THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1997)44

NHS Management Executive
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4 August 1997

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Dear Colleague

PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND : 1998/99

Summary

1. Priorities and Planning Guidance for the NHS in Scotland for 1998/99 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 Boards are requested to circulate this MEL to GPs in their area, for information and for action as appropriate.

Yours sincerely

KEVIN WOODS
Director of Strategy and Performance Management

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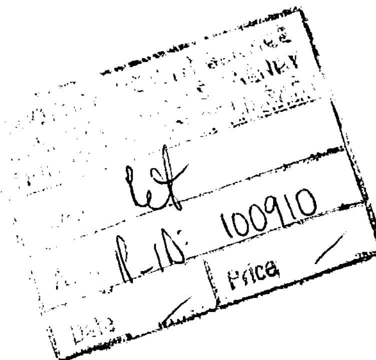

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PRIORITIES AND PLANNING GUIDANCE FOR THE NATIONAL HEALTH SERVICE IN SCOTLAND 1998-99

Introduction

1. The Priorities and Planning Guidance provides the overall policy context for the planning and delivery of health services for the coming year, and focuses the National Health Service in Scotland on the most important national priorities. The 3 existing clinical priorities have been retained:

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

2. These should continue to be planned in the context of the 4 established strategic aims of the National Health Service in Scotland:

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

and a new strategic aim:

- tackling inequalities.

3. Fairness and equity are fundamental to the National Health Service. The Government intends to tackle inequalities in health and in access to health services, ensuring that healthcare in Scotland continues to be largely free at the point of use and delivered on the basis of clinical need and the availability of clinically effective treatment.

4. The Government intends to publish, in the autumn of 1997, a White Paper setting out its proposals for the future of the National Health Service in Scotland. A number of steps have already been taken to reduce wasteful and inefficient bureaucracy. As well as setting the priorities for the NHS for 1998/99, this guidance sets out a new approach which the NHS should adopt immediately to prepare the way for, and provide a context for, proposals in the forthcoming White Paper. It signals an important change in behaviour, and the inter-relationships between Health Boards, Trusts and GPs in particular, and sets out new collaborative arrangements which should be adopted now to ease the implementation of further policy developments later this year and next.

Health Improvement Programmes

5. Patients look to all those involved in the National Health Service - Health Boards, NHS Trusts, Primary Care practitioners and others - to work together to provide them with effective care, delivered efficiently, and to put their interests first.

6. To help achieve these aims Health Boards, Trusts and General Practitioners should now work together to produce a Health Improvement Programme for the people of each Health Board area. Health Boards are expected to lead the preparation of these programmes, but must do so with the active engagement of Trusts and General Practitioners. Health Boards and Trusts should ensure that clinicians are involved in the development of these programmes. All parties involved must be committed to the successful implementation of the Programmes. Health Board and Trust Chairmen are expected to take personal responsibility for ensuring that the programmes are agreed by end-December 1997.

7. Necessary first steps in the preparation of Health Improvement Programmes will include open discussions between Health Boards and Trusts to share and agree all relevant information in the light of existing services strategies including financial baselines. Having agreed the baseline information, the aim of these discussions will be to identify the mutually supportive objectives and action to be taken by each organisation over the coming years to improve the health of the population. The extent to which the Programmes serve the greater good of the population and secure health gain will be a key criterion by which Boards and Trusts will be held accountable. The principal agenda for Trusts will be the implementation of relevant Health Improvement Programmes. Collaboration and co-operation will help to improve quality. It is important to emphasise the need to focus on health gain and improved outcomes for local populations.

8. Health Improvement Programmes should:

- build on existing Health Board service and financial plans and Trust plans;
- cover a period of 5 years;
- include firm plans for 1998/99 and provisional plans for later years which should nevertheless be as firm as possible;
- be open to public scrutiny, recognising the role of the local health council.

9. Taking account of the guidance set out in the remainder of this document, each programme should set out:

- proposals to protect the public health, including emergency planning;
- proposals to promote health;
- proposals to analyse and tackle health inequalities;
- service changes and developments, including those involving primary care (see paragraphs 23-28, 31 and Annex G);
- a rolling programme for the implementation of evidence-based clinical guidelines and clinically effective practice, to be monitored through clinical audit (see paragraphs 32-35);

- resource assumptions including locally generated efficiencies - eg from Shields, and the actions set out in MEL(1997)36 (see paragraphs 36-38);

- human resource strategies (see Annex D);

- how efficiency in the use of existing assets will be maximised; proposed capital investments; and changes in the National Health Service's estate (see Annex E);

- Information Management and Technology strategies (see Annex F).

10. Health Boards which secure a significant level of service from Trusts outwith their areas should involve these Trusts as appropriate in preparing Health Improvement Programmes. Health Boards should also involve the Scottish Ambulance Service NHS Trust in discussions. Health Improvement Programmes will be prepared annually, rolling forward the previous year's 5 year Programme to firm up plans for the following year and to include a new Year 5. Health Boards will continue to agree annual Corporate Contracts with the Management Executive. Health Boards' Purchasing Intentions will no longer be required.

