THE SCOTTISH OFFICE

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National Health Service in Scotland
Management Executive

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Dear Colleague

PRIORITIES AND PLANNING GUIDANCE FOR 1995/96

1. Last December I issued for the first time Priorities and Planning Guidance for the NHS in Scotland. It was designed to serve 2 purposes. First, to set out in a reasonable degree of detail how we expect the NHS to change and what we expect it to be achieving by the medium to long-term. This was designed to ensure that the agenda for the NHS was as clear as it reasonably can be and to provide a context for strategic planning by individual Health Boards.

2. The second purpose was to elaborate in detail the kinds of developments and changes that we think individual Health Boards needed to achieve in 1994-95 if they were to make reasonable progress towards the achievement of the long-term agenda. The intention was to give Health Boards as clear a picture as we can of what we expect them to achieve in the year ahead and to provide a basis for the 1994 round of accountability reviews.

3. This Priorities and Planning Guidance for 1995-6 is intended to fulfil the same 2 objectives. Although the format has changed to an extent, reflecting the views expressed by Health Boards, you will see that the essential elements of the agenda have changed very little.

The Planning Context

4. The starting point for elaborating our expectations of Health Boards is the statement of the purpose of the NHS which was contained in the Patient's Charter and in the Framework for Action. It remains as valid now as it did then. It is:

- to promote good health;
- to diagnose and treat those who are ill; and
- to provide health care for those with continuing needs

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irrespective of the individual's ability to pay, in partnership with people and with other organisations, and within the resources that the country makes available. In seeking to achieve that purpose we must in everything we do follow the key principles of corporate governance - openness, probity and accountability.

5. A key element of the long-term planning context is the recognition of primary care as the foundation of the NHS and the need to ensure the necessary investment in services and infrastructure to enable the sector to fulfil its role. The continual development of high quality services based in the community is essential to underpin the shift of activity from the hospital sector to the primary sector. This shift in the balance of care continues a well established trend. Over the last 20 years or more lengths of stay have fallen year after year, reflecting changes in clinical practice. As a result, the number of acute in-patient beds required to deliver an increasing amount of activity has fallen year after year. I expect these trends to continue. Although I intend that the treatment of patients will increasingly take place in primary care settings, we can only assume that acute hospital activity will continue to increase as a result of medical advance and other factors. But, also as in the past, changes in medical technology and other developments - particularly the rapid development of day surgery - will mean that this increase in activity can continue to be delivered with a steadily reducing number of acute in-patient beds.

6. Over the last 2-3 years waiting times have fallen dramatically as a result of the guarantees and targets published in the Patient's Charter and in your local charters. This is despite an increasing number of patients being treated each year. The NHS in Scotland can be proud that it is now treating more patients than ever before, more quickly and more cost-effectively. Those are trends which will want to continue in 1995-6 and beyond.

7. The policy of Care in the Community is now developing real momentum in Scotland. Health Boards, local authorities and housing agencies are working together to plan and implement the development of a wide range of community-based facilities. This is being facilitated by the transfer of resources from the NHS to local authorities. As a result the closure of a number of long-stay institutions is now in train, and more will follow. Again, this is a trend which will continue into the long-term and which I hope will be accompanied by even closer relationships between health and social care agencies, particularly through the development of joint purchasing.

8. In the course of 1995/96 a considerable amount of information will become available on the cost effectiveness of different models of health care. In particular the Health Purchasing Information Centre will come on stream, information on further outcome measures will become available from CRAG, advice on clinical effectiveness will be produced by Directors of Public Health and in addition increased output from the Cochrane Centre and the Centre for Reviews and Dissemination in York will provide information which will allow Health Boards to determine the marginal benefits to be derived from increased investment in specific services. In order to make maximum use of this information Health Boards will need to be aware of their current patterns of expenditure. In the course of 1995/96 Health Boards should analyse the current expenditure pattern in each main care group. This information is essential to ensure that commissioning of services becomes more sophisticated and that Boards can

predict the improvements in health gain they can expect from increased levels of investment in different services.

