THE SCOTTISH OFFICE

Department of Health

NHS
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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG
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Dear Colleague

PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND 1997/98

Summary

1. Priorities and Planning Guidance for the NHS in Scotland for 1997/98 is attached.

Action

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

3. Health Board Managers are requested to circulate this MEL to GPs in their area, for information only. The guidance is being circulated to GP Fundholders for their individual attention and action.

Yours sincerely

KEVIN J WOODS
Director of Purchasing

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PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND 1997-98

Introduction

1. The Priorities and Planning Guidance each year provides the overall context for planning and delivering of health services for the coming year, and focuses the NHS in Scotland on the most important national priorities.

2. This year's guidance builds on that of last year - MEL(1995)51 - and should be read in conjunction with it. Last year's guidance set out four strategic aims for the NHS:

- improving health;
- developing primary care;
- promoting care in the community; and
- reshaping hospital services.

and three clinical priorities:

- mental health;
- coronary heart disease and stroke; and
- cancer.

Much has been achieved in the past twelve months and our principal aim this year is to continue to make future progress on this agenda. Annex A of last year's guidance set out specific goals for the service to pursue as appropriate when implementing the supporting objectives to the 4 strategic aims listed above. This is developed in **Annex A**

3. Health Boards must make sure they reflect the contents of this Priorities and Planning Guidance in their:

- local health strategies;
- purchasing intentions, which should be issued in draft in September;
- contracts with NHS Trusts and other providers;
- Corporate Contracts with the Management Executive; and
- Inter-relationships with primary care.

NHS Trusts must make sure they reflect the guidance in their:

- business planning; and
- contracts with Health Boards, GP Fundholders, and other purchasers (e.g. the N.S.D.).

Trusts must also ensure they publish their tariffs by 31 January

GP Fundholders and where appropriate GPs must make sure they reflect the guidance in their:

- purchasing plans; and
- practice plans.

Commissioning Better Health

4. The report of the Working Group on the Roles and Responsibilities of Health Boards chaired by Professor Sir Robert Shields was published on 3 June 1996, under MEL (1996)45. Health Boards should have plans in place to complete the required changes **by 31 March 1998.**

5. More effective health care has been partly responsible for the improvements in health gained to date. Other agencies have a significant contribution to make to health improvement. It is therefore important for Health Boards to create **effective health alliances** with local authorities and other bodies. They should continue to play an active part in Drug Action Teams. In framing their health promotion strategies, Boards should have particular regard to the national priorities but should also address local needs and variations in health among people living in their areas.

6. The Shields Report emphasises the key role of the Health Boards in safeguarding public health, and Boards should therefore ensure the effectiveness of their arrangements for preventing and controlling outbreaks of **communicable disease.** They should also ensure their **emergency planning arrangements** are effective.

7. Subject to the outcome of consultation, GP fundholders and Health Boards should work within the accountability framework for GP fundholding which forms part of the Shields Report.

Development of Primary Care

8. The longer term aim is to achieve the development of a primary care centred NHS. The benefits to be gained from this approach are: services which are more responsive to the needs of patients; improved access to care; improved continuity of care through better co-ordination of services; and more cost effective use of resources.

9. The principles of a primary care centred NHS are:

- decisions about the provision or purchasing of healthcare being taken as close to patients as possible. Those closest to patients (GPs and other members of the primary health care team - PHCT) are well placed to know patients' needs and ensure that they are met, either within primary care or by accessing other services;
- the GP or other member of the PHCT planning the care of individual patients and co-ordinating the delivery of that care either in a primary care setting or, where appropriate, within secondary care.

10. These principles also involve changes within primary care and the relationships between primary care and others. These include:

- seeing primary care, acting in the best interests of patients, as the central focus of the health care system with other services in a supporting role;

- development of the capacity within primary care to provide as wide a range of appropriate local services as possible and to secure secondary care services for patients only when they need that specialist input;
- GPs and the PHCT having a broader population perspective looking at needs across the practice or locality as a whole, as well as the needs of individuals, and planning for the future;
- primary care teams and Health Boards working together in planning for the whole area and commissioning healthcare services; and
- giving patients real influence about the services which they may need- this also brings with it a responsibility on the part of patients to use services appropriately.

Boards need to work with primary care practitioners and others, including Community Health Service Providers to bring about these changes.

Acute Services Planning

11. In January 1996, the Secretary of State initiated a review of the planning assumptions for acute services used by the NHS in Scotland. This review concluded that consolidated guidance including evidence of good practice in managing peaks of emergency admissions should be issued to the NHS in Scotland. This guidance is being prepared by the Management Executive in consultation with appropriate clinicians and others in the NHS. In the meantime, all Health Boards and Trusts should ensure that effective arrangements are in place to meet demand for emergency care, taking account of seasonal variations. A note of the main conclusions of the review is at **Annex B**.

12. Building on recent successes, whereby waiting times of over 12 months have virtually been eliminated, Boards should maintain the long-stop guarantee on inpatient waiting times at a maximum of 12 months, and continue to aim for a maximum wait of 9 weeks for an outpatient referral. Boards should increasingly move towards giving local guarantees on **total** waiting times, and to their progressive reduction.

Focusing on National Priorities

13. In last year's guidance 3 priorities for action in the short to medium term were identified:- **mental health, coronary heart disease/stroke, and cancer.** In seeking to achieve change in these priority areas, continuity is extremely important. It has therefore been decided to continue with the same priorities next year.

14. There is great potential for significant health gain in these areas. In each case, there is increasing evidence of the clinical effectiveness and cost-effectiveness of different health care interventions and growing knowledge of how services can be improved. **Annexes C-E** set out actions expected of Boards during 1996-97 in the 3 national priority areas to reduce mortality and morbidity as a result of these conditions. Health Boards should report their progress on these and their future work plans in their Corporate Contracts for 1997-98. The NHSiS must **demonstrate** a continuing focus on the priority areas, but objectives not selected as top priorities are also important. 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 continue.**

Mental Health

15. Various initiatives have been taken nationally and locally to develop services for people with mental illness and to prevent its occurrence. However, more needs to be done by Boards and their social work, housing and other partners to promote joint development of local, comprehensive mental health services throughout Scotland appropriate to:

- the scale of the problem (on which the recent OPCS Surveys of Psychiatric Morbidity in Great Britain provide useful evidence);
- Prevention and the potential for health gain. The major impact of mental illness on individuals and their families and the economic and social consequences for them and society generally;
- the needs generated by mental illness which often require combinations of health and social care;
- the links between mental health and drugs and alcohol misuse; and
- the implications for public safety as a result of the small percentage of people with severe mental illness who may present a risk to themselves or others.