11. NHS Trusts should prepare an Implementation Plan consistent with the Health Improvement Programme. These plans should:

- show how the Health Improvement Programme is to be put into effect within the Trust, with transparent links and cross references to the agreed Programme;

- identify the consequences and risks for the Trust in relation to: current and future clinical support services, funding sources (both capital and revenue), costs, human resources, capital assets and information management and technology.

Implementation Plans should be agreed with the host Health Board to ensure they support delivery of Health Improvement Programmes and that resource assumptions are consistent. For Trusts which deliver a significant level of service to people from more than one Health Board area it will be appropriate to discuss their Implementation Plans with each of the relevant Health Boards. Implementation Plans should be submitted to the Management Executive by end March 1998 having been agreed with relevant Health Boards to demonstrate that Trust financial targets will be met. Guidance will be issued on the further information which Trusts will need to submit. Trusts' strategic plans will no longer be required by the Management Executive: Health Improvement Programmes will become the focus for Trusts' planning.

12. It is important that GPs (including GP fundholders) participate in the preparation of the Health Improvement Programme for the area. Their practice plans should reflect how they will contribute to the implementation of the Programme as well as their own practice development.

13. A planning timetable setting out the various stages in preparing Health Improvement Programmes for Health Boards, Trusts and GPs is attached at Annex B. For the current year the timetables should be regarded as a guide although the dates for submission of Health

Improvement Programmes and Trust Implementation Plans should be regarded as fixed points.

Improving Health

14. While premature deaths from cardiovascular disease and cancer have been falling in recent years they remain major causes of death and disability. The Scottish Health Survey provides us with robust baseline data covering key areas of Scotland's health and the conditions and lifestyle behaviours which contribute to it. The survey supports the case that there is clear evidence of the extent to which continuing poor diet, smoking and excessive drinking of alcohol and lack of adequate physical exercise contribute to these conditions and to other serious diseases such as respiratory illness. The survey data also illustrate the inequalities in health which persist. People living in areas of deprivation are shown to have a far greater prevalence of ill health than the rest of the population. Detailed survey data is being provided for Health Boards' respective areas, to supplement local data already available, and to assist them in targeting action where health need is greatest.

15. Coronary Heart Disease (CHD) and Stroke continue to be the leading causes of death in Scotland, and our ranking in international league tables for mortality from these diseases continues to be far too high. Since much of this is preventable, there is considerable scope for improvement in the life-expectancy of the Scottish population. Given the link between CHD risk and deprivation, the health gain from health promotion activities may be enhanced by specifically targeting services to help people living in deprived areas. Health Boards' CHD/Stroke strategies are to be finalised by end-March 1998. Implementation of the actions identified in these strategies should be taken forward during 1998/99. A specific focus on CHD/Stroke by Boards also has the potential to reduce premature cancer deaths since the determinant risk factors are similar for both diseases.

16. Given the social and economic consequences which can affect people with severe and/or enduring mental health problems, the NHS should pay particular attention to the scope for improving mental health. Boards should continue to develop and implement local strategies for mental health in liaison with their social work, housing and other planning partners. These multi agency strategies should draw on the guidance provided in the Framework for Mental Health Services in Scotland to be published later this year.

17. Since the report on Commissioning Cancer Services in Scotland was published in April 1996 a great deal of planning has been undertaken to improve services for patients with cancer. These plans have identified many ways in which services can be developed, and the changes which are proposed should make a significant contribution to improvements in the health of the population. The plans emphasise the importance of prevention as well as the need for improvements in the diagnosis and treatment of patients with cancer. Although it is clear that the changes that are required will take some years to achieve, implementation of these plans is a priority in 1998/99.

Inequalities in Health

18. There is now clear evidence that relative poverty is causally associated with many forms of ill-health. Tackling health inequalities requires a comprehensive, co-ordinated

approach from a variety of agencies - in particular local authorities - sustained over a long period. Health Boards should play a leading part in this effort by tackling health inequality at a variety of points along the chain of cause and effect.

19. Using data largely available from existing sources, there should be systematic efforts to collect and disseminate information that illuminates the nature and scale of health inequalities. This should draw on wider sources of information such as social and demographic information. Health Boards may find pooling information and information available for wider geographical areas useful in this process. Health Boards should remember that inequalities exist not just by economic status but also as a result of gender, disability and ethnicity. Sharing of information of this kind with other partners, such as local authorities and voluntary organisations, will be necessary.

20. Health Boards should promote equity through better use of health services. At present there is considerable evidence to suggest that patients vary in their ability to access care. This may be due to a variety of factors including patient expectations as well as availability of services. Health Boards should consider how services might be realigned in order to promote equity of access, including the provision of primary care and specialist services. It is also important for Health Boards and Trusts to work closely with GPs on referral patterns and their effect on access to treatment. In addition, it is necessary to recognise that deprivation is associated with poorer outcomes of health care as well as access to services and Boards will need to consider how their decisions are informed by an understanding of outcome in deprived groups.

