THE SCOTTISH OFFICE

9855 NHS
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National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

3 August 1995

Dear Colleague

PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND: 1996/97

Summary

1. Priorities and Planning Guidance for the NHS in Scotland for 1996/97 is attached.

Action

2. Health Boards, NHS Trusts and GP Fundholders are expected to take account of the guidance in deciding priorities and preparing local plans.

3. Health Boards are requested to circulate this MEL to GP Fundholders within their area for action and GPs for information.

Yours sincerely

KEVIN J WOODS
Director of Purchasing

Addressees

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Chief Executives NHS Trusts

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APPENDIX

PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND: 1996/97

Introduction

1. The purpose of the Priorities and Planning Guidance each year is to provide the overall context for the planning and delivery of health services for the coming year, and to focus the NHS in Scotland on the most important national priorities.

2. The characteristics and health needs of local populations vary in different parts of the country. Local plans, drawn up in consultation with the public and with other agencies, should reflect local needs and priorities within this statement of national policies and priorities. The purpose of this guidance is to give a broad direction; specific quantified objectives and targets will be agreed in corporate contracts between each Health Board and the Management Executive of the NHS in Scotland, and in service contracts between purchasers (Health Boards and GP Fundholders) and providers (NHS Trusts and Units).

3. In developing local purchasing strategies and plans Health Boards are expected to take full account of the views of all GPs. In their turn, GP Fundholders are expected to take account of these locally agreed strategies, as well as the broad priorities set out in this guidance in shaping their own purchasing plans. Further guidance on the accountability framework for Fundholders was issued for consultation in February and definitive guidance will follow later this year. Boards and Fundholders are expected to work together within this framework.

The Policy Context

4. The starting point for setting priorities for the NHS in Scotland is the policy context set by the NHS and Community Care Act (1990) and "Scotland's Health: A Challenge to us All". The purpose of the NHS was summarised in the Patient's Charter and in the Framework for Action. It is:-

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

irrespective of the individual's ability to pay, in partnership with people and other organisations, and within the resources that the country makes available.

5. In seeking to achieve this purpose the NHS in Scotland must follow the key principles of corporate governance - openness, probity and accountability.

Strategic Objectives

6. Within the overall policy context, the NHS in Scotland has developed a number of key strategic objectives.

Improving Health

7. First, and foremost in the national strategy is the aim to improve the health of the people of Scotland by assessing need, promoting health, preventing illness and improving the clinical-effectiveness and cost-effectiveness of health care interventions.

There are 4 key strands to this work:

- developing proactive cost-effective strategies for health promotion;
- the building of health alliances between Health Boards and other agencies whose work impinges upon the health of the population of Scotland;
- the linking of the purchasing strategies of Health Boards and their GP Fundholder partners to health improvement targets to ensure that the substantial resources available for health care are targeted on issues of health improvement; and
- a growing emphasis on the effectiveness of health care interventions, to ensure that finite resources are used to the best effect.

Developing Primary Care

8. 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 this sector to fulfil its role. The continuing development of a network of high quality services based in the community working closely with primary health care teams is essential to underpin the shift of activity from the hospital sector to the primary care sector. This shift in the balance of care continues a well established policy which is expected to be reinforced by implementation of Health Board primary health care strategies. The long-term objective is to achieve the development of a primary care led NHS in which decisions about the purchasing and provision of health care are taken as close to patients as possible.

Promoting Care in the Community

9. The development of community care aims to allow people to receive health care services while they continue to live as independently as possible, in their own homes or in a homely setting in the community. This is facilitated first by developing new services in the community, which then enable resources to be released from institutional care to fund more flexible and appropriate care for people either in or close to their own homes. Implementation of this strategy demands that Health Boards, Local Authorities, Housing and other agencies work together with NHS Trusts/Providers, users and carers to plan carefully and implement the development of a wide range of community based facilities. To assist with this task bridging finance continues to be available. As the policy develops the transfer of resources from the NHS to Local Authorities is expected to continue on the basis of local agreements about the relative care responsibilities of health and social work authorities. The

current trend of the closure of a number of long-stay institutions is therefore expected to continue into the longer term.