16. To build on the initiatives already in train and to fill in gaps that remain, a national strategic framework is being prepared. Its purpose is to:

- generate consensus over the key issues in achieving transition to local, comprehensive mental health services;
- provide a template against which local purchasers and providers, in consultation with service users and carers, can assess progress and agree priorities for action that are related to outcomes and to clinical and cost-effectiveness; and
- establish a yardstick by which the Scottish Office can assess local strategies and action plans and monitor progress.

17. The framework will underline the need for local strategies to:

- cover the spectrum of services including primary care, community and hospital services and the promotion of mental health as well as its treatment;
- be multi-disciplinary and multi-agency with a focus on joint planning, commissioning and working; and
- involve very closely clients/patients and carers.

18. To assist in the process of developing the framework, which will be the subject of extensive consultation with the NHS and others during the remaining months of 1996, a new external reference group is being established with membership drawn from a wide range of disciplines and from users and carers. Its role is to ensure that the development of mental health services in Scotland is guided by those with current experience of planning, commissioning, providing and using mental health services. Further information about the progress expected in 1997-98 in developing mental health services is set out in **Annex C.**

Coronary Heart Disease/Stroke

19. In 1994, there were over 15,000 deaths in Scotland from CHD and almost 8,000 from stroke. In total, these 2 diseases accounted for 40% of all deaths in Scotland, or 23% of all life-years lost due to premature deaths in that year. Deaths from CHD happen at a younger average age than those of stroke, but rehabilitation after a non-fatal stroke takes much longer than after a non-fatal AMI and imposes significantly more burdens on the NHS and the community at large.

20. Much of the burden imposed by CHD and stroke is preventable. A Policy Review "CHD in Scotland" was published in January 1996, the NMAC report "The Management of Patients with Stroke" was published in 1994 and a number of SIGN guidelines on these diseases are expected during 1996/97. As a consequence of this work, the ME will be expecting Boards to outline their strategies for dealing with these diseases in their 1997/98 Corporate Contracts. Boards' CHD/Stroke strategies will be expected to be comprehensive, covering prevention, treatment and rehabilitation, to have been drawn up with full involvement of GPs, whether fundholders or not, and to consider:

- whether they are getting best value from their existing pattern of services;
- whether there is the right balance of treatment, rehabilitation and prevention to ensure that maximum health gain is achieved from existing CHD and stroke resources;
- whether there is a case for increasing the Board's expenditure on CHD and Stroke; and
- to begin to consider what changes they expect to see in CHD and Stroke mortality and morbidity as a result of implementing their strategies.

21. Some Boards may already have developed CHD and Stroke strategies, and these may only require updating in the light of more recent work. Other Boards may be at an early stage in their strategy development, in which case we would expect Boards to outline their work programme on strategy development for the year ahead in their Corporate Contracts. Further information about the progress expected in 1997-98 in developing CHD/Stroke services are set out in **Annex D.**

Cancer

22. The implications of the Calman/Hine report for cancer services in Scotland have been examined by a sub-committee of the Scottish Cancer Co-ordinating and Advisory Committee (SCCAC). The conclusions and recommendations of the sub-committee are set out in their report on Commissioning Cancer Services. The basic recommendation in the report is that a new structure for cancer services should be developed in Scotland based on a network of expertise in cancer care reaching from primary care through to Cancer Units in district general hospitals to Cancer Centres.

23. To achieve an effective and integrated system of services for patients with cancer there are a number of key tasks which need to be addressed. These include:

- developing a clear understanding of the current patterns of services, including referral patterns and methods of treatment;

- developing guidance on best practice which should be followed in the diagnosis and treatment of patients with cancer - this applies to primary care as well as to secondary and tertiary services;
- assessing the appropriate configuration of services for each tumour site based on the best available evidence;
- assessing the changes in staffing, training and in diagnostic and treatment facilities to ensure that appropriate standards of care and treatment can be achieved;
- establishing appropriate mechanisms for monitoring the process and outcome of care and treatment for patients; and
- developing programmes of research and development into new techniques for the care and treatment of patients with cancer.

24. Considerable work will be required to achieve the necessary improvements in services for patients with cancer and it is likely to take several years to implement all of the required changes. Health Boards and Trusts should however be able to make significant progress during 1996-97 and plans for the development of services should begin to be implemented through contracts for 1997-98. Strategies to tackle cancer should focus both on prevention and the provision of services. Health education is a key element in preventing cancer and Boards should place particular emphasis on initiatives to reduce smoking and alcohol misuse and improve diet. Boards will recognise the overlap between the risk factors for cancer and CHD/Stroke. The Management Executive has issued a planning framework for cancer services identifying the key responsibilities and setting out a timetable with milestones for 1996-97. Progress against the objectives and milestones set out in this planning framework will be monitored during 1996-97. The main responsibilities for developing cancer services in line with the recommendations in the report on Commissioning Cancer Services are listed in **Annex E.** Further guidance is being developed in a report on the role of palliative and primary care in cancer services due to be issued later this year.

The Local Planning Context

25. Health Boards' forward plans should demonstrate what action they will take in 1997/98 to improve services and achieve improved health outcomes for people suffering from the conditions outlined in the National Priorities (Annexes A-C) according to the key aims and supporting objectives (listed in MEL(1995)51); what results they expect such actions to achieve; 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. Boards' purchasing intentions and contracts with the Trusts must reflect the three national priorities, as should GP Fundholders'.

26. 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 F** sets out work in hand and reports available on these areas alongside work commissioned for publication in the next few months.

Contract Development

27. Since the introduction of the NHS reforms, considerable progress has been made in the development of contracting. We now need to take stock of emerging lessons and in preparation for the 1997/98 contracting rounds, Health Boards, GP Fundholders and Trusts will wish to take account of:

1. Guidance issued under cover of MEL(1996)4 which emphasised the need for clinicians to be involved in contract development and negotiation.

2. Contracting discussions should be placed firmly in the context of a clear understanding of the likely financial resource available for the contract period ahead together with the longer term financial strategies of purchasers.

3. Scope for simplifying the contracting process, which will be taken forward in the review of the contracting manual due to issue by the end of the summer.

4. The recommendations of the Shields Report on Health Board Roles and Responsibilities that the ME should investigate ways of simplifying quality monitoring processes outwith contracting.

28. In last year's guidance the NHS in Scotland was advised to consider the potential for agreeing longer term contracts. This should be a key aim for the 1997/98 contracting round, and Boards, Fundholders and Trusts are asked to consider and agree by September 1996 how they intend to achieve this. Moving to contracts which span financial years will enable a longer term clinical perspective to be brought into the process, and enable the workload associated with contract negotiation to be distributed throughout the calendar year rather than concentrating it into a 3 month period early in the new year. Possibilities include the bringing forward of contract renewal within 1996/97; or the rolling forward of existing contracts to an agreed point in 1997/98; or selecting some contracts such as services subject to the 3 national priorities for consideration in this way. A suitable area to begin the extension to longer contracts might be, mental health. Where services are changing and have benefited from the provision of bridging finance for a period of longer than one year, contracts could cover a longer period. Whatever approach is locally agreed all service activity must be covered by an agreed contract at any point in time. **Annex G** sets out a model Planning and Contracting Timetable which purchasers and providers should amend as appropriate as they develop longer term contracts.

