THE SCOTTISH OFFICE
Department of Health

NHS
MEL(1999)15

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

15th February 1999

Dear Colleague

1999/2000 CORPORATE CONTRACT

Summary

1. This guidance provides advice on the 1999/2000 Corporate Contract.

Action

2. Health Boards should submit draft Corporate Contracts for 1999/2000 to the Management Executive, in the requested format, by 1 March 1999.

Yours sincerely

Geoff Scaife

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Chief Executive
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1999-2000 CORPORATE CONTRACTS

1. This guidance provides specific advice on the format for 1999/2000 Corporate Contracts. It sets these in the context of the White Paper 'Designed to Care: Renewing the NHS in Scotland'.

2. The guidance asks for a consistent approach across the NHS in Scotland, focusing attention on fundamental tasks and using performance measurement as a management tool. Health Boards, the State Hospital, the Common Services Agency (CSA) and the Scottish Ambulance Service are expected to adhere to these requests in their responses to this guidance.

3. Corporate Contracts will need to reflect the Year 1 of HIPs and TIPs which have been agreed by Boards and Trusts. Corporate Contracts are primarily the accountability mechanism by which the Government can ensure that public money is invested wisely in the NHSiS, and they should be the subject of local discussion between Boards and Trusts before submission to the ME. It is also important to ensure consistency between objectives included in Corporate Contracts and Trust Implementation Plans (TIPs). Therefore there should be consistency between the objectives and impacts included in Corporate Contracts and the similar elements in the relevant TIPs.

National Strategic Framework

4. NHS MEL(1998)63 – Priorities and Planning Guidance for the NHS in Scotland 1999-2002 - is set in the context of the Comprehensive Spending Review which has resulted in additional funding of £1.8 billion for the NHS in Scotland over the next 3 years. All Health Boards, the State Hospital, the CSA, the Scottish Ambulance Service and NHS Trusts are expected to take full account of the Priorities and Planning Guidance in preparing Corporate Contracts, Health Improvement Programmes (HIPs), Trust Implementation Plans (TIPs) and other strategic documents.

5. The MEL has re-affirmed the 3 national clinical priorities and the 5 established strategic aims for the NHS in Scotland. An important focus of the improving health and tackling inequalities strategic aims should be the health of children and young people, and due attention should also be given to services for children.

6. Corporate Contracts are the main tool for the accountability of Health Boards, the State Hospital, the CSA and the Scottish Ambulance Service to the NHS Management Executive. They should set out the key objectives against which Health Boards and the Trusts in their areas intend their achievements to be assessed. Specific output and outcome measures, which show progress against the objectives, must be included for each objective rather than a reliance on "management process measures" which neither show how services are being improved nor whether objectives are being achieved. We hope to see further progress in this area in 1999/2000 Corporate Contracts.

7. The standardised format of Corporate Contracts has worked well and in keeping with that approach we are proposing some core indicators for monitoring progress. These core indicators could as easily be used to monitor progress in accordance with HIPs. Annex A sets out a set of suggested indicators that can be used to monitor whether progress is being made in delivering improvements in services. The list should be seen as a menu from which to develop suitable indicators. Health Boards, the State Hospital, the CSA and the Scottish Ambulance Service are not expected to use all these indicators for this year's Corporate Contract, but should treat them as an agenda for developing indicators. Our intention is to agree with Boards a set of indicators which

can be used to monitor progress both in-year and at the Accountability Reviews. As far as possible Health Boards, the State Hospital, the CSA and the Scottish Ambulance Service should try to set explicit targets for the relevant indicators. The intention is that individual Health Boards fine-tune the measures to suit their own particular set of circumstances. Some data may not be available and it will be for discussion with Boards whether additional data should be collected. Where Health Boards, the State Hospital, the CSA and the Scottish Ambulance Service have identified other measurable outcomes these should be included. This approach should facilitate discussion on progress against objectives and the signing off of Corporate Contracts. **For 1999/2000 Corporate Contracts Health Boards are asked to continue to use the format used in 1998/99 as set out in Annex B.**

8. Objectives contained in the Corporate Contract should:

- concentrate on the key issues in each area;
- be specific, quantified and timed, with specific, quantified and timed milestones which will demonstrate their achievement;
- focus on outcomes and impacts on health.

The Priorities and Planning Guidance requires the NHS in Scotland to place quality at the centre of everything it does, and, subject to the passage in Parliament of the Health Bill, this will be backed by a statutory duty. Rather than having a separate section on quality, quality initiatives should be included in each part of the Contract, including measurable targets and indicators. As for last year, all Corporate Contracts should be short and concise, totalling no more than 20 sides each.