21. Health Boards should consider how best to address causes of ill-health in ways which give particular help to people from disadvantaged groups. For example, experience shows that to meet the needs of disadvantaged people it is more effective to direct health promotion and disease prevention work at a cluster of linked issues rather than single themes. Health promotion should be directed towards both health-related behaviours and more fundamental determinants of health. Alliances with other organisations such as local authorities and voluntary organisations will be important for both strands of this work. Growing evidence shows that issues such as social isolation and exclusion are major determinants of ill-health in their own right. Closer partnership and joint planning with local authorities will be necessary if the social effects and material causes of deprivation-associated ill-health are to be improved. This approach should be reflected in the implementation of forthcoming guidance on drug misuse services which will set national objectives in this area. Health Boards should also be prepared to advise local authorities on the health aspects of transport, environment, planning, employment and housing policy.

22. Health Boards need to review the allocation of their resources to ensure they are being targeted appropriately on areas of deprivation. They should look systematically at all of their resources, and consider if reallocation of them in favour of deprived areas, including Urban Regeneration Partnerships and Priority Partnership Areas, is appropriate.

Developing Primary Care

23. The NHS should ensure that all primary care practitioners play a central role in the strategic planning process and in developing local health services in the interests of their

patients. A primary care centred service is fundamental to achieving the strategic aims of the NHS in Scotland. Strong, effective primary care is essential to the development of a patient focused approach, to the provision of seamless care which responds to people's needs, and, in its gatekeeping role, to the appropriate and cost effective use of the health care system as a whole.

24. Primary care teams and Trusts need to ensure that there is an integrated approach to the delivery of local services. Primary care teams also have a responsibility to co-ordinate the care of patients through the complexities of the whole system. The aim should be to promote a seamless service, not only within the health service, but also with other agencies, including social work and the voluntary sector. This requires a collaborative approach with effective communication at clinical and managerial levels. Health Boards and Trusts should support the development of services in a primary care setting which are clinically and cost effective.

25. Primary care practices are at different stages of development and there is a need to support and develop them. Health Boards should build on the many examples of good practice and take action to enhance clinical quality through improvements in education and training, research and development, and clinical audit. The aim is to build effective multi-disciplinary teams within primary care, operating from good quality premises, supported by an effective communications infrastructure, and with appropriate links with others who deliver health care.

26. Primary care teams have a key role in relation to the 3 clinical priorities and in tackling inequalities in health. Health Boards should ensure that their plans in these areas give full consideration to the contribution which primary care teams make.

Promoting Care in the Community

27. The Government is committed to the sensitive development of community care, so that wherever practicable people are able to live at home or in as domestic an environment as possible while receiving the care and support they need. In 1998-99 the NHS should focus on finalising and implementing mental health strategies drawn up in the light of the Framework for Mental Health Services in Scotland. The NHS should also continue to work closely with social work, housing and other agencies to ensure that people requiring care receive the full range of services they require.

28. Later in 1997 the Government will be consulting on the relationship between health and social care services. The Government also intends to establish a Royal Commission on Long Term Care. In the meantime it is important that the National Health Service should work closely with the partners in social work and housing to ensure that momentum is maintained in establishing and extending the range of care, support and services for vulnerable individuals and groups in the community. The NHS should continue to ensure effective hospital discharge planning to minimise the possibility of hospital beds becoming blocked by patients whose needs are best met elsewhere. Close joint working with local authorities will be essential to ensure effective hospital discharge.

Reshaping Hospital Services

29. The Acute Services Review is examining the role of acute hospital services within the network of clinical services in Scotland. It will take into account the effect of factors such as: patient convenience; evidence on clinical effectiveness and outcomes; new technology; and developments in primary care and care in the community. A series of Bulletins will be issued reporting on work as it progresses.

30. The Review is intended to establish a series of clear planning principles to guide the development of acute services in Scotland over the next 5-10 years. The Review is being taken forward initially through the work of 7 Sub-Groups, dealing with Renal Disease, Peripheral Vascular Disease, Cardiac Disease, Neurology and Neurosurgery, Treatment Services for Children, Diagnostic and Support Services, and Quality Assurance and Accreditation. The 5 clinical areas selected for detailed consideration have been chosen because they represent different aspects of the Service and provide differing opportunities for modelling of important service issues, from which it is intended to develop planning principles applicable to the Service in a more general way. Several of the Sub-Groups will also look at immediate problems in their area and workforce implications.

31. The review is expected to be completed in the late Spring of 1998. In the interim the National Health Service should continue to develop proposals to reorganise acute services where clinical benefits can be achieved. MEL(1996)92 which offered guidance on the management of emergency admissions remains in force and the National Health Service must ensure that it is has in place robust plans for the coming winter and beyond. Similarly, continuous improvements in waiting times should be sought. Levels of day case activity should be reviewed, and the targets set out in the Accounts Commission's report ('Better By The Day? - Day Case Surgery in Scotland') adopted with the aim of achieving them progressively during 1998/99.