Reshaping Hospital Care

10. Advances in medical technology are proceeding apace. In recent years there has been a dramatic expansion in the level and range of care delivered on a day care basis. Similarly new technologies have changed the way in which some care is now delivered including for instance the introduction of minimally invasive surgical techniques which have a major impact on the length of time patients can expect to stay in hospital. At the same time the successful implementation of national strategies is beginning to have an impact on the traditional interface between hospital services and those provided in the primary and community care sectors. It is important to ensure that the secondary and tertiary sectors provide proper support to the implementation of primary health care and community care strategies, and that appropriate investments are made in each sector to enable hospital services to concentrate on delivering high quality care to patients who need the specialist skills and (in the case of acute hospitals complex technology) available therein.

11. There is in addition increasing evidence that better clinical outcomes for some conditions can be achieved by aggregating clinical activity in centres of excellence, to ensure that the necessary supporting infrastructure is in place, to enable clinical skills to be maintained and to make best use of expensive and new technologies. In the light of these forces for change, Health Boards and GP Fundholders need to reflect upon the best way in which they can secure the very highest quality of secondary and tertiary hospital services for the population. In doing this purchasers should give careful consideration to the competing forces of centralisation and accessibility.

Supporting Strategies

12. In support of these key strategic objectives are a number of important aims, which in large part will be the key to successful achievement of national strategies. In summary they are:-

- supporting the overwhelming desire of those who work in the NHS to put patients first, in accordance with the aims and objectives of the Patient's Charter;

- the pursuit of clinical effectiveness, through the development of clinical guidelines and protocols, and by the implementation of systematic clinical audit;

- the continued search for better value for money;

- the promotion of clinical excellence by investing in training and education, and by supporting an active programme of NHS funded research and development;

- the development of health care organisations as they take on new roles and responsibilities arising from the NHS reforms.

13. Diagramatically the 4 key objectives and 5 supporting aims can be illustrated as follows:

	Improving Health	Developing Primary Care	Promoting Care in the Community	Reshaping Hospital Care
Education, Training, Research and Development				
Clinical Effectiveness				
People Centred Care				
Value for Money				
Organisational Development				

The achievement of each of the key objectives requires a range of activity across the spectrum from education and training, to ensuring value for money. Annex A sets out the key national targets in each of the areas identified.

Priority Setting

14. Against this strategic background it is necessary to set some priorities for action in the short to medium term. The value of any priority setting process becomes diminished if it does not distinguish the most important objectives from other requirements. If everything is a priority, nothing is a priority. But this does not mean that those objectives not selected as top priorities are unimportant; far from it. There is a range of established baseline requirements and objectives set out in previous guidance which every NHS purchaser and provider knows they are expected to meet by virtue of being part of the NHS. **Momentum on these must be maintained, alongside the new management focus required in the priority areas identified in this guidance.**

15. In seeking to achieve change in a few priority areas, the work of recent years on needs assessment, and on improving clinical and cost-effectiveness now provides an opportunity to focus efforts across the whole spectrum of health services - from improving health through developing primary care to delivering secondary and tertiary care - on a few specific conditions which are major health problems for the people of Scotland. The medium term priorities listed below represent the most important national priorities over the next 2-3 years; they will need to be supplemented by local priorities in line with local health needs and health

targets. The national priorities are:

- mental health
- cardio/cerebro vascular disease
- cancer

16. There are many reasons why these 3 areas are priorities for the NHS in seeking to improve the health of the people of Scotland. They are all major health problems in terms of the number of people who are affected. The severity and enduring nature of the associated illnesses means that together these conditions account for major disability and morbidity. In each case, however, there is emerging evidence on the effectiveness of different health care interventions and an increasing knowledge base on how services can be improved. Many of the specific health targets set nationally focus on avoidable premature mortality as a result of these conditions and the local targets set by Health Boards to improve health in most cases include specific targets in these areas.

Mental Health

17. Mental illness covers a broad spectrum of illness and to meet health care needs, varying responses are needed. The Scottish Needs Assessment Programme report estimated that 30% of the adult population of Scotland suffer from a mental health problem at some point in their lives and that around 10% of the population in a year will be diagnosed by their general practitioner as having a mental health problem. Little emphasis has so far been put on preventing mental illness or on improving primary care diagnosis and support for people with mental illness. There is however considerable research evidence that it is possible for service interventions to achieve an impact on the quality of life for sufferers, their families and carers, total disability and mortality.