9. The Performance Template plan should be included as part of the Corporate Contract for 1999/2000. This template shows Health Boards' planned levels of expenditure and activity for the main programmes of care and should therefore be closely related to the aims and objectives in the Corporate Contract. Because of this close relationship, it makes sense to treat the performance template plan as an integral part of the Corporate Contract.

10. Health Boards, the State Hospital, the CSA and the Scottish Ambulance Service may wish to produce fuller documents for their own purposes, for example a more detailed list of subsidiary objectives for use as a work plan to support the achievement of Corporate Contract objectives. These, however, are not required for Corporate Contracts. Corporate Contracts should contain the following 11 core sections[1], in addition to sections reflecting other local priorities:

Core section:	**Including:**
Improving health	The health of children and young people.
Tackling inequalities	
Developing primary care	The 'patient-centred' NHS.
Promoting care in the community	Joint working with local authorities and other organisations.
Reshaping hospital services	The establishment of Managed Clinical Networks; continuing improvements in the achievement in day case targets; maintaining pressure on reducing waiting times and meeting guarantees, and having robust plans in place to manage peaks in admissions.
Cancer	The continuing reconfiguration of cancer services with a focus on the establishment of Managed Clinical Networks; progress towards target 2000.
CHD/Stroke	An accurate reflection of the Health Board's comprehensive CHD/Stroke strategy; progress towards target 2000.
Mental Health	An accurate reflection of the implementation of the mental health strategies developed by Health Boards in 1998/99 using the framework as a template and including the needs of children, young people, and women as described in the PPG.
Development of 'seamless care'	The integration of services between primary, secondary and tertiary care providers, with integrated care pathways and the use of the Joint Investment Fund between Trusts.
Year 2000 issues	Identification of anticipated pressures and measures that will be taken to address these.
Performance Template Plan	Planned expenditure and activity levels by care programme.

[1] These core sections underpin the Management Executive's expectations of Health Boards. The State Hospital, the CSA and the Scottish Ambulance Service are nonetheless invited to consider the applicability of these sections to their respective responsibilities and functions. It is however recognised that not all will apply to these bodies.

11. In addition, Boards, the State Hospital, the CSA and the Scottish Ambulance Service are expected to monitor and manage their expenditure rigorously to deliver fully their HIPs. Trusts' 3 financial duties remain, and all Trusts are expected to fulfil them. Allocations for 1999/2000 were issued on 6 November 1998. Boards will continue to be responsible for agreeing Trust Implementation Plans and monitoring the implementation of HIPs throughout the year.

12. Draft Corporate Contracts should be submitted to the Management Executive by **1 March 1999.** This will allow for one month in which to agree any suggested amendments of the drafts before the Accountability Reviews. The aim will be to complete any negotiations about the content of the Corporate Contracts prior to the Review meetings.

13. The Management Executive would be grateful if these could be sent in electronic format, either on disk or by e-mail. (This also applies to HIPs and TIPs.) The Performance Managers and their e-mail addresses are as follows:

Performance Manager	**Email Address**
Catherine Brown (North Boards)	catherine.brown@scotland.gov.uk
Nikki Brown (West Boards)	nikki.brown@scotland.gov.uk
Norman Harvey (East Boards)	norman.harvey@scotland.gov.uk
Ian Williamson (State Hospital, CSA, Scottish Ambulance Service)	ian.williamson@scotland.gov.uk

14. As in previous years, the Chief Executive intends to sign off Corporate Contracts for 1999/2000 at the conclusion of the Accountability Review meetings, subject to satisfactory resolution of any outstanding issues.