Quality

32. Achieving the highest quality of care for patients is a key objective of the National Health Service. It is a shared responsibility for everyone working in the Service, and covers all aspects of health care including the effectiveness of clinical practice, the environment in which it is delivered, and responsiveness to the needs of patients.

33. Central to the quality of health care is the effectiveness of clinical care and treatment. Work at all levels on the development of research-based clinical guidelines and local protocols, implementation of systematic clinical audit and development of clinical outcome indicators which allow critical review of performance, will continue to be targeted on the Service's 3 clinical priorities and other areas with potential for health gain; and increasing emphasis will be placed on ensuring that the results are applied in improving clinical practice and the quality of care for patients. The Common Core Work Programme of nationally sponsored activity in support of these goals is set out in Annex A. Guidance on research and development is set out at Annex C.

34. Encouraging progress is being made in developing services that are more responsive to patients. The NHS should give renewed impetus to its efforts to involve patients in the

planning and delivery of their care; to provide them with more information on conditions, prevention, procedures and services; and to respond positively to their views and preferences. Organisational processes should be designed around the patient's experience regardless of the setting, to ensure continuity of care from the GP through hospital to rehabilitation in the community. One example might be the use of information technology in booking systems to allow out-patient appointments to be made while patients visit their GPs. A collaborative approach between those involved is crucial, and will be particularly important in addressing the 3 clinical priorities, set out at paragraph 1 above. In addition, the NHS should continue to:

- exert downward pressure on inpatient and outpatient waiting times and monitor the impact. In doing so, they should address the factors leading to patients joining waiting lists, including GP referral patterns and the inter-relationships between outpatient and inpatient waiting lists;

- work towards the elimination of mixed sex accommodation;

- audit implementation of the named nurse initiative in line with national guidelines.

35. The National Health Service is already investing in a variety of methods to monitor the quality of service provision as a means of assuring and improving standards and of demonstrating to staff and patients a commitment to quality. Under the auspices of the Acute Services Review, but encompassing all parts of the Service, a multi-disciplinary group drawn from the Health Service and the Management Executive will be making recommendations on the benefits and limitations of different approaches to quality monitoring and, in particular, whether to promote accreditation in the National Health Service.

Resource Assumptions

36. As part of their Health Improvement Programmes Health Boards must continue with the development of robust 5 year rolling financial strategies to link service aims and objectives to service plans, with a clear indication of the associated resource shifts. These financial strategies should provide an agreed framework for detailed planning by Boards, Trusts and Primary Care, and should be underpinned by agreement between Boards and Trusts on the detailed service changes required to bring those strategies to fruition. The identification of financial and service risks should be a key part of the strategies, together with plans for addressing those risks should they occur.

37. Boards are expected to assess the relative efficiency of the Trusts from whom they obtain services, seeking to ensure that the less efficient improve their performance. Generally, priority should be given to reducing the cost of bureaucracy, especially within the finance and human resources functions, including greater co-operation and sharing of activities among Boards and Trusts with the aim of maximising resources available for patient care.

38. Current expenditure plans in Scotland envisage a real terms increase in resources for the National Health Service in 1998/99. The level of funds from within this total available to Health Boards is largely dependent on the extent to which increases in demand led FHS

(Family Health Service) expenditure (predominantly on prescribed drugs) has to be accommodated before HCHS (Hospital and Community Health Service) resources are allocated. It is vital therefore that the Boards continue to monitor and manage expenditure in the non-cash limited sector with vigour. Indicative HCHS allocations will be issued to Health Boards shortly to enable planning to proceed on a firm basis. Subject to receipt of a satisfactory HIP, all Boards will receive a 4% cash uplift (1.25% real terms) which together with locally generated efficiencies is to meet the cost of service developments and pay and price inflation.

Freeing up Resources for Patient Care: Reducing Bureaucracy

39. The White Paper to be published in the autumn will set out proposals for replacing the internal market, with the intention of reducing bureaucracy. In the interim, the National Health Service is expected to ensure that an increasing proportion of the total resource is invested in improving health care and in improving health.

40. The division of the National Health Service into a large number of autonomous organisations and competition between them have led to duplication of services and loss of economies of scale. The contracting process has led to excessive paperwork. MEL(1997)36 issued on 10 July 1997 requested Health Boards and Trusts to submit their plans for reducing bureaucracy and overheads. The implementation of these plans should proceed without delay.

Conclusion

41. The proposals for the National Health Service in Scotland set out in this guidance are intended to ensure that we secure a high quality public service which provides taxpayers with good value for money. Collaboration and co-operation within the National Health Service will help to improve quality across the service and support the teamwork on which good health care depends. The delivery of high quality care is the goal of everyone working in the National Health Service. A collaborative and focused approach in 1998/9 will help to make a major impact in preventing illness and responding to the needs of patients.