Cardio[cerebro] vascular Disease

18. Each year in Scotland, coronary heart disease, stroke and peripheral vascular disease together account for almost half of all deaths, over 100,000 hospital admissions and a massive burden of chronic illness. Much of this is potentially preventable and much can be done to improve the quality of life of people with established disease and reduce complications. There is an increasing knowledge base about risk factors and effective interventions ranging from prevention, to treatment and rehabilitation to which the NHS needs to respond.

Cancer

19. There are about 28,000 new cancer cases in Scotland each year. One in three Scots will get the disease and one in four will die from it. The multiplicity of tumour sites, the different stages at which they present, the complications of the disease and the complexity of treatment present a major challenge to the NHS. Cancer is still regarded by the public as being particularly threatening and about which there are considerable taboos, and yet it is an area in which there is also emerging evidence about the scope for improvement of health service responses.

The Local Planning Context

20. Health Boards' forward plans should demonstrate what action they will take in 1996/97 to improve services and achieve improved health outcomes for people suffering from the conditions outlined above in the strategic context set out in paragraphs 6-12; and how results will be monitored. The priorities set out 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 the priorities will be agreed in corporate contracts between the Management Executive and Health Boards and in service contracts between purchasers and providers.

21. In drawing-up plans and discussing proposals locally for service improvement purchasers and providers need to be aware of the range of guidance reports and reviews available and in production. Annex B sets out work already in hand and reports available on these areas alongside work commissioned for publication in the next few months.

Contract Development

22. Annex C sets out the planning and contracting timetable for the year ahead. In developing contracts to address the priorities outlined above, purchasers and providers will want to consider the style and timing of contracts. Improving health in the areas identified above will need sustained change over a number of years and contracts may therefore need to be set in a longer term context matching the changes required. The timetable set out in Annex C still requires contracts to be signed off each year, however this should increasingly be in the context of long-term agreements between purchasers and providers. The main central requirement is that all activity should be covered by a signed contract at any given time.

23. In addition contracts will need to become more sensitive to variations in performance against contract and more sophisticated in terms of expected health gain for specific care groups. In the long term contracts will need to reflect the health needs of the population and be sensitive to case mix if they are to support and sustain the priorities identified in this guidance.

Conclusion

24. I would encourage purchasers and providers to be innovative and imaginative as to how they might achieve change in the areas set out in this guidance and look forward to seeing their proposals for "designing" the service they would want to deliver for their local population. I believe that by selecting a few key areas where we have good information on health needs and on the effectiveness of clinical care we are now well placed to make an impact on the services provided for people in these client groups. Resources are finite, and

we cannot therefore make an impact on improving the quality of care in all areas in each year but, by being selective, we can make a major impact on the health of people suffering from cancer, cardio/cerebro vascular disease, and mental illness in 1996/97. This should be our objective for the year ahead and the focus of discussion in the 1997 Accountability Reviews.

GEOFF SCAIFE
Chief Executive NHS in Scotland

ANNEX A

Paragraphs 6-12 summarised the key objectives and supporting strategies for the NHS in Scotland. The following paragraphs set out in greater detail specific national goals which purchasers and providers should pursue as appropriate.

1. **Promote best practice and clinical excellence among all health professionals by investing in training and education, and by supporting an active programme of NHS funded research and development**

1.1 Promotion of continuing education and development of primary care practitioners.

1.2 An increase in proportion of patient care be provided by fully trained doctors and dentists. Health Boards and Trusts to increase the number of consultants Trusts employ. Some expansion may be met from junior doctors and dentists hours monies where posts make a direct contribution to reducing junior doctors and dentists hours.

1.3 The Registrar and Senior Registrar grades to be merged in 1996 into the new Specialist Registrar grade under the Calman Report recommendations. More structured specialist training through the introduction of new training programmes under training and service agreements between Trusts and Postgraduate Deans is needed to produce an increase in candidates for Consultant posts in the shortage Specialties.

1.4 All junior doctors and dentists to have contracted hours of duty down to 72 hours by 31 December 1996. Actual working hours not to exceed 56 hours.

1.5 Boards and Trusts to establish and implement local R and D strategies; to identify current levels expenditure on R and D; and to allocate a specific budget for R and D.