15. Details of dates, agenda and attendance at Accountability Reviews will be issued shortly.

ANNEX A

CORE INDICATORS FOR MONITORING PROGRESS WITH HIPS AND CORPORATE CONTRACTS

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
IMPROVING HEALTH		
1. Protect population from communicable diseases. For example: (a) foodborne disease (b) tuberculosis (c) meningitis (d) childhood diseases (diphtheria, tetanus whooping cough, polio, Hib, and MMR)	(i) Incidence (number of cases per 1,000 population) (ii) Change in incidence over previous year. (iii) % of children under 2 immunised against 95% target. Change over previous year.	These measures may indicate whether a Board has a relatively high incidence and whether progress is being made in reducing incidence.
2. Prevent sexually transmitted diseases (STD)	(i) Number of cases per 1,000 population (ii) Change in incidence over previous year	These measures would indicate whether Board has a relatively high incidence of STD and whether the incidence is rising or falling
3. HIV/AIDS	(i) Trends in the number of new cases	The trend in the number of new cases needs to be interpreted with care since the number of new cases recorded each year are quite small.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
IMPROVING HEALTH (contd)		
4. Risk factors: (a) smoking behaviour (b) alcohol consumption (c) physical exercise (d) diet	(i) % of adults or children smoking (ii) % consuming alcohol in excess of recommended levels (iii) % undertaking moderate exercise weekly (iv) performance against targets in Scottish Diet Action Plan.	Statistics on these lifestyle factors are collected through the Scottish Health Survey, though this is only carried out every 3 years. Health Boards may carry out own surveys and may therefore be able to provide additional and more up-to-date figures.
5. Health promotion	(i) Expenditure per head of population on health promotion compared with Scottish average, and changes in expenditure per head	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
TACKLING INEQUALITIES		
During 1998-99 Health Boards have generally focused on collecting information about inequalities and developing strategies. In 1999-2000 the focus should shift towards implementing strategies for reducing health inequalities and irregularities in service provision.	Possible areas for monitoring progress in reducing inequalities might include: (a) uptake of breast and cervical screening programmes; (b) uptake of childhood immunisation programmes; (c) risk factors (e.g. smoking); (d) access to services (cardiac surgery or cancer treatment); (e) incidence, survival rates and mortality rates from cancer; (f) mortality rates from coronary heart disease; (g) several aspects of child health including: maternal smoking rates, low birthweight babies, breastfeeding rates, dental health. These areas are intended simply as examples. In service provision one measure is expenditure on community based services per head of population in deprived areas compared with more affluent areas.	Progress in reducing health inequalities might be monitored by using the Carstairs deprivation measure to compare the most affluent and the most deprived population groups - for example the difference between the most affluent and most deprived 20% of the Health Board's population.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
DEVELOP PRIMARY CARE (ALL SERVICES)		
Community nursing services (District nursing, health visitors and PAMs.)	(i) Planned change in community activity compared with last year's outturn (ii) % variance between forecast outturn and plan (iii) Expenditure per head of population on other community services (iv) Contacts per 1,000 population compared with Scottish average	These measures indicate the level of provision of other community services, the planned changes, and the extent to which plans are being achieved.
Improving monitoring of non-cash limited expenditure	Variance between indicative allocations and expenditure on non-cash limited services, including: (i) GMS (non-cash limited) (ii) GDS (iii) GOS (iv) GPS (non-cash limited)	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
DEVELOP PRIMARY CARE (GENERAL MEDICAL SERVICES)		
Developing services	(i) % of practices providing optional services for: - child health surveillance - minor surgery - basic health promotion (ii) % of practices offering chronic disease management for: - asthma - diabetes (iii) Number of practice nurses (WTE) per 100,000 population in Health Board (iv) Number of practices with practice development plans. (v) Number of practices with quality practice or accreditation awards.	Comparison with national averages and recent trends would indicate progress in developing these services.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
DEVELOP PRIMARY CARE (GENERAL PHARMACEUTICAL SERVICES)		
Improve management of drugs bill	(i) **% of prescriptions for generic products** comparison with Scottish average and change over previous year (ii) DDDs per 1000 patients per month for hypnotics and anxiolytics (iii) DDDs per 1000 patients per month for antibiotics	
DEVELOP PRIMARY CARE (GENERAL DENTAL SERVICES)		
	(i) % of children aged 5 free from dental caries compared with Scottish average and national target (level and recent trend) (ii) % of children aged 0-2 registered with dentist (iii) % of all children under 18 registered with a dentist (iv) % of all children under 18 receiving dental services from the CDS (*need to eliminate double counting)	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
DEVELOP PRIMARY CARE (GENERAL DENTAL SERVICES) (contd)		
	(v) % of adults aged 45-54 without own teeth compared with Scottish average and national target of <10% by 2000. (vi) NHS dentists per head of population.	
PROMOTING CARE IN THE COMMUNITY (ALL MENTAL ILLNESS)		
Developing community services	(i) % of total expenditure on mental health budget (including resource transfer) accounted for by inpatient care (ii) Resource transfer per head of population (iii) Planned change in community activity compared with previous year (iv) % variance between forecast outturn and planned change in community activity	These measures apply to all mental health services including services for people under 65 and old age psychiatry.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
PROMOTING CARE IN THE COMMUNITY (ALL MENTAL ILLNESS)		
Developing community services	(v) Planned change in resource transfer compared with previous year (vi) % variance between forecast outturn and planned change in resource transfer	These measures apply to all mental health services including services for people under 65 and old age psychiatry.
PROMOTING CARE IN THE COMMUNITY (MENTAL ILLNESS FOR PEOPLE UNDER 65)		
To provide appropriate care for those living in the community. (a) Care Programme Approach (b) Community Mental Health Teams and Acute Psychiatry	(i) Number of people under 65 per 100,000 population on CPA; (ii) Number of contacts between patients on CPA and CMHT staff. (iii) Expenditure on CMHTs per head of population under 65 (iv) Percentage of CMHTs who have co-terminous boundaries with Social Work teams and LHCCs	Comparisons between each Health Board's figures and Scottish averages as well as Changes within each Board would provide information about the relative level of provision and the extent to which services are developing. (The Accounts Commission/SWSG Report provides a baseline.)

