THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

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St. Andrew's House
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Health Boards

For information:

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To be copied to UGMs and GP Fundholders for information

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Dear Colleague

ACCOUNTABILITY REVIEWS
PRIORITIES AND PLANNING GUIDANCE FOR 1994/95

1. I thought it would be helpful to set out the broad context within which Health Boards are being asked to plan, and to put next year in the long term context. In particular I want to reaffirm the goals of "Framework for Action" as setting the NHS agenda and to make clear our national priorities for 1994/95. I also want to set out resource assumptions for use in forward planning. I appreciate that this guidance is late in view of the timetable required for contracting in 1994/95. My intention in future years will be to issue similar guidance in July/August, but I would ask you nevertheless to seek to ensure that contracts for 1994/95 reflect the priorities set out in this guidance. This material is also relevant to the 1994 round of Accountability Reviews, about which I will be writing separately to Chairmen. Guidance will be issued early next year on the future development of local health strategies.

LONG TERM CONTEXT

2. What we are trying to achieve nationally over the next decade is a shift in the balance between health and social care; and between primary, secondary and tertiary care. This is to ensure that people receive care and treatment according to their needs and that the component parts of the National Health Service work together more closely.

Our overall aims are:-

(i) the development of a network of primary care services (ie services provided by general practitioners and other services based in the community) which will deliver effective

preventive, diagnostic and treatment services and a wide range of domiciliary and day care services. This will enable the acute hospital and long-stay services to concentrate on delivering high quality care to patients who need the specialist skills (and in the case of acute services the complex technology) available in acute hospitals and long-stay facilities.

(ii) within the acute hospital sector, a higher proportion of activity being undertaken on an out-patient or day case basis and a higher proportion of specialist health care being delivered in a primary care setting.

(iii) greater clarity about the respective roles of the NHS and local authorities in meeting the continuing needs of people who are mentally ill or suffer from learning disabilities and the frail elderly. This will involve local authorities progressively taking responsibility for caring for people who do not need specialist medical and nursing care. The result will be contraction of the NHS long-stay sector, investment in community based facilities, the transfer of resources to local authorities and the development of joint purchasing between the NHS and local authorities.

(iv) to promote better health and to help people to improve their own health and health care. This encompasses promotion of healthy lifestyles, self treatment of minor ailments, understanding the opportunities and limitations of the various health services provided (both NHS and private), and responsible use of these services.

3. In parallel with these broad shifts, we are looking to improve the effectiveness and cost-effectiveness of treatment and care. This means an increasing emphasis on information about the outcomes of clinical interventions and about the costs associated with them. We want to ensure that people enjoy the best possible level of health as a result of our efforts. We also expect those who use the services of the NHS to feel that they are being dealt with in a way they are entitled to expect; this implies a greater emphasis on local views and wishes and user satisfaction. We also attach priority nationally to purchasers developing closer links with their local communities and establishing a sound dialogue which influences their purchasing.

RESOURCE ASSUMPTIONS

4. The long-term trend has seen increases in activity in the acute hospital sector of 1-2% per year. Even allowing for the strategic changes described above including the intention to tilt the balance away from inpatient care towards day case, outpatient and primary care, there is as yet no evidence to suggest that growth in activity will slow down or level off. Boards will, therefore, have to decide for each specialty what rate of growth in activity they can accommodate within the resources likely to be available to them. This should be included in contracts. Nationally we expect activity levels in the acute hospital sector to increase by 2.5% in 1994/95.

5. In considering the resources available to your Board you can assume that sufficient funds will be available to maintain current levels of service and to accommodate demographic changes and medical advance. In negotiating contracts for 1994-95 you should ensure that overall a

minimum improvement in efficiency of 2% is achieved. This is the least that is required to achieve the NHS programme on a national basis. Boards may well wish to seek higher improvements to sustain local changes. Boards will also wish to discriminate between their many providers in seeking increased efficiency taking into account their relative costs etc. Increased efficiency might be achieved by more service for the same funding or by maintaining or increasing levels of service for reduced funding ie cash releasing savings. It will be for the Board to determine and negotiate.

6. Moves towards weighted capitation will continue to be made as outlined in the seminars on 14th December and in the allocations letter which is to be issued within the next few days.

1994/95

7. I attach at Annex A a slightly revised version of the chart issued last year which translates the 3 main aims of the Framework for Action into more specific objectives. The material in Annex B translates these specific objectives into long-term and short-term actions and targets. The key points for 1994-5 are summarised in the following paragraphs. Annex D sets out the annual planning timetable.