29. Momentum should be maintained in the development of costing for contracting, including the use of Health Resource Groups (HRG). Updated national costing guidance will issue by late summer 1996.

Financial Strategy

30. Pivotal to the above is the need for Boards to have a financial strategy that links the various service strategies and purchasing plans. As a general rule the strategies should cover at least 3 years ahead and detail the resource shifts necessary to deliver both the national and the Board's stated targets to improve services and health outcomes.

31. For financial planning purposes, all Trusts should assume that the policy will continue that all pay and price increases must be met through increased efficiency. Boards and Fundholders will wish to assess the relative efficiency of the providers from whom they purchase. Generally the NHS in Scotland should continue to seek opportunities for increased efficiency using techniques such as benchmarking.

32. The level of funds which will be available to Health Boards is largely dependent on the extent to which increases in demand led FHS (Family Health Service) expenditure have to be accommodated at the expense of HCHS (Hospital and Community Health Services) resources. The forecast outturn is taken into account in determining the next year split between FHS and HCHS provision, it is vital therefore that the Boards continue to monitor and manage expenditure in the non-cash limited sector with rigour.

Conclusion

33. Purchasers and providers are expected to be innovative and imaginative in how they achieve change in the areas set out in this guidance and should present clear proposals for delivering improvements in the services available to their local population. By selecting a few key areas where there is a major health need and where there is good information on best practice and the effectiveness of clinical care the NHS in Scotland is now well placed to secure health improvement. By being focused and selective, the NHS in Scotland can make a major impact in 1997-98 in preventing mental illness, cancer, and coronary heart disease/stroke, as well as responding to the needs of those already ill. This should be the aim for the year ahead.

The following paragraphs develop the goals for the service to pursue as appropriate when implementing the guidance.

1. **Clinical Effectiveness.** The pursuit of clinical effectiveness, through the development of clinical guidelines and protocols, and by the implementation of systematic clinical audit:

1.1 Implementation of the Common Core Work Programme for 1997/98 to guide and co-ordinate work of national bodies supporting improvement of clinical effectiveness.

1.2 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.

1.3 Support to be given to ensure evidence based practice occurs more fully in primary care: Health Boards to work with primary care practitioners on the implementation of clinical guidelines and programmes of audit. All General Medical Training Practices to have a rolling programme of audit.

1.4 Local clinical audit strategies and investment in clinical audit to reflect local purchasing and primary care strategies covering all specialities co-ordinated through Area Clinical Audit Committees. Review proportion of clinical audit funds going to primary care and with what outcome.

1.5 Encourage the wider acceptance and active use, of local or practice-based formularies in the primary care sector.

2. **People-Centred Care.** 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:

2.1 Update and re-publish local health charters.

2.2 Maintain downward pressure on in-patient and out-patient waiting times and shorten long-stop guarantee to maximum 12 months. Begin moves to total waiting time guarantees.

2.3 Improve communications with patients including written information about services and 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.

2.4 Support systems for ensuring patient involvement in practices' decision making and Health Boards to monitor the operation of practice based complaints procedures.

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

2.6 Patient's Charter rights, guarantees and national and local standards **must** be maintained.

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

3. **Value for Money.** The continued search for better value for money:

3.1 Each Health Board to analyse expenditure by the main care programmes in the Contracting Template, to plan shifts of resources from secondary to primary care and from hospital to community, and to develop a supporting Financial Strategy.

3.2 Health Boards to support innovative systems of delivering out-of-hours primary care.

3.3 Health Board to produce an investment plan for primary care premises and manpower.

3.4 Analyse percentage and value of GPFH savings being used in relation to developing services within primary and secondary care. Review the proportion of development funds and of resource release funds going to primary care.

4. **Education, Training, Research and Development.** Promote best practice and clinical excellence among all health professionals by investing in training and education, and by supporting an active programme of NHS funding and research.

4.1 The NHS in Scotland to encourage the pursuit of relevant continuing education and development for primary care practitioners.

4.2 An increasing proportion of patient care should be provided by fully trained doctors and dentists. The NHS in Scotland to increase the number of Consultants Trusts employ.

4.3 The Registrar and Senior Registrar grades are being replaced in 1996-97 by the Specialist Registrar grade under the Calman Report recommendations. Trusts and Postgraduate Deans to continue implementation of structured specialist training. This should maintain and improve standards in training, while producing an increase in the number of candidates for consultant posts in the shortage specialities.

4.4 All doctors and dentists in the training grades should have had their contracted hours of duty down to 72 hours a week (by 31 December 1996), and actual hours spent working should not exceed 56 hours a week.

4.5 Trusts and GP practices to establish and implement local training strategies for all staff. Some education and training costs may be offset by junior doctors' hours moneys where such education/training leads to the development of new

skills and wider decision-making powers of non-medical and dental staff and makes a direct contribution to a reduction in junior doctors' hours.

4.6 More structured specialist training for nurses, midwives and health visitors through the introduction of new training programmes in accordance with the UKCC report of Post-Registration Education and Practice (PREP) to be developed with the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), and supported by training contracts between trusts and the education sector.

4.7 Health Boards and Trusts to monitor and improve research management and costing to ensure the smooth implementation of the research exercise triggered by the Culyer Report.

4.8 The NHS in Scotland to recognise the value of evidence based practice.

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

5. **Organisational Development.** Develop Healthcare Organisations as they take on new roles and responsibilities arising from NHS Reforms:

5.1 Health Boards should conclude the implementation of the Shields Report.

5.2 Health Boards to ensure that their management costs are reduced to the equivalent of £10 per head of weighted population by the end of 1997-98, i.e. their costs for the full year 1998-99 should not exceed that figure.

5.3 Health Boards to support the organisational development of primary care.

5.4 All Health Boards to support and encourage the development of GP fundholding and to set up or improve co-ordination between GPFHs in monitoring and sharing of information.

5.5 Health Boards and Trusts to ensure chairmen and non-executives continue to develop their respective roles to improve the effectiveness of their boards: the findings of the Accounts Commission study into Corporate Governance, published Autumn 1996, will assist this process.

5.6 Trusts and Health Boards should ensure that they have appropriate local pay strategies and mechanisms in place.

5.7 Trusts should take account of the Management Executive guidance on management costs including the revised M2 formula.

5.8 Health Boards should ensure that their commissioning is sufficiently geared towards contracting for better health care which is evidence-based and delivers improved outcomes. They should involve health professionals at all stages of the negotiations and contract monitoring should reflect that emphasis.

