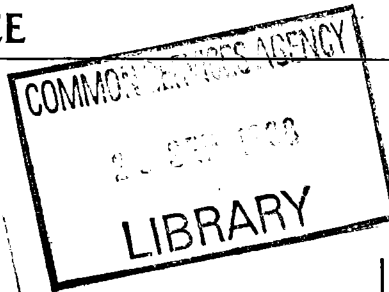
THE SCOTTISH OFFICE

Department of Health



NHS
MEL(1998)63

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

Telephone 0131-244
Fax 0131-244 2323

25th September 1998

Dear Colleague

PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND 1999-2002

Summary

1. Priorities and Planning Guidance for the NHS in Scotland for 1999-2002 is attached.

Action

2. All Health Boards and NHS Trusts, with their planning partners, are expected to take account of the guidance in preparing plans for the management and delivery of local health care services.

3. Health Boards are requested to circulate this MEL to GPs in their area, for information.

4. This MEL is available on The Scottish Office web site: http:/www.show.scot.nhs.uk/dtc

Yours sincerely

Catherine Brown

for KEVIN J WOODS
Director of Strategy and Performance Management

Addressees

For action:

General Managers, Health Boards

Chief Executives, NHS Trusts

General Manager, State Hospital

Chief Executive, Scottish Ambulance Service

General Manager, CSA

For information:

Chief Executive, Health Education Board for Scotland

Director, Scottish Health Advisory Service

Executive Director, SCPMDE

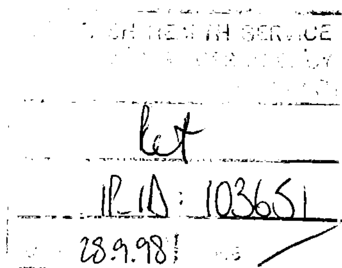
Chief Executives, Scottish Local Authorities

For additional copies:
Brian Nisbet
NHS Management Executive
Performance Management Division
Room 269
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131 244 2841
Fax: 0131 244 2051

General enquiries to:
Catherine Brown
NHS Management Executive
Performance Management Division
Room 265
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2276
Fax: 0131-244 2051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CONTENTS

Section 1 Introduction

Section 2 HIPs, TIPs and Financial Reporting

Section 3 Quality

Section 4 Strategic Aims

Section 5 Clinical Priorities

Annex A Ensuring Service Continuity beyond the Year 2000

Annex B Human Resources in the NHS in Scotland

Annex C Estates

Annex D Information Management and Technology Strategy

Annex E Planning Timetable

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PRIORITIES AND PLANNING GUIDANCE FOR THE NATIONAL HEALTH SERVICE IN SCOTLAND 1999/2002

SECTION 1

INTRODUCTION

1.1 The Priorities and Planning Guidance is the framework for the planning and delivery of health services in the coming 3 years, and focuses the National Health Service in Scotland (NHSiS) on the most important national priorities.

1.2 The context for this guidance has been set by the Government's White Paper "Designed to Care", the Green Paper "Working Together for a Healthier Scotland", and the Comprehensive Spending Review, which has resulted in additional funding of £1.8 billion for the NHS in Scotland over the next three years.

1.3 During the time period covered by this guidance further policy initiatives can be anticipated. However, the Government believes it is important to align the service and financial planning timetables, and to adopt a longer-term horizon for this guidance. This should help the NHSiS to plan with greater certainty. Against a background of significant constitutional, organisational and service change, the agenda for the coming years emphasises the need to implement existing strategic plans which will deliver improved services to the patient and put in place measures which ensure the performance of the NHSiS continues to improve in terms of quality, effectiveness and efficiency.

1.4 The **strategic aims** already established by the Government remain. They are:

- **improving health;**
- **tackling inequalities;**
- **developing primary care;**
- **developing community care;** and
- **reshaping hospital services.**

In retaining these strategic aims, the Government has decided that an important focus of the improving health and tackling inequalities effort should be the health of children and young people. The NHSiS should also ensure that due attention is given to services for children and young people in pursuing the other strategic aims and clinical priorities.

1.5 Similarly the 3 existing **clinical priorities** have been retained;

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

This is the 4th year when these priorities have been identified, reflecting the continuing significance of these diseases as causes of mortality and morbidity and the scope for improvement in service delivery.

1.6 As this guidance now covers a 3-year timescale it may be necessary to give further consideration to the continuing validity of these priorities in the light of constitutional change, progress with service development and because of new pressures, but in general the intention is to see through the implementation of current policy.

1.7 The publication of this guidance coincides with the creation of new NHS Trusts which will take on their responsibilities from 1 April 1999. This is a significant stage in the implementation of "Designed to Care", and these new organisations will play an important part in implementing the main actions which flow from this guidance. It is appropriate to restate, therefore, the objectives of Government policy for the NHSiS. They are:

- to improve consistently the quality and effectiveness of services to patients;
- to put patients and their needs at the centre of service development;
- to improve health and reduce inequalities;
- to promote partnerships between patients and professionals who care for them;
- to promote the integration of the different parts of the NHSiS and provide seamless services; and
- to promote partnerships between the NHSiS and other organisations whose work can help improve health and the quality of services.

Successful organisations in the modernised NHSiS will be able to demonstrate that they are focused on these goals and are working as part of the NHS family.