8. The emphasis in 1994/95 will be on building healthy alliances; improving quality and outcomes through effective purchasing; improving contracting; and developing primary and community care. Our intention is to build on work currently underway in developing strategies and ensure that appropriate processes and organisational arrangements are in place to deliver purchasing objectives.

Healthy Alliances

9. A major role of boards is to improve the health of their resident population. Given that the determinants of health are often outwith the direct control of the NHS, it is critical that alliances are forged so that all parties of the community are working together for maximum health gain. Some boards have made good progress in establishing flourishing partnerships with local businesses, other statutory bodies and voluntary agencies to work jointly for the improved health of the local population. The leadership of non-executive members of the health board can be particularly helpful in forging productive links with the community. We expect to see increasing involvement in innovative multi-agency initiatives, particularly those aimed at deprived areas and populations.

Strategy

10. By the end of 1994, we need to have agreed acute and mental health strategies for each Health Board and to be beginning to pull these together into revised local health strategies which give clear messages to providers of purchasing intentions in the long term. The changes we are seeking over the next 10 years are truly strategic and will depend upon providers making radical changes in the way they deliver services. We are envisaging a shift of resources to local authorities for community care of around £150-200m and associated with that a reduction of at least 30% in the number of staffed long stay beds purchased by Boards for people who are mentally ill or have learning disabilities; and a substantial reduction in the number of long-stay beds for the frail elderly.

Similarly development towards care being delivered in a primary setting will have implications for acute providers and we anticipate a reduction of about one-third in the number of acute beds over the decade (compared with the baseline of 1990-91). Changes of this magnitude will need robust planning by providers and it is therefore essential that purchasers map out clearly what they intend.

Primary Care

11. During 1994 priority should be given to the development of primary care to ensure effective, efficient co-ordinated delivery of services within local communities whenever it is possible and cost effective to do so. By the end of 1994 we expect all boards to have completed their strategy for primary care in consultation with primary care practitioners and to have agreed it with the Management Executive. It is our intention that the first priority for investment should be the development of services in the primary care or other community settings. A proportion of the revenue released from reducing the size of the long-stay sector should be directed to securing services for clients living in the community. It is particularly important for the primary care sector to respond effectively to caring within the community for the elderly and for those with mental health problems and learning disabilities and to meet the demands being made by the increase in day surgery and shorter lengths of stay in the acute sector. We will be looking to the Boards to extend GP fundholding and promote effective performance in primary care, including the development of team working, facilitating the evolution of management and planning in general practice and effectiveness in prescribing.

Quality and Outcomes

12. We expect to see purchasers become increasingly specific as to the quality of outcomes and processes which they contract for and monitor. This is not possible without close dialogue with clinicians within the purchasing team, and with providers (including clinicians). The recommendations of the Kyle Report on core clinical outcome measures, of the Thomson Report on the interface of clinical audit with management, of the recently published strategy for research and development, of the core quality template agreed recently and the work now in hand with the Royal Colleges on clinical guidelines should all assist purchasers to take forward this dialogue for 1994/95. From time to time the Joint Working Group on Purchasing will draw Boards' attention to ways in which clinical effectiveness might be improved through contracting. In addition I expect Health Boards to develop their own measures and to consider how clinical effectiveness can be improved locally, as was discussed during this year's round of Accountability Reviews.

Community Care

13. Successful care in the community requires the development of a wide spectrum of services; hospital-based in-patient care, various forms of supported accommodation, day services ranging from day hospitals to drop-in centres and domiciliary services ranging from community mental health teams to domiciliary respite care services. Some of these will be organised by a single agency but increasingly most should be jointly financed and purchased by the NHS, social work and housing agencies working together. An increasing proportion of these services will be based in the community and may be provided by non-statutory agencies.

Health Boards need to develop a shared understanding with their social work and housing partners of what spectrum of services is needed for their populations. They also need to agree with their long-stay providers what volume and kind of services they will want to purchase, how this pattern is to be achieved, what resources it will release and how these are to be deployed (which will include the transfer of significant resources to local authorities).

14. In addition, the need to ensure discharge policies are working and that acute and assessment beds are not being blocked remains a priority.

Resource allocation and value for money

15. Long-term resource assumptions are described in paragraphs 4-6 above. Specific requirements for 1994/95 are set out in Annex C.