ACUTE SERVICES REVIEW

1 SUMMARY OF FINDINGS

1.1 Following a sudden rise in the demand for emergency admission in December 1995 and the early part of 1996 the Secretary of State received representations about the pressures facing acute hospital services in Scotland.

1.2 In response the Secretary of State asked the Chief Executive of the NHSiS to undertake a review of the planning assumptions for acute services used by the NHSiS. The formal terms of reference of the review are:

> To review the planning assumptions used by the NHS in Scotland in developing acute hospital services by considering:
>
> 1. trends (in activity and changing patterns of care, resource utilisation, staffing etc.);
>
> 2. factors which may affect those trends and the response to them (including the need to take account of peaks in demand); and
>
> 3. models which may be appropriate for acute services in future.

The review was announced on 12 January and a report requested by the end of April 1996.

1.3 The work of the review has been informed by a process of consultation with Health Boards, NHS Trusts, and representatives of clinical professions in Scotland.

Findings

1.4 The long standing hierarchy of hospital care which identifies roles for community hospitals, district general hospitals, and tertiary (usually teaching) centres is challenged by changing clinical practice. These challenges appear to have the greatest consequences for district general hospitals because of the expanding role of primary and community care, the trends to day case surgery, and to a growing belief that better clinical outcomes can be achieved by centralising clinical activity in specialist centres.

1.5 The acute bed model was devised to assist in planning new hospitals and to challenge variations in performance in the drive to increase efficiency. In its application the acute bed model should be supplemented by Boards and Trusts using locally generated information of caseload intensity and quality to help determine the level of services required to meet the needs of acutely ill patients.

1.6 The emphasis given to 'beds' and 'occupancy' as measures of resource and efficiency fails to acknowledge the importance of case-mix, staffing levels, and patient throughput per bed as determinants of workload intensity.

1.7 Efficiency in the acute sector increased at the rate of 4% a year between 1985-86 and 1990-91, but by only 2% a year in the period between 1991-92 and 1994-95. Over this latter period, real terms spending on acute hospital services increased by £155m (i.e. by 3.8% a year on average)

1.8 The growth over time in the number of patients treated in acute hospitals is determined by the overall resources available to Trusts - staffing, diagnostic and treatment facilities, and beds - and by improvement in the efficiency with which these resources are used. The consultation exercise carried out during this review has revealed widespread concern that the increase in the resources available to Trusts in recent years has not kept pace with the rapid growth in patient numbers. Concern has also been expressed that Trusts cannot continue to generate the efficiency improvements required to meet the growth in demand. The results - as perceived by staff in the service - are increasing difficulties in coping with peaks in demand, and increasing levels of strain on staff.

1.9 Placing restrictions on further bed closures is, by itself, unlikely to provide a solution. Beds cannot be used to treat additional patients unless Trusts can afford to pay for the extra staff and other resources required for diagnosis, treatment and care. Indeed, as pointed out in 1.22 below, fixing the number of beds could simply prevent Trusts from adapting to changing patterns of demand and changing patterns of care.

1.10 Between 1979-80 and 1994-95 the number of inpatient and day cases has increased on average by 3.1% a year. For most of this period (up to 1991-92) the annual rate of increase was 2.5%, but since then has risen to 5.5% a year.

1.11 The rapid growth in the number of day cases explains much of the recent increase, and the proportion of elective patients treated as day cases has risen from 38.1% in 1991-92 to 52.2% in 1994-95.

1.12 The number of emergency inpatient admissions increased by almost 4% a year on average between 1991-92 and 1994-95, while the number of elective inpatient cases remained largely unchanged. Emergency cases as a proportion of all inpatient cases has expanded steadily and now account for 60% of all inpatient admissions. This means that the scope for accommodating peaks of demand in beds normally used for non-emergency work has diminished, and when peaks in emergency workload occur the disruption to the non-emergency work of the hospital is correspondingly greater.

1.13 The growth in the number of emergency admissions is not well understood; a multiplicity of factors is involved. Ageing of the population is not the principal reason; and increases in admission are observed across most diagnostic categories. A significant part of the growth is explained by a relatively small number of patients who have numerous admissions within a 5 year period. These are not readmissions due to treatment failure or to early discharge; the patients concerned are commonly over 75 and have appropriate need for admission arising from their chronic and multiple morbidity.

1.14 Emergency admissions show a predictable seasonal fluctuation, with peaks in the winter months. The size of the seasonal variation has remained relatively stable; between 1982 and 1994 the difference between the peak average occupancy and its low point averages 12% of occupied beds. The timing of the winter peak is most likely to be determined by cold weather and fluctuations in respiratory disease. During peak admission periods length of hospital stay tends to increase despite the pressure on hospitals, which, other things being equal might be expected to reduce lengths of stay. This is because during winter peaks the increase in admissions is age related.

1.15 During the winter crisis of early 1996 Scottish hospitals managed to cope with difficult circumstances because staff worked flexibly and beyond their contracts. The situation in Edinburgh Royal Infirmary was exceptional in part because of failure of water supply, ward closures due to multiply-resistant staphylococcus aureus (MRSA) infections and the increased number of accidents among the tens of thousands of Hogmanay revellers. The problems faced by hospitals were compounded by staff sickness. Many hospitals had contingency plans which worked well. Nevertheless, it is clear that staff were under considerable strain during this period.

1.16 Social work authorities also faced a rapid increase in demand for their services. Emergency duty arrangements were in force in all authorities throughout. Whilst discharges from NHS hospitals assisted by social work authorities continued, there is a perception in the NHS that social workers were unable to keep pace with increased discharge referrals from hospitals, and hospital clinicians believe the problems of admission were compounded by the difficulties of arranging discharges.

1.17 Within the NHS there is a widespread view that increasing numbers of acute hospital beds are 'blocked' by patients awaiting discharge, even outside periods of peak demand. The principal causes of this are delay in care assessment processes and budgetary pressures on social care. Claims that this is a problem are growing. However, there is no consistent definition of a 'blocked bed'.

1.18 Pressures on acute hospitals are increasing because of changes in "supply" as well as demand. Perhaps the most significant of these are due to changes in junior doctors training and growing specialisation. There is currently difficulty in staffing A & E departments, and careers in general medicine, the speciality which receives the majority of emergency admission are increasingly less attractive in an era of specialisation.

1.19 The ability of hospitals to cope with fluctuations in the demand for emergency demand is fundamentally influenced by management arrangements within hospitals and between the hospital and other care providers. There are many examples of good practice in Scotland, but scope for improvement in the management of fluctuations in caseload remains.

1.20 Indicators of stress on hospital services similar to those recommended by SOAU and suggested by Dr Dunnigan and adapted to local circumstances do not appear to be routinely used in all hospitals to influence the management arrangements in hospital.