1.6 Implementation of single research funding stream in the light of the outcome of the review of ACT(R).

1.7 Major decisions and investments to be underpinned by appropriate research.

2. **Pursue Clinical Effectiveness, through development of clinical guidelines and protocols, and by the implementation of systematic clinical audit**

2.1 Implementation of Common Core Work Programme for 1996/97 (which will be announced later in the summer) to guide and co-ordinate work of national bodies supporting improvement of clinical effectiveness.

2.2 Purchasers, Primary Care Practitioners and Providers to take action to implement clinical guidelines and good practice statements in a manageable number of locally agreed care areas.

2.3 Local clinical audit strategies and investment in clinical audit to reflect local purchasing and primary care strategies.

2.4 Health Boards to work with primary care practitioners on the implementation of clinical guidelines and programmes of audit.

3. **Put Patients first**

3.1 Update and republish local health charters.

3.2 Maintain downward pressure on inpatient and outpatient waiting times and improve waiting time guarantees.

3.3 In all contacts with the health service, ensure patients are treated with respect and dignity.

3.4 Improve the quality of communications with patients including informing them in advance of the type of accommodation they can expect on admission to hospital if they are to be cared for in a mixed sex ward.

3.5 Monitor implementation of "named nurse" in line with national guidelines.

4. **Improve value for money**

4.1 In light of priorities identified in this guidance review financial strategy to ensure developments are in line with priorities.

4.2 Each Health Board to analyse expenditure by care programme to inform financial strategy.

4.3 National Costing Project to extend to all specialties and comparative costs at procedure level to be published.

4.4 Action to promote effective prescribing and keep drugs bill within target limits.

5. **Develop Health Care Organisations as they take on new roles and responsibilities arising from NHS Reforms**

5.1 All Health Boards to implement organisational development strategies in the light of guidance on their roles and responsibilities to be issued before April 1996.

5.2 All Health Boards to support and encourage the development of GP Fundholding.

5.3 All Boards to support the organisation and development of the primary health care team through preparation of practice development plans.

5.4 All Boards and Trusts to develop a succession strategy for identified key posts by 31 December 1996.

5.5 All Boards and Trusts to have in place, by 31 March 1997, a timetable for introduction of structured individual performance appraisal.

ANNEX B

REPORTS AND REVIEWS IN SUPPORT OF PRIORITY TOPICS

1. Earlier this year a major consultation paper issued to the service on clinical and cost-effectiveness - "Roles and Relationships" - proposing the development of a Common Core Work Programme to steer the efforts of professional and other groups working at a national level in the pursuit of clinical and cost-effectiveness. Responses to consultation are now being analysed and it is clear that there is widespread support throughout Scotland for the development of a Common Core Work Programme. This should not only help guide those national professional bodies producing advice on clinical and cost-effectiveness, but also should provide better support for those involved locally in implementing recommendations.

2. The Clinical Resource and Audit Group (CRAG) and the Joint Working Group on Purchasing are advising the Chief Executive and Chief Professional Officers on topics which might be included in the first year of a Common Core Work Programme - 1996/97. The intention is that clinical guidelines or good practice statements, and costed options for purchasers should be developed in a limited number of specific topic areas. In parallel with this activity, but in slightly different timeframes, national work on health needs assessment and the National Audit Activity should be co-ordinated with the development of clinical guidelines and good practice statements.

3. This rolling pattern can be illustrated by looking at the activity which is likely to take place over 3 phases.

Phase 1	**Phase 2**	**Phase 3**
Assess Needs Publish Clinical Guidelines/ Good Practice Statements	Implement in Practice	Audit Results

4. To set in train this rolling programme work is now under way in CRAG, in the Scottish Intercollegiate Guidelines Network (SIGN), in the Scottish Health Purchasing Information Centre (SHPIC), and in the Scottish Needs Assessment Programme (SNAP) to produce complementary needs assessments and advice for clinicians and purchasers in 1996/97. This work will guide and inform future effort and investment. In advance of the results of that work being available, however, there is already a wide range of good practice statements, clinical guidelines, policy reviews and information on services for some of the main health problems of Scotland which can be put to use in 1996/97 while work on the Common Core Work Programme is getting underway.

5. The following table is a draft of a matrix which is being compiled to support the development of a Common Core Work Programme. It lists reports produced at a national level in Scotland and indicates when others are likely to be published. It has derived from work undertaken by Dr Dorothy Moir, Director of Public Health, Lanarkshire Health Board, to pull together the wide range of material available to the NHS in Scotland.