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
PROMOTING CARE IN THE COMMUNITY (MENTAL ILLNESS FOR PEOPLE UNDER 65) (contd)		
	(v) Percentage of re-settled patients (with more than one year in hospital) who have received a multi-disciplinary review during the past year	Comparisons between each Health Board's figures and Scottish averages as well as Changes within each Board would provide information about the relative level of provision and the extent to which services are developing. (The Accounts Commission/SWSG Report provides a baseline.)
In-patient care	(i) Number of occupied bed days per 1,000 population (ii) Planned change in number of occupied bed days compared with previous year (iii) % variance between forecast outturn and plan	These measures would show how the level of inpatient provision per head of population compares with the Scottish average, and how much progress is being made in transferring care into the community.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
PROMOTING CARE IN THE COMMUNITY (OLD AGE PSYCHIATRY)		
To provide appropriate care for those living in the community.		
(a) Care Programme Approach	(i) Number of people over 65 per 100,000 population on CPA;	Comparisons between each Health Board's figures and Scottish averages as well as changes within each Board would provide information about the relative level of provision and the extent to which services are developing. (The Accounts Commission/SWSG Report provides a baseline.)
	(ii) Number of contacts between patients on CPA and CMHT staff.	
(b) Community Mental Health Teams and Old Age Psychiatry	(iii) Expenditure on CMHTs per head of population over 65	
	(iv) Percentage of CMHTs who have co-terminous boundaries with Social Work teams and LHCCs	
	(v) Percentage of re-settled patients (with more than one year in hospital) who have received a multi-disciplinary review during the past year	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
PROMOTING CARE IN THE COMMUNITY (OLD AGE PSYCHIATRY) (contd)		
In-patient care (Old Age)	(i) Number of occupied bed days per 1,000 population (ii) Planned change in number of occupied bed days compared with previous year (iii) % variance between forecast outturn and plan	These measures would show how the level of inpatient provision per head of population compares with the Scottish average, and how much progress is being made in transferring care into the community.
PROMOTING CARE IN THE COMMUNITY (LEARNING DISABILITIES)		
To provide appropriate care for those living in the community. (a) Care Programme Approach (b) Community Learning Disabilities Teams (c) Pattern of expenditure on learning disabilities	(i) Number of people per 100,000 population on CPA; (ii) Number of contacts between patients on CPA and CLDT staff. (iii) Expenditure on CLDTs per head of population (iv) Resource transfer per head of population. (v) % of total expenditure on learning disabilities budget (including resource transfer) accounted for by in-patient care	Comparisons between each Health Board's figures and Scottish averages as well as changes within each Board would provide information about the relative level of provision and the extent to which services are developing.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
PROMOTING CARE IN THE COMMUNITY (LEARNING DISABILITIES) (contd)		
Developing community services	(i) Planned change in community activity compared with previous year (ii) % variance between forecast outturn and plan (iii) Planned change in resource transfer (iv) % variance between forecast outturn and planned level of resource transfer	These measures would show the planned changes in community activity and the extent to which the plans are being achieved.
In-patient care	(i) Occupied bed days per 1,000 population (ii) Planned change in number of occupied bed days compared with previous year (iii) % variance between forecast outturn and plan	These measures would show how the level of inpatient provision per head of population compares with the Scottish average, and how much progress is being made in transferring care into the community.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
RESHAPING HOSPITAL SERVICES		
Waiting lists and times: (a) In-patient and day cases	(i) Number of patients with guarantee waiting longer than 12 months for treatment (ii) Number off patients on true waiting list compared with target (iii) Number of patients on deferred waiting list compared with March 1997 (iv) Total number of patients on true and deferred list per 1,000 population compared with Scottish average	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
RESHAPING HOSPITAL SERVICES (contd)		
(b) Out-patients	(i) % of patients waiting longer than guarantee for each of 6 specialties (and change over previous year) (ii) length of out-patient guarantee periods for 6 specialties (compared with other Boards) (iii) % of patients seen within 9 weeks of referral (comparison with Scottish average and change over previous year)	
(c) A & E Waiting Times	(i) Arrival to completion of treatment: - trolley cases (% seen within 2 hours) - walking wounded (% seen within 2.5 hours) Comparison with Scottish average and Comparison with previous year.	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
RESHAPING HOSPITAL SERVICES (contd)		
Acute Hospital Services	(iv) Forecast outturn change in emergency cases compared with planned change	
	(v) Day cases as a % of all elective cases, comparison with Scottish average and with figures for previous year	Day case rates long with average length of stay and throughput per bed provide useful indicators of the efficiency with which acute services are being delivered.
	(vi) Case mix adjusted average length of stay	
	(vii) Case mix adjusted throughput per bed	
	(viii) Cancellation rate for elective cases	
	(ix) Did not attend rates for outpatient appointments	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
NATIONAL PRIORITIES: MENTAL ILLNESS		
Health Promotion	(i) Expenditure on health promotion for mental illness per head of population	
Post Natal Depression	(i) Percentage of mothers diagnosed with post-natal depression in first year post partum	PPG (1999-2002) refers
Admissions to hospital	(i) Number of admissions to mental illness hospitals per 1,000 population (ii) Number of emergency re-admissions to mental illness hospitals within 28 days of discharge per 1,000 population	These measures give an indication of the stability of discharge arrangements
Number of Detentions	Number of detentions per 100,000 population under: - Section 24/25)Mental Health (Scotland) - Section 26) Act 1984 - Section 18) - CP Act 1996	The Mental Welfare Commission publishes this information in its Annual Reports