16. With regard to efficiency improvements, the Management Executive wants purchasers to begin to use comparable data on costs and activities in supporting their purchasing decisions. Boards also need to develop a clear view of the proportion of activity that should be accommodated in primary care and in hospital; and in the latter, of what balance should be struck as between, out-patient, day case and in-patient provision.

Contracting

17. It is essential that contracts now move away from simple block to, at least modified block with indicative volumes and re-opener clauses, or cost and volume contracts. All contracts should be signed by 31 March 1994 at the latest. Purchasers will also need to ensure that appropriate arrangements are in place for the effective management and control of contracts. By the end of 1994/95, the Management Executive will expect Health Boards to be able to report activity against contracts and to be able to monitor this within the year.

Empowering Staff - Purchaser Development

18. I attach a high priority to the goal of empowering staff which is set out in Framework for Action. I recognise that from April 1994 the majority of staff will be employed by NHS Trusts and that Health Boards will be able directly to influence only their own staff. Nevertheless the success of the Board is dependant on the ability of its staff to act efficiently and effectively as purchasers. A priority for the Board will therefore be to act vigorously to empower and develop its staff as purchasers. We would expect to see not only the identification and provision of effective training and education programmes but also the setting of individual objectives for all staff which clearly reflect and progress the Board's strategic purpose and values. The Board will also wish to ensure that a communication system is in place which provides for feedback and evaluation of the views of staff and informs the further development of staff.

19. I will write to the State Hospital in the near future with a version of this letter tailored to their specific circumstances.

20. I hope this guidance is helpful to Boards.

GEOFF SCAIFE
Chief Executive
NHS in Scotland

FRAMEWORK FOR ACTION
1994 ROUND OF ACCOUNTABILITY REVIEWS

AIMS	OBJECTIVES	
IMPROVE HEALTH	. **Promote health**	. Build healthy alliances . Deploy research information . Deliver effective health education .
	. **Prevent disease**	. Improve screening . Improve immunisation
IMPROVE CARE	. **Target services better to needs**	. Plan future development/disinvestment . Develop care in the community . Improve support services
	. **Improve primary care**	. Improve delivery of primary care . Improve management of primary care . Improve prescribing effectiveness
	. **Ensure a person-centred NHS**	. Develop consumer involvement . Meet Charter commitments . Reduce waiting times . Improve responsiveness to complaints . Increase day case utilisation
	. **Improve quality and outcomes**	. Improve clinical care . Improve clinical outcome . Increase application of clinical audit and research
	. **Ensure efficient use of resources**	. Improve bed use, Improve use of non-ward accommodation levels . Improve use of estate . Improve use of supplies
	. **Maintain financial control**	
EMPOWER STAFF	. Ensure appropriate staffing	. Match resources to needs . Plan for future needs
	. Empower and develop staff	. Set objectives and feedback . Provide training and education . Improve communication

IMPROVING HEALTH

Long-term Aims:

- 40% reduction in deaths from coronary heart disease (from 1990 to 2000);
- 15% reduction in deaths from cancer (from 1986 to 2000);
- 30% cut in smoking in 12 to 24 year olds (from 1986 to 2000);
- 20% cut in smoking in 25 to 65 year olds (from 1986 to 2000);
- 20% cut in drinking above recommended limits (from 1986 to 2000);
- 60% of 5 year olds to have perfect teeth by the year 2000;
- meet local targets for reductions in deaths from stroke, accidents, lung breast, cervical cancer, HIV/AIDS, drugs;
- 95% of child population immunised against:
  - diptheria;
  - whooping cough;
  - tetanus;
  - polio;
  - MMR;
  - HIB;
- 95% of 10 to 14 year old girls immunised against rubella;
- 80% of women between 50 and 64 years to be screened for breast cancer over a 3 year period;
- 80% of women between 20 and 60 to be screened for cervical cancer.
- drug misuse controlled

In 1994 - 1995:

- health liaison groups working effectively;
- priorities, key settings and key groups clearly defined;
- well-targeted, well-evaluated health promotion programmes;
- all health boards to have smoking, eating and alcohol policies themselves, and reflected in their contracts;
- recommendations of Inverclyde Report on screening implemented;
- strategies developed to prevent drug misuse and for provision of services for misusers.