1.21 There is a need to plan the management response to sudden rises in demand in terms of the overall 'system of care'. Health Boards have a central role in ensuring the adequacy of plans and through their service contracts for ensuring that the needs of acutely ill emergency patients receive the appropriate priority in their requirements of providers.

1.22 NHS Trusts which receive emergency admissions have an understandable wish to protect their 'non emergency beds' when emergency admissions rise to ensure they are able to meet patient charter guarantees for waiting times. As an alternative Trusts should consider developing plans to meet pressures of peak demand and charter guarantees by utilising the totality of their resources flexibly throughout the year.

1.23 Some of the increased demand for rising demands for emergency admission could be theoretically, treated other than by admission to inpatient wards in hospital. Most of the innovation in practice is centred on admission units with 24 hour diagnostic support services. There is widespread concern about the capacity of primary care to develop sufficiently quickly in response, or indeed whether it is an appropriate alternative for the care of many patients referred as emergencies.

1.24 The suggestion that there should be a 'moratorium' on bed reductions is unrealistic. Health services must change in response to new patterns of need, and in response to developing medical technologies. It would also have implications for existing PFI schemes. Fixing for some indeterminate period of time, one aspect of supply ignores the interplay these changes, and could prevent the **appropriate** transfer of resources within hospitals and between hospitals and alternative forms of provision. On the other hand, the legitimate pursuit of greater efficiency and changes to accommodate changes in working practices need to be managed with proper regard to the quality of care, and the workload intensity which higher rates of throughput bring to hospital staff (see para 1.8). Occupancy of hospital beds is only a partial measure of efficiency of these factors, and ought to be supplemented by other local measures of workload intensity in determining the scope for changes in bed complements.

Recommendations

1.25 The Department of Health should commission further work on the role of the district general hospital in the overall hierarchy of hospital care, taking account of the continued search for efficiency and the need for balance between local and 'centralised' provision of specialist clinical services.

1.26 When Health Boards and Trusts are determining the resources required (staff, diagnostic services, after-care beds etc.) to meet acute health care needs they should recognise the contribution which community, district and tertiary hospitals can play in meeting these needs, including during times of peak demand.

1.27 Calculation of bed numbers to meet levels of expected caseload should be undertaken locally, rather than nationally; they should have due regard to individual specialities and to indicators of quality as suggested the Scottish Office Audit Unit as well as caseload intensity such as patient throughput per bed.

1.28 Planning future bed requirements should acknowledge the continuing increase in emergency admissions.

1.29 Health Boards should regularly review the need for acute admissions, particularly those for emergency care. Through their service contracts they must ensure that effective arrangements exist for meeting seasonal fluctuations in caseload, and contingency plans to deal with sudden short term increases in demand. These plans should be developed with GPs, NHS Trusts and other service providers.

1.30 NHS Trusts should review their arrangements for receiving emergency admissions, drawing on the growing number of innovative models, including admission units.

1.31 NHS Trusts should plan to use the totality of their hospital resources flexibly throughout the year to accommodate fluctuations in caseload and meet Patient's Charter guarantees.

1.32 Health Boards, NHS Trusts and Social Work authorities should review regularly their discharge planning and care assessment arrangements to ensure they can accommodate seasonal and short term fluctuations in caseload.

1.33 The implications of initiatives to reduce junior doctors hours and to restructure specialist training for the quality of medical care available to emergency cases should be reviewed through the Scottish Advisory Committee on the Medical Workforce.

1.34 NHS Trusts should review the adequacy of their methods of determining nurse staffing levels as caseload and patient dependency change over the short term.

1.35 Consideration should be given to funding initiatives aimed at the alternative management of emergency cases. This might be done in the context of the GP total fundholding scheme pilots or through the primary care development fund.

MENTAL HEALTH

1. Policy on mental health has been set out clearly in the Minister of State's two speeches in Autumn 1995 to the International Conference on Mental Health and the SHAS Conference. Key points are that:

- care in the community is to be pursued enthusiastically but with sensible caution;
- there must be joint working among all the disciplines and agencies involved;
- patients, relatives and carers must be closely involved at all stages;
- no hospital should close without replacement facilities and services being in place and properly resources; and
- no person should be discharged from NHS long-stay care without an agreed care plan.

2. The strategic framework, which will be the subject of extensive consultation during the remaining months of 1996, should be used by Health Boards in taking forward the development of comprehensive local mental health services in partnership with social work, housing and other agencies and with users and carers. Other national initiatives that will help in this process include:

- guidance to be issued later in 1996 as a result of pilot work in Glasgow and Stirling on development of the Care Programme Approach;
- the reports and good practice statements of the CRAG Working Group on Mental Illness which held its final conference last March;
- the survey of child and adolescent mental health services undertaken by Professor Parry-Jones and Ms Maguire of the University of Glasgow and issued under cover of MEL (1996)46; and
- the work of SIGN on guidelines and of SNAP on needs assessment.

3. Health Boards and their planning partners should make significant progress during 1997-98 towards developing comprehensive local mental health services. In particular, the Management Executive will be looking for evidence that strategies and purchasing plans:

- cover the full spectrum of services including primary care, community and hospital services and engender clarity about their respective roles;
- cover the prevention of mental illness as well as its treatment;
- give priority to the needs of people with serious and enduring mental illness and complex social care needs;
- are produced and implemented on a genuinely multi-disciplinary and multi-agency basis;
- involve closely users and carers;
- transfer resources from hospital to community services;
- include locally relevant objectives with clear priorities and measurable targets, and procedures for monitoring progress and evaluating the impact of different interventions; and
- make use of clinical guidelines, good practice statements, audit reports etc.

4. Specific areas requiring attention include:

- implementation of the Care Programme Approach for people with long-term mental illness;
- child and adolescent mental health services;
- services for mentally disordered offenders and others requiring similar services; and
- measures to prevent the misuse of drugs and alcohol, and to provide treatment (notably those set out for Boards in the report "Drugs in Scotland: Meeting the Challenge").

CORONARY HEART DISEASE/STROKE

Health Boards should:

2.1 Develop with the full involvement of GPs a coherent strategy for tackling CHD and Stroke, spanning health promotion, treatment and rehabilitation, with a particular emphasis on what the strategy will achieve in health gain terms, both for those without pre-existing disease, and for those needing treatment and rehabilitation.

2.2 Examine their current provision of and expenditure on health promotion and plan to increase resources for prevention, aimed at the main CHD and Stroke risk factors of smoking, diet and exercise, and hypertension. Ensure that the costs and effectiveness of such programmes are carefully monitored, evaluated and reported.

2.3 Take account of the overlaps between risk factors in respect of CHD/Stroke and cancer.

2.4 Recognise the importance of aiming the health promotion messages on smoking, exercise and diet at children, who are the next generation of adults.