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
NATIONAL PRIORITIES: MENTAL ILLNESS (contd)		
Mentally Disordered Offenders	(i) Number of referrals to the State Hospital per 100,000 population (ii) Number of patients admitted to the State Hospital per 100,000 population (iii) Number of patients taken back from the State Hospital per 100,000 population (iv) Number of Forensic Community Psychiatric Nurses per 100,000 Population (v) Number of patient contacts with Forensic Community Psychiatric Nurses per 100,000 population	The Mentally Disordered Offenders Strategy was launched in January 1999.
Child and Adolescent Psychiatry	(i) Number of staff with Mental Health qualification, dedicated to child and adolescent working in primary care environment (ii) Average waiting time for out-patient referral to specialist team (iii) Maximum waiting time for referral to specialist team	The Framework for Mental Health Services in Scotland refers.

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
NATIONAL PRIORITIES: MENTAL ILLNESS (contd)		
Liaison Psychiatry	(i) Number of staff providing dedicated liaison mental; health service to General Hospitals per 100,000 Population	The Framework for Mental Health Services in Scotland refers.
NATIONAL PRIORITIES: CARDIO/CEREBROVASCULAR DISEASE		
Reduce premature deaths Improvements in Services	(i) Age standardised mortality rates among people under 65 from CHD per 10,000 population. (Level and trend compared with Scottish average) (ii) Age standardised mortality rates among people under 65 from cerebro-vascular disease per 100,000 population (Level and trend compared with Scottish average) (iii) Intervention rates per million population for: - angiography - angioplasty - Coronary Artery Bypass Grafts (iv) Average waiting time for CABGs (v) % of patients waiting over one year for CABG	

HEALTH BOARD OBJECTIVE	INDICATOR	COMMENTS
NATIONAL PRIORITIES: CANCER		
Reduce premature deaths	(i) Age standardised mortality rate among people under 65 from cancer per 100,000 population. (Level and trend compared with Scottish average)	
Screening programmes for breast and cervical cancer	(ii) % uptake of screening programmes against national targets (iii) change in uptake rates over previous year	
Improve services	Possible measures of improvement might include: - increases in specialist nursing staff - additional outreach sessions by consultant oncologists - improved access to radiotherapy and chemotherapy - reduced waiting times (e.g. for outpatient referrals or for radiotherapy) - improved palliative care facilities	HIPs and Corporate Contracts have identified a wide range of improvements in services for patients with cancer. As far as possible, Health Boards should identify indicators that can be used to monitor progress in these areas.

Annex B

STRATEGIC AIM OR CLINICAL PRIORITY			
Longer term objective as set out in HIP	**Action**	**Milestones to monitor in-year progress**	**Desired impact on health of population**
1.	**1.** **2.** **3.**	**1.** **2.** **3.**	**1.**
2.	**1.** **2.** **3.**	**1.** **2.** **3.**	**1.**
Etc	**1.** **2.** **3.**	**1.** **2.** **3.**	**1.**