SECTION 2

HEALTH IMPROVEMENT PROGRAMMES

2.1 Last year a new process for health service planning was introduced. Health Boards, NHS Trusts, primary care practitioners and others were required to work together in an open and collaborative manner to produce a Health Improvement Programme (HIP) for the people of each Health Board area. These new arrangements generally worked well but worked best where baseline information and mutually supportive objectives were agreed at the outset by all parties involved. In the coming year the process needs to be developed further to ensure that HIPs are collectively owned and seen as the authoritative reference point for local health care systems. It is the Health Board's responsibility to ensure that the people it serves fully understand how planned changes and new developments will secure health gain and will be for the greater good of the local population. This is a key aspect of performance on which Boards and Trusts will be measured.

2.2 Health Improvement Programmes for 1999-2000 should:

- build on the existing HIP in terms of overall strategy for the 5 years commencing 1 April 1999, taking account of the respective roles and responsibilities of Health Boards and Trusts as set out in "Designed to Care";
- demonstrate that a collaborative approach has been taken locally with the new Trust organisations, clinicians, GPs, local authorities and others;
- provide a firm plan for 1999-2000 which sets a clear agenda for those responsible for delivering services;
- take full account of service pressures which may be anticipated as we pass into the new millennium, including the potential effects of date change (**Annex A**);
- recognise the role of the local health council and be readily understood from the patient's perspective; and
- contribute to the development of community planning in association with local authorities.

2.3 Taking account of the guidance in this document, and other advice issued by the Management Executive, each programme should set out:

- proposals to protect the public health, including emergency planning; and, in collaboration with local authorities, measures to safeguard the public health from communicable - including foodborne - disease;
- proposals to promote health;

- proposals to analyse and tackle health inequalities;
- proposed service changes and developments;
- plans for the delivery of waiting list targets;
- a programme to improve clinical effectiveness.

2.4 In addition the HIP should make clear references to and be supported by the following:

- **a human resource strategy** - setting out local plans to implement "Towards a New Way of Working" - and local workforce, education and training plans which support service development objectives **(Annex B)**

- **an estates strategy** - taking account of the reconfiguration of Trusts: a consolidated Trust Estates Strategy reflecting the 1999-2000 HIP must be agreed with each Trust's host Health Board by 30 June 1999. It should be noted that the Management Executive plans to issue soon an updated estates management policy statement together with associated mandatory requirements This will take into account the intention set out in "Designed to Care" for Health Boards to have increased powers in relation to capital planning and property in their area**(Annex C)**

- **an information management and technology strategy** - jointly agreed by the Health Board and NHS Trusts, which will support the objectives of "Designed to Care" and the recommendations of the Acute Services Review **(Annex D)**

- **a financial strategy** - guidance on the format of financial strategies will be issued in due course following further consultations. Financial strategies will need to be set in the context of firm plans for securing efficiencies at national, regional and local levels and reflecting guidance on securing best value for support services. The Government remains firmly committed to securing a substantial release of resources for patient services following abolition of the internal market and reconfiguration of Trusts.

2.5 Health Boards which secure services from Trusts outwith their areas should involve them as appropriate. The Scottish Ambulance Service and the State Hospital should prepare Health Improvement Programmes for the services they provide. Health Boards should continue to agree annual Corporate Contracts with the Management Executive, as should the State Hospital and the Common Services Agency (CSA).

Trust Implementation Plans

2.6 The principal agenda for the newly established NHS Trusts will be the implementation of the relevant Health Improvement Programmes and one of the first priorities of each new NHS Trust will be to prepare a Trust Implementation Plan (TIP).

Given the management changes underway, it is essential from the outset that Trust Chairmen take personal responsibility to secure the involvement of clinicians and primary care practitioners as well as the new Trust team. Implementation Plans should be agreed with the host Health Board to ensure they support the delivery of Health Improvement Programmes and that resource assumptions are consistent.

2.7 A report prepared by the Development Group on HIP/TIP development and sharing good practice was issued on 21 July. To assist Health Boards and Trusts develop their performance management relationships, a guidance note was issued on 31 August. This note identifies core principles and key elements which the Management Executive will need to see incorporated locally together with some criteria which can be used to assess how well performance management systems are working.

2.8 A timetable for the preparation of HIPs, TIPs and Corporate Contracts is at **Annex E.**

Resource Assumptions and Financial Reporting

2.9 Health Boards must continue with the development of 5 year rolling finance strategies to link service aims and objectives to operational plans with a clear indication of the associated resource shifts. The Government's Comprehensive Spending Review sets spending levels, including £1.8 billion new money over the next 3 years. Details of allocations and financial reporting arrangements will be the subject of separate guidance.

SECTION 3

QUALITY

3.1 The Government expects the NHSiS to achieve the highest possible standards of healthcare and to assure the public that these are being achieved. This is a shared responsibility for everyone working in the Service, and covers all aspects of healthcare including the effectiveness of clinical practice, the environment in which it is delivered, and responsiveness to the needs of patients.

Clinical Effectiveness

3.2 Central to the quality of healthcare is the effectiveness of clinical care and treatment. Following an internal review, it has been decided that work in Scotland on clinical effectiveness should continue to be led by the Clinical Resource and Audit Group (CRAG), chaired by the Chief Medical Officer, and that various steps should be taken to develop a stronger strategic direction, to promote a more integrated and co-ordinated approach, and to ensure that the tools that are being developed are actually being used to improve clinical practice in all parts of the Service. Health Improvement Programmes and Trust Implementation Plans must set out local strategies to implement the product of these initiatives.