The matrix is constantly evolving as more publications or audit work come to light, but already provides a useful outline of available publications. Contributions to make it more comprehensive would be welcome. Once final decisions on the context of a Common Core Work Programme for 1996/97 have been taken, a separate circular will be issued setting out details. In the meantime topics likely to feature in a Common Core Work Programme for 1996/97 are shown in capitals in the attached matrix.

COMMISSIONING FOR HEALTH GAIN IN SCOTLAND 1996/97
MATRIX OF WORK PUBLISHED AND IN PROGRESS JUNE 1995

ANNEX B

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome Indicators	Purchasing notes	Research	Policy Reviews
Mental Illness	Mental health overview	Role of primary care in MI (CRAG/SCOTMEG) (September 1995)				2 UK reviews	Mentally disordered offenders
	Mental health in the workplace (November 1995)	Management of anxiety and insomnia (NMAC)				UK and local projects	
	OPCS study of psychiatric morbidity (Summer 95)	Mental health records (CRAG/SCOTMEG) (November 1995)					
		Position Statement on Primary Prevention of Mental Illness (CRAG/SCOTMEG) (November 1995)					
		Management of aggression (CRAG/SCOTMEG) (February 1996)					
20% reduction in men drinking>21 units/week and women drinking >14 units	Alcohol misuse	Alcohol and DT (CRAG/SCOTMEG)				Evaluation of national minimum intervention projects Exploration of motivation & attitudes	
(4772 individuals returned to Scottish Drug Misuse Database in 1993/94)	Problem drug misuse					Routes into and out of misuse Harm reduction programmes Prevalence of drug misuse Use of ectasy and newer drugs	Drugs Task Force Report - Drugs in Scotland: Meeting the Challenge

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome Indicators	Purchasing notes	Research	Policy Reviews
	DEMENTIA (SNAP July 1995)		Use of antipsychotic drugs in geriatric psychiatry (CRAG Occasional Paper - 11) Dementia carer involvement (CRAG Occasional Paper - 37) Dementia client survey (CRAG Occassional Paper - 8)			Tool development for: Needs assessment Needs of carers	
15% reduction in suicide, all ages (English target) (912 suicide deaths in 1993)	Suicidal behavior (November 1995)	Depression in Primary Care (CRAG) ECT Therapy (CRAG/SCOTMEG) (October 1995) Neurosurgery and mental disorder (CRAG/SCOTMEG) (February 1996) Observation of acute psychiatrically ill in hospital (CRAG/SCOTMEG) (June 1995)	Lithium monitoring (CRAG Occasional Paper - 21)	Suicide (CRAG 94) Deaths within <1 year of discharge Outcome indicators in acute psychiatry (March 1996)	Depression in primary care	Suicides & undetermined deaths in SE Scotland Suicide within 28 days of discharge UK projects	
		SCHIZOPHRENIA (CRAG/SCOTMEG) **SCHIZOPHRENIA (CSAG)**		Admission/readmission rates Sudden deaths on anti-psychotic drugs/ suicide		UK and local projects	

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome Indicators	Purchasing notes	Research	Policy Reviews
Cardio-, cerebro-, and peripheral vascular disease	Cardiac disease (July 1995)	Thrombolytic therapy (CRAG)	Thrombolytic treatment for AMI (CRAG Occasional Paper - 19)	48 hour mortality after AMI	Thrombolytic therapy	Strategies for management of CHD	CHD (June 1995)
40% decrease CHD deaths <age65 (3105 deaths<age 65 in 1993)		Acute Chest Pain (SIGN Dec 1995)	Cardio Pulmonary resuscitation (CRAG Occasional Paper - 48)	30 day mortality after AMI	Acute Chest Pain (Dec 95)	Genetic studies Heart failure	
			Initiation of oral anticoagulant therapy (CRAG Occasional Paper - 49)			Primary-secondary risk factor intervention	
30% reduction in smoking -age12 -24 years and 20% reduction in age 25-64 years	Tobacco misuse Health promotion in primary care (April 1996)					Nicotine therapy Uptake of smoking in adolescents Smoking among low income women	
		HYPERTENSION, FOCUS ON THE ELDERLY (SIGN 96/97)			**HYPERTENSION, FOCUS ON THE ELDERLY (96/97)**		
	Exercise (March 1996)		Post MI exercise Testing (CRAG Occasional Paper - 3)			Dietary change	
Reduce stroke mortality by 40% <65) (745 deaths <65 in 1993)	**ACUTE STROKE**	**ACUTE STROKE (SIGN Sept 1995)**	**STROKE AUDIT**	30 day mortality after stroke	**ACUTE STROKE (96/97)**	Stroke service delivery	
		HYPERTENSION, FOCUS ON THE ELDERLY (SIGN 96/97)	Stroke Unit in DGH (CRAG Occasional Paper - 44)	56 day discharge home after stroke	**HYPERTENSION, FOCUS ON THE ELDERLY (96/97)**	Cochrane Collaboration Review of the Management of Stroke	
			Outcome of stroke Rehabilitation (CRAG Occasional Paper - 4)				