ANNEX A

COMMON CORE WORK PROGRAMME

1. The common core work programme aims to improve health and the quality, effectiveness and cost-effectiveness of clinical care in the National Health Service in Scotland by providing advice and information on selected priority topics. Further details of the programme are given in the leaflet which was issued under cover of MEL(1997)26.

2. Much of the programme supports the 3 national priority areas - cancer, mental health and coronary heart disease/stroke - but important topics outwith these areas are selected if there is clear, immediate potential to improve health and/or clinical care. The programme provides a substantial opportunity for a wide range of organisations to influence priorities in the National Health Service through the submission of topics for the programme.

3. The topics for 1997-98 are:-

- Lung Cancer
- Chest Pain
- Dental Caries
- Hypertension, with a focus on the elderly
- Dementia
- Schizophrenia
- Acute Stroke
- Breast Cancer
- Colorectal Cancer
- Hip Fracture; and
- Peptic Ulcer

4. Possible additional topics for 1998-99 are being actively considered, and any selected for inclusion in the programme will be notified to the Service in due course.

5. The following table is a simplified, concise matrix which has been compiled to support the programme. It lists reports and guidelines on programme topics which have been produced, and indicates when others are likely to be published.

ANNEX B

PLANNING TIMETABLE

	ME	HB	Units/Trusts	GPs + GPFH
APRIL		Strategy review/LHS update		
MAY	Debate Priorities			
	Consult on Priorities & Planning Guidance			
JUNE	Draft Priorities and Planning Guidance		Provide final audited accounts	GPFHs submit formal outturn report for year to 31 March to HB on performance against plan
JULY	Issue Priorities and Planning Guidance	Begin discussions with Trusts and GPs on HIP in light of existing plans and available resources	Begin discussions with HB and GPs on HIP in light of existing plans and resources	Begin discussions with HB and Trusts on HIP in light of existing plans and resources
AUGUST		Continue preparation of HIP	Continue preparation of HIP	Continue preparation of HIP
		Provide final accounts	Discuss capital proposals with host HB and other major users	GPFHs' draft provisional business plan
			Submit capital proposals	

	ME	HB	Units/Trusts	GPs + GPFH
SEPTEMBER		Continue preparation of HIP	Continue preparation of HIP and draft TIP	Continue preparation of HIP
		Endorse Unit/Trust Capital Plans		
		Submit Capital proposals (where appropriate)		
OCTOBER	Review Capital Plans	Submit draft HIP to ME	Submit capital charges estimates	
		Publish Director Public Health Report	Service costs to be discussed with HB and GPs	
		Publish Annual Report		
NOVEMBER	Discuss capital plans	Finalise HIP	Continue preparation of Trusts' Implementation Plan in light of HIP	
	Final Public Expenditure settlement			
DECEMBER	Allocate capital. Notify revenue allocations	Submit final HIP		
JANUARY	Notify Trusts of External Financing Limits	Submit draft Corporate Contract		
FEBRUARY	Discuss Corporate Contracts	HB finalise offers of allotted sums to GPFHs	Agree implementation plan with HB	GPFHs negotiate final budget based on preferred activity and costs with HB
MARCH	Discuss Corporate Contracts	Ensure comprehensive service plans in place	Submit implementation plan (including financial plan) to ME	

ANNEX C

RESEARCH AND DEVELOPMENT

1. Health Boards, Trusts and Primary Care professionals should be working towards the integration of research and development, guidelines and audit in a manner designed to promote service developments for the local population based on evidence. Research programmes should be integrated with the local evidence-based healthcare initiatives. Research strategies should outline how research relates to local needs and how results will inform future practice.

2. Research is a routine and necessary part of the work of the NHS. Accordingly:

- Health Boards Trusts, GPs and other agents delivering family health service must continue to ensure that patient care services associated with research are provided and funded.

- such arrangements must include any excess element of treatment costs arising from the research.

3. A separate budget, the R&D Support Fund, has been established to meet the costs of research conducted within the Health Service. Applications for funding from 1998-99 are currently in progress and were described under cover of MEL(1997)7.

4. A statement of partnership will be published in August 1997 specifying the circumstances under which the NHS will support non-commercial externally funded R&D by meeting associated patient care costs. The Concordat between the UK Health Departments and the Medical Research Council (MRC) (published in May 1997) explains arrangements between the NHS and MRC; there are similar arrangements with other Research Councils. The NHS is required to ensure that it meets its obligation under these agreements.

ANNEX D

HUMAN RESOURCES

1. The National Health Service is undergoing a period of significant change designed to ensure that the Service continues to be managed to provide patients with effective care, efficiently delivered, with their interests at the core of all service delivery. The traditional investment in capital and new technology to support service developments now needs to be underpinned by a similar investment in the people who work in the Service.