Priorities

9. An important part of planning is the need to set a limited number of priorities which represent the most important areas for action. These are the main areas in which we expect to see change in the short-term and therefore on which Health Board's forward plans should focus. By concentrating on these, purchasers and providers of health care and services alike can contribute to our overall success. The 7 priorities are:

9.1 building effective alliances with other local agencies to improve health;

9.2 shifting the balance of care from secondary to primary care and improving the quality and range of primary care services available to the population;

9.3 shifting the balance of care from health to social care through agreed, joint community care plans;

9.4 increasing value for money, by improving efficiency and effectiveness;

9.5 ensure that people are given real opportunities to influence planning and decision making and that they receive services responsive to their needs ie treatment as an individual, not a case;

9.6 improving quality of care by ensuring that protocols are developed in key clinical quality areas, outcomes are systematically monitored, and that investment increasingly is committed to interventions shown to be effective;

9.7 developing the purchasing function of Health Boards.

This does not mean that nothing else matters - far from it: there is a significant programme of work to which we are already committed, which is required to ensure that the NHS continues to meet the full range of its responsibilities. The maintenance or achievement of agreed standards and targets is expected, and these include, for instance: maintaining financial control, meeting activity targets, waiting time guarantees, the achievement of quality standards and the provision of a safe and appropriate environment.

Success Criteria for 1995/96

10. The 7 priorities listed above are defined in a general way so that the Management Executive, purchasers and providers can reach agreement on local markers of success. Key indicators of progress towards medium-term priorities will be agreed in corporate contracts between the Management Executive and Health Boards. Successful progress towards the delivery of these priorities will be monitored through in-year performance monitoring and the Accountability Reviews. An indication of the success criteria for the delivery of the 7 major priorities is set out in Annex A.

11. I expect Health Boards to reflect the priorities set out above in drawing up draft corporate contracts for 1995/96 and in contract negotiation. Plans should be set out under the headings identified in paragraph 6 but I would encourage Boards to be innovative and imaginative as to how they might achieve change in these areas, and look forward to seeing their proposals in draft corporate contracts. **Annex A sets out the national agenda and national targets. It is not intended to prescribe the content of local plans. Health needs and priorities vary from Health Board to Health Board and local plans should reflect local needs and priorities.** I would, however, emphasise that corporate contracts, as with NHS contracts, need to become more quantified and more clearly based on outputs and outcomes which can be measured, rather than tasks for completion by a certain date. As a minimum I would expect to see in each corporate contract the following:

11.1 aggregated contract activity as per the contracting template developed by the Joint Working Group on Purchasing;

11.2 targets for minimum efficiency levels in providers with which Health Boards have contracts;

11.3 waiting time targets and guarantees;

11.4 targets for movement of activity from the secondary to primary and health to social care sectors, together with the funds to be transferred to the local authority for the development of community care and from the hospital to the primary care sector;

11.5 targets for GP fundholding;

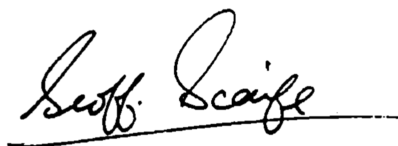
11.6 targets for the management of the FHS and HCH Drugs Bills;

11.7 performance targets for the Ambulance Service.

1995 Accountability Review

12. As in this year's Accountability Reviews, I wish to use the meetings to discuss and agree forward objectives and targets for the year ahead. Increasingly, however, I want to focus discussion on identifying criteria for success and on agreeing measurable targets and performance indicators. I hope that throughout 1994 we can improve in-year performance monitoring and that only major issues that have not been resolved bilaterally in-year between Management Executive and Health Board staff are on the Accountability Review agenda.

13. Draft corporate contracts should be submitted to the Management Executive by 31 December. I will write towards the end of the year setting out dates for Accountability Review meetings in 1995.