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome indicators	Purchasing notes	Research	Policy Reviews
		Peripheral vascular disease (NMAC)			Leg ulcers (October 1995)	Cochrane Collaboration Review of the management of Peripheral vascular disease	
		PROPHYLAXIS OF VENOUS THROMBOEMBOLISM (SIGN Autumn 1995)			Peripheral vascular disease - drugs (96/97)		
Cancer	Cancer care In Glasgow	Management of non-surgical cancer services (CRAG/SCOTMEG)	Cervical screening	5 year cancer survival	Commissioning cancer care (SCTN Sept 1995)	UK Projects Scottish Cancer Therapy Network and Focus Groups - Breast, Colorectal and Lung.	Interim Report of Working Group on Commissioning Cancer Services
15% reduction in cancer mortality in the <65s (4244 deaths <65 in 1993)	Tobacco misuse	Palliative cancer care (CRAG)			Palliative cancer care (Sept 1995)	Palliative care resources	
		Palliative Radiotherapy (SIGN July 1995)			Palliative Radiotherapy (July 1995)		
		Ovarian Cancer (SIGN Sept 1995)	Ovarian cancer		Ovarian Cancer (Sept 1995)	Genetic studies in breast, ovary, colon cancer	
		MANAGEMENT OF BREAST CANCER (SIGN 96/97)	Breast screening		**BREAST CANCER TREATMENT (96/97)**	Image intensification in mammography	
		COLORECTAL CANCER TREATMENT (SIGN 96/97)			**COLORECTAL CANCER TREATMENT (96/97)** Screening for colo-rectal cancer (96/97)	Surgical techniques for colon cancer UK colorectal screening Adjuvant chemotherapy	

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome indicators	Purchasing notes	Research	Policy Reviews
Oral Health	Oral cancer						
60% to have perfect teeth at 5 years by 2000	Dental caries in children		Satisfaction with emergency dental service for children in Glasgow (CRAG Occasional Paper -2)			Dental Health Services Research Unit. Scottish Dental Epidemiological Programme. Health Visitor intervention with children under 5.	
>90% aged 45-54 retaining teeth by 2000	Adult oral health (Jan 1996)		Patient comfort following dental extractions (CRAG Occasional Paper - 25)				
	Routine orthodontics						
		Tonsillectomy (SIGN Dec 1995)	Audit of tonsillectomy		Tonsillectomy (Dec 95)		
Diabetes Reduce: -Blindness by 33% -End stage renal failure by 33% -Limb amputation by 50%	Diabetes - other complications (SIGN Winter 1995)	Diabetic registers retinopathy (SIGN Winter 1995) Diabetes - other complications (SIGN Sept 1995)	Dietetic advice for NIDDM Management of IDDM in children and adolescents Community based audit (Lanarkshire) (CRAG Occasional Paper - 9)	Diabetic Ketoacidosis	St Vincent declaration ~amputations ~blindness (August 1995) (others 96/97) Diabetes mellitus	Shared care Screening for retinopathy UK projects	