IMPROVING CARE

Target Services Better to Needs:

Long-term Aims:

- better match between local health needs and services;
- better integration of primary, secondary, community care;
- planned retraction from surplus secondary provision:
  - reduction of around 5,000 acute beds by the year 2000;
  - reduction of around 8,000 long-stay mental health beds by the year 2000;
  - unquantified reduction in long-stay provision for the frail elderly;
- planned development of primary and community services:
  - 8,000 new community places by 2000 (supported by health boards and local authorities);
- all ambulance services meeting ORCON standards.

In 1994-95:

- all health boards to have agreed acute and mental health strategies based on sound needs assessment;
- development of a wider range of residential, domiciliary and day services in co-operation with social work and housing agencies;
- 600 long-stay mental health places transferred into the community;
- progress with transferring to local authorities care of the frail elderly;
- £10m to be transferred to local authorities for development of community care;
- Health Boards monitoring waiting times for:
  - assessment;
  - community placement;
  - day/respite care.
- all Boards to have arrangements for monitoring nursing home care which reflect local Social Work Department arrangements for monitoring residential care;

- all Boards to take action to ensure 1995/96 contracts, and if possible 1994/95 contracts also, reflect the needs of homeless people. In particular contracts should ensure that:

  - arrangements are implemented to improve delivery of care in line with CMO's letter of 18 October 1993;

  - links are established with Housing Authorities to identify people with health problems;

  - leaflets are produced explaining access to health services for homeless people;

  - primary care teams have appropriate links with housing providers, and that housing providers have access to help in assessing health needs of homeless people;

  - outreach arrangements are established for those living in hostels, shelters and sleeping rough.

- Health Boards making effective use of SNAP/CRAG/SCOTMEG output measured, for example, by monitoring:

  - number of congenitally dislocated hips, diagnosed late;

  - number of cataracts carried out by day surgery.;

- improved clinical effectiveness through contracting by, for example, implementing the recommendations of Joint Working Group on Purchasing on:

  - pulmonary embolism;

  - diabetic retinopathy;

  - radiotherapy for lung cancer and/or other local initiatives;

- Health Boards building on work carried out in 1993/94 on stroke to achieve improved effectiveness of stroke services;

- Health Boards analysing cost effectiveness and current expenditure pattern on each main care group;

- developing the purchasing function.

IMPROVING CARE

Improving Primary Care:

Long-term Aims:

- well managed, effective, primary care service;
- improved prescribing effectiveness;
- better utilisation of community pharmacy services.

In 1994-95:

- all health boards to complete strategies for the development of primary care;
- review staffing structure and ensure key senior staff in post for primary care;
- review management information systems for the development of primary care;
- extension of GP fundholding to cover at least 30% of the population in each Health Board area by 1995-96;
- increase in resources allocated to primary care;
- an increase in the number of GPs meeting higher target for primary immunisation;
- an increase in the number of GPs meeting higher target pre-school booster immunisation;
- a 10% increase in generic prescribing by GPs in each Health Board;
- 25% of GP practices adopting a GP Charter;
- 20% of GP practices with practice development plans;
- develop local strategies for management of the FHS drugs Bill;
- at least 40% of GP practices operating practice formularies;
- ensure systems in place for clinical review of all repeat prescribing;
- develop local policies to reduce the use of anxiolytics and hypnotics;
- develop local consensus guidelines on the rational use of ulcer healing drugs and antibiotics.

IMPROVING CARE

Ensure a Person Centred NHS:

Long-term Aims:

- NHS users having:
  - access to suitable NHS health care, irrespective of special needs or disabilities;
  - waiting times within guaranteed periods;
  - accurate, relevant and understandable explanations, and involvement and choices so far as is practical;
  - treatment as a person, not a case;
  - close linkages between different aspects of health care;
  - comments and complaints treated seriously, and dealt with fairly and quickly.

In 1994-95:

- develop consumer involvement in planning and in monitoring service delivery by better liaison with local health councils and increased use of surveys/focus groups;
- meet and develop charter commitments, both national and local, particularly on access, smooth referral, admission and discharge procedures, patient communication and treatment with respect and dignity;
- on waiting times:
  - ensure 30 minute maximum wait after appointment;
  - meet guarantees on maximum out-patient waiting times;
  - meet maximum in-patient/day case special guarantees;
  - meet long-stop guarantee;
  - meet A&E targets;
  - improve cancellation and "did not attend" rates.
- on complaints:
  - meet local targets for response times;
  - improve complainant satisfaction with results;
  - use complaints to improve services.
- meet local targets for proportion covered by named nurse.

