the strategies set out in the plan. In particular, it should set out:

- The overall financial position of the NHS Board.
- Where key resource shifts are taking place.
- How "new" resources are being invested.
- Demonstrate that the actions and developments set out in the plan are affordable and sustainable.

This section of the plan will be supported by detailed financial proformas. It is not felt appropriate to include the detailed proformas within the LHP, however it is of prime importance that financial information given within the plan is consistent with the financial proformas. A working group is currently being established to develop the financial proformas and guidance will be issued in the late autumn regarding the information which will be required for 2003/04. Whilst the timetable is still to be agreed, it will be consistent with that for the LHPs and final plans will be required by 31 March 2003.

Structure of LHPs

11. The structure of LHPs, subject to the common format for NHS National Priorities (paragraph 8) and the framework for financial planning (paragraph 10), is a matter for the local discretion of each NHS Board in conjunction with its Community Planning partners.

Public/Community Involvement

12. The development and production of a LHP should be part of a continuous process of engagement with the public and local community about local health improvement and improving local health services and part of this process of engagement should also include NHS staff. The production of a LHP is an integral part of the continuous public engagement/involvement process and should not be seen as an end in itself. The LHP should include a measure of feedback on progress during the previous year. There should also be feedback to participants in the engagement process indicating how their views have been taken into account.

The Process/Timetable for LHPs

13. Local Health Plans will be produced on an annual basis to integrate with the annual NHS Accountability Review process. This annual cycle will also facilitate the need for Community Planning partnerships to report on their own progress on an annual basis. In setting out an NHS Board's overall strategic direction a LHP will be expected to adhere to a 3 year planning timescale. It is not anticipated that the annual LHPs will contain significant changes in strategic direction from one year to the next.

14. The LHP and Joint Health Improvement Plan(s) will be developed in partnership with an NHS Board's Community Planning partners. It is expected that an NHS Board will, in the context of the Community Planning process, ensure that the LHP and JHIP(s) take into account the visions and objectives of the Community Plan(s) and the NHS National Priorities.

15. The assessment of LHPs, as part of the Accountability Review process, will be underpinned, in part, by the PAF's quantitative indicators and qualitative assessments.

16. The timetable for the production of LHPs is set out below:

March	-	Approval of LHP by NHS Board by 31 March and submission to Health Department.
May-July	-	Assessment of LHPs as part of the annual NHS Accountability Review process.
		Formal feedback to NHS Boards on LHPs as an integral part of the Department's response arising from the Accountability Review process.
September	-	Department issues NHS National Priorities (revised, if necessary, and appropriate on an annual basis).

Planning Period

September-February:	-	Planning period for NHS Boards and Community Planning partners and LHP input into Community Planning process.
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Within Planning Period

- End January - Submission of draft common formats for NHS National Priorities Implementation Plans from NHS Boards to the Department.
- End February) - Formal agreements concluded between the Department and NHS Boards on NHS National Priority Implementation Plans.
- March - Approval of LHP by NHS Board by 31 March and submission to Health Department.