2. The responsibility for managing human resources rests with the Chairmen, Chief Executives and General Managers of Health Boards and Trusts and with GPs in primary care. Equally, the development of organisations in the primary care sector should be supported with clear human resources strategies.

3. There are 2 distinct strands to this changed focus:

- to deliver the strategic objectives of the NHS; and
- to deliver effective operational support.

4. The first objective will be achieved through the development of flexible employment practices, through human resources planning, teamwork, and training and management development strategies which equip staff to embrace change. The second objective will be achieved through the provision of a high quality human resources service, proactive industrial relations policies, and the ability to monitor individual organisational performance.

5. To take forward these objectives Health Boards, Trusts and Primary Care practitioners should collaborate to develop human resources strategies as part of Health Improvement Programmes which set out:

- a costed plan for the workforce for the 5 year period which reflects the need to have the right number of appropriately trained staff in the right place to deliver the proposals identified in the Programme;

- a training and development plan to support local and national priorities;

- good employment practices, which are people focused, family friendly, and responsive to the rights of employees, in order that employers are able to attract and retain high quality staff, and which explicitly address the benefits to be gained from re-training staff to increase the versatility of the workforce.

6. Trust Implementation Plans should show how Human Resources strategies are to be put into effect.

ESTATES

1. The National Health Service estate is a valuable asset which needs to be effectively managed to meet the changing needs of the Service. In developing Health Improvement Programmes, the National Health Service should prepare capital and estate management proposals which:

- ensure maximum resources are directed at the clinical process rather than buildings;
- free recurring revenue and generate non-recurring funds from disposals which can be used to fund major change in local health services; and
- avoid wasteful duplication of expensive capital equipment.

2. Health Boards and Trusts are expected to agree estates strategies, consistent with their Health Improvement Programme and including the needs of primary care, taking into account:

- agreed clinical service plans;
- information and professional advice on how major physical assets can be used differently, including utilisation studies; and
- the need to reduce the estate to the minimum necessary to meet health care needs and thereby free resources for reinvestment.

3. Trust Implementation Plans should show how estates strategies are to be put into effect.

INFORMATION MANAGEMENT AND TECHNOLOGY

1. The national strategic framework for Information Management and Technology to be published in August 1997 is designed to provide a national infrastructure and facilitate development of an information rich health service at a local level. That cannot be achieved by each health body acting in isolation from their other partners. As part of their Health Improvement Programmes, the NHS should:

- prepare an agreed Information Management and Technology strategy which reflects clinical care strategies;
- identify ways in which the new opportunities presented by modern information technology can be harnessed to speed communication and reduce paperwork;
- have mutually agreed plans on how the Year 2000 (the 'millennium time bomb') challenge to pre-programmed information processors (in information management and technology, medical equipment and estates) is to be met.

2. Trust Implementation Plans should show how Information Management and Technology strategies are to be put into effect.

3. All future major capital investment in Information Management and Technology must be tested against these principles.

4. Fundamental to the development of Information Management and Technology in local health services is the need to achieve local co-ordination of telecommunications management. Health Boards are required to ensure that this happens in accordance with NHS MEL (1996)80.

ANNEX G

FUTURE ARRANGEMENTS FOR THE CARE OF THE DYING AND BEREAVED

1. The final report of the National Panel for the Care of the Dying and the Bereaved in Scotland was published earlier this year.

2. Task Forces at Trust level should be responsible for the implementation of the report at local level. Trusts should include Care of the Dying and the Bereaved in their Trust Implementation Plans and should audit activities as an integral part of their quality monitoring arrangements. Health Boards should be responsible for ensuring that arrangements are in place for the provision of care to the dying and bereaved, and that this is adequately monitored and audited. Detailed guidance is provided in the report.

3. Some Task Forces will remain at Board level due to the size of the population they serve. The number and role of GPs involved with Task Forces should, whenever possible, be increased and liaison with Social Work services in the care and support of patients at home and their relatives should be promoted.

COMMON CORE WORK PROGRAMME

MATRIX OF WORK PUBLISHED AND UNDERWAY : JULY 1997

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
CORONARY HEART DISEASE/STROKE						
ACUTE CHEST PAIN : ECG NEGATIVE		SIGN : Publication due late 1997				
ACUTE CHEST PAIN : MYOCARDIAL INFARCTION/ SECONDARY PREVENTION		SIGN : Publication due early 1998	DPH : Published August 1995	CR-OC : Survival After Admission For Acute Myocardial Infarction : Published Dec '95	3 CSO funded projects	
ACUTE CHEST PAIN : STABLE ANGINA		SIGN : Publication due September '97	SHPIC : Publication due March 1998		1 CSO funded project	
ACUTE STROKE	SNAP : Published November 1994		SHPIC : Publication due Autumn 1997	CR-OC : Discharge Home After Admission For Stroke : Published Dec '94 & Dec '95 CR-OC : Survival After Admission For Stroke : Published December 1995		NMAC : The Management Of Patients With Stroke Published 1993