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3. Shifting the Balance of Care from Health to Social Care, Through Agreed Community Care Plans

3.1 Health Boards should begin implementation of joint community care plans agreed with partner agencies and organisations during 1994/95.

3.2 Demonstrable progress should be made by Health Boards towards locally agreed targets for reducing long stay mental health and learning disability beds and long stay provision for the frail elderly. A corresponding improvement in the provision of community places to support this retraction from institutionally based care should be demonstrable. The medium term target for the NHS in Scotland as a whole is to develop services in the community to replace around 8000 long-stay hospital beds by the year 2000.

3.3 Purchasers should provide evidence that they are working closely with Local Authorities in planning services for all those vulnerable groups within our communities, including children with special needs, those with physical disabilities, the elderly, minority ethnic groups and the homeless.

4. Increasing Value for Money, By Improving Efficiency and Effectiveness

4.1 Throughput per acute staffed bed and occupancy rates should increase; and the average length of stay of patients in acute beds should decrease. The Scottish Office Audit Unit targets for improving day case surgery should be achieved within a maximum of 3 years. The ratio of new to return out-patient attendances should continue to be scrutinised, with a reduction achieved in the number of review appointments. The unit cost of care negotiated with providers should demonstrably take into account these efficiency improvements.

4.2 There should be clear evidence that Boards are applying knowledge obtained from the Scottish Office Audit Unit, National Audit Office and published studies on technology which indicate opportunities for increasing value for money.

4.3 Boards should analyse the current expenditure pattern in each main care group to ensure that commissioning of services becomes more sophisticated and that Boards can demonstrate measurable improvements in health gain flowing from their investment levels in different services.

4.4 The effectiveness and cost effectiveness of joint working on health, and health promotion activity, should be evaluated.

4.5 All efficiency targets agreed between the Health Board and the Management Executive should be met.

5. Ensure a People Centred NHS

5.1 All Health Boards to agree and publish a Consumer Involvement Strategy which ensures that local people have an opportunity to influence the Local Health Strategy, the purchasing plan and local priorities.

5.2 Evidence of at least 1 major area where purchaser has responded to views of the public (and made a change).

5.3 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.

5.4 Meet waiting times guarantees and set targets to reduce cancellation and "did not attend" rates.

5.5 Meet complaints response targets and gear up to act on recommendations of Wilson Committee report.

6. Improving Quality through the development and implementation of clinical care protocols, Systematic Monitoring, Investing in Interventions shown to be Effective, and ensuring that Strategies for Research, Development and Audit are in Place

6.1 Purchasers must ensure that contracts focus more on improving clinical outcomes and that more systematic area-wide audit takes place. To do this, mechanisms for involving health professionals in the contracting process must be implemented. Improvements must be made in the use of studies of effectiveness of different models of care.

6.2 The scope and range of outcome measures in use should be increased to include, for example, outcomes of health promotion activity as well as Primary and Secondary Care.

6.3 Purchasers should produce plans for more appropriate investment in services known to be effective. They should also aim to show evidence of identifying interventions which are less effective. In each case the processes and the results of such change should be evaluated. In particular purchasers should ensure that the results of clinical audit have an impact on the way services are delivered.

6.4 Purchasers should ensure that protocols are developed in key clinical quality areas eg hospital acquired infection, pressure sores, etc and quality of care assessed against agreed outcomes and targets through systematic monitoring.

6.5 Research needs and priorities should be identified; and Health Boards should work collaboratively to support research and share results (for example on "low tech" means of delivering care or on the effectiveness of management techniques).

7. Developing the Purchasing Function of Health Boards

7.1 Health Boards should ensure that opportunities for education and training are provided for their employees to ensure more effective use of staff.

7.2 Boards should pay close attention to the development of the purchasing organisation and the personal development of individual members of staff.

7.3 Health Boards should ensure that all Board staff, working through the Performance Management Scheme, have objectives which contribute to the effectiveness of commissioning arrangements. A crucial part of this process is an appropriate communication system to provide feedback and evaluation.