3.3 Complementing the work of CRAG and related bodies such as the Scottish Intercollegiate Guidelines Network (SIGN), the White Paper announced the intention to establish a Scottish Health Technology Assessment Centre (SHTAC) to undertake appraisals of the evidence on the clinical and cost effectiveness of innovations in healthcare including new drugs. It will provide advice to support decision making in Boards and Trusts. Proposals regarding the establishment of SHTAC will be issued for consultation during the Autumn of 1998.

Clinical Governance

3.4 The White Paper also announced plans for improved clinical governance to ensure that the emphasis on the quality of services to patients is reflected in the responsibilities and management of Trusts. Subject to the passage of legislation, Trusts' statutory duties will be amended to make explicit their responsibility for quality of care. Ensuring delivery of care of high clinical quality is a key responsibility of Trust boards and will constitute a major part of their agendas. A consultation paper on how these mechanisms should be put in place was issued in August and the intention is to issue guidance in the Autumn to allow Trusts to prepare for the statutory introduction of clinical governance from 1 April 1999. The adequacy of local arrangements will be reviewed during 1999/2000.

Quality Assurance

3.5 In addition, the Government has decided that there is a need for an external element to provide assurance to the public that services are safe and are being delivered to the highest standards possible. It has accepted the recommendation of the Acute Services Review that a national system for assuring the quality of healthcare should be established, led by a new

National Standards Group (NSG) which will be a multi-disciplinary body, including representatives of the public and patients. Proposals for the establishment of NSG and for the piloting of the new approach to quality assurance and accreditation, initially in the priority areas of cancer, coronary heart disease and mental health, will be issued during the Autumn of 1998.

Integrated Care

3.6 Securing seamless services which enable patients to pass from one part of the NHS to another without feeling as though they are being passed from pillar to post is fundamental to the quality of patients' experience and a key aim of "Designed to Care". This requires specific attention to the integration of services within LHCCs in Primary Care Trusts, through Managed Clinical Networks for acute services, and by using the Joint Investment Fund between Trusts. Specific areas which should be the focus for effort to achieve greater integration are the management of hospital admission and discharge, and chronic disease management. Such an approach will require Boards and Trusts to target investments carefully and to use the opportunities of the Joint Investment Fund to re-design services to achieve greater integration.

Patient-Centred NHS

3.7 An essential element in a high quality service is responsiveness to the needs and wishes of patients. The White Paper stated that every aspect of the planning and delivery of services should be designed from the perspective of patients. In pursuit of this objective, a Designed Healthcare Initiative has been launched and various steps have been taken to encourage the involvement of patients and the public in decisions about their own care and treatment and about health services generally and to provide them with more information about their health and about the options for treatment. The White Paper stated that progress in these areas would be a key test of organisational performance and Boards and Trusts will be expected to demonstrate what they have achieved in taking them forward.

3.8 The Designed Healthcare Initiative was announced by the Minister in February 1998. Details are set out in MEL(1998)20. Funding of £1 million annually over the 3 years 1998-2001 has been made available to support a number of pilot sites for improving the quality of care to patients through the redesign of services, including the development of one-stop clinics. Bids for the first tranche of funding were received by the end of May 1998. Two allocations were announced in July and further awards will be made in October. Bids for the second tranche will be invited early in the New Year.

Patient's Charter

3.9 A new national Patient's Charter, balancing the rights and responsibilities of patients and setting a framework for continuing local development of standards, will be issued for consultation during the Autumn. Continuing effort is required to ensure that local Charters are targeted on the quality of care, that they deal with the issues which concern patients most, and that standards rise steadily. In this respect, Boards and Trusts will be expected to maintain their efforts to eliminate **mixed sex accommodation** on which further guidance will be issued shortly.

Patient Information

3.10 More information about health and illness is accessible to patients and the public than ever before. This will have profound effects on people's expectations of health services and on relationships between patients and health professionals. To assist in responding to this situation, the Scottish Association of Health Councils and Scottish Health Feedback published in March 1998 a report, funded by the Scottish Office, entitled 'Putting People in the Picture'. Boards and Trusts are encouraged to make use of this report; consideration is currently being given to further ways in which the Management Executive can assist in taking forward the commitment in the White Paper to improving patient information.

3.11 In parallel, work is underway to extend the NHS Helpline to provide more information on health and social work services nationally and locally. The intention is to introduce the new service during 1999.

Responsiveness to the Public

3.12 Services need to be responsive not just to the needs of individual patients but also to the preferences of the general public. Steps have been taken to develop the role of local health councils working in partnership with Health Boards and NHS Trusts to improve services. With their Health Council, Boards and Trusts are encouraged to find new ways of ensuring public involvement in their planning of services. The creation of Primary Care Trusts presents exciting new opportunities in this field. To assist them in grasping these opportunities, a project is being developed in consultation with the Scottish Consumer Council and the Scottish Association of Health Councils. The Scottish Office is also funding a 3-year project, led by Volunteer Development Scotland, to develop the role of volunteers in all parts of the NHS.