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

CORONARY HEART DISEASE/STROKE

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
AMBULATORY BLOOD PRESSURE MONITORS			SHPIC : Published October 1996			
ANTI-THROMBOTIC THERAPY		SIGN : Publication due September '97				
CARDIAC REHABILITATION			SHPIC : Publication due March 1998		1 CSO funded project	
CORONARY HEART DISEASE IN SCOTLAND	SNAP : Publication due August 1997				4 CSO funded projects	PHPU : Published January 1996
CORONARY REVASCULARISATION		SIGN : Publication due early 1998				
DIABETES : CARDIOVASCULAR DISEASE		SIGN : Publication due August 1997	SHPIC : Publication due September '97			
HEALTH RELATED PHYSICAL ACTIVITY	SNAP : Published December 1996					
HEART FAILURE		SIGN : Publication due Winter 1997/8	SHPIC : Publication due March 1998		2 CSO funded projects	
LIPID LOWERING INTERVENTIONS		SIGN : Publication due May 1998	SHPIC : Publication due August 1997		1 CSO funded project	

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

CORONARY HEART DISEASE/STROKE

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
OBESITY		SIGN : Published November 1996	SHPIC : Publication due August 1997			
PERIPHERAL VASCULAR DISEASE	SNAP : Publication due February 1998	SIGN : Publication due September '97			CSO funding for Cochrane Review Group	
PROPHYLAXIS OF VENOUS THROMBOEMBOLISM		SIGN : Published September 1995				
STENTS FOR CORONARY ARTERY DISEASE			SHPIC : Published October 1996			
STROKE			SHPIC : Publication due August 1997	CR-OC : Discharge Home After Admission For Stroke : Published Dec '94 & Dec '95 CR-OC : Survival After Admission For Stroke : Published December 1995	CSO funding for Cochrane Review Group 2 CSO funded projects	NMAC : The Management Of Patients With Stroke Published 1993
STROKE : MANAGEMENT OF PATIENTS WITH STROKE. ASSESSMENT, INVESTIGATION, IMMEDIATE MANAGEMENT AND SECONDARY PREVENTION		SIGN : Published May 1997			1 CSO funded project	NMAC : The Management Of Patients With Stroke Published 1993

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
CORONARY HEART DISEASE/STROKE						
STROKE : MANAGEMENT OF PATIENTS WITH STROKE. COMPLICATIONS/DISCHARGE PLANNING/ REHABILITATION		SIGN : Publication due September '97				
STROKE: MANAGEMENT OF PATIENTS WITH STROKE. MANAGEMENT OF CAROTID STENOSIS AND CAROTID ENDARTERECTOMY		SIGN : Published May 1997			1 CSO funded project	
STROKE : MANAGEMENT OF SWALLOWING DISORDERS		SIGN : Publication due September '97				
THROMBOLYTICS/THROMBOLYTIC THERAPY			DPH : Published August 1995 SHPIC : Publication due Autumn 1997			
CANCER						
BREAST CANCER	SNAP : Publication due October 1997	SIGN : Publication due November '97	SHPIC : Publication due August 1997	CR-OC : Survival By Health Board : Published July 1996	5 CSO funded projects.	
BREAST CANCER - UPTAKE OF SCREENING			SHPIC : Publication due August 1997			

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

CANCER

CANCER					8 CSO funded projects	
CANCER OF THE LARGE BOWEL				CR-OC : Survival By Health Board : Published July 1996		
CANCER CARE IN GLASGOW : A MODEL FOR REGIONAL CANCER CARE IN SCOTLAND	SNAP : Published June 1994					
CANCER OVERVIEW	SNAP : Publication due October 1997					
CERVICAL CANCER : GUIDELINES ON FAIL-SAFE ACTIONS FOR THE FOLLOW-UP OF WOMEN WITH ABNORMAL CERVICAL SMEAR RESULTS						ME : Published March 1995
CERVICAL CANCER : GUIDANCE TO HEALTH BOARDS ON PURCHASING FOR CERVICAL SCREENING			ME : Published September 1996			
COLO-RECTAL CANCER	SNAP : Publication due February 1998	SIGN : Publication due August 1997			2 CSO funded projects	
LUNG CANCER		SIGN : Publication due October '97	SHPIC : Publication due March 1998	CR-OC : Survival By Health Board : Published July 1996		

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

CANCER

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
ORAL CANCER	SNAP : Published June 1994. Updated Report published May 1996					
OVARIAN CANCER		CRAG : Published August 1995	DPH : Published August 1995	CR-OC : Survival By Health Board : Published July 1996	1 CSO funded project	
THE USE OF PALLIATIVE RADIOTHERAPY FOR NON SMALL-CELL LUNG CANCER		SIGN : Published May 1996	ME : MEL(1993)156 Published December 1993			
REPORT OF WORKING GROUP ON INTERNAL QUALITY CONTROL FOR CERVICAL CYTOPATHOLOGY LABORATORIES						ME: Published September '95
TESTICULAR GERM CELL TUMOUR		SIGN : Publication due winter 1997/8				