2.5 Develop explicit objectives for CHD/Stroke in contracts for the provision of health promotion services.

2.6 Agree with their health alliance partners and with the ME a range of performance indicators for health alliances and begin collecting monitoring data.

2.7 Implement clinical guidelines for the detection and treatment of high blood pressure.

2.8 Promote clinical guidelines to improve selection of patients for surgical treatments for heart disease and stroke and plan to implement SIGN guidelines when available.

2.9 Establish the existing proportion of patients treated in multi-disciplinary Stroke Units both in the acute and recovery phase of the stroke and outline plans for increasing the proportion.

2.10 Review rehabilitation services for Stroke patients with a view to establishing whether or not more could be more cost-effectively delivered in the community.

2.11 Review the level of resources for rehabilitation after both heart attacks and strokes, again ensuring that the costs and effectiveness of such programmes are carefully monitored, evaluated and reported, and if appropriate plan to increase investment in these programmes.

CANCER

Main responsibilities for developing cancer services in line with the recommendations the report on Commissioning Cancer Services.

Purchasers

- Health Boards should work closely with GPs in developing purchasing plans, and in some circumstances it will be appropriate for Boards to co-operate with each other in developing their plans.
- Boards should also work closely with Trusts and voluntary sector providers in determining the appropriate reconfiguration of services, in specifying levels and standards of services, and in agreeing the information required to monitor standards of service.
- Boards should discuss with providers the changes required to achieve improvements in cancer services, and should negotiate these changes through their contracts with providers.
- Boards should prepare initial plans for the reconfiguration of cancer services and submit these plans to the Management Executive by 30 September 1996.
- These plans should be reflected in Boards' purchasing strategies for 1997-98, in their Corporate Contract with the Management Executive and in their contracts with providers.
- Health Boards should examine their current provision of health promotion and plan to increase resources for prevention, aimed particularly at smoking, alcohol misuse and diet, taking account of measures recommended in the Scottish Diet Action Plan

Trusts

- Trusts should notify purchasers if they wish to be designated as a cancer unit, and should indicate the tumour sites for which they are seeking designation as a unit. (A Cancer Unit may include more than one Trust).
- Trusts should undertake a review of their existing services (in discussion with Health Boards) and should identify areas where changes are required to achieve the necessary improvements in services.
- They should ensure that they have protocols and guidelines established and implemented for the diagnosis and treatment of patients with cancer.
- They should ensure that they have in place clear management structures for implementing and monitoring changes in services, and for providing purchasers with the information which they require to monitor services.

ANNEX F

COMMON CORE WORK PROGRAMME

1. Last year's Priorities and Planning Guidance discussed the proposed 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. There was widespread support for this idea throughout Scotland, and as a result the Common Core Work Programme has been introduced. This is discussed more fully in NHS MEL(1995)84.

2. The purpose of the Common Core Work Programme is to help improve health and the quality, effectiveness and cost-effectiveness of clinical care by providing the service with information and advice (such as a needs assessment or a clinical guideline) on a small number of important clinical topics. Much of the work of the Programme will support the 3 service priority areas identified in the Priorities and Planning Guidance but it will not be limited to these areas. The Programme will also include topics which are important because there is clear, immediate potential to improve health and/or clinical care. it may be, for example, that, as a result of research or clinical audit, clear evidence is available of good practice in an area in which there is known to be significant variation in practice or outcome. The Common Core Work Programme will provide an opportunity to build on local work, identify additional work needing to be planned for and developed, agree national guidance, and support implementation.

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 Baseline Audit Publish Clinical Guidelines/Good Practice Statements	Implement Change in Practice	Audit Results Identify outcomes

4. The main organisations associated with the Common Core Work Programme are:-

- Clinical Resource and Audit Group (CRAG) and its sub committees (e.g. National Projects Committee, Clinical Outcomes Working Group, Clinical Audit Subcommittee);
- Chief Scientist Office (CSO);
- National Professional Advisory Committees;
- Scottish Health Purchasing Information Centre (SHPIC);
- Scottish Intercollegiate Guidelines Network (SIGN); and
- Scottish Needs Assessment Programme (SNAP).

5. The eight topics selected for 1996-97 were:

- Dementia;
- Schizophrenia;
- Acute stroke;
- Hypertension with a focus on the elderly;
- Breast cancer;
- Colorectal cancer;
- Hip fracture; and
- Peptic ulcer.

These are likely to be rolled forward to 1997-98. Possible additional topics are being actively considered.

6. The following table is a matrix which has been compiled to support the development of the Common Core Work Programme. It lists reports produced at a national level in Scotland and indicates when others are likely to be published. Further details on the new topics, and an update to the matrix will be issued once final decisions on the CCWP are taken in the Autumn.

ANNEX B

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

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
Mental Illness	Mental health overview	Role of primary care in MI (CRAG/SCOTMEG) (November 1995)	Child and adolescent psychiatry (CA92/09) (August 1997) Patient transfer & resettlement from a secure hospital (CA94/19) (January 1997)			2 UK reviews	Mentally disordered offenders
	Mental health in the workplace (November 1995) OPCS study of psychiatric morbidity (Summer 95)	Management of anxiety and insomnia (NMAC) Mental health records (CRAG/SCOTMEG) (November 1995) Position Statement on Primary Prevention of Mental Illness (CRAG/SCOTMEG) (January 1996) Prevention + Management of agression (CRAG/SCOTMEG) (July 1996) Psychiatric patients presenting in A&E DEPARTMENTS (NMAC) (December 1996) The future role of Psychiatric Nursing in the community (July 1996) Guidelines on community care programme approach (SWSG) (September 1996)				UK and local projects	
	Suicidal behaviour amongst young people			Suicide within 1yr of discharge from Psychiatric Hospital			

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
20% reduction in men drinking > 21 units per week and women drinking > 14 units	Alcohol misuse	Alcohol and DT (revised) (CRAG/SCOTMEG)				Evaluation of national minimum intervention projects Exploration of motivation & attitudes	
(6359 Clients on Scottish Drug Misuse database , 1994/95)	Problem drug misuse	Good practice in substitute prescribing (ownership ?) (Public Health Policy Unit) (September 1996)	Proposed national audit on electro-convulsive therapy (ECT) start February 1996			Routes into and out of misuse Harm reduction programmes Prevalence of drug misuse Use of ecstasy and newer drugs	Drugs Task Force Report - Drugs in Scotland : Meeting the Challenge
	DEMENTIA (SNAP July 1995)	**DEMENTIA (SIGN March 1997)** Report by Working Group on Acute Beds and the Elderly	**INVOLVING CARERS OF PEOPLE WITH DEMETIA IN AUDIT PROCESSS (CA 90/2)** **DEMENTIA CARER INVOLVEMENT** (CRAG Occasional Paper - 8) Use of anti-psychotic drugs in geriatric psychiatry (CRAG Occasional Paper - 11)			Tool development for : Needs assessment Needs of carers	
15% reduction in suicide, all ages (English target) (624 suicide deaths in 1994)	Suicidal behaviour (November 1995)	Depression in Primary Care (CRAG) ECT Therapy (CRAG/SCOTMEG) (July 1996) Neurosurgery and mental disorder (CRAG/SCOTMEG) (July 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 (July 1996)	Depression in primary care	Suicides & undetermined deaths in SE Scotland Suicide within 28 days of discharge UK projects	