SECTION 4

STRATEGIC AIMS

In retaining the strategic aims and clinical priorities, the Government recognises that Health Boards and Trusts in different parts of Scotland have achieved more change in some sectors than others. Accordingly, careful consideration needs to be given to the local priority for investment and change in the light of progress to date. In all cases, however, Boards and Trusts must be able to demonstrate the impact of their investment decisions, show how they connect to and contribute to the achievement of specific goals, and that the returns are commensurate with the scale of investment.

IMPROVING HEALTH

4.1 Consultation on the Government's Green Paper "Working Together for a Healthier Scotland" concluded earlier this year and will be followed by a White Paper which will set out the agenda for improving Scotland's Health. White Papers on Tobacco Control and Alcohol will also be published shortly. Boards should set out in their HIPs the actions they intend to take to measure lifestyle changes in the short term, and health gain in the medium to longer term. Some practical examples of the use of intermediate indicators to evaluate health gain were issued in May 1997.

4.2 Within this overall framework the Government believes that the health of children and young people should be an important focus for the NHSiS in conjunction with other agencies. In developing their response to the challenges posed by the health of children, the NHSiS should take account of the UN Convention on the Rights of the Child, in particular Article 24 about children's health and rights of access to health care services, and the Acute Services Review's conclusions on child health services.

4.3 There is a widespread recognition that the health of children from the earliest age offers the prospect of improvements in health throughout life. The health services have achieved much in improving the health of mothers and young children but the effects of deprivation, domestic violence and pressures to adopt lifestyles which may harm health persist throughout childhood into parenthood, and present a continuing challenge. Joint work between the NHSiS and others is important to the delivery of a co-ordinated programme of action which should address:

- maternal care, including preconception and antenatal care, and including lifestyle, nutrition and substance abuse;

- children's nutrition, and in particular improving the uptake of breast feeding (Target - by 2005, 50% of mothers still breastfeeding at 6 weeks) and children's dental health (Targets - 60% of 5 year old school entrants to have no cavities, fillings or extractions and children aged 12 to have no more than 1.5 teeth decayed, missing or filled);

- the reduction of accidents to children which are the principal cause of death and injury;
- a comprehensive screening, surveillance and immunisation programme for maternal and child health in line with national guidance and targets;
- the level of teenage pregnancy;
- the health care needs of young people who are homeless or suffer social exclusion in other ways - for instance through substance misuse; and
- risk factors which can be shown to predict later behavioural disorder and educational failure

4.4 Substance misuse poses a significant threat to the health of younger people, though its effects are by no means limited to them. Guidance on the planning and provision of drug misuse services was issued in November 1997 (MEL (97)77) and remains in force. The guidance sets out a range of national strategic objectives and key performance and activity indicators. Health Boards are expected to work towards achieving these objectives with their partners on Drug Action Teams and other agencies. Further advice on requirements and on monitoring arrangements will be issued shortly, and will concentrate on the areas of shared care highlighted in these objectives and indicators.

Breast and Cervical Screening

4.5 Screening programmes are important to the maintenance of good health. Their success depends on the effective operation of call and recall arrangements and follow-up investigation. There are 2 national population based screening programmes: the breast screening programme which aims to contribute to a 25% reduction in mortality from breast cancer by 2000; and the cervical screening programme which aims to reduce the incidence of invasive cervical cancer by 25% by 2000. Both programmes are now well established in Scotland and the Government is committed to the continuing provision of high quality and effective screening for all eligible women in Scotland. The quality and effectiveness of these programmes must be reviewed regularly in line with national guidance.

TACKLING INEQUALITIES

4.6 The Government recognises that securing improvement in the health of Scots cannot be achieved solely by changing lifestyles. The Green Paper contains proposals to tackle a range of issues which impact on health and in particular on health inequalities. Health Boards and NHS Trusts need to demonstrate that where inequalities exist whether by economic status, gender, disability, ethnicity or access to services, there is a clear and sustainable programme of action to tackle them. Similarly, Boards need to consider inequalities in the incidence and prevalence of certain diseases and in the effectiveness of treatments.

4.11 Primary Care Trusts will wish to be clear about the impact of investment decisions on the numbers and complexity of patients being managed within primary care and the utilisation of resources in other parts of the local health care system. PCTs will also wish to ensure that full advantage is taken of the opportunities presented by unified budgets by promoting cost effective prescribing. Support should be given to GPs to improve clinical practice through the provision of comparative information, access to pharmaceutical advice, the development of protocols between primary and secondary care and arrangements for reviewing repeat prescribing.

DEVELOPING COMMUNITY CARE

4.12 Within the health service the creation of Primary Care Trusts is intended to foster the development of integrated primary and community health care services, including those for the elderly, the mentally ill and people with a learning disability. Achieving this integration is vital to securing the seamless services which people need, and the new PCTs must put this objective at the centre of their development plans.

4.13 The NHSiS cannot deliver the Government's plans alone. Effective joint working with local authorities and others is needed. Experience with the Framework for Mental Health Services in Scotland has demonstrated the benefits which can flow from integrated planning and service delivery. Guidance will be issued shortly which will set out the Government's view of ways in which services can be planned to deliver better outcomes for people with community care needs. The NHSiS must play a full and constructive part together with local authorities in implementing the guidance.