MENTAL HEALTH

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
THE BURDEN OF MENTAL HEALTH PROBLEMS	SNAP : Publication due August 1997				2 CSO funded projects	

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

MENTAL HEALTH

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
DEMENTIA	SNAP : Publication due August 1997	SIGN : Publication due October 1997	SHPIC : Publication due August 1997		3 CSO funded projects	
DEMENTIA - CT SCREENING			SHPIC : Publication due August 1997			
EFFECTS OF THE CHANGING PATTERNS OF SERVICE PROVISION AND THEIR HEALTH, SOCIAL & ECONOMIC IMPLICATIONS	SNAP : Publication due August 1997				3 CSO funded projects	
FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND					3 CSO funded projects	ME:Publication due August '97
INVOLVEMENT OF SERVICE USERS IN ASSESSING NEED FOR COMMISSIONING AND MONITORING MENTAL HEALTH SERVICES	SNAP : Publication due August 1997				1 CSO funded project	
MENTAL HEALTH IN THE WORKPLACE	SNAP : Publication due August 1997					

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

MENTAL HEALTH

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
MENTAL HEALTH OVERVIEW	SNAP : Published December 1994			CR-OC : All Deaths Within 1 Year Of Discharge: Published Dec '94 & Dec '95 CR-OC : Deaths At Ages Under 65 Within 1 Year Of Discharge: Published Dec '94 & Dec '95	3 CSO funded projects	
PUBLIC HEALTH AND MENTAL HEALTH GAIN	SNAP : Publication due August 1997					
SCHIZOPHRENIA	SNAP : Publication due October 1997	SIGN : Publication due September `97	SHPIC : Publication due August 1997		4 CSO funded projects	CRAG:Services For People With Schizophrenia Published April 1995
SUICIDAL BEHAVIOUR AMONG YOUNG ADULTS	SNAP : Publication due August 1997				2 CSO funded projects	
SUICIDE				CR-OC : Suicide Within 1 Year Of Discharge: Published Dec '94 & Dec '95		

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/MF GUIDANCE

COMMON CORE WORK PROGRAMME

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/MF GUIDANCE
ADULT ORAL HEALTH	SNAP : Publication due August 1997					
DENTAL CARIES IN CHILDREN	SNAP : Published June 1994. Updated report due Oct '97					
DENTAL : CARIES PREVENTION		SIGN : Publication due mid 1998			1 CSO funded project	
DENTAL : THIRD MOLAR EXTRACTION		SIGN : Publication due early 1998				
DIABETES	SNAP : Publication due December 1997					
DIABETES : CARDIOVASCULAR DISEASE		SIGN : Publication due August 1997	SHPIC : Publiation due September '97			
DIABETES : CHILDREN & YOUNG PEOPLE WITH DIABETES		SIGN : Published December 1996				
DIABETES : MANAGEMENT OF DIABETIC FOOT DISEASE/AMPUTATIONS		SIGN : Published March 1997	SHPIC : Publication due August 1997			
DIABETES : PATIENTS & CARERS		SIGN : Publication due August 1997				

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE

COMMON CORE WORK PROGRAMME

HEALTH TOPIC	NEEDS ASSESSMENT	CLINICAL GUIDELINES	PURCHASING NOTES	OUTCOME INDICATORS	RESEARCH	POLICY REVIEWS/ME GUIDANCE
DIABETES : MANAGEMENT OF DIABETES IN PREGNANCY		SIGN : Published December 1996				
DIABETES : MANAGEMENT OF DIABETIC RENAL DISEASE		SIGN : Published March 1997				
DIABETES : PREVENTION OF VISUAL IMPAIRMENT		SIGN : Published May 1996	SHPIC : Published November 1996			
DYSPEPSIA, PEPTIC ULCER & HELICOBACTER PYLORI	SNAP : Publication due February 1998	SIGN : Published September 1996	SHPIC : Published September 1996			
ELDERLY PEOPLE WITH FRACTURED HIP		SIGN : Publication due August 1997				
HIP FRACTURE	SNAP : Publication due August 1997				2 CSO funded projects	
HYPERTENSION IN THE ELDERLY	SNAP : Publication due August 1997	SIGN : Publication due September '97	SHPIC : Publication due November 1997			
ORTHODONTIC CARE	SNAP : Publication due August 1997					

Further information on the common core work programme can be obtained from:

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Edinburgh EH1 3DG
Telephone : 0131 244 2215

Abbreviations:

CR-OC	Clinical Outcomes Working Group
CRAG	Clinical Resource And Audit Group
CSO	Chief Scientist Office
DPH	Directors Of Public Health
ME	Management Executive
NAMAC	National Medical Advisory Committee
PHPU	Public Health Policy Unit
SIGN	Scottish Intercollegiate Guidelines Network
SHPIC	Scottish Health Purchasing Informatiion Centre
SNAP	Scottish Needs Assessment Programme