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
		SCHIZOPHRENIA (CRAG/SCOTMEG) SCHIZOPHRENIA (CSAG)(April 1996) SCHIZOPHRENIA (SIGN March 1997)	DEPOT NUROLEPTIC DRUG ADMINISTRATION (CA96/4) (July 99)	Admission/readmission rates Sudden deaths on anti-psychotic drugs suicide		UK and local projects	
Cardio-, cerebro- and peripheral vascular disease	CHD (May 1996)	Thrombolytic therapy (CRAG)	Health board plans to reduce mortality from coronary heart disease (CA90/16)	48 hour survival after AMI	Thrombolytic therapy	Strategies for management of CHD	CHD (January 1996)
40% decrease CHD deaths < age 65 (2656 deaths < age 65 in 1994)		Acute Chest Pain (SIGN November 1996) Heart Failure (SIGN March 1997)	M'ment of out of hospital cardiac arrest by Ambulance Service (CA92/14) Care of patients with suspected myocardial infarction in GP Community hospitals (CA94/10) Congenital Heart Disease (CA93/05) (September 97) Early management of patients with Myocaardial Infarction (CA94/16) (December 1997) Thrombolytic treatment for AMI (CRAG Occasional Paper - 19) Cardio Pulmonary resuscitation (CRAG Occasional Paper - 48) Initiation of oral anticoagulant therapy (CRAG Occasional Paper - 49)	30 day survival after AMI	Acute Chest Pain (Dec 1996)	Genetic studies heart failure Primary - secondary risk factor intervention	
30% reduction in smoking - age 12 - 24 years and 20% reduction in age 25 - 64 years	Tobacco misuse Health promotion in primary care (April 1996) Exercise (March 1996)		Post MI exercise testing (CRAG Occasional Paper - 3)			Nicotine therapy Uptake of smoking in adolescents Smoking among low income women Dietary change	

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
Reduce stroke mortality by 40% < 65	**ACUTE STROKE**	**ASSESSMENT OF ACUTE STROKE (SIGN June 1996)**	**TOWARDS MONITORING THE QUALITY AND EFFECTIVENESS HOSPITAL STROKE SERVICES (CA94/23) (June 1999)** **GUIDELINES FOR STROKE MANAGEMENT AND AN AUDIT TOOL (CA94/25) (JUNE 1999)** **PATIENT AND CARER SATISFACTION WITH HOSPITAL & COMMUNITY SERVICES AFTER STROKE (CA94/27) (July 1997)**	30 day survival after stroke	**ACUTE STROKE (1996/97)**	Stroke service delivery	
(726 deaths < 65 in 1994)		**HYPERTENSION, FOCUS ON THE ELDERLY (SIGN January 1997)**	Outcome of stroke rehabilitation (CRAG Occasional Paper - 4)	56 day discharge home after stroke	**HYPERTENSION FOCUS ON THE ELDERLY (96/97)**	Chocrane Collaboration Review of the Management of Stroke	
	HYPERTENSION IN THE ELDERLY (December 1996)	The Management of Stroke (NMAC)	Stroke Unit in DGH (CRAG Occasional Paper - 44)				
		Swallowing disorders following Stroke + other Neurological disorders (NPAC)(September 1995) **SECONDARY PREVENTION OF ACUTE STROKE (excluding carotid endarterectomy)(SIGN June 1996)** **MANAGEMENT OF CAROTID STENOSIS (SIGN October 1996)** **MANAGEMENT OF SWALLOWING DISORDERS AFTER ACUTE STROKE (SIGN June 1996)** **REHABILITATION FOLLOWING ACUTE STROKE (SIGN Sept 1996)** **PREVENTION AND MANAGEMENT OF THE COMPLICATIONS OF ACUTE STROKE (SIGN September 1996)** **DISCHARGE PLANNING AFTER ACUTE STROKE (SIGN January 97)**					

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
	COLORECTAL CANCER TREATMENT (SIGN OCT 1996)		OUTCOME FOLLOWING COLORECTAL CANCER SURGERY (CA91/36)		COLORECTAL CANCER TREATMENT (96/97)	Surgical techniques for colon cancer UK colorectal screening Adjuvant chemotherapy	
					Screening for colo-rectal cancer (96/97)		
Oral Health 60% to have perfect at 5 years by 2000	Dental caries in children		Audit of children born with clefts of lip and palate (CA94/1) (March 1998)			Dental Health Services Research Unit. Scottish Dental Epidemio-logical Programme Health Visitor intervention	
			Satisfaction with emergency dental service for children in Glasgow (CRAG Occasional Paper - 2)				
> 90% aged 45 - 54 retaining teeth by 2000	Adult oral health (January 1996)		Patient comfort following dental extractions (CRAG Occasional Paper - 25)				
	Routine orthodontics						
		Tonsillectomy (SIGN March 1997)	Audit of tonsillectomy (CA90/15)		Tonsillectomy (Dec 95)		

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
	PERIPHERAL VASCULAR DISEASE (Nov 1996)	PERIPHERAL VASCULAR DISEASE (NMAC)	THE DEVELOPMENT OF VASCULAR AUDIT IN SCOTLAND (CA91/26) (December 1996)		Leg ulcers (October 1995)	Cochrane Collaboration Review of the management of peripheral vascular disease	
		PERIPHERAL VASCULAR DISEASE (SIGN NOVEMBER 1996)					
		PROPHYLAXIS OF VENOUS THROMBOEMBOLISM (SIGN September 1995)			Peripheral vascular disease - drugs (96/97)		
Cancer	Cancer care in Glasgow	Management of non-surgical cancer services (CRAG/SCOTMEG)	Auditing the Scottish Cervical screening programme (CA91/12)	5 year cancer survival	Commissioning cancer care (SCTN Sept 1995)	UK Projects	Interim Report of Working Group on Commissioning
			Audit of testicular teratomas use of CT planning (CA91/35)			Scottish Cancer Therapy	
			Carcinoma of the Larynx (CA94/14)			Network and Focus Groups - Breast, Colorectal and Lung	
15% reduction in cancer mortality in the < 65s	Tobacco misuse						
		Palliative cancer care (CRAG)	Palliative care facilitators project (CA92/41)	Outcome measures in Palliative care (NCHSPCS June 95)	Information for purchasers (NCHSPCS June 95)		
					Palliative cancer care (April 1996)	Palliative care resources	
(4152 deaths < 65 in 1994)							
		Palliative Radiotherapy (SIGN July 1995)			Palliative Radiotherapy (July 1995)		
		Palliative Radiotherapy in non small cell lung cancer (SIGN Jan - Mar 1996)					
		Ovarian cancer (SIGN July 1995)	Ovarian cancer audit (CA91/16)		Ovarian cancer (Sept 1995)	Genetic studies in breast ovary, colon cancer	Cancer Genetics Services in Scotland (SCCAC, Sept 95)
	BREAST CANCER	MANAGEMENT OF BREAST CANCER (SIGN January 1997)	SCTN NATIONAL BREAST CANCER AUDIT (CA94/21)		BREAST CANCER TREATMENT (96/97)	Image intensification in mammography	Cancer Genetics Services in Scotland (SCCAC)