IMPROVING CARE

Improving Quality and Outcome

Long-term Aims

- healthy treatment environment;
- improved clinical care;
- improved clinical outcomes;
- research base informing decisions on care;
- well developed systems of clinical audit;
- well developed organisation-wide quality assurance systems (including use of clinical guidelines).

In 1994-95:

- ensure healthy treatment environment by monitoring:
  - Health Board smoking policy;
  - Health and Safety requirements;
  - other statutory requirements;
  - other Health Board policies;
  - accident prevalence;
  - prevalence of untoward incidents;
- improve care by monitoring:
  - pressure sore prevalence;
  - hospital acquired infection prevalence;
  - pain and discomfort protocols for assessment and provision of pain relief;
- improve clinical outcome by increasing range and coverage of outcome measures being recorded; using output of CRAG working group and Royal College clinical guidelines effectively, for example, by comparing results and stimulating discussion with providers and clinicians on how outcomes can be improved; and by improving speed of access to outcome statistics. Key indicators in 1994-95, as identified in CRAG working group report;
  - deaths within 30 days of admission for fractured neck of femur;
  - discharge home within 2 months of admission for fractured neck of femur;

IMPROVING CARE

Efficient Use of Resources:

Long-term Aims:

- increase annually the number of acute in-patient discharges and day cases by 1-2%;
- increase in-patient throughput per acute staffed bed by 3-4% annually;
- increase average occupancy rates of staffed acute in-patient beds to 80%;
- reduce the average length of stay in acute beds by 3% annually;
- increase the proportion of acute in-patient and day cases treated as day cases by 1% per annum;
- increase energy efficiency by reducing volume consumption by 1½-2% per year to 2000;
- mandatory purchasing of 50% of supplies.

In 1994-95:

- ensure contract monitoring systems allow tracking of actual efficiency verses contract requirements;
- increase efficiency by a minimum of 2%;
- devise strategies for the introduction of new drug treatment;
- demonstrate clear progress towards longer term aims.

IMPROVING CARE

Maintaining Financial Control:

Long-term Aims:

- control all NHS expenditure;
- distribute resources to Health Boards equitably;
- achieve weighted capitation parity funding for both revenue and capital charges;
- no simple block contracts, all contracts to be activity based;
- contracts to incorporate the results of the costing project, with greater recognition of the impact of activity;
- contracting to be at specialty/directorate level;
- to manage the NHS Drugs Bill, both FHS and HCH, and achieve significant reductions in costs;
- minimise management and administration costs.

In 1994-95:

- Health Boards and CSA to be in income and expenditure balance throughout the year and NHS Trusts to meet their financial duties;
- all authorities to ensure that proper financial management systems are in operation, especially covering the control and reporting of funds, including up to date standing financial instructions;
- capital charge funding to move to 40% weighted capitation;
- all contracts to be either cost and volume or modified block contracts; and simple block contracting to cease;
- all contracts to be signed within the timetable set;
- rate of growth in drugs bill to reduce by 2% (from the predicted increase of 8.45% in 1994/95);
- generic prescribing to account for no less than 50% of prescriptions.

IMPROVING CARE

Empowering and Developing Staff as Purchasers

As self-governing bodies Trusts have full responsibility for planning and delivering the human resources strategies and programmes necessary to achieve their contractual and other obligations. This annex therefore deals only with the action required by Health Boards.

Long-term Aims:

- effective and empowered purchasing teams.

In 1994 - 1995:

- Training and Education Programme;
- Objectives for all Board Staff;
- Communication system to provide feedback and evaluation;
- Evaluation of development needs for 1995.

FINANCIAL GUIDELINES TO INFORM CONTRACT NEGOTIATIONS FOR 1994/95

1. As in previous years it is for you to determine the assumptions on which you wish to base the contract negotiations for 1994/95. Paragraphs 4 and 5 of the covering letter offer planning assumptions. This annex deals with more detailed issues of relevance to 1994-5. They are as follows:-

- Doctors and Dentists in Training: It has now been decided to transfer 100% funding for doctors and dentists in training from Health Board budgets to the Scottish Council for Postgraduate Medical and Dental Education with effect from 1 April 1994. It has also been decided to the transfer of study leave budgets for these doctors and dentists.