4.14 Services for people with a learning disability need to be developed jointly by the NHSiS, social work departments and housing authorities, users and carers and other agencies in the statutory, voluntary and private sectors. Some progress has been made in the renewal of these services, but much remains to be done. Guidance on the development of services for those with a learning disability will be published in 1999 to assist with their modernisation. In the short term, all NHSiS bodies should ensure that they maintain and improve the care environment for those whose home is an NHS hospital. Where plans have been agreed to establish new services to replace hospital care, momentum should be maintained. Nationally, priority within the NHS will be given to completion of the Royal Scottish National Hospital resettlement programme.

4.15 Health Boards working with local authorities and the independent sector should continue to ensure appropriate services are provided for elderly people. The forthcoming guidance on community care will set the context for improving joint working to optimise those services; and the report of the Royal Commission on funding of long-stay care for the elderly, expected to be published early in 1999, will have implications for the way in which services develop.

4.16 The effective and equitable operation of the resource transfer arrangements remains an important mechanism to achieve change and better service integration. Guidance on the resource transfer arrangements, restating the principles of the current scheme, and clarifying how it should operate, will be published before the end of 1998. Where new services are being established to replace NHS long-stay facilities, there will continue to be a need for

4.7 The NHSiS should work in partnership with other organisations to ensure that the underlying causes and social effects of ill health are addressed. A number of Government initiatives will help the NHSiS to tackle inequalities in their area:

- Healthy Living Centres: these are a new development with funding available from 1999-2000. Bids will be invited by the New Opportunities Fund for pilot projects to encourage good health especially in disadvantaged communities and those with the worst health records;

- New Deal and Social Inclusion initiatives: measures to foster social inclusion, secure training and employment, improve child care, strengthen local communities, and make them safer places offer real opportunities for health gain. Boards and NHS Trusts should offer support where initiatives fit their health improvement aims. Social inclusion partnerships, New Community Schools and steps to improve children's well being and achievement offer particular scope.

DEVELOPING PRIMARY CARE

4.8 The development of primary care is central to the Government's objective of a patient centred health service. The creation of Primary Care Trusts provides a unique opportunity to focus on the provision of high quality, integrated primary care services tailored to the needs of local communities.

4.9 Key to the success of the new arrangements will be the close involvement of primary care clinicians in the formulation of the TIP and the fostering of a culture and ways of working which allow decisions about the management and delivery of care to be devolved as far as possible to the primary care professionals responsible for providing it.

4.10 In this environment priorities for the PCTs will be:

- establishing effective, self-managed primary health care teams based on general practice

- extending the range of services available in primary care settings

- supporting the development of Local Health Care Co-operatives as clinically led networks focused on improving services, quality and standards

- developing appropriate infrastructure by exploiting IT to improve the management of patients and by investing in modern, well equipped health centres to extend the range of services available in primary care settings; and in so doing to optimise the use of FHS and community resources.

robust arrangements to be in place to meet the costs of the transition. Bridging finance from a national pool issued for specific projects will be limited to a small number of schemes in future. Guidance on the new arrangements will be issued shortly. Meanwhile, Health Boards and NHS Trusts must ensure that, where they continue to provide long-stay accommodation, that it is maintained at a suitable standard to provide a reasonable living environment for the patients there.

RESHAPING HOSPITAL SERVICES

4.17 The report of the Acute Services Review recommended new initiatives to drive up standards, cut waiting lists and streamline services across the whole NHS. The task of putting into place the recommendations presents a unique opportunity to plan services which will take the NHSiS well into the next century.

4.18 Health Boards and NHS Trusts must take account of the Review in their Health Improvement Programmes and Trust Implementation Plans and start work now to refine the way services are delivered for the greater convenience, comfort and safety of patients. In this context, Trusts should be aware of the need to have in place a programme to control hospital acquired infection. The ME plans to issue guidance on this in due course.

4.19 An Acute Services Group has been established to develop more specific guidance on the implementation of the Review's recommendations. The Group's initial programme is to provide further details on:

- the establishment of managed clinical networks; and
- ambulatory care centres.

4.20 Separately, further work is being undertaken on the implementation of the proposed Resource Centre for Remote and Rural Areas, on quality assurance and on pathology services.

4.21 The Review highlighted the need for stronger planning at a regional level if the concept of managed clinical networks is to work effectively across existing Health Board boundaries. Whilst this is not solely an issue for acute services, Health Boards are required to review with the Management Executive the arrangements which are to be put in place to strengthen planning links among them.

4.22 Health Boards and NHS Trusts also need to bear in mind existing commitments to improve the delivery of services. Guidance on the management of emergency admissions (MEL 1996(94)) remains in force and plans developed locally in accordance with that guidance should be reviewed annually. Progress needs to be maintained in working towards the day case targets set out in the Accounts Commission's Report "Better by the Day - Day Case Surgery" and adopted by the NHS in last year's planning guidance. Specific targets for each Health Board area must be agreed as part of the Corporate Contract.

Waiting Lists and Waiting Times

4.23 Increasing the amount of surgery undertaken on a day care basis can contribute to the reduction of waiting times for patients. Achieving reductions in waiting lists and times must be achieved; they are the biggest concern of patients and long waiting times are incompatible with a service committed to providing accessible, patient-centred services.