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome Indicators	Purchasing notes	Research	Policy Reviews
Bone and joint problems	Hip and Knee replacement					Osteoporosis Arthritis Disability	
	Osteoporosis (May 1996)	Hormone replacement therapy (CRAG)					
		HIP FRACTURE (SIGN 96/97)	**HIP FRACTURE AUDIT**		**HIP FRACTURE (96/97)**	Cochrane review on fracture	
	Fractured neck of femur			30 mortality 56 day discharge home		UK projects	
Maternal and child health	Teenage pregnancy	Pregnancy and childbirth (CRAG/SCOTMEG)		Teenage conception rates		Contraceptive advice School sex education	Policy review on maternity services
Reduce conception rate <16 by 50%	Maternity care	Antenatal care (CRAG/SCOTMEG July 1995)			Antenatal steroids (July 1995)	Antenatal care	At home in hospital (1993)
		Pain relief in childbirth (CRAG/SCOTMEG Autumn 1995)	Labour analgesia (CRAG Occasional Paper - 18)			Midwife managed care	
50% breastfeeding at 6 weeks	Breastfeeding	POSTNATAL ISSUES : POSTNATAL DEPRESSION (CRAG/SCOTMEG Autumn 1995)	Breastfeeding (CRAG Occasional Paper - 28)			UK projects	Health services in schools (autumn 95)
95% immunisation			Community child health medical audit (CRAG Occasional Paper - 6)				
			Growth screening (CRAG Occasional Paper - 40)				
		CONGENITAL DISLOCATION OF THE HIP (CRAG/SCOTMEG)					

Health Problem Targets and Scope	Needs Assessment	Clinical Guidelines Good practice Statements	Clinical Audit	Outcome Indicators	Purchasing notes	Research	Policy Reviews
Asthma		Acute hospital care for asthma (SIGN 95/96) Revision of GP guidelines for management of asthma (SIGN 96/97)	Closing the audit loop (CRAG Occasional Paper - 42)	Childhood asthma hospital stay >4 days		Shared care UK projects	
Pain management		Post operative pain control (NMAC Sept 95)	Audit in pain clinics (CRAG Occasional Paper - 39)			Survey of community pain prevalence Management of chronic (non-malignant) pain	
Incontinence		Incontinence (CRAG/SCOTMEG)	Urinary incontinence as an indicator of quality (CRAG Occasional Paper - 15) Making continence relevant (CRAG Occasional Paper - 27)			Research agenda for effective recognition and management of incontinence Assessment of female incontinence Introduction of guidelines and protocols for incontinence	
PEPTIC ULCER		**HELICOBACTERPYLORI (SIGN 96/97)**			**PEPTIC ULCER (SHPIC 96/97)**	Helicobacter	

KEY :
CAPITAL LETTERS denotes Common Core Work Programme topic
Publications without specifird date - are already available
Publications with date - show expected publication date

PLANNING AND CONTRACTING TIMETABLE

	ME	HB	UNITS/TRUSTS	GPs + GPFH
APRIL	Sign off corporate contracts	Strategy review/LHS update		
MAY	Public expenditure survey. Consult on priorities and Planning Guidance	Provide final accounts	Provide final accounts	
JUNE	Draft priorities & Planning Guidance			Submit formal outturn report for year to 31 March to HB on performance against plan
JULY	Issue Priorities and Planning Guidance	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 Draft provisional business plan
SEPTEMBER		Notify purchasing Intentions Tell ME about significant purchasing shifts Endorse Unit/Trust Capital Plans Submit Capital Plans (where appropriate) Submit information strategy to ME	Submit capital plans Submit financial pro-formas Submit information strategy to ME	Finalise and submit business plans Notify purchasing intentions

PLANNING AND CONTRACTING TIMETABLE

	ME	HB	UNITS/TRUSTS	GPs + GPFH
OCTOBER	Review Trust Business Plans	Consult on Community Care Plans	Submit capital charges estimates	
	Review Capital Plans	Publish Director Public Health Report		
		Publish Annual Report		
NOVEMBER	Discuss capital plans	Negotiate contracts	Provide initial prices	
	Final Public Expenditure settlement		Negotiate with purchasers	
DECEMBER	Allocate capital Notify revenue allocations	Draft Accountability Review Action Plans	Negotiate contracts	Negotiate contracts
	Reconcile purchaser/provider intentions	Negotiate contracts	Submit draft business plans to ME	
JANUARY	Notify Trusts of External Financing Limits	Agree final purchasing intentions	Provide final prices	
		Submit Accountability Review Action Plans		
FEBRUARY	Hold Accountability Reviews (provisional)	HB finalise offers of allotted sums to GPFHs		Negotiate final budget based on preferred activity and costs with HB.
MARCH	Hold Accountability Reviews (provisional)	Sign off contracts	Sign off contracts	Sign off contracts
	Sign off Corporate Contracts	Issue Community Care Plan	Publish business Plans	