- Ambulance Service: From 1 April 1994 Health Boards will be responsible for purchasing accident and emergency ambulance services direct from the Scottish Ambulance Service and provider units will require to purchase non-emergency patient transport services from the Scottish Ambulance Service. The total funds for ambulance services will be transferred from the Commons Services Agency budget to Health Boards on 1 April 1994. The funds relating to the non-emergency patient transport services will be identified by provider unit. This will enable the Boards to include these funds in their contracts with provider units for patient care and treatment. During the period to 31 March 1994 the Scottish Ambulance Service will enter into Service Level Agreements with Health Boards for accident and emergency services and with provider units for non-emergency patient transport services. For the period 1 April 1994 to 31 March 1995 all the funds in respect of ambulance services will be ring-fenced and Health Boards and provider units will reimburse The SAS for the services provided on the basis of 12 equal payments in order to ensure that the total running costs of the Ambulance Service are recovered. Subject to experience it is proposed to remove the ring-fencing from 1 April 1995 to allow purchaser/provider relationship to develop fully. From April 1995 provider units may invite competitive tenders for the non-emergency patient transport service.

- Transfer of Resources to Local Authorities: In line with the proposals agreed at the July round of Joint meetings funds will be top sliced and allocated by reference to the relative progress Boards have made in transferring resources to Local Authorities.

2. A number of changes are also to be made to the way in which allocations are made from 1 April 1994. A number of off-the-tops will no longer be separately identified but subsumed in the basic weighted capitation allocation. This applies to the following:

Pre-1969 Patients
Project 2000
Medical Audit
UFC
Transfer from Capital
Revenue Income
Health Board Members' Payments

HiB Vaccine

The allocations will be adjusted to ensure that these changes have a neutral effect.

3. Sufficient capital funds will be made available to meet normal equipment replacements, statutory requirements, to make progress in improving the quality of the hospital estate, for existing capital commitments to be met and a start made to the major acute strategies.

4. The increasing pressures on the Family Health Services programme continues to constrain the funds available for hospital and community care provision. Sustained effort is required to put pressure on those areas where costs can be reduced in the primary care area.

5. The allocation for each Board will take account of the effects of all the changes mentioned above. It is anticipated that despite the introduction of the unified budget and the later announcements of the Secretary of State's PES settlement that the allocation letter will still be issued before Christmas.

PLANNING AND CONTRACTING TIMETABLE

	ME	HB	UNITS/ TRUSTS	GPFH
JULY	Issue priorities guidance (delayed) to Nov in 1993)	Discuss service plans and LHS with providers and GPs Draft forward Community Care Plan	Discuss service plans and providing strategy with all purchasers	Discussions with HBs and providers
AUGUST		Draw up purchasing intentions Make purchasing shifts clear to providers	Discuss capital plans with major purchasers	Draw up purchasing intentions
SEPTEMBER		Intimate purchasing intentions Tell ME about significant purchasing shifts Endorse Unit/Trust Capital Plans Submit Capital Plans Submit information strategy to ME	 Submit capital plans Submit financial pro-formas Submit information strategy to ME	Finalise business plans
OCTOBER	Review Trust Business Plans Review Capital Plans	Consult on Community Care Plans	Submit capital charges estimates	Intimate Purchasing Intentions
NOVEMBER	Discuss capital plans Final Public Expenditure settlement	Negotiate contracts	Provide initial prices Negotiate with purchasers	Negotiate contracts
DECEMBER	Allocate capital Notify revenue allocations Reconcile purchaser/ provider intentions	**In 1994 only, final primary care strategy** Draft Accountability Review Action Plans Negotiate contracts	Negotiate contracts Submit draft business plans to ME	Negotiate Contracts

ANNEX D

	ME	HB	UNITS/ TRUSTS	GPFH
JANUARY	Notify Trusts of External Financing Limits	Agree final purchasing intentions Submit Accountability Review Action Plans	Provide final prices	
FEBRUARY	Hold Accountability Reviews	HB finalise offers of allotted sums to GPFHs		
MARCH	Hold Accountability Reviews Sign off Action Plans	Sign off contracts strategy Issue Community Care Plan Produce Board Research and Development Programme	Sign off contracts Publish business Plans	Sign off contracts
APRIL	Sign off Action Plans	Strategy review/ LHS update **In 1994 only: Draft Primary Care Strategy**		
MAY	Public expenditure survey	Provide final accounts	Provide final accounts	
JUNE	Draft priorities & Planning Guidance	Publish Dir Public Health Report		