4.24 In 1998/9, additional resources of £44.5 million have been made available specifically to tackle waiting lists, and a Support Force established to assist the Service in securing sustained reductions. The inpatient/day case waiting list must be reduced to below 84,650 by 31 March 1999 and below 75,000 by 31 March 2002.

4.25 As Health Boards and NHS Trusts implement their plans to achieve long-term reductions in waiting lists and waiting times, they should ensure that they make effective progress towards the year 2002 target. Annual plans to achieve progress to this target must be set out in HIPs and TIPs and formally agreed with the ME. In drawing them up, Health Boards and Trusts should ensure that they take full account of the implications for other agencies such as the Scottish Ambulance Service and the Scottish National Blood Transfusion Service, and consult them as appropriate. These plans must ensure that local waiting times guarantees and the 12 months "long-stop" guarantee are met at all times. Patients have a right to receive treatment within the guaranteed times which Health Boards have set. Moreover, minimal waiting times are good clinical practice. Health Boards and NHS Trusts should also ensure compliance with outpatient waiting time guarantees and monitor the overall waiting times which patients experience from GP consultation to hospital discharge. Resources have been provided to drive down waiting lists and waiting times and the Service must ensure that reductions are delivered.

SECTION 5

CLINICAL PRIORITIES

Cancer

5.1 Guidance on the reconfiguration of cancer services was issued in MEL (1996)54 and remains in force. Progress to date has been encouraging, but implementation of the required changes is incomplete. In the coming year Health Boards and NHS Trusts must ensure that all hospitals wishing to treat cancer patients have in place agreed local written guidelines drawn up in collaboration with relevant specialists in other institutions. All clinicians involved in the treatment of patients with cancer should participate in collaborative programmes of open, multi-disciplinary prospective audit concentrating initially on breast, lung, colorectal and ovarian cancers. The Cancer Quality Assurance/Audit Steering Group of the Scottish Cancer Group will provide the strategic focus for this work. All Health Boards should assess their pharmaceutical services against the guidance in NHS MEL (1997) 66 and draw up appropriate action plans to address deficiencies.

5.2 At national level the Scottish Cancer Group has been set up to take forward the further development of cancer services taking account of the recommendations of the Acute Services Review in respect of managed clinical networks and quality assurance and accreditation. The Group's key tasks will be to work with Boards and Trusts to help implement their local cancer strategies in line with national standards; to monitor and evaluate the clinical effectiveness programme in cancer in order to change clinical practice and the delivery of care generally and also particularly from the patient's perspective; and to provide advice on nationally agreed initiatives for the delivery of cancer services, including programmes of prevention and screening.

5.3 Cancer genetics services will be a particular focus for action in 1999/2000. Detailed guidance for the development of services on a co-ordinated basis with earmarked funding will be issued during October.

CHD/Stroke

5.4 Encouraging progress has been made in reducing mortality from coronary heart disease but it remains a major cause of death and disability. A substantial amount of planning has been undertaken to develop CHD/stroke strategies for local areas covering the complete spectrum of interventions and much promising work has been done to target health promotion activities on the most vulnerable groups. This progress must be maintained. Health Boards should keep their strategic plans for CHD/stroke under review, bearing in mind the findings of the Acute Services Review and the SNAP Report on Coronary Heart Disease. They should review access to services and address inequalities associated with age, sex, place of residence, social background and ethnicity. Steps should be taken to ensure that relevant SIGN guidelines are implemented and audited. Work should continue with GPs and other primary care practitioners to develop the range of services provided in primary care settings.

5.5 Diabetes is frequently associated with cardio-vascular complications, including CHD and Stroke. Boards and Trusts should review their services for diabetes to ensure that the NHS can fulfil all the requirements of the St Vincent's Declaration. Examination of diabetic services in the context of the Joint Investment Fund may be helpful in this regard.

5.6 Following the report of the Acute Services Review, a CHD Task Force has been set up with the overall remit of developing a managed clinical network of cardiac services. In view of the finding of the Review that the mortality of patients on cardiac waiting lists currently exceeds operative mortality rates, the Task Force has been asked to give priority to investigating and quantifying the scope for increased intervention rates for coronary revascularisation. Further guidance, based on these findings will issue during 1999, but for the time being Boards should plan to move towards a rate of coronary artery bypass grafting (CABG) of 600 per million population by 31 March 2001; this figure has been suggested by the British Cardiac Society. Health Boards' proposals in relation to the reduction of waiting times have already allowed a start to be made in this area.

5.7 Once it has dealt with this first priority the Task Force will look at wider aspects of CHD and stroke management, including evaluating the concept of intermediate care as a way of working across primary and secondary care boundaries in terms of developing managed clinical networks.

Mental Health

5.8 Guidance issued on mental health and set out in MEL (1997)62 requires Health Boards and their planning partners to prepare joint mental health strategies. These joint mental health strategies must use the Framework for Mental Health Services in Scotland as a template. The resulting configuration of mental health services, the NHS component of which will be managed by the new Primary Care Trusts provide new opportunities to make a difference to the experience of the service user. The changes required need enlightened leadership, good team working and a consistent focus on quality development. In commissioning services, Health Boards are expected to ensure that the processes of service change receive proper attention A significant amount of planning work has been done and 1999/2000 should see substantial progress being made in implementation and service re-profiling. A multi-agency approach to the planning and provision of services is essential. It is equally important to secure the close involvement of those using the service and those who care for them.