Health Problem Target and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
Diabetes	Diabetes (June 1996)	Diabetes registers retinopathy (SIGN Winter 1995)		Diabetic Ketoacidosis	St Vincent declaration ~ amputations ~ blindness (Aug 95)(others 96/97)	Shared care Screening for retinopathy UK projects	
Reduce : ~ blindness by 33% ~ end stage renal failure by 33% ~ limb amputation by 50%		Diabetes - other complications (SIGN Sept 1995)	Management of IDDM in children and adolescents (CA92/20)				
		Diabetic visual impairment (SIGN Jan - Mar 1996)	Diabetic Ketoacidosis-diagnosis & initial treatment (CA92/21)		Diabetes mellitus		
		Diabetic information (SIGN Jan - Mar 1996)	Diabetic outcomes project (CA95/02) (September 1998)				
		Diabetic patients and carers (SIGN Jan - Mar 1996)					
		Diabetic foot (SIGN April 1996)					
		Diabetic renal disease (SIGN April 96)	Community based audit (Lanarkshire) (CRAG Occasional Paper - 9)				
		Diabetic children (SIGN June 1996)					
		Diabetic pregnancy (SIGN June 1996)					
		Diabetic cardiovascular (SIGN Aug 96)					
Bone and joint problems	Hip and knee replacement		AVAILABILITY OF HIP REPLACEMENT SURGERY IN 6 WEST SCOTAND HEALTH BOARDS (CA91/42)			Osteoporosis Arthritis	
			Congenital talipes equino -varus (CA93/04)			Disability	
	Osteoporosis (May 96)	Hormone replacement therapy (CRAG)					
	Fractured neck of femur	HIP FRACTURE (SIGN May 1996)	OUTCOME OF SURGERY AND REHAB AFTER HIP FRACTURE (CA93/01) (March 1998)	30 survival 56 day discharge home	HIP FRACTURE (96/97)	Cochrane review on fracture UK projects	

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
Maternal and child health	Teenage pregnancy	Pregnancy and childbirth (CRAG/SCOTMEG)		Teenage coception rates	Caring for sick children (Scottish Office 1994)	Contraceptive advice	Policy review on maternity services
						School sex education	
							Health services in schools (Autumn 95)
Reduce conception rate < 16 by 50%	Maternity care	Management of Early Pregnancy Loss (NMAC, 1996)	Audit of detection of fetal abnormalities (CA91/12)				
		Antenatal care (CRAG/SCOTMEG July 1995)	Caesarean section (CA93/08) (March 1997)		Antenatal steriods (July 1995)	Antenatal care	
			Clinical guidelines & audit in obstetric practice (CA94/11) (June 1999)			Midwife managed care	
		Pain relief in childbirth (CRAG/SCOTMEG Autumn 1995)	Labour analgesia (CRAG Occasional Paper - 18)				
50% breastfeeding at 6 weeks	Breastfeeding	POSTNATAL ISSUES : POSTNATAL DEPRESSION (CRAG/SCOTMEG Autumn 1995)	Scottish joint breast feeding initiative (CA91/27)			UK projects	
		Breastfeeding Facts Pack- information for professionals (HEBS Dec 1995)	Breastfeeding (CRAG Occasional Paper - 28)				
		Supporting breastfeeding in your Primary Healthcare team (Scottish Office November 1995)					
95% immunisation			Community child health medical audit (CRAG Ocassional Paper - 6)				
		CONGENITAL DISLOCATION OF THE HIP (CRAG/SCOTMEG)	Growth screening (CRAG Occasional Paper - 40)				

ANNEX G

PLANNING AND CONTRACTING TIMETABLE
(Should be amended to take account of changes in the timing and length of contracts)

	ME	HB	UNITS/TRUSTS	GPs + GPFH
APRIL		Strategy review/LHS update		
MAY	Sign off corporate contracts. Consult on priorities and Planning Guidance.	Provide final accounts.		
JUNE	Draft priorities and Planning Guidance.		Provide final accounts. Publish Strategic Plans.	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 capital plans. Submit financial pro formas.	Finalise and submit business plans. Notify purchasing intentions.

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

Health Problem Targets and scope	Needs Assessment	Clinical Guidelines Good Practice Statements	National and Local Clinical Audit Projects	Outcome Indicators	SHPIC / DSPH Purchasing Notes	Research	Policy Reviews
Asthma		Acute hospital care for asthma (SIGN April 1996)	Scottish confidential inquiry into asthma deaths (CA94/18) (September 1997)	Childhood asthma hospital stay > 4 days		Shared care	
						UK projects	
			Closing the audit loop (CRAG Occasional Paper - 42)				
		Revision of GP guidelines for management of asthma (SIGN Sept 96)					
Pain management		Post operative pain control (NMAC Sept 95)	Management of patients within out-patient pain clinics (CA91/4)			Survey of community pain prevalence	
			Audit in pain clinics (CRAG Occasional Paper - 39)				
		The management of patients with Chronic Pain (NMAC)				Management of chronic (non-malignant) pain	
Incontinence		Incontinence (CRAG/SCOTMEG)	Urinary incontinence as an indicator of quality (CRAG Occasional Paper - 15)			Research agenda for effective recognition and management of incontinence	
			Making continence relevant (CRAG Occasional Paper - 27)			Assessment of female incontinence	
						Introduction of guidelines and protocols for incontinence	
Stomach problems PEPTIC ULCER	PEPTIC	HELICOBACTERPYLORI (SIGN 96/97)			PEPTIC ULCER (SHPIC 96/97)	Helicobacter	
Complimentary Medicine		Integration of complimentary therapies as part of treatment (NMAC, April 96)					
		Patient equipment in the Community (SCOTMEG/NPAC)(December 1995)					

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

CRAG National Projects are identified by reference no. CA/
Local projects published as CRAG Occasional Papers are also shown