5.9 Consistent with the Government's aim of addressing services for children and young people, Health Boards should give consideration to early detection and intervention in respect of

- Postnatal depression
- Domestic violence
- Smoking during pregnancy
- Substance and alcohol abuse in women.

5.10 The Mental Health Reference Group (MHRG), has been set up to ensure mental health services in Scotland are developed from a firm base of knowledge and experience. The

Group comprises representatives of patient, carer and voluntary organisations, local authorities, clinical professions working in mental health services and the Management Executive.

5.11 The MHRG will support the implementation of the Framework nationally by developing good practice statements and guidelines, by ensuring as far as possible that development and practice are evidence-based; and locally, by working with Health Boards, NHS Trusts and others to ensure the guiding principles of the Framework are delivered.

Mentally Disordered Offenders

5.12 Consultation on the development of services for mentally disordered offenders ended in July 1998. A statement of Government policy will issue once Ministers have considered the responses to consultation. The aim is to strengthen and expand the joint agency approach to care and services for this group of patients. In the meantime the NHSiS should continue with its plans for local in-patient forensic units, separate from general psychiatry intensive care units. Boards and Trusts must work together to ensure the timely repatriation of patients who no longer need high security services at the State Hospital, Carstairs.

ENSURING SERVICE CONTINUITY BEYOND THE YEAR 2000

1. It is important to bear in mind that the change to the new millennium is not solely - or even primarily - an Information Management and Technology issue. The date change and the potential for disruption to systems clearly have to be addressed in the IM&T context and the issues covered in IM&T strategies(see Annex D). But the wider challenges to service delivery and the need to ensure the continuity and safety of services during and after the millennium date change also need to be addressed.

2. Health Boards and their partners should therefore set out clearly in their HIPs a plan identifying anticipated pressures and measures which will be taken to deal with them. The plan should reflect comprehensive local assessment of additional or changed demand for healthcare services consequent upon:

- millennium celebrations;
- extended millennium public holidays;
- millennium date change induced failure or reduced reliability of equipment or any utility or other service essential to the continuity, safe operation or public access to the clinical and supporting services of the NHS;
- possible failure of equipment or of any service essential to the care of patients at home, nursing home or otherwise in the community;
- public health implications of possible failure of equipment or service necessary to the safe supply, storage or processing of food or water; and
- possible interruption of communications or transport links upon which reinforcement and support of local NHS services normally depend.

Systems and Equipment

3. Testing of systems and equipment for year 2000 compliance will continue to be a major issue in the lead up to the millennium date change. Not all systems can be tested and for some that can, the balance of risk may require no testing and a focus on contingency. Trusts should consider carefully the back up arrangements for testing operational and critical systems and also consider having service cover provided by another Trust during the testing. These cross cover arrangements will also need to be agreed by the appropriate Health Boards. Consideration will also need to be given to the funding and organisation of replacement systems where rectification or workaround is not practicable - this will have an impact on capital investment priorities. Health Boards will need to take the lead in area wide (level 3) contingency planning (using the well established emergency planning processes) taking into account potential difficulties within and between Trusts as well as difficulties in other social agencies, infrastructure and suppliers such as utilities. Level 3 contingency plans should be worked up now and be completed **by 31 December 1998.**

HUMAN RESOURCES IN THE NHS IN SCOTLAND

1. Implementing "Towards a New Way of Working"

1.1 The Human Resources Strategy for the NHS in Scotland *"Towards a New Way of Working"* indicated that the principles of effective human resource management would be taken forward locally as a core element of the HIPs/TIPs process through the production of local human resource strategies by Health Boards and Trusts.

1.2 *"Towards a New Way of Working"* sets a number of specific objectives and target dates which should be reflected in local HR strategies:

- review all temporary contracts by October 1998;
- implement action plans to fully meet the requirements of the New Deal for Junior Doctors by April 1999;
- establish clear Equal Opportunities policies which support flexible working, job share and other family-friendly practices by May 1999;
- develop and implement measures to improve the personal safety and security of staff by July 1999;
- define Partnership Agreements by October 1999;
- secure a reduction to 3% in sickness absence and eliminate accidents causing personal injury by March 2000; and
- develop action plans to attain the "Positive about Disability" by April 2000.

1.3 An Education and Training Strategy for the NHS in Scotland is currently being developed. This will support:

- broader access to education, training and development across the NHS;
- the use of occupational standards and SVQs to strengthen career progression opportunities;
- a more coherent approach to Continuing Professional Education and Development;
- the Government's Welfare to Work Programme;
- more effective use of information technology and open learning.

1.4 In formulating HIPs and TIPs, Health Boards and Trusts should include specific Education and Training Plans which give particular attention to:

- developing a framework to support Continuing Medical Education and Continuing Professional Development for all clinical staff;
- the application of occupational standards and Scottish Vocational Qualifications, in partnership with the Scottish Qualifications Authority;
- developing and supporting programmes such as Unison's 'Return to Learn'; broadening access to learning;
- the education and training implications of service development plans;
- developing 'people managing' skills; and
- generally widening access to learning for all staff.

1.5 Health Boards and Trusts will shortly receive guidance on the development of a comprehensive and inclusive Occupational Health Service for all staff, including general medical and dental practitioners and their staff. As a minimum this is likely to require Health Boards and Trusts to provide:

- pre-employment checks for all prospective employees;
- screening programmes;
- health surveillance and assessment;
- immunisation programmes;
- health promotion programmes; and
- a confidential counselling service.

1.6 Plans to develop a comprehensive and inclusive Occupational Health Service in line with this guidance should be included in local HR strategies.

2. Better People Management

Integrated Workforce Planning

2.1 *"Towards a New Way of Working"* made a commitment to improve and integrate workforce planning for the NHS in Scotland. Our aim is to ensure an adequate and affordable supply of appropriately trained staff to meet the evolving needs of a modern health service and to ensure that the NHS workforce is sufficiently flexible to respond to change and new developments in service delivery. In order to achieve this aim, central and local workforce planning processes must be better synchronised and streamlined. An improvement in the quality and flow of information is also essential. Further guidance will be issued to all Health Boards and Trusts on the information requirements to support better planning. Health Boards and Trusts are expected to ensure that the workforce implications of HIPs and TIPs are assessed and presented in their local workforce plans.

Locum Doctors

2.2 The recent Accounts Commission's report *"Doing the Rounds"* noted that the use of locum doctors in Scotland's hospitals is increasing and made a number of recommendations to improve the management of locums. Health Boards and Trusts will receive further guidance on the use of locums shortly and will be expected to develop strategies and practices to improve the effectiveness of locum use. Similar issues apply to the management and use of bank and agency nurses.

New Deal: Welfare to Work:

2.3 Reducing unemployment and tackling social exclusion are key priorities for Government under its *New Deal: Welfare to Work* programme. As a significant public sector employer, the NHS in Scotland has an important part to play in supporting the New Deal. Opportunities exist for Health Boards and Trusts to work with the Employment Service to give unemployed people the chance of a career in the

NHS. Guidance has recently been issued to NHS employers on the New Deal and participation in this initiative is strongly encouraged.

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 STRATEGY

1. In broad terms, the main emphasis on the use of Information and Management Technology and in strategies for developing its use further will be on systems supporting clinical care. However, accurate management information is also needed to help make sure services are delivered efficiently and performance targets are set.

2. "Designed to Care" set out some of the possibilities offered by information technology in terms of improved reliability and co-ordination of care. It also stated the intention to accelerate the process of using new technology to enhance ways of ensuring the safe flow of information about patients between GPs, hospitals and other health professionals. Amongst specific initiatives, targets were set for:

- Linking GPs to the secure telecommunications network, NHSnet (the programme to do so has now been completed).
- Linking all other NHS organisations to NHSnet (this programme is now under way).
- Ensuring, through the electronic links between GPs and hospitals, that patients know the date of any hospital outpatient appointment before they leave their GP's surgery (to be achieved by 2002).
- Using the Community Health Index (CHI) number in all NHS computer based systems in order to identify patients and relevant information about them wherever they are treated. (all systems to be using the CHI number by the end of 1999).

3. The Acute Services Review gave further emphasis to the role of Information Technology by:

- Identifying it as the real key to efficient and seamless services.
- Supporting the use of the CHI number in systems as a unique patient identifier.
- Attaching critical importance to the development of coherent information and communications systems for the NHS in Scotland.

Action Required

4. The NHSiS National IM&T Programme Board will focus its efforts on implementing a strategy which will deliver the actions and targets set out in "Designed to Care". In developing local IM&T strategies, Health Boards, working closely with NHS Trusts and others who provide healthcare, should also put the White Paper objectives at the forefront of their plans. Co-ordination must extend to the planning and management of telecommunications (voice and data) facilities.

5. Local IM&T strategies should be reflected in HIPs and firm intentions for implementing the strategies should be included annually in Trust Implementation Plans.

*PLANNING TIMETABLE TO 31 MARCH 1999

	Management Executive	Health Boards	Units/Trusts
September	Issue Priorities and Planning Guidance Review capital plans	Begin discussions with new Trusts on HIP in light of existing plans and likely resources	Begin discussions with HB on HIP
October	Mid-year performance reviews with HBs Issue guidance on finance strategies Notify revenue allocations Issue policy statement on estate management	Mid-year progress report on Corporate Contract Continue preparation of HIP with all planning partners	Submit capital charge estimates Continue discussion with HBs, clinical staff, and GPs on development of HIP Consider with GPs, and primary care practitioners proposals for the establishment of LHCCs
November	Allocate capital Issue strategic guidance on IM&T Mid-year performance reviews with HBs. Issue consultation papers on SHTAC and NSG Issue guidance on statutory introduction of clinical governance	Continue preparation of HIP Agree outline proposals for LHCCs with Trusts	Continue preparation of HIP and prepare draft TIP Agree outline proposals for LHCCs with HB
December	Issue MEL on Accountability Reviews and Corporate Contracts	Submit draft HIP to ME Agree indicative budgets for Trusts	Continue preparation of TIP and development of LHCCs
January	Set dates for Accountability Reviews	Submit draft Corporate Contract	
February	In-year reviews with Health Boards Discuss Corporate Contracts	In-year reviews with ME	
March		Submit final HIP and Corporate Contract Agree TIP and Trust Budget	Agree TIP and Trust budget

*Timetables for subsequent years will be issued as